STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING 00 B. WING	07/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: July 24, 25, 26, 27, 28, and 31, 2023. Facility number: 001144 Provider number: 155668 AIM number: 200256980 Census Bed Type: SNF/NF: 115 Residential: 7 Total: 122 Census Payor Type: Medicare: 11 Medicaid: 64 Other: 40 Total: 115 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 3, 2023.	F 0000	Allegation of Compliance Please accept the following plan of correction for the complaint survey completed on July 31, 2023. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Surveyor; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community. We respectfully request consideration for a desk review and paper compliance.	
F 0552 SS=D	483.10(c)(1)(4)(5) Right to be Informed/Make Treatment			

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

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Bldg. 00	Decisions §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.			
	Based on record review and interview, the facility failed to inform the resident's family in advance of the treatment risks, benefits and additional options for psychiatric services and failed to obtain a physician's order for treatment prior to the implementation of psychiatric services for 1 of 24 residents reviewed for resident rights. (Resident 110) Findings include: The clinical record for Resident 110 was reviewed on 7/26/23 at 12:36 p.m. The resident's diagnoses included, but were not limited to, unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, delusional disorders, amnesia, anxiety	F 0552	ol class="NumberListStyle1 SCXW181993673 BCX8" role="list" start="1" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" 1. On 8/11/23, the physician order for psychiatric services was completed and family member was updated and notified again of reasoning for continued services, risks versus benefits and alternative options for the resident and documented in the resident record. Family members agreed	08/18/2023

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	disorder, and major depressive disorder. The admission MDS (minimum data set) assessment, dated 2/20/23, indicated the resident was severely cognitively impaired. The quarterly MDS, dated 5/23/23, indicated the resident was severely cognitively impaired. A nurse's note, dated 5/15/23 at 1:40 p.m., indicated a call was placed and message left for the resident's family member regarding giving consent for psychiatric services. The resident's record lacked documentation of the family member's response to the phone message or consent given for psychiatric services. The record lacked documentation of the family member being notified of informed reasoning for services, risks versus benefits, and alternative options for the resident. The record indicated the resident was seen by the psychiatrist on 2/24/23, 3/27/23, 5/22/23, 6/19/23, 6/23/23 and 7/17/23. The record laced a physician's order by the primary physician for the resident to be seen by psychiatric services. On 7/28/23 at 11:30 a.m., the VPCO (Vice President of Clinical Operations) presented a copy of a consent form for mental health services signed by the Social Service Assistant and Executive Director dated 2/17/23. The notice indicated the resident's family gave verbal consent over the phone for the resident to be seen for psychiatric services. Review of the Admission Agreement signed by the facility and family on 2/10/23 indicated, "Facility will arrange for physician visits as		with continued psychiatric services and care. 2. Residents receiving psychiatric services were reviewed to ensure consents were obtained, physician orders completed, and appropriate documentation of the family member being notified. Any concerns noted were corrected immediately. ol class="NumberListStyle1 SCXW181993673 BCX8" role="list" start="3" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" 3. social services team was provided education from the Vice President of Clinical Operations to ensure understanding of social services responsibility to inform the resident’s family in advance of psychiatric treatment risks, benefits and additional options for psychiatric services and per admission agreement obtaining physician orders for treatment prior to the implementation for psychiatric services.	

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	authorized under this Agreement and may arrange for the following ancillary services when prescribed by a physician:...(k) Psychiatric or psychological treatment." During an interview with the VPCO on 7/28/23 at 1:30 p.m., she indicated part of the ancillary orders obtained on admission, included the resident being able to see psychiatric services. During an interview with the Social Service Assistant on 7/31/23 at 10:00 a.m., she indicated she was not aware that the resident had not had an order to see the psychiatrist. It was usually part of the standard ancillary orders obtained on admission. On 7/31/23 at 8:05 a.m., the Admission Coordinator presented a copy of the facility's new Resident Handbook. Review of this handbook included, but was not limited to, "... page 24 Free Choice: The resident shall have the right to:...(b) Be fully informed in advance about care and treatment or any changes in that care or treatment that may affect the resident's well-being..." 3.1-3(n)(2) 3.1-4(4)(c)		4. The Director of Nursing and/or Unit Manager will review new residents receiving psychiatric services to validate proper documentation of family consent and physician orders received prior to initiating psychiatric services M-F for (4) weeks and continue monthly for no less than (2) additional months. Any corrective action needed will be completed immediately. The results of these audits will be presented to the Quality Assurance/Performance Improvement committee meeting for a minimum of three months to validate 100% compliance and then on-going per routine QAPI reviews. Plan to be updated as indicated.	
F 0580 SS=G Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;			

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	(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations			

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	under §483.15(c)(9). Based on record review and interview, the facility failed to ensure prompt notification to the physician of rectal bleeding for a resident on an anticoagulant, which resulted in the resident's hospitalization for anemia and acute blood loss. The resident had to have a blood transfusion for 1 of 3 resident's reviewed for physician notification. (Resident 82) Findings include: The clinical record for Resident 82 was reviewed on 7/26/23 at 10:16 a.m. The diagnoses included but were not limited to, iron deficiency anemia secondary to blood loss, hemorrhage of anus and rectum, diverticulosis of intestine without perforation or abscess without bleeding, acute posthemorrhagic anemia, presence of cardiac implants and grafts, chronic atrial fibrillation, heart disease, and left ventricular failure. The Admission MDS (Minimum Data Set) assessment, dated 6/2/23, indicated the resident was cognitively intact. The care plan, dated 6/5/23, indicated the resident was on anticoagulant therapy related to atrial fibrillation and risk for deep vein thrombosis. The goal was for the resident to be free from extensive bruising or bleeding. The interventions included, but were not limited to; administer medications as ordered by the physician; and monitor for side effects every shift; monitor, document, and report as needed any adverse reactions such as dark or bright red blood in stools. The physician's order, dated 5/27/23, indicated the resident received Eliquis (blood thinner/reduces blood clotting) 5 mg (milligrams) twice daily for	F 0580	ol="" role="list" start="1" 1. Resident 82 experienced no ill effects related to the alleged deficient practice. Her hemoglobin on admission to the hospital was 9.2 and did not drop to 7.0 until the following day. The resident has since returned to the facility and has restarted anticoagulant therapy. Facility NP completed assessment following return to facility. NP reviewed and agreed with the current treatment plan. 2. Residents receiving anticoagulants have the potential to be affected by the alleged deficient practice and an audit was conducted by the clinical team to confirm that all residents receiving anticoagulant therapy have monitoring orders in place, and physician notification has occurred properly for others on anticoagulants that may have experienced side effects. 3. Licensed nurses and QMAs were re-educated by the Staff Development Coordinator beginning on 8/3/2023 on change of condition policy including required physician notification if side effects for anticoagulants are noted. On-going anticoagulant monitoring order entry will be reviewed by nurse management during the 24-hour post admit chart review process. ol="" role="list" start="4" 4. The Director of Nursing and/or	08/04/2023

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	congestive heart failure related to left ventricular failure.. The physician's orders, dated 5/28/23, indicated the resident received aspirin low dose 81 mg daily for coronary artery disease. The physician's order, dated 5/29/23, indicated to observe the resident for bleeding, including black tarry stools, and to chart the appropriate code and notify the physician if any symptoms were observed. The nurse's note, dated 7/15/23 at 3:05 p.m., indicated the resident complained of constipation and rib pain. A laxative was given, the resident had a large bowel movement, and was bleeding from the rectum with the bowel movement. The resident was cleansed, and the bleeding was monitored. The nurse did not see any active bleeding. The NP (Nurse Practitioner) gave new orders for a chest x-ray. The NP note, dated 7/15/23 at 11:50 p.m., indicated the resident was seen by the NP for complaints of rib pain. An order was given for a chest x-ray. The note did not address any symptoms of bleeding. The Resident's MAR (medication administration record) for July 2023 indicated the following: - On 7/15/23 the resident's aspirin and Eliquis were administered as ordered and no bleeding was documented on the resident's anticoagulant symptom monitoring. - On 7/16/23 the resident's aspirin and Eliquis were administered as ordered and no bleeding was documented on the resident's anticoagulant symptom monitoring. - On 7/17/23 in the morning the resident had		Unit Manager will review residents on anticoagulants to validate proper physician notification of side effects has occurred daily for (4) weeks and continue weekly for (8) weeks then monthly for no less than (3) additional months. Any corrective action needed will be completed immediately. The results of these audits will be presented to the Quality Assurance/Performance Improvement committee meeting for a minimum of three months to validate 100% compliance and then on-going per routine QAPI reviews. Plan to be updated as indicated.	

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	symptoms of bleeding, as indicated by a "Y" for yes, however it did not indicate what symptoms the resident displayed and did not indicate any physician notification. The resident's aspirin and Eliquis were administered as ordered. The MAR (electronic medication administration record) note, dated 7/18/23 at 7:23 a.m., indicated the resident's Eliquis 5 mg tablet was held due to rectal bleeding. The Change in Condition note, dated 7/18/23 at 11:15 a.m., indicated the resident had gastrointestinal (GI) bleeding. The nurse was notified by the CNA (Certified Nurse Aide) that the patient had a large amount of dark red blood and blood clots found in her brief. The nurse went to evaluate the resident and she reported she had not voided in two days. The patient was catheterized and 750 mL (milliliters) of amber, cloudy, thick urine was removed. The NP was notified and recommended to send the resident to the hospital. The Hospital note, dated 7/21/23, indicated the resident reported she had begun having red blood clots in her bowel movements. She had been on Eliquis for about 1 year and the bleeding was spontaneous. She reported epigastic pain and urinary hesitancy. She was admitted in consultation with gastroenterology. Her aspirin and Eliquis were held. She was transfused with 2 units of packed red blood cells. She underwent colonoscopy which showed no active bleeding but did show evidence of likely diverticular bleeding recently that was likely exacerbated by the presence of Eliquis therapy. She was instructed to restart her Eliquis on 7/22/23 and her aspirin on 7/25/23.			

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	During an interview on 7/25/23 at 8:55 a.m., Resident 82 indicated she had gone to the hospital after two days of bleeding from her rectum. During an interview on 7/26/23 at 12:25 p.m., RN 8 indicated he was the RN on duty when the resident went out to the hospital. She was having large amounts of blood in her stool. He was told in report she had some blood but wasn't showing any symptoms of blood loss, so he waited for the NP to come in because it was morning. Then the CNA had told him there was some blood in her brief. That's when he checked it out. They did not tell him how long it had been going on. He was told in report from the night shift nurse the resident had a few large clots in her brief. He had no clue if they'd reported it to the doctor. He was not aware of any bleeding a few days prior. He held the Eliquis because the night shift nurse said she had blood clots. She had just been changed by night shift before coming in, so he didn't see anything. He took them at their word and the CNA came and got him shortly after pill pass. He didn't actually see the blood, as the CNA had already taken out the trash and she had already tossed it. He did assess her rectum and he didn't see any hemorrhoids. She had a little bit of blood in her brief. It was just spotty at that point. He would notify the physician of bleeding for residents on anticoagulants normally right away. During an interview on 7/28/23 at 11:14 a.m., CNA 11 indicated she had worked with the resident on 7/15/23 for an entire shift. She had observed a very large amount of blood in the resident's brief. It was a lot of blood mixed in with her bowel movement and it filled her brief. It looked like there were clots in it. She immediately let her nurse know but she did not know if the nurse informed			

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	the doctor. During an interview on 7/28/23 at 11:35 a.m., NP 9 indicated she saw the resident on 7/15/23 for rib pain. She did not know of any bleeding. That was not the issue she was notified of. She would definitely expect to be notified of bleeding because of her being on a blood thinner. If she had active bleeding, she would have looked at her medications and definitely done some laboratory tests, such as a stool sample or a complete blood count. On 7/15/23 no one informed her of any bleeding, and they definitely did not tell her the resident had blood in her brief. During an interview on 7/28/23 at 2:36 p.m., NP 10 indicated she was the one who sent the resident out and she did observe the bleeding. The brief was saturated with frank blood and there were blood clots which were approximately silver dollar sized. It was concerning. She did not believe she was notified between 7/15/23 and 7/18/23. She'd had concerns of not being notified related to resident concerns since the turnover of the DON (Director of Nursing). The change in a Resident's Condition or Status policy, provided on 7/31/23 at 8:10 a.m. by the DON, last revised 2/2021, included, but was not limited to, "... The nurse will notify the resident's attending physician or physician on call when there has been a(an)... c. adverse reaction to medication... d. significant change in the resident's physical/emotional/mental condition... i. specific instruction to notify the physician of changes in the resident's condition... a 'significant change' of condition is a major decline or improvement in the resident's status that... will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical			

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	interventions..." 3.1-5(a)(2) 3.1-5(a)(3)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure the Minimum Data Set assessments were correctly documented for behaviors for 1 of 25 residents reviewed for accuracy of assessment. (Resident 86) Findings include: The record for Resident 86 was reviewed on 7/26/23 at 11:37 a.m. The diagnoses included, but were not limited to, developmental disorder of speech and language, anxiety disorder, altered mental status, and lack of expected normal physiological development in childhood. The care plan, dated 7/1/21 and revised on 4/29/22, indicated the resident had behavior problems of expressing frustration, agitation, anxious and restless by throwing items and making disruptive sounds. The nurse's note, dated 3/9/23 at 1:39 p.m., indicated Resident 86 had been resting abed, had pulled the call bell out of wall and thrown it across the room, had taken his glasses and thrown them across the room, had hollered out several times, resident yells and had attempted to hit the nurse and CNA (Certified Nursing Aide) while providing incontinent care. He was offered a snack and drink, but all interventions had been	F 0641	p paraid="1923339244" paraeid="{fa710caa-e854-4d2c-a1a8-a7f31aa3cb89}{254}" > 1. The 3/15/23 MDS behavior assessment was revised to reflect the status of resident 86. p paraid="1374621086" paraeid="{6f74e080-44ca-49fb-a62d-8e60d9e06f94}{24}" > 2. All residents experiencing behaviors have the potential to be affected by the alleged deficient practice. The Resident Assessment Instrument (RAI) Director reviewed the MDS assessments completed over the last 30 days and assessments requiring revision were completed as needed.	08/18/2023

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	non-effective. The Quarterly MDS (Minimum Data Set) assessment, dated 3/15/23, indicated the resident was moderately cognitively impaired and did not exhibit behavioral symptoms such as hitting, kicking, pushing, scratching, and grabbing during the 7-day look back period. During an interview on 7/31/23 at 11:00 a.m., Social Services indicated the resident had been fine when she did her assessments. She had a check list that she went by and auto-populated. She reviewed the nurse's notes for behaviors. She made rounds with the nurse's and went to the morning meetings to discuss any issues of behaviors. She had seen Resident 86 after one of his behaviors. The assessment was not accurate for the, 3/15/23, assessment and the behaviors should have been documented. The Certifying Accuracy of the Resident Assessment policy provided by the Executive Director on 7/31/23 at 2:20 p.m., indicated but was not limited to, "... 3. The information captured on the assessment reflects the status of the resident during the observation ('look back') period for that assessment. Different items on the MDS may have different observation periods..."		·3. Our social services team was provided education from the Vice President of Clinical Operations to ensure understanding of completing MDS behavior assessments accurately per RAI manual. ·4. The RAI Director and/or MDS Coordinator will review at least (5) resident MDS behavior assessments for accuracy weekly for (4) weeks and continue monthly for no less than (2) additional months. Any corrective action needed will be completed immediately. The results of these audits will be presented to the Quality Assurance/Performance Improvement committee meeting for a minimum of three months to validate 100% compliance and then on-going per routine QAPI reviews. Plan to be updated as indicated.	
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			

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	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 observation, record review, and interview, the facility failed to ensure pressure ulcer prevention interventions were provided as indicated in the resident's care plan for a resident with a known history of pressure ulcers for 1 of 7 residents reviewed for pressure ulcers (Resident 34). Findings include: The record for Resident 34 was reviewed on 7/28/23 at 9:15 a.m. The diagnoses included, but were not limited to, lack of coordination, unsteadiness on feet, muscle weakness, type 2 Diabetes Mellitus, hyperglycemia, dysphagia following cerebral infarction, left flaccid hemiplegia, Stage 3 pressure ulcers, vascular dementia, cognitive communication deficit, osteoarthritis, and the presence of tendon and bone implants. The Quarterly MDS (Minimum Data Set) assessment, dated 7/10/23, indicated the resident was severely cognitively impaired. She required extensive assistance of 2 staff members for bed mobility and transfers. The care plan, dated 8/19/19 and last revised on 7/15/23, indicated the resident had an unstageable pressure area to the sacrum, which was a Stage 3.	F 0686	p="" paraid="1447319377" paraeid="{6f74e080-44ca-49fb-a62d-8e60d9e06f94}{131}">1. Resident 34's treatments and preventative measures to sacral area are ongoing and improvements continue. The wound on the resident's right heel had resolved prior to the annual survey and heel boots are in place as a preventative measure. 2. Residents identified at risk for pressure injury have the potential to be affected by the alleged deficient practice. An audit was conducted by the wound care nurse to confirm that residents identified at risk have preventative interventions implemented with orders for monitoring. 3. Clinical staff were educated starting 8/1/23 by staff development nurse on the prevention of pressure injuries policy including the proper use of preventative positioning devices and reviewing the resident Kardex to identify all preventative interventions for the residents. 4. The unit manager and/or designee will review 5 random residents	08/14/2023

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	The interventions included, but were not limited to, turn and reposition the resident every two hours with while in bed to avoid direct pressure to the at-risk areas and bony prominences (dated 5/7/21), apply heel boots while in bed (dated 5/8/23), and apply a pressure reduction wedge while in bed (dated 5/13/20). The nurse's note, dated 2/25/23 at 8:58 a.m., indicated the resident required total assistance with care. The nurse's note, dated 5/3/23 at 2:27 p.m., indicated the CNA (Certified Nurse Aide) called the nurse into the resident's room. The resident had at large blister on the right heel. The blister measured 8 cm (centimeters) long by 5 cm wide. The area was cleansed with normal saline and covered with a 4 by 4 dressing. The Wound Observation Tool, dated 5/5/23, indicated the resident had a facility acquired pressure ulcer to the right heel and was a SDTI (suspected deep tissue injury). The preventative measure was for new heel lift boots. There was 20% (percent) non-granular and 80% intact blister with a small amount of bloody drainage. The wound measured 5 cm long by 3.6 cm wide by 0.1 cm deep. The peri wound was intact, ecchymosis tissue. The current wound was to cleanse the wound with normal saline and apply calcium alginate, place an ABD (abdominal gauze pad) pad, and wrap the heel in kerlix daily on Monday, Wednesday, and Friday. The new order was for new heel lift boots to be obtained and to place the resident on the wound MD consult list. The dietitian and therapy were notified. The nurse's note, dated 5/7/23 at 12:15 p.m., indicated the resident had an area to her right heel		across all shifts for proper use of preventative positioning devices daily for (4) weeks and continue weekly for (8) weeks then monthly for no less than (3) additional months. Any corrective action needed will be completed immediately. The results of these audits will be presented to the Quality Assurance/Performance Improvement committee meeting for a minimum of three months to validate 100% compliance and then on-going per routine QAPI reviews. Plan to be updated as indicated. IDR Request: We respectfully disagree with the surveyors finding that actual harm was caused to resident 34 due to the facility's alleged failure to ensure appropriate interventions were in place to prevent the development of two unstageable pressure ulcers. The area on the resident's heel resolved on 6/16/2023 and the area on the resident's sacrum continues to improve with the treatment and interventions that remain in place.	

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	and the treatment was to be continued. Heel protectors were to be kept on and the feet elevated related to the area on the heel. The Wound Observation Tool, dated 5/11/23 indicated the wound doctor saw the facility acquired SDTI and classified the heel wound as unstageable. The wound was worsening with necrotic tissue present and measured 8 cm long by 5 cm wide by 0.1 cm deep. There was 10% granulation tissue and 90% eschar. The Wound Observation Tool, dated 5/31/23, indicated the facility acquired unstageable pressure ulcer to the sacrum was first observed on 5/26/23. The preventative measures were a low air loss mattress. The wound had 100% slough tissue present (yellow, tan, white, stringy). The wound measured 2 cm long by 0.7 cm wide by 0.1 cm deep. The new pressure ulcer was noted on the sacrum, a low air loss mattress was ordered, a pressure reduction wedge was obtained for the patient, the Wound MD was to follow up Thursday, and therapy and the dietitian were notified. The Wound Observation Tool, dated 6/8/23, indicated the resident's Stage 3 pressure would to the right heal measured 0.4 cm long by 1.7 cm wide by 0.1 cm deep. There was a new order for treatment to cleanse the wound with normal saline, apply Medi-honey, and place a silicone foam border dressing daily. The wound was stalled. The Wound Observation Tool, dated 6/16/23, indicated the sacral wound was improving and measured 1 cm long by 0.4 cm wide by 0.1 cm deep. There were no new orders and indicated to cleanse the wound with normal saline and to			

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	apply Medi-honey, and cover with a 4 by 4 silicone foam border dressing daily. The wound was stalled, and the preventative measures were for low air loss mattress, and pressure reduction wedge. The nurse's note, dated 6/26/23 at 12:59 p.m., indicated the resident's air boots were to be always on, when in bed. The Wound Observation Tool, dated 6/30/23, indicated the Stage 3 wound to the sacrum had 90% granulation tissue and 10% slough. The wound measured 0.7 cm long by 0.2 cm wide by 0.1 cm deep. The wound was healing. The nurse's note, dated 6/30/23 at 10:20 a.m., indicated the resident was continued on the air mattress for healing of the sacral wound to the coccyx and therapy had been involved with e-stim treatment as well. when in bed she wore heel boots from the area to the right heel which had healed and looked good. The Wound Observation Tool, dated 7/7/23, indicated the Stage 3 wound to the sacrum had 100% granulation tissue. The wound measured 0.4 cm long by 0.2 cm wide by 0.1 cm deep. The Wound Observation Tool, dated 7/21/23, indicated the facility acquired pressure ulcer to the sacrum was now a Stage 3 with 100% granulation tissue and measured 0.5 cm long by 0.4 cm wide by 0.1 cm deep. The current treatment orders were to cleanse the wound with normal saline and apply Medi-honey, cover with a 4 by 4 silicone foam border every day and were to be continued. The wound was almost closed. During an observation on 7/27/23 at 1:36 p.m.,			

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	with the wound nurse and wound doctor, the wound doctor indicated the wound hadn't improved and her orders were for dressing changes daily and as needed, the low air loss mattress, supplements for liquid protein, and Med Pass. The resident had been on e-stim for a little while. The staff turned and repositioned the resident, she could not do it on her own. The wound measured 0.7 cm long by 0.5 cm wide by 0.1 deep. It was a little bigger in size from her previous observation. The new order would be for a cream to be applied daily and left open to air, because it was a little sloughy. A pillow was under the resident's feet with her heels resting directly on the pillow. No lift boots were observed on the resident. An air mattress was on the bed. The resident had a bowel movement, and a CNA was obtained by the wound nurse to clean the resident before the dressing treatment could be applied. The CNA placed the resident's heels back, directly on the pillow and did not float the heel or apply any heel boots. During an observation of incontinence care on 7/27/23 at 1:45 p.m., CNA 16 provided care on the resident. The Wound Nurse assisted the CNA with the care. A brief was placed on the resident. Upon completion of the care, the resident was rolled onto her left side and a wedge was applied behind the resident's back. A blanket was placed between her knees, and her heels were placed directly on the pillow again. No lift boots were observed. During an interview on 7/28/23 at 9:06 a.m., QMA (Qualified Nurse Aide) 17, indicated the resident required a mechanical lift, due to her inability to turn and reposition. She was not able to roll herself.			

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	During an observation on 7/28/23 at 9:08 a.m., the resident's right ankle was crossed over her left ankle with her right heel resting directly on the pillow. Her left heel was resting on the mattress. She had no lift boots on. During an interview on 7/28/23 at 10:01 a.m., LPN (Licensed Practical Nurse) 12, indicated the resident would be turned from side to side for pressure ulcers. They would use a wedge pillow to cushion the bony prominences. The heels would be kept elevated above the mattress. The resident had boots available. Her feet rubbed together. During an interview on 7/28/23 at 10:41 a.m., CNA 18 indicated residents with pressure ulcers would be turned from side to side while in bed. During meals, they would be placed on their backs. The heels would be floated with a pillow between the ankles. Their heels would be floated by hanging them over the pillow. The Prevention of Pressure Injuries policy, last revised January 2023, was provided by the Director of Nursing on 7/28/23 at 11:40 a.m. The policy included, but was not limited to, " ... Prevention ... 6. Do not rub or otherwise cause friction on skin that is at risk of pressure injuries ... Mobility/Repositioning ... 3. Provide devices and assistance as needed ..." 3.1-40(a)(1)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic			

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	jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to ensure appropriate fluid status management related to administration of diuretics, clarification of orders for duplicate therapy, and weight monitoring for 1 of 3 residents reviewed for fluid status management. (Resident 26) Findings include: The clinical record for Resident 26 was reviewed on 7/26/23 at 1:07 p.m. The diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), pleural effusion, CHF (congestive heart failure), dyspnea, pneumonia, acute respiratory failure, ischemic cardiomyopathy, chronic atrial fibrillation, nonrheumatic aortic valve insufficiency, Stage 3 chronic kidney disease, presence of automatic cardiac defibrillator, presence of cardiac pacemaker, cardiac arrhythmia, edema, hypertension, chronic pulmonary edema.	F 0692	1.p paraid="916304191" paraeid="{1802beef-40d8-4d67-99e5-19e02a8ba0e5}{94}" >1. Resident #26's fluid status management including order validation was reviewed by the NP on 8/2/2023. 2. Residents identified at risk for altered fluid status have the potential to be affected by the alleged deficient practice. An audit was conducted by the nurse management team to identify residents at risk. The NP reviewed and validated appropriate orders related to their diagnosis.	08/18/2023

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	The care plan, dated 12/31/18 and last revised on 5/22/23, indicated the resident had an alteration in his respiratory status due to COPD, respiratory failure, CHF, pneumonia, shortness of breath when laying flat, chronic respiratory failure, and a history of RSV (respiratory syncytial virus). The interventions included, but were not limited to, administer medications as ordered, observe labs, response to medication and treatments, and report changes or worsening of condition to the physician as warranted. The physician's order, dated 1/28/23, indicated to administer bumetanide 2 mg (milligrams) twice daily for CHF. The physician's order, dated 4/27/23, indicated to administer bumetanide 2 mg twice daily for CHF until 5/1/23. The NP's (Nurse Practitioner) note, dated 5/1/23 at 1:44 p.m., indicated the physician ordered bumetanide 2 mg by mouth twice daily for three days then to continue bumetanide daily as ordered to treat the resident's edema. The clinical record lacked documentation of any orders input into the resident's record to administer the bumetanide twice daily followed by the orders to administer it daily, or any clarification of the orders due to the resident's already receiving bumetanide 2 mg twice daily. The nurse's note, dated 5/6/23 at 8:30 a.m., indicated the nurse noticed the resident's bumetanide 2 mg was missing. The pharmacy was contacted and said the order was discontinued on 5/1/23. The nurse faxed the order for bumetanide and its active status. The pharmacy contacted and ensured that they received the fax. The nurse		. 3. Nursing staff were educated by staff development nurse on the medication and treatment orders policy including clarification of duplicate orders, process for obtaining missing medications, and/or notification to provider of doses missed, obtaining and documenting daily weights including parameters for notifying the provider. . 4. The Director of Nursing and/or designee will review missing medication report, daily weights for completion and notification when appropriate, and review new order listing report for duplicate orders during morning clinical review daily M-F for (4) weeks and continue weekly for (8) weeks. Any corrective action needed will be completed immediately. The results of these audits will be presented to the Quality Assurance/Performance Improvement committee meeting for a minimum of three months to validate 100% compliance and then on-going per routine QAPI reviews. Plan to be updated as indicated.	

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	pulled the 2 mg dose from the emergency drug supply and made the on call manager aware. The nurse's note, dated 5/6/23 at 4:00 p.m., indicated the nurse called the pharmacy to follow up on the resident's bumetanide not being in the medications sent from the pharmacy. The pharmacy stated that they received the order and that the medication would be coming in the night delivery. The nurse's note, dated 5/7/23 at 8:00 a.m., indicated the nurse contacted the pharmacy again because the resident's bumetanide was not in the order from pharmacy. The pharmacy indicated they had a new policy that all orders faxed to the pharmacy had to be signed by a physician or be a verbal order. The nurse printed out the order and signed their name and indicated it was a verbal order. The facility could not provide any delivery slips for the resident's bumetanide for 5/6/23 or 5/7/23 or any additional emergency drug supply dispense receipts to show the resident was provided his 4:00 p.m. dose of bumetanide on 5/6/23, or the 8:00 a.m. dose on 5/7/23. The nurse's note, dated 5/7/23 at 9:14 a.m., indicated the resident's 8:00 a.m. and 4:00 p.m. doses of bumetanide were not in the bags from the pharmacy. The resident was short of air upon assessment, with crackles in his lungs, swollen legs, a distended abdomen, and his groin area was very swollen. His oxygen saturation was 89 to 91% on 4 lpm (liters per minute) of oxygen by nasal cannula. The resident was assisted to sit up in his wheelchair and his symptoms were unrelieved. The physician was notified and gave orders for a dose of furosemide 40 mg/4 mL			

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	(milligrams per milliliter) 4 mL immediately. The nurse administered the medication after pulling it from the emergency drug kit. The resident was in bed in Fowler's position and indicated his shortness of breath felt better. The nurse's note, dated 5/7/23 at 9:45 a.m., indicated a new order was received from the physician to send the resident to the hospital for evaluation and treatment if his condition did not improve or he became unstable. The nurse's note, dated 5/7/23 at 10:58 a.m., indicated the resident was sent to the hospital for respiratory distress. His oxygen was 91% on 4 lpm of oxygen, The hospital note, dated 5/12/23, indicated the resident was admitted to the hospital on 5/7/23. He had admitting diagnoses of pneumonia of both lungs due to infectious organism, dyspnea, and chest pain. The active hospital problems included acute on chronic systolic CHF, CHF exacerbation, and COPD. He presented to the ER with complaints of dyspnea for weeks which had gotten progressively worse over the last few days. He'd had a nonproductive cough for three days. He had worsening lower extremity edema. He was well enough to return to the facility after a few days. The resident was discharged to the facility on 5/12/23. The physician's order, dated 6/28/23, indicated the resident was to have his weight obtained daily. The July 2023 TAR indicated the following: -The resident's daily weight every day shift was not documented on July 11, 13, 14, 16, 18, or 24, 2023. - On July 5, 2023, the resident weighed 263 lbs			

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	(pounds), which was a 8.1 lb gain from his previous weight on July 4, 2023 of 254.9 lbs. During an interview on 7/28/23 at 11:18 a.m., NP 10 indicated in the past she had ordered to increase his bumetanide for a few days. She was not aware of any missed doses, but yes absolutely she would expect them to tell her if he had any missed doses. She had ordered daily weights on him, but it had not been long. She expected to always be notified of any weight gain, shortness of air, anxiety due to the shortness of air, if he was refusing medications, or any noncompliance. She wanted to know if there was a 3 to 5 lb weight gain over night. She just started that because she had to tightly monitor him. There was a couple of times he had been in the hospital related to fluids. Usually if there was a weight gain she would adjust his medications. She had not been notified of any missed weights. During an interview on 7/28/23 at 1:19 p.m., LPN (Licensed Practical Nurse) 12 indicated the aides usually got the weights for them and let them know what they were. They used the mechanical lift scale for him. He usually did get up every day. There was not any reason why they wouldn't get his weight. The nurses that worked would document if he refused, if he didn't get up, or why they didn't get it. It signed off on the medication administration record and if they refused the nurse would document the refusal in a progress note. They would notify the physician immediately of a weight change. He had a lot of CHF issues she monitored. She would tell her immediately because she would likely have to give him medications to address his fluids. If he gained 3 to 5 lbs in a day she would definitely let the NP know. She would document the notification in the progress notes under the daily weight in the			

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	block. The holes in the MAR were where they did not obtain or document it. It should be signed off and indicate why it was not obtained. She reviewed the weight gains in July and indicated the nurse practitioner should have been notified. They would usually reweigh to verify the weight and then notify the physician. During an interview on 7/28/23 at 2:11 p.m., NP 10 indicated she had reviewed the resident's clinical record and could not locate documentation for the missing weights on the resident's TAR. She was not notified of any missing weights. She was not notified of his weight gain on 7/5/23. The facility had one mechanical lift that didn't have a scale, but that was not an excuse. The daily weights were very important for the resident because he was very brittle and could exacerbate very fast. He could be fine in the morning and then they got her in the afternoon and he had wheezes and fluids. The bumetanide was important for him as well. She indicated the orders she gave were to administer the bumetanide twice daily for three days, so he should have had it twice a day on 5/1/23, 5/2/23, and 5/3/23, after that it was to go back to one tablet daily. She did not give any order to continue it twice daily. During an interview on 7/31/23 at 11:58 a.m., NP 10 indicated from what she could tell there was a clerical error. Instead of doing the order one time a day they put 2 times daily. It was put in wrong. She had no idea what happened. She didn't know what she looked at that said one time daily. She would think that whoever the nurse was giving the medication daily would recognize it. She had no idea why she would have thought it was once daily. If the resident was already receiving the medication twice daily, and she ordered to increase it to twice daily, she would think			

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	someone would have brought it to her attention and told her he already received it twice daily. She would have probably increased the dosage of bumetanide further than the 2 milligrams twice daily. The order to give 2 milligrams twice daily didn't actually modify his treatment plan at all. He could have received it more frequently, up to 10 mg daily. During an interview on 7/31/23 at 12:11 p.m., LPN 13 indicated if she noticed a change she would tell the NP and then whatever orders they gave here she would process. Nurses obtained the orders and put them in the computer. If the order was a duplicate, or the resident was already receiving the medication she call the NP and ask her what she would like to do. She would contact her and let her know there was an error with the order. Maybe she missed it or it would need to be increased permanently or decreased. It was not her call so she would call the NP. During an interview on 7/31/23 at 12:15 p.m., the DON (Director of Nursing) indicated they did not have any other slips from pharmacy for removal of any bumetanide other than the one dose. They would have a record of it if it was pulled. During an interview on 7/31/23 at 12:21 p.m., the VPCO (Vice President of Clinical Operations)indicated the NP herself had been the one who put in an order on 4/28/23 to administer the order for bumetanide. She did not have an explanation for why the NP would have written an order a few days later to increase the dose to twice daily when the resident was already receiving the dose. The Medication and Treatment Orders policy, provided on 7/31/23 at 8:10 p.m. by the DON, last			

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	revised July 2016, included, but was not limited to, "... 1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state... 7. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order... 9. Orders for medications must include... Name and strength of the drug... Number of doses, start and stop date... Dosage and frequency of administration... Route of administration... clinical symptoms for which the medication is prescribed... Any interim follow-up requirement... 11. Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available... 12. Orders not specifying the number of doses, or duration of medication, shall be subject to automatic stop orders... One (1) day prior to the date the stop order is to become effective, the nurse supervisor/charge nurse on duty must contact the prescriber or attending physician to determine if the medication is to be continued..." 3.1-46(a)(1)			
F 0740 SS=G 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			

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	and substance use disorders. Based on record review and interview, the facility failed to ensure residents received behavioral health services as required for 1 of 3 resident's reviewed for behavioral health services. This deficient practice resulted in a resident with ineffective behavior interventions and uncontrollable behaviors. (Resident 86) Findings Include: The record for Resident 86 was reviewed on 7/26/23 at 11:37 a.m. The diagnoses included, but were not limited to, developmental disorder of speech and language, anxiety disorder, altered mental status, and lack of expected normal physiological development in childhood. The Quarterly MDS (Minimum Data Set) assessment, dated 6/15/23, indicated the resident was moderately cognitively impaired. The MDS indicated the resident did not exhibit behavioral symptoms such as hitting, kicking, pushing, scratching, and grabbing. The care plan, dated 7/21/21 and last revised on 2/1/23, indicated the resident had behavior problems of expressing frustration, agitation, anxious and restless by throwing items and making disruptive sounds. The interventions included, but were not limited to, administer medications as ordered and monitor and document for side effects and effectiveness. Caregivers were to provide opportunities for positive interaction and attention. Staff were to stop and talk with him when passing by, encourage activities of resident's interest, provide supplies and assistance as needed for self-directed activities and pursuits, encourage family conversations and visits as feasible, explain	F 0740	1. Resident 86 was not harmed related to the alleged deficient practice. Resident was seen by in-house psychiatric services on 7/31/23. IDT reviewed resident's care plan and updated appropriate interventions related to behaviors and behavior monitoring orders updated as indicated. 2. All residents have the potential to be affected by the alleged deficient practice. Residents experiencing aggressive and uncontrollable behaviors over the last 30 days were reviewed by the IDT to verify appropriate interventions were in place, care planning and behavior monitoring orders updated as indicated. 3. Clinical staff were educated by the staff development nurse related to the Behavior Management Policy with emphasis on reviewing residents that experience aggressive or uncontrollable behaviors and initiating interventions for prevention. Our social services team was provided education from the Vice President of Clinical Operations to ensure understanding of provision of behavioral health services for residents with aggressive and uncontrollable behaviors. 4. The Director of Nursing and/or designee will review progress notes for residents experiencing aggressive behaviors to verify	08/04/2023

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	all procedures to the resident before starting and allow the resident adequate time to adjust to changes, intervene as necessary to protect the rights and safety of others. Approach and speak in a calm manner, divert attention, and remove the resident from the situation and take to an alternate location as needed. Meet the resident's needs, monitor behavior episodes, and attempt to determine underlying cause, consider the location, time of day, persons involved, and situations and document behavior and potential causes. Provide a program of activities that is of interest to the resident and accommodate the resident's status, provide one on one attention, and engage in conversation with the resident, provide redirection as needed and remove from overly stimulating areas and situations. The resident was to deescalate in his room with activities of choice and television programs to help him calm down. The nurse's note, dated 7/20/22 at 4:47 p.m., indicated the resident was yelling out, throwing objects at other residents, and trying to hit the other residents and staff. The nurse's note, dated 8/25/22 at 4:57 p.m., indicated the resident threw a chair and a trash can in the common area. The resident was returned to his room to decrease stimulation. The resident then smacked and kicked the nurse and pinched and smacked the CNA (Certified Nurse Aide) assisting the nurse. Staff decreased bright lighting, offered snacks and a drink, turned on the TV to a show of the his choice, provided perineal care, and gave PRN (as needed) Tylenol in case the resident was in pain and could not communicate it. The interventions were not effective. When asked resident what was upsetting him, he shrugged his shoulders. The DON was notified, and a note was given to social		social services support has been provided and documented, along with care plan review and revision as appropriate M-F for (4) weeks and continue weekly for no less than (2) additional months. Any corrective action needed will be completed immediately. The results of these audits will be presented to the Quality Assurance/Performance Improvement committee meeting for a minimum of three months to validate 100% compliance and then on-going per routine QAPI reviews. Plan to be updated as indicated.	

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	services for possible evaluation from psychiatric services. The nurse's note, dated 9/30/22 at 5:34 p.m., indicated the resident was throwing his cup and dinner plate tray. When asked what was bothering him, he pointed across hallway to another resident's room who was yelling out. The interventions were ineffective. The resident then attempted to hit the nurse. He was not easily redirected at that time. His behavior was unchanged. The nurse's note, dated 10/29/22 at 4:56 p.m., indicated the resident hit another resident in the right arm. She could not get out of the resident's way. Resident 86 had a history of combative behavior towards staff and other residents, throwing objects into the hallway and was currently screaming. He was not easily redirected. Staff provided a less stimulating environment, removed harmful objects he had thrown into the hallway for his and the other residents' safety. The nurse's note, dated 10/30/22 at 3:15 p.m., indicated the resident was witnessed by staff pinching another resident. The CNAs separated Resident 86 from the other residents for safety and the resident scratched and pinched the CNAs right arm and left red marks on the CNAs forearm. The resident was non-compliant with education. The interventions to decrease stimuli, assess for pain, and administer medications were ineffective. The resident was not easily redirected. The on-call NP (Nurse Practitioner), on call manager, and the DON (Director of Nursing) were notified and spoke about sending the resident out to a behavioral facility. The nurse's note, dated 11/17/22 at 5:15 p.m.,			

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	indicated the resident was throwing objects into the hallway, at staff, and into his roommate's side of the room and hitting staff. The nurse's note, dated 11/25/22 at 9:33 a.m., indicated during morning rounds, staff informed the nurse that the resident had behaviors the night before. The resident had pulled both closet doors off the tracks and threw them, the resident managed to break the bedside table, nightstand, and threw water all over his room. The nurse's note, dated 11/25/22 at 10:48 a.m., indicated a call was placed to the resident's family member related to the resident behaviors. The family member indicated she had been aware and was unsure what the cause or reason for behaviors was. The nurse's note, dated 3/7/23 at 3:35 p.m., indicated the resident was upset due to the ice cream parlor being closed, not being able to get a haircut, and not being able to get fast food for lunch. The resident started grabbing supplies off the nurse's cart and throwing them. The resident was asked to stop and offered snacks and diet pop. The resident continued to throw things and tried to swing at the employee who took him to his room to provide incontinent care. The resident continued to throw all items in his room including trash cans, books, remote, his glasses, and anything that he could grab to throw across the room. The resident hit and pinched two employees. The resident was asked to stop and to talk or write down what was wrong. The resident continued to throw everything. Staff called the resident's family member in hopes of de-escalation of behaviors', and he seemed to deescalate while talking to his family member. The resident was able to calm down and wanted to come back out			

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	to the living room. Moments later the resident took off his glasses and threw them across the room. While throwing his glasses they hit another resident in the face. The resident's family member, unit manager and social services was made aware. The nurse's note, dated 3/8/23 at 11:26 a.m., indicated the resident threw ink pens at two residents, pinched another, and tore up the nurse's medication cart. The nurse's note, dated 3/21/23 at 6:35 p.m., indicated the resident was in bed, dry, and watching television at 4:00 p.m. The resident started having behaviors. He started throwing items to the other side of the room. The resident stated he was upset about not having a haircut and wanted one. Staff cleaned his room up. The resident continued to throw his glasses, call light, and other items across the room. The nurse's note, dated 3/22/23 at 4:32 p.m., indicated the resident hit, slapped, and punched a CNA while providing care. The nurse's note, dated 3/29/23 at 6:55 p.m., indicated the resident had behaviors in the living room. He started flipping off the other residents and throwing anything that he could grab, including throwing a remote across the living room. The remote didn't hit anyone. He was taken to his room and put in bed with the call light in reach. He continued to have behaviors in his room. He tore the call light out of the wall and threw everything that he could reach across the room. The nurse's note, dated 4/17/23 at 6:14 p.m., indicated the CNA reported that the resident threw a notepad and pen towards another			

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	resident. The nurse took the resident to his room. He hit the nurse and CNA. He was placed in his room alone. He continued to throw anything that he could reach across his room. He then came out into the hallway and continued to throw walkers, canes, bedside commodes, and medical supplies across the hallway. The nurse called the resident's family member in hopes to attempt to de-escalate the resident's behaviors. He calmed down enough to apply the cream and ten minutes later he ate his dinner in his room. He continued to throw items in his room and items in the hallway including his glasses. Nursing management, the night shift nurse, and the resident's family member were made aware. The nurse's note, dated 5/5/23 at 6:43 p.m., indicated the resident was in the common area on the 100/400 unit, and went behind a resident who was sitting in a chair watching television) and tried to hit the CNA. The CNA removed the resident from 100/400 Unit. She took him back to the 600 Unit. He attempted to hit another resident on the way back to the 600 Hall. The nursing management and the resident's family member was made aware of the resident's behaviors. During an interview on 7/26/23 at 11:00 a.m., Social Services indicated her social service notes on follow-up with the residents would be documented in the computer under the general note section. The facility did not have any resident charting on paper form. The clinical record lacked documentation indicating the resident was evaluated and treated at a behavioral health facility for his behaviors or followed up by Social Services for the resident's psychological needs after his behaviors.			

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	During an interview on 7/27/23, at 10:30 a.m., QMA 7 indicated Resident 86 was nonverbal. He would make noises, but he could make his needs known. He would write on paper. He did have behaviors. The resident had a difficult time controlling his emotions. The staff used interventions but sometimes they were ineffective. He was mostly destructive with his own personal items. Some interventions that were effective was sitting and talking with the resident. Calling his family member usually calmed him down. When the resident got out of control staff would take him to his room and turn on the television. The QMA indicated he thought how a staff member approached the resident made a difference. The resident could get aggressive with his behavior. He was not sure why there wasn't a follow up on sending the resident to a behavior facility. The nursing staff would report his behavior and received orders to send the resident to a behavioral facility to the Unit Manager and the Social Service Director and they were responsible for making the arrangements and following up. During an interview on 7/27/23 10:45 a.m., LPN (Licensed Practical Nurse) 13 indicated she was aware the resident had behaviors. The Unit Manager, or Social Services should follow-up on the behavioral referrals. Once the nursing staff receive the order to send the resident to a behavioral facility, they would make the arrangements. During an interview on 7/27/23 at 2:08 p.m., VPCO (Vice President of Clinical Operations) indicated a behavioral health facility declined to admit the resident because of his mental disabilities. The resident did need to go to a behavioral health facility. A follow-up should have been done. There were facilities that accepted residents like			

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	Resident 86. The resident functioned at a five-year-old level. The resident's MDS indicated he was moderately cognitively impaired, which surprised her because she thought it would be lower. She did not know if other agencies were contacted. The clinical record did not indicate there was documentation indicating a follow-up was done. A reevaluation of the interventions should have been, and Social Services should have followed-up on the resident's behaviors. During an interview on 7/28/23 at 10:18 a.m., the DON indicated staff should follow the residents care plan. Staff should always make attempts to prevent the behaviors. They should be monitoring for agitation and what issues upset the resident. The resident would be taken back to his room for his outburst and to protect the other residents. The private room worked out well for the resident. The DON indicated she could not locate documentation regarding a follow-up. During an interview on 7/28/23 at 10:30 a.m., the ED (Executive Director) indicated staff should identify what triggered the resident and try to prevent the behavior. He indicated the unit could keep ice cream stocked if the ice cream shop was closed. The resident was impatient and wanted things done when he indicated he needed something. He felt like prevention would decrease the resident behaviors. The Behavior Assessment and Manage policy provided on 7/28/23 by the VPCO, included but was not limited to, "... It is important to understand causes of behavior problems in our residents ... ..." Behaviors may be related to physical discomfort, overstimulation, unfamiliar surroundings, complicated tasks and frustrating interactions. 1. Examine the behavior; What was			

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	the behavior? Was it harmful to the individual or others? What happened just before the behavior occurred? Did something trigger it? What happened immediately after the behavior occurred? How did you react? Could something be causing the person pain? Consult a physician to identify any causes related to medications or illness. 2. Explore potential solutions; What are the needs of the resident? Are they being met? Can adapting the surroundings comfort the person? How can you change your reaction or approach to the behavior? Are you responding in a calm and supportive way? 3. Try different responses; Did your new response help? Do you need to explore other potential causes and solutions? If so, what can you do differently? ...Understanding the nature of the issue/condition and addressing the underlying causes have the potential to improve the quality of the resident's life and lives of those with whom the resident interacts. Once behaviors have been assessed, the next step is to develop a resident-specific care plan base directly on the conclusion/underlying cause. If behaviors place the resident or others at risk for harm, immediate action is required to prevent any harm. The focus of the care plan should be to address the underlying cause or causes, reversing the daily display of troubling behaviors, and preventing any harm from occurring..." 3.1-37(a) 3.1-43(a)(1)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable			

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CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

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	physical, mental, and psychosocial well-being. Based on interview and record review, the facility failed to adequately implement social services to address the continuous behavior of crying, pacing, agitation, restlessness and adjustment to the secured unit for a resident with a diagnosis of dementia for 1 of 3 residents reviewed for Dementia Care. (Resident 110) Findings include: The clinical record for Resident 110 was reviewed on 7/26/23 at 12:36 p.m. The diagnoses included, but were not limited to, unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, delusional disorders, amnesia, anxiety disorder, and major depressive disorder. A physician's order, dated 2/10/23, indicated the resident received Ativan 0.5 mg (milligrams) one tablet two times a day for anxiety. The medication was discontinued on 2/12/23 and a new order for Lorazepam 0.5 mg one tablet every 12 hours PRN (as needed) was received. This medication was then discontinued on 2/24/23 by the psychiatrist. A nurse's note, dated 2/10/23 at 1:38 p.m., indicated the resident arrived on the secured unit with family. She appeared to have a short attention span and wandered up and down the hall unsure what to do. A nurse's note, dated 2/10/23 at 6:18 p.m., indicated from the time of admission the resident had been wandering frequently crying out loud, tears down her face, and indicated she did not know if she could do this. When questioned as to what it was she was talking about, the resident	F 0744	p="" xml: paraid="1165780699" paraeid="{1244deb6-8fdc-4881-b5b9-8057e72ee9f3}{164}">1. Resident #110 returned from Behavioral Health Hospital with physician order changes. Psychosocial assessment completed by social services, resident is at baseline and care plan interventions continue to be effective. 2. All residents with dementia have the potential to be affected by the alleged deficient practice. Residents with dementia experiencing behaviors over the last 30 days were reviewed by the IDT to verify appropriate interventions were in place, care planning and behavior monitoring orders updated as indicated. 3. Our social services team was provided education from the Vice President of Clinical Operations to ensure understanding of provision of behavioral health services for residents with behaviors to include but not limited to, behaviors of crying, pacing, agitation, restlessness and adjustment to the secured unit. Social Services Consultant (Lacy Beyl and Company Healthcare Consulting) has been contracted to begin providing monthly social services support and oversight. 4. The Director of Nursing and/or designee will review progress	08/18/2023

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	was unsure. She was very easily frustrated, anxious and shaky at times. The NP (Nurse Practitioner) spoke with the resident in regards to this behavior, reviewed the medications and medical record and gave a new order for Ativan due to the staff reporting depression, anxiety and agitation. A nurse's note, dated 2/11/23 at 1:57 a.m., indicated the resident was wandering in and out of several residents rooms, but was easily redirected. Exit seeking several times that evening and a wanderguard was placed. The resident was sad and crying at breakfast. A nursing behavior note, dated 2/11/23 at 6:22 a.m., indicated the resident's roommate was heard hollering. Upon entering the room, observed resident climbing into bed with roommate. The resident was able to be redirected. A physician's order, dated 2/13/23, indicated the staff were to document the number of episodes the resident had per shift of target behavior of pacing, agitation, restlessness or none twice a day. An entry into the eMAR system (electronic medication administration system), dated 2/16/23 at 7:47 a.m., indicated the resident was administered the PRN Lorazepam 0.5 mg for anxiety. An entry into the eMAR system, dated 2/17/23 at 8:02 p.m.., indicated the resident was administered the PRN Lorazepam 0.5 mg for anxiety. The Admission MDS assessment, dated 2/20/23, indicated the resident had severe cognitive impairment; had no mood or behavior issues; and		notes for residents experiencing behaviors to verify social services follow-up and care plan updates as appropriate M-F for (4) weeks and continue weekly for no less than (2) additional months. Any corrective action needed will be completed immediately. The results of these audits will be presented to the Quality Assurance/Performance Improvement committee meeting for a minimum of three months to validate 100% compliance and then on-going per routine QAPI reviews. Plan to be updated as indicated.	

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	wandered daily with the risk of wandering to a potentially dangerous place. A care plan, initiated on 2/21/23 with a review date of 5/24/23, indicated the resident had altered psychosocial needs related to dementia and anxiety. The goal was for the resident to not have any unidentified problems related to dementia and anxiety. The approaches included, but were not limited to, monitor for behavior every shift; provide non-pharmacological interventions such as offer reassurance and conversation and 1 to 1; and document if noted and arrange for psychiatric consult if needed. A Social Service note, dated 2/24/23 at 3:01 p.m., indicated the psychiatrist saw the resident for an initial visit per facility request. The Ativan was discontinued and a new order for Zoloft was received due to depressed mood. A physician's order, dated 2/25/23, indicated the resident received Zoloft 50 mg daily for depression. A physician's order, dated 2/27/23, indicated the staff were to observe the resident for side effects of the psychotropic medications twice daily. A nurse's note, dated 5/15/23 at 1:40 p.m., indicated the resident's family member was called and a message was left to give consent for psychiatric services to follow. The clinical record lacked a follow-up by nursing or Social Services to indicate if the family gave consent or not. A nurse's note, dated 5/19/23 at 10:22 p.m., indicated the resident was having increased			

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	crying spells; walking up and down hallway crying, and several attempts to get out the door. The resident continued to repeat "why are you doing this to me?" The resident was unable to express what she meant. Staff would redirect often by offering snacks, toilet, fluids, and activities which helped at the time, but behaviors would continue soon after. The resident was experiencing increased difficulty with performing ADL's (Activities of Daily Living) and became very agitated when trying to change clothes, or was assisted in the restroom. She liked to follow staff as they went into other residents rooms and became very agitated when staff tried to redirect her out. A nurse's note, dated 5/20/23 at 10:22 p.m., indicated the resident was very emotional in the evening, pacing up and down the hallway crying and going in and out of rooms as if she was looking for something or someone. The resident was unable to explain what was upsetting her due to cognitive decline. Numerous redirections given such as food, fluids, restroom, and activities which helped for a short time, but the resident went right back to previous behavior. A nurse's behavior note, dated 5/21/23 at 9:01 p.m., indicated the resident was crying a lot this evening, asking why people were doing this to her, and pacing up and down the hall. After 7 attempts, the resident finally took her medications. A psychiatric note, dated 5/22/23, indicated the resident was crying on the unit that people had beaten her up before, she was dying and her baby was out there. Staff reported these distressing delusions had been occurring for the past several weeks. A new order was received to start Risperdal 0.25 mg twice daily for paranoid			

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	delusions related to dementia. A nurse's behavior note, dated 5/22/23 at 5:33 p.m., indicated the resident had been pacing up and down the hallways, walked in and out of other residents' rooms and had periods of crying. The Quarterly MDS assessment, dated 5/23/23, indicated the resident had severe cognitive impairment; was ambulatory; had no mood issues except poor appetite; no wandering; and had occasional physical behaviors not directed at others. A care plan, dated 5/24/23, indicated the resident used psychotropic medications related to dementia - anti-psychotic and anti-depressant medications. The goal was for the resident to remain free of psychotropic drug related complications including, but not limited to, movement disorder and cognitive or behavioral impairment. The approaches included, but were not limited to, discuss with physician and family regarding ongoing need for use of medication; review behaviors and interventions and alternate therapies attempted and their effectiveness; monitor and document any adverse reactions to the psychotropic medications including behavior symptoms not usual to the person; and monitor and record occurrence of target behavior symptoms and document. A physician's order, dated 5/24/23, indicated the resident received Remeron 7.5 mg one time daily for anorexia. A nurse's note, dated 6/8/23 8:34 p.m., indicated that when the resident had been given a shower that shift, the resident became very agitated kicking, hitting, and punching which required 3			

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	staff to assist her. Lots of redirection and encouragement was given without success. The resident was very hard to get to change her clothes, change her pull-up, and with overall personal care. A nurse's late entry note, dated 6/19/23 at 8:09 a.m., indicated the psychiatrist was in to see the resident and discontinued the Risperdal due to seizures and wrote a new order for Depakote for behaviors with delusions. Staff were to monitor and update as needed. A physician's order, dated 6/20/23, the resident received for Depakote delayed release tablets 125 mg, one tablet twice daily for dementia with behaviors. A nurse's note, dated 6/27/23 at 9:19 a.m., indicated the resident refused all medications. A nurse's note, dated 7/13/2023 at 10:22 p.m., indicated the resident was anxious and agitated when it was time for a shower. The shower was refused by resident and no other attempts were made to try to get the resident to take a shower, so as not to agitate her even more. A nurse's behavior note, dated 7/15/2023 at 7:32 a.m., indicated the resident was tearful that morning during breakfast as she was sad she had lost her dog. The resident appeared to have increased anxiety. Once the dog was located, the resident calmed down. A physician's progress note, dated 7/15/23 at 11:59 p.m., indicated staff reported the resident had been in tears and voicing she wanted to die. Staff were to continue to monitor.			

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	An entry into the eMAR system, dated 7/17/23 between 8:40 a.m. and 8:45 a.m., indicated the resident refused all her morning medications. A psychiatric note, dated 7/17/23, indicated the staff reported the resident to have been in tears and voicing wanting to die as she had misplaced her dog. The resident was to continue her Depakote and staff were to continue to monitor and update accordingly. During an interview with CNA 22 on 7/28/23 at 10:30 a.m., she indicated the resident has good and bad days, especially when family visited and then had to leave. When she had episodes of crying, agitation, etc, staff did refer and let Social Services know so she could follow up with the resident. In an interview with the Social Service Assistant on 7/31/23 at 11:00 a.m., she indicated she did do daily rounds and talked with the nurses everyday to determine if they needed anything or if there were any issues with the residents. The resident's clinical record lacked documentation of any Social Service follow-up after admission to the facility, services for adjusting to the secured unit, or for the continuous behavior of crying, pacing, agitation, and restlessness . On 7/31/23 at 10:55 a.m., the Director of Social Services presented a signed copy of her job description dated effective that day as she forgot to sign it at time of hire. The Regional Support Nurse also presented a copy of the Social Services Assistant's job description signed 5/19/22. Review of these job descriptions included, but were not limited to, "Summary:			

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	Ensures residents and families are assisted with personal and environmental difficulties which predispose illness or interfere with obtaining maximum benefits from medical care by performing the following duties: Essential Duties and Responsibilities: ...1. Regularly oversees and assists with resident evaluation and treatment. This includes but is not limited to: communicating with and evaluating resident (s); providing services to promote optimum resident social and mental health; promote understanding by staff of social and emotional factors of health problems; working cooperatively with interdisciplinary team to develop, implement, and regularly evaluate resident plans of care;..communicate resident concerns, preferences, choices, customs, and needs to the interdisciplinary team and direct care staff...3. Regularly communicates with resident (s) and families regarding social services. This includes but is not limited to: evaluating mental and cognitive functioning of residents and social needs; communicating with families regarding resident interests and preferences; as well as importance and purpose of medical recommendations; planning and /or otherwise promoting activities to enhance resident social and mental well-being. 4. Ensures proper documentation is maintained. This may include but is not limited to: update and audit of social services assessments, completion of the MDS information as necessary, ensures reportation of social services matters in progress notes. 5. Performs quality assessment and assurance functions, including but not limited to, daily regulatory compliance rounds; observation of provision of social services, record reviews; implementation of corrective measures, staff members, residents, family interviews..." 3.1-37(a)			

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F 0745 SS=E Bldg. 00	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.			
	Based on record review and interview, the facility failed to ensure appropriate social services follow-up after unwanted and inappropriate behavior interactions from a resident with behavior concerns for 8 of 9 residents reviewed for Social Services. (Residents 24, 80, 320, 57, 20, 60, and 86) Findings include: 1. The nurse's note, dated 11/25/22 at 9:33 a.m., indicated while rounding on Resident 86 due to his behaviors, the resident's roommate (Resident 24) indicated he felt unsafe in the room with Resident 86 and wanted to be dressed and taken out of room. He did not want to return to the room while his roommate was in the room. He was immediately dressed and removed from room and placed in common area. The resident was mobile in a wheelchair. The Significant Change MDS (Minimum Data Set) assessment, dated 6/26/23, for Resident 24 indicated the resident was moderately cognitively impaired. He required extensive assistance with bed mobility and extensive assistance for transfers. The record lacked documentation of any social services follow-up for Resident 24. 2. The nurse's note, dated 3/7/23 at 3:35 p.m., indicated Resident 86 was upset due to the ice	F 0745	1.p class="Paragraph SCXW255127710 BCX8" xml:lang="EN-US" paraid="18061249" paraeid="{5e6c3df7-c9dd-4c80-a008-7b4f93e66062}{240}" >1. Residents 24, 80, 320, 57, 20, 60, and 86 were not harmed by the alleged deficient practice. Social Services provided psychosocial follow-up and supportive documentation entered into the resident's record. 2. All residents have the potential to be affected by the alleged deficient practice. Residents experiencing unwanted and inappropriate behavior interactions over the last 30 days were reviewed by the IDT to verify appropriate follow-up and interventions were in place, care planning and behavior monitoring orders updated as indicated. . 3. Our social services team was	08/18/2023

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	cream parlor being closed, not being able to get a haircut, and not being able to get fast food for lunch. The resident was able to calm down and wanted to come back out to the living room. Moments later the resident took off his glasses and threw them across the room. While throwing his glasses they hit Resident 80 in the face. The Quarterly MDS assessment, dated 5/23/23, for Resident 80 indicated the resident was severely cognitively impaired. She required extensive assistance with bed mobility and transfers. She was mobile in her wheelchair. The record for Resident 80 lacked documentation of any social services follow-up. 3. The nurse's note, dated 5/5/23 at 6:43 p.m., indicated Resident 86 was in the common area on the 100/400 Unit. He went behind Resident 320 who was sitting in a chair watching television and grabbed the resident's hair. The CNA removed the resident from 100/400 Unit. The Annual MDS assessment, dated 6/23/23, for Resident 320 indicated the resident was severely cognitively impaired. She required extensive assistance with bed mobility and transfers. She was mobile in a wheelchair. The record for Resident 320 lacked documentation of any social services follow-up. 4. The incident report, dated 7/10/23, indicated Resident 86 became agitated with staff while in the corridor. Resident 57 had been walking by and Resident 86 reached out and pinched her in the right arm as she went by. Nursing and social services provided support, follow up, and a complete daily assessment for the resident for		provided education from the Vice President of Clinical Operations to ensure understanding of required provision of behavioral health services and follow-up for residents experiencing unwanted and inappropriate behavior interactions. Social Services Consultant (Lacy Beyl and Company Healthcare Consulting) providing monthly social services support and oversight starting on 8/17/2023. . 4. The Director of Nursing and/or designee will review nurses' notes for residents experiencing unwanted and inappropriate behavior interactions from other residents to verify social services support has been provided and documented M-F for (4) weeks and continue weekly for no less than (2) additional months. Any corrective action needed will be completed immediately. The results of these audits will be presented to the Quality Assurance/Performance Improvement committee meeting for a minimum of three months to validate 100% compliance and then on-going per routine QAPI reviews. Plan to be updated as indicated.	

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	three days. The Quarterly MDS assessment, 6/28/23, for Resident 57 indicated the resident was severely cognitively impaired. She required supervision with bed mobility and transfers. She was mobile with the assistance of a walker. The record for Resident 57 lacked documentation of any social services follow-up. 5. The incident report, dated 4/18/23, indicated Resident 86 became agitated with staff and began throwing items. Resident 20 was ambulating in her wheelchair in the hallway and Resident 86 hit her in the arm as she went past him. Nursing and social services were to continue providing support, follow up and complete daily assessment. The Annual MDS assessment, dated 6/26/23, for Resident 20 indicated the resident was cognitively intact. She required supervision with bed mobility and independent with transfers. She was mobile in a wheelchair. The record for Resident 20 lacked documentation of any social services follow-up. 6. The nurse's note, dated 10/30/22 at 3:15 p.m., indicated Resident 86 was witnessed by staff pinching Resident 60. The CNA's separated Resident 86 from the other residents for safety. The Annual MDS assessment, dated 7/5/23, for Resident 60 indicated the resident was moderately cognitively impaired. She required extensive assistance with bed mobility and transfers. She was mobile with a wheelchair.			

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	The record for Resident 60 lacked documentation of any social services follow-up. 7. The record for Resident 86 was reviewed on 7/26/23 at 11:37 a.m. The diagnoses included, but were not limited to, developmental disorder of speech and language, anxiety disorder, altered mental status, and lack of expected normal physiological development in childhood. The care plan, dated 7/21/21 and last revised on 2/1/23, indicated the resident had behavior problems of expressing frustration, agitation, anxious and restless by throwing items and making disruptive sounds The Quarterly MDS assessment, dated 6/15/23, indicated the residents was moderately cognitively impaired. The MDS indicated the resident did not exhibit behavioral symptoms such as hitting, kicking, pushing, scratching, and grabbing. The clinical record lacked documentation indicating Resident 86 was evaluated for a behavioral health facility for his behaviors or follow up by Social Services for the resident's psychological needs after behavior outburst. During an interview on 7/26/23 at 11:00 a.m., the Social Service Director indicated her social service notes on follow-up with the residents would be documented in the computer under the general note section. The facility did not have any resident charting on paper form. During an interview on 7/27/23, at 10:30 a.m., QMA (Qualified Medication Aide) 7 indicated Resident 86 did have behaviors. The resident had a difficult time controlling his emotions. The			

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	resident could get aggressive with his behavior. The nursing staff would report the resident's behaviors. During an interview on 7/27/23 10:45 a.m., LPN (Licensed Practical Nurse) 13 indicated she was aware the resident had behaviors. She indicated the Unit Manager and Social Services should follow-up on the behavioral referrals. During an interview with the Social Service Assistant on 7/31/23 at 11:00 a.m., she indicated she did do daily rounds and talked with the nurses everyday to determine if they needed anything or if there were any issues with the residents. On 7/31/23 at 10:55 a.m., the Director of Social Services presented a signed copy of her job description dated effective that day as she forgot to sign it at time of hire. The Regional Support Nurse also presented a copy of the Social Services Assistant's job description signed 5/19/22. Review of these job descriptions included, but were not limited to, "Summary: Ensures residents and families are assisted with personal and environmental difficulties which predispose illness or interfere with obtaining maximum benefits from medical care by performing the following duties: Essential Duties and Responsibilities: ...1. Regularly oversees and assists with resident evaluation and treatment. This includes but is not limited to: communicating with and evaluating resident (s); providing services to promote optimum resident social and mental health; promote understanding by staff of social and emotional factors of health problems; working cooperatively with interdisciplinary team to develop, implement, and regularly evaluate resident plans of care;..communicate resident			

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	155668	A. BUILDING 00 B. WING	07/31/2023

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	concerns, preferences, choices, customs, and needs to the interdisciplinary team and direct care staff...3. Regularly communicates with resident (s) and families regarding social services. This includes but is not limited to: evaluating mental and cognitive functioning of residents and social needs; communicating with families regarding resident interests and preferences; as well as importance and purpose of medical recommendations; planning and /or otherwise promoting activities to enhance resident social and mental well-being. 4. Ensures proper documentation is maintained. This may include but is not limited to: update and audit of social services assessments, completion of the MDS information as necessary, ensures reportation of social services matters in progress notes. 5. Performs quality assessment and assurance functions, including but not limited to, daily regulatory compliance rounds; observation of provision of social services, record reviews; implementation of corrective measures, staff members, residents, family interviews..." 3.1-34(a)(1) 3.1-34(a)(2)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.			

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	(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure the dishwashing equipment was at an appropriate temperature to disinfect dishes. This had to potential to affect all 115 resident residing in the facility. Findings include: During an observation on 7/24/23 at 9:39 a.m., the dishwasher's temperature gauge read 110 degrees F (Fahrenheit) during the wash cycle and the rinse cycle read 109 degrees F. During an interview on 7/24/23 at 9:45 a.m., the Dietary Manager indicated he was not happy with the dishwasher temperature. During an observation on 7/26/23 at 12:53 p.m., the dishwasher's temperature gauge read 110 degrees F on the wash cycle and the rinse cycle read 108 degrees F. During an interview on 7/26/23 at 12:55 p.m., the District Manager indicated the low temperature was due to the staff running the hot water on the dishes, while running the dishwasher. He educated the staff on not using the hot water while using the dishwasher.	F 0812	1.p class="Paragraph SCXW80933199 BCX8" xml:lang="EN-US" paraid="125871767" paraeid="{b1b69a5d-21d0-4ce9-b184-1d14eb015132}{52}" >1. On 8/15/2023, Auto-Chlor installed a booster heater to supplement the low-temperature dish machine to increase the water temperatures going into the machine preventing the residual water temperature of the wash or rinse cycles to drop below 120 degrees. 2. All residents have the potential to be affected by the alleged deficient practice. . 3. Education was provided to dietary staff on measuring and recording dish machine	08/15/2023

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	During an observation on 7/31/23 at 8:27 a.m., the dishwasher label indicated the following: -Water temperature minimum of 120 degrees. -Chlorine Residual 50 ppm minimum. -Minimum wash 56 seconds. Rinse 24 seconds. -The washer was running at 112 degrees F on the wash cycle. The rinse cycle was at 100 degrees F. During an interview on 7/31/23 at 8:30 a.m., the District Manager indicated it would read low when it was running. The machine was chlorine based. He had talked to the dishwasher company, and they indicated it wouldn't read at temperature all the time. The temperature dropped because the wash cycle was running. It was a low temperature washer. The dishwasher company changed out the thermometer over the weekend and they indicated someone had hit it with something. During an interview on 7/31/23 at 9:26 a.m., the Environmental Manager indicated there had been no issues in the kitchen with getting hot water. The boiler was right next to the kitchen, so there shouldn't be an issue with the water temperature getting hot enough. A new thermostat was placed on the dishwasher last week on Wednesday 7/26/23 or Thursday 7/27/23. The dishwasher company's system dishwasher specifications were provided by the District Manager on 7/31/23 at 11:15 a.m. The specifications indicated the " ... A4 [energy rating] Water Saver Low energy dish machine .... B. Water Supply Temp (temperature) 120 small circle [degrees] F Minimum ... Note: This unit does not produce heat or steam ..." 3.1-21(i)(3)		temperatures to validate water temperatures remain above 120 degrees. . 4. The Executive Director and/or Registered Dietician will audit that dish machine temperatures are maintained above 120 degrees at least (5) days a week for (4) weeks and then at least weekly for no less than (2) additional months. Any corrective action needed will be completed immediately. The results of these audits will be presented to the Quality Assurance/Performance Improvement committee meeting for a minimum of three months to validate 100% compliance and then on-going per routine QAPI reviews. Plan to be updated as indicated.	

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F 0883 SS=E Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;			

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	(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on record review and interview, the facility failed to ensure residents were offered pneumococcal vaccinations as recommended by the CDC (Centers for Disease Control) for 3 of 5 residents reviewed for pneumococcal immunizations. (Residents 377, 18, and 22) Findings include: 1. The record for Resident 377 was reviewed on 7/28/23 at 8:48 a.m. The record indicated Resident 377 was 71 years old and had received PCV13 (pneumococcal conjugate vaccine) on 6/4/22. The record lacked documentation of any offer for the resident to receive the recommended second dose of either PCV20 or PPSV23 (pneumococcal polysaccharide vaccine) after one year as recommended by the current CDC guidance. 2. The record for Resident 18 was reviewed on 7/28/23 at 8:50 a.m. The record indicated Resident	F 0883	1.p paraid="1804191182" paraeid="{0bd3fb36-afe0-443f-b8df-b9c5fd979be7}{253}" >1. Resident #377, 18, and 22' s pneumococcal vaccinations records were reviewed education provided and recommended doses offered. 2. All Residents have the potential to be affected by the alleged deficient practice. An audit was conducted by the nurse management team to identify all current residents with recommended doses due. Education was provided and vaccinations offered.	08/18/2023

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	18 was 80 years old and had received one dose of PCV13 on 4/2/21. The record lacked documentation of any offer for the resident to receive the recommended second dose of either PCV20 or PPSV23 after one year as recommended by the current CDC guidance. 3. The record for Resident 22 was reviewed on 7/28/23 at 8:52 a.m. The record indicated Resident 22 received 1 dose of PPSV23 on 3/10/21. The record lacked documentation of any offer for the resident to receive the recommended second dose of either PCV20 or PCV15 after one year as recommended by the current CDC guidance. During an interview on 7/27/23 at 2:15 p.m., the Vice President of Clinical Operations (VPCO) indicated they had become aware of issues with their pneumococcal vaccines not being up to date a couple of weeks prior, when they did their survey preparation visit. They realized they were deficient and had developed a plan to correct it, but had not yet taken any steps to correct the deficiency. They'd had a change over in management, when the previous Director of Nursing left, the Infection Preventionist had to step up into her role and they had not yet taken steps to offer vaccines per the current CDC guidelines. During an interview on 7/31/23 at 8:31 a.m., the VPCO indicated they had educated the former DON and Unit Manager on utilizing an app to tell them what pneumonia vaccines should be offered, including how to download and utilize it, but did not yet implement its use and had not conducted an audit of the resident's vaccination status.		. 3. Nursing management staff were educated by Vice President of Clinical Operations on the pneumococcal vaccination policy and the use of CDC recommended app for determining appropriate doses of pneumococcal vaccination, and the requirement for providing education, obtaining consent or declination, administering doses and documentation. The Infection preventionist will review all admissions ongoing for current vaccination status and recommended doses. Education will be provided, consent or declination obtained, orders entered, and doses administered. . 4. The Director of Nursing and/or designee will review all new admissions weekly for (4) weeks then monthly for no less than (2) additional months. Any corrective action needed will be completed immediately. The results of these audits will be presented to the Quality Assurance/Performance Improvement committee meeting for a minimum of three months to validate 100% compliance and then on-going per routine QAPI reviews. Plan to be updated as	

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	On 7/31/23 at 8:52 a.m., The VPCO provided the facilities most current Pneumococcal Vaccination policy, and indicated it was last revised March 2022 but it did indicate to follow current CDC guidelines for Pneumococcal Vaccinations. Guidance for Pneumococcal Vaccine Timing for Adults was obtained from the CDC's website on 7/31/23. The guidance included, but was not limited to, "... Make sure your patients are up to date with pneumococcal vaccination... Adults greater than 65 years old Complete pneumococcal vaccine schedules... Prior vaccines... PPSV23 only... Option A... PCV20... Option B... PCV15... PCV13 Only... Option A... PCV20... Option B... PPSV23..." 3.1-13(a)		indicated.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: July 24, 25, 26, 27, 28, and 31, 2023. Facility number: 001144 Residential Census: 7 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 3, 2023.	R 0000	Allegation of Compliance Please accept the following plan of correction for the complaint survey completed on July 31, 2023. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the	

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			Federal and State Laws. This facility appreciated the time and dedication of the Surveyor; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community. We respectfully request consideration for a desk review and paper compliance.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for			

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	every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure coverage by staff for First Aid. This had the potential to affect all 7 residents residing in Assisted Living. Findings include: The review on 7/28/23 at 2:47 p.m., of the staff schedule, dated 7/25/23 to 7/31/23, indicated the following: -On 7/25/23, the 6:30 p.m. to 6:30 a.m. shifts had no staff with First Aid certification. -On 7/26/23, the 6:30 p.m. to 6:30 a.m. shifts had no staff with First Aid certification. -On 7/27/23, the 6:30 p.m. to 6:30 a.m. shifts had no staff with First Aid certification. -On 7/28/23, the 6:30 p.m. to 6:30 a.m. shifts had no staff with First Aid certification. -On 7/29/23, the 6:30 a.m. to 6:30 p.m. shifts had no staff with First Aid certification. -On 7/29/23, the 6:30 p.m. to 6:30 a.m. shifts had no staff with First Aid certification. -On 7/30/23, the 6:30 a.m. to 6:30 p.m. shifts had no staff with First Aid certification. -On 7/30/23, the 6:30 p.m. to 6:30 a.m. shifts had no staff with First Aid certification. -On 7/31/23, the 6:30 p.m. to 6:30 a.m. shifts had no staff with First Aid certification. The facility provided First Aid certification cards for LPNs (Licensed Practical Nurse) 29 and 30. During an interview on 7/31/23 at 10:38 a.m., the DON indicated there were only two staff members with First Aid, which were LPNs 29 and 30. There	R 0117	1. There is a staff member that holds a current First Aid Certification at the facility 24 hours a day. Those identified as needing First Aid Certification have completed or been scheduled for completion. . 2. All residents residing in residential care have the potential to be affected by the alleged deficient practice. . 3. The Nursing Management Team was provided education by the Vice President of Clinical Operations on the residential care regulation requiring a staff member to have an active First Aid Certification 24-hours a day. Nursing staff will have First Aid Training to ensure there is 24-hour staff coverage as required. First Aid Certification will be scheduled for new staff as needed. .	08/18/2023

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	were no others with First Aid. They had someone scheduled to come in and do First Aid for the nurses on August 28, 29, and 30th. They had coverage on Monday thru Friday and every other weekend, from 7:30 a.m. to about 4:00 p.m. on the weekdays, and the 6:30 a.m. to 6:30 p.m. shift on every other weekend. During an exit interview on 7/31/23 at 2:52 p.m., the Vice President of Clinical Operations indicated she could not locate a policy for CPR and First Aid, but followed the State regulations.		4. The Director of Nursing and/or will audit the daily nursing schedule to verify there is a staff member with a current First Aid Certification 24-hours a day. This audit will continue daily for (4) weeks then weekly for no less than (2) additional months. Any corrective action needed will be completed immediately. The results of these audits will be presented to the Quality Assurance/Performance Improvement committee meeting for a minimum of three months to validate 100% compliance and then on-going per routine QAPI reviews. Plan to be updated as indicated.	
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to ensure the dishwashing equipment was at an appropriate temperature to disinfect dishes. This had to potential to affect all 7 residents residing in the facility. Findings include: During an observation on 7/24/23 at 9:39 a.m., the dishwasher's temperature gauge read 110 degrees F (Fahrenheit) during the wash cycle and the rinse	R 0154	1. On 8/15/2023, Auto-Chlor installed a booster heater to supplement the low-temperature dish machine to increase the water temperatures going into the machine preventing the residual water temperature of the wash or rinse cycles to drop below 120 degrees. 2. All residents have the potential to be affected by the	08/15/2023

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	cycle read 109 degrees F. During an interview on 7/24/23 at 9:45 a.m., the Dietary Manager indicated he was not happy with the dishwasher temperature. During an observation on 7/26/23 at 12:53 p.m., the dishwasher's temperature gauge read 110 degrees F on the wash cycle and the rinse cycle read 108 degrees F. During an interview on 7/26/23 at 12:55 p.m., the District Manager indicated the low temperature was due to the staff running the hot water on the dishes, while running the dishwasher. He indicated he would educate the staff on not using the hot water while to using the dishwasher. During an observation on 7/31/23 at 8:27 a.m., the dishwasher label indicated the following: -Water temperature minimum of 120 degrees. -Chlorine Residual 50 ppm minimum. -Minimum wash 56 seconds. Rinse 24 seconds. -The washer was running at 112 degrees F on the wash cycle. The rinse cycle was at 100 degrees F. During an interview on 7/31/23 at 8:30 a.m., the District Manager indicated it would read low when it was running. The machine was chlorine based. It was 100% dependent on the hot water. He had talked to the dishwasher company, and they indicated it wouldn't read at temperature all the time. The temperature dropped because the wash cycle was running. It was a low temperature washer. The dishwasher company changed out the thermometer over the weekend and they indicated someone had hit it with something. During an interview on 7/31/23 at 9:26 a.m., the		alleged deficient practice. 3. Education was provided to dietary staff on measuring and recording dish machine temperatures to validate water temperatures remain above 120 degrees. 4. The Executive Director and/or Registered Dietician will audit that dish machine temperatures are maintained above 120 degrees at least (5) days a week for (4) weeks and then at least weekly for no less than (2) additional months. Any corrective action needed will be completed immediately. The results of these audits will be presented to the Quality Assurance/Performance Improvement committee meeting for a minimum of three months to validate 100% compliance and then on-going per routine QAPI reviews. Plan to be updated as indicated.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHARLESTOWN PLACE AT NEW ALBANY	4915 CHARLESTOWN RD NEW ALBANY, IN 47150

(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
	Environmental Manager indicated there had been no issues in the kitchen with getting hot water. The boiler was right next to the kitchen, so there shouldn't be an issue with the water temperature getting hot enough. A new thermostat was placed on the dishwasher last week on Wednesday 7/26/23 or Thursday 7/27/23. The dishwasher company's system dishwasher specifications were provided by the District Manager on 7/31/23 at 11:15 a.m. The specifications indicated the " ... A4 [energy rating] Water Saver Low energy dish machine .... B. Water Supply Temp (temperature) 120 small circle [degrees] F Minimum ... Note: This unit does not produce heat or steam ..."			