STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155383	A. BUILDING 00 B. WING	07/11/2024

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WASHINGTON HEALTHCARE CENTER	8201 W WASHINGTON ST INDIANAPOLIS, IN 46231

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00432234, IN00433695 and IN00437554. Complaint IN00432234 - No deficiencies related to the allegations are cited. Complaint IN00433695 - Federal/state deficiencies related to the allegations are cited at F550. Complaint IN00437554 - No deficiencies related to the allegations are cite. Survey dates: July 8, 9, 10 and 11, 2024. Facility number: 000393 Provider number: 155383 AIM number: 100289340 Census Bed Type: SNF/NF: 53 Total: 53 Census Payor Type: Medicare: 1 Medicaid: 37 Other: 15 Total: 53 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on July 16, 2024.	F 0000		
F 0550 SS=D	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keira Gilmore	ED	07/29/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Bldg. 00	§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as			

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	required under this subpart. Based on observation, interviews and record reviews, the facility failed to ensure a resident (Resident B) was treated with respect and dignity during a care plan meeting when she attempted to express her concerns for 1 of 3 residents reviewed for dignity. Findings include: On 7/8/24 at 10:16 a.m., Resident B was observed as she reclined in her bed and played a game on her smartphone. During a general and initial interview, Resident B indicated the Executive Director (ED) had hurt her feelings and made her angry. Resident B indicated she did not feel comfortable talking about the ED and was afraid she would get in trouble if she continued to complain about the way she felt she had been treated. Resident B indicated, she had been in a care plan meeting with the Social Service Director, the Minimum Data Set Coordinator (MDSC) and her best friend who helped her coordinate her care was on speakerphone. During the meeting, the ED had been asked to come to the room since Resident B and her friends had several additional care concerns that needed to be addressed. When the ED came and got involved in the conversation, she said something that offended Resident B. When Resident B attempted to inform her of the offense, she addressed the ED by saying, "hey you," but before she could finish, the ED cut her off and pointed her finger in her face and said, "excuse me, I am not a 'you' I'm a person and you will treat me with respect." Resident B was astonished and told the ED back, "you'll have to earn my respect." Then the ED replied, "I don't feel much like respecting you at all." After that, the ED abruptly ended the care plan meeting and told the MDSC and SSD to leave	F 0550	F550 The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. The facility is requesting paper compliance for this citation. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? Resident B was followed by social service with no concerns noted. ED identified in 2567 is no longer working at facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. All residents who had a care plan meeting within the last 30 days were interviewed by Social Service Director/designee to ensure residents were treated with respect and dignity during the care plan meeting. No concerns were identified. What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?	08/02/2024

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	the room and the ED left too. Resident B indicated the door was slammed on the way out, and she was speechless. She cried from embarrassment and anger and finished talking with her friend who helped calm her down. During a confidential interview, it was indicated, a verbal altercation was overheard between Resident B and the ED. Resident B had not known or had not remembered the ED's name because the ED was relatively new to the building. When Resident B addressed the ED as "you," she had not done so with negative intentions, but she just didn't know the ED's name. It was indicated, the tone and attitude of the ED's voice was much more aggressive than appropriate and it was unprofessional to argue, end the meeting, and slam the door. During a confidential interview, it was indicated, Resident B was a unique character with several personality quirks and oddities. When someone talked to Resident B, they would need to be patient as she tended to go on tangents and get sidetracked with unrelated topics/stories. Resident B had some cognitive/intellectual impairments that sometimes made her sound and act childish, but overall, she was a cooperative and pleasant resident who had a good rapport with most of the staff members and even gave them little gifts like snacks and candy. With her oddities, Resident B was sometimes misunderstood and would snap back at people, but if the person was patient, Resident B would come back around and apologize. Staff members who knew Resident B, knew not to take it seriously or personally. The ED, however, was new to the building and did not know Resident B very well. During a recent care plan meeting, Resident B addressed the ED as "you" and used a		All staff attending care plan meetings were in-serviced on resident rights and dignity Attendees at care plan meeting will be asked if residents are being treated with respect and dignity. If any concerns voiced, appropriate action will be taken How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? To ensure compliance, the ED/Designee is responsible for the completion of the Dignity QA tool weekly times 4 weeks, monthly times 6 and then quarterly. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. Date of compliance: 8/2/2024	

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	backscratcher to point at the ED to address her, and the ED took great offense to it. The ED interrupted Resident B, pointed back at her, and with a disrespectful tone told her to treat her with respect. Resident B indicated she also deserved respect, but the ED replied that she did not feel like Resident B deserved respect. The ED ended the meeting and made everyone leave. During an interview on 7/10/24 at 11:00 a.m., Resident B's friend indicated, she had been on speakerphone during the care plan meeting and requested the ED to come and address several of her concerns. Resident B's friend had concerns related to her wound treatment changes and medication regimen. During the conversation, the ED raised her voice at Resident B and demanded that Resident B treat her with more respect than she had. Resident B became upset and tearful. Resident B's friend indicated her actions had been very unprofessional. During a confidential interview, it was indicated, someone went in to check on Resident B, as they routinely did when they were there. They found Resident B crying, which was odd, as Resident B was usually very pleasant and jovial. Resident B retold the story of the incident where the ED had been rude and disrespectful to her and made Resident B feel like she did not matter. During an interview on 7/11/24 at 11:42 a.m., the ED indicated, she had been asked to come down to a care plan meeting for Resident B because the resident and her representative had many care concerns that needed to be addressed. The ED indicated she did not remember what led up to the incident, but Resident B had been using foul language and was being disrespectful to her and the staff. At one-point, Resident B held up her			

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	backscratcher in an aggressive manor and pointed it into the ED's face and called her, "you." The ED indicated she had been offended and felt demeaned, so she told Resident B, "to get respect you have to earn respect." The ED ended the care plan meeting because they were not getting anywhere productive, and she did not remember slamming the door. On 7/10/24 at 10:55 a.m., Resident B's medical record was reviewed. She was a long-term care resident who had diagnoses which included but were not limited to mild cognitive impairment, dementia and depression. The most recent minimum data set (MDS) assessment was a quarterly assessment dated 5/7/24 which indicated Resident B was cognitively intact and had no behaviors coded for the look-back timeframe. Resident B's care plan was reviewed and lacked documentation or revision of a history or risk of behaviors related towards staff. Resident B's observations and events lacked documentation of behavioral concerns related towards staff. During the survey entrance conference on 7/8/24 at 9:30 a.m., a copy of the facilities' Residents Rights policy was requested and provided by the ED. The policy was titled, "American Senior Communities Resident's Rights," revised 10/2023. The policy indicated, "The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility			

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	must protect and promote the rights of each resident ...The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States, and to be free from interference, coercion, discrimination, and reprisal from the facility ... The resident has the right to be treated with respect and dignity ...." This citation relates to Complaint IN00433695. 3.1-3(t)			
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response.			

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	(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. Based on observations, interviews and record reviews, the facility failed to ensure Resident Council Grievance concerns related to call light wait and response times were addressed in a timely and effective manner to prevent ongoing concerns. This deficient practice had the potential to affect 10 of 53 residents who attended the Resident Council Meeting and complained on behalf of all 53 residents who resided in the facility. Findings include: On 7/9/24 at 9:36 a.m., the call light for room 310 was observed. It was illuminated, flashed and alarmed at the nurse's station. Several staff members passed the light. On 7/10/24 at 11:00 a.m., Resident 35 was heard as she yelled out, "Nurse!" over and over. After five minutes, Resident 35 yelled again, with a louder voice and frustrated tone. This visitor knocked and entered her room to ask what the resident needed assistance with. Resident 35 indicated she wanted to get out of bed, but no one would listen to her. Within seconds of the visitor's entrance into the room, 4 staff members came to answer the	F 0565	F565E Resident/Family Group and Response. Based on interview and record review, the facility failed to ensure. Resident Council Grievance concerns related to call light wait and response time were addressed in a timely manner to prevent ongoing concerns. This deficient practice had the potential to affect 10 of 53 residents who attended the Resident Council Meeting and complained on behalf of all 53 residents who resided in the facility. The building is requesting paper compliance for this citation. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Applicable staff have responded to the following concerns and presented responses and follow up to the resident council call lights wait and response time. How other residents having the potential to be affected by the	08/02/2024

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	light. On 7/10/24 at 11:28 a.m., Resident 12's call light was illuminated, flashed and sounded at the nurses' station. After more than 5 minutes, this visitor knocked and asked the resident what she needed assistance with. The resident indicated she was still waiting for her morning medications. During the interview, the Executive Director (ED) entered the room to take over her concern. On 7/10/24 from 11:37 a.m. until 11:43 a.m., the call light for room 306 was illuminated, flashed and sounded at the nurses' station. Two nurses stood at the medication cart one door down from the illuminated call light and carried on a personal conversation. This visitor saw two Certified Nursing Aides, (CNAs) who came up the hall and asked if room 306's light had been answered. One unidentified CNA indicated; they were on the way to address it at that time. On 7/10/24 at 11:43 a.m., the call light for room 319 turned on. Two nurses were sitting at the nurses' station. The alarm at the nurses' station continued for over 5 minutes before the ED came to the nurses' station and asked someone to answer the light. At 11:52 a.m., one of the nurses took a glass of ice to the room and turned off the light. On 7/11/24 at 9:16 a.m., room 303's bathroom call light was observed illuminated and sounded for over 5 minutes. This visitor knocked and entered to ask the resident what she needed assistance with and found the resident on the toilet. At that time, the ED came to take over the concern. On 7/11/24 at 12:49 p.m., the call light for room 310 was observed illuminated and alarmed for over 5 minutes. There were two nurses at the desk who		same deficient practice will be identified and what corrective action will be taken? • All residents have the potential to be affected. All staff have been inserviced related to responding to call lights in a timely manner by ED/designee IDT completed interviews with residents to ensure call lights are responded to in a timely manner. • A resident council meeting will be held to ensure resident concerns are addressed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? • Resident council minutes will be reviewed by ED/Designee to ensure any concern identified has appropriate follow up documented on grievance form. Resident satisfaction will be reviewed with the resident for each grievance identified. How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? • SSD/MCSS/designee will complete a resident council QAPI • Resident Council Meeting will be held 2x/month X 4 months to monitor resident concerns and ensure adequate resolution and acceptance by Resident Council	

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	did not get up to answer the light until this visitor knocked and entered the room. On 7/10/24 at 1:20 p.m., the Resident Council Minutes were reviewed and revealed the following. A meeting was held on 4/5/24 and 11 residents were present. They complained that call light response time was too long, "night shift concerns for call lights." A Follow-Up response form dated 4/5/24 indicated education and in-service was provided to staff to answer call lights on time. A meeting was held on 4/26/24 and 7 residents were in attendance. They complained that call light response time was improved, but they still waited a long time. A meeting was held on 5/3/24 and indicated, concerns identified during the previous meeting, "call lights not answered promptly. A Follow-Up form dated 5/3/24 indicated staff had been educated on answering call lights promptly. A meeting was held on 7/5/24 and 8 residents were in attendance. They complained, "half an hour up to an hour [call light] wait time." A Follow-Up form dated 7/8/24 indicated education was provided to the staff to address call light wait times. Records of the above-mentioned education/in-service records were requested and provided by the Regional Director of Clinical Services (RDCS) on 7/10/24 at 1:50 p.m. The In-Service binder was reviewed. Although there were various attendance sheets with staff signatures and a summary of the meeting, there was no accompanying documentation of what		members. By what date the systemic changes will be completed: 8/2/2024	

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	was reviewed, how it was reviewed, and/or additional education or training for ineffective in-services. Additionally, there were several attendance logs with signatures, but no summary or title of the in-service. On 7/10/24 at 2:00 p.m., the RDCS indicated, the previous Director of Nursing (DON) had been responsible for the implementation and organization of the Facility's In-Service Program, but evidently had not kept up with the documentation. No additional documentation could be provided. On 7/11/24 at 1:00 p.m., the RDCS provided a copy of the current facility policy titled, "Resident Council," dated 2/2020. The policy indicated, "The facility will promote and support the resident's right to participate and organize resident council. The council will be used to communicate concerns, give suggestions for future programming and events, and otherwise participate in and guide facility life ... concerns or suggestions from the meeting will be addressed by the appropriate department. The Executive Director will review all minutes and concerns to ensure thorough resolution of concerns ...." 3.1-3(k)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the			

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	interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observations, interview, and record review, the facility failed to ensure a resident, (Resident 3) was included and engaged in a meaningful activity program according to her routine and preferences to maintain and/or enhance her quality of life as a totally dependent resident for 1 of 3 residents reviewed for Activity Programming. Findings include: On 7/8/24 at 10:43 a.m., Resident 3 was initially observed in bed in her room. She wore a hospital gown, her hair was flattened on one side, and her lips and gums were observed to have a buildup of unidentified goopy debris. Her side of the room was darkened as the privacy curtain between her, and her roommate's side had been pulled so that the natural light from her roommate's window could not be viewed. The ceiling lights were off. Resident 3's TV was off, and there was no music. She was positioned in bed with the head of her bed (HOB) elevated as her tube feeding pump was hooked up and running. Resident 3 leaned on her left side, and her eyes were open, but she stared at a bare blank wall. There were no pictures, calendar, murals, mirrors etc., she clutched an old, naked baby doll. No other toys or stuffed animals were observed. She reached out her hand, and grasped firmly as she made a whimpering, crying tearful sound. At that time, her roommate, Resident 40 indicated, she cried a lot, sometimes it was real, sometimes it was for attention. Resident 40 indicated, staff almost never got her out of bed, and as far as	F 0679	F679- Based on observations, interview, and record review, the facility failed to ensure resident (Resident 3) was included and engaged in a meaningful activity program according to her routine and preferences to maintain and/or enhance her quality of life as a totally dependent resident for 1 of 3 residents reviewed for activity programming. The building is requesting paper compliance for this citation. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Resident 3 will have an ongoing resident centered activities program that incorporates the resident's interests, hobbies and cultural preferences. Resident care plan will be updated with applicable activities. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? • All residents who are totally dependent/ inability participate in program have the potential to be affected. • Social Enrichment Director/ Desi gnee reviewed all residents care plans and activity	08/02/2024

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	155383	A. BUILDING 00 B. WING	07/11/2024

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	Resident 40 knew, no one took her to activities either. Sometimes Resident 40 would play Disney music for her on her phone and Resident 3 liked to clap along to it. Resident 3 was observed in bed for the remainder of the day on 7/8/24. On 7/9/24 at 10:00 a.m., Resident 3 was observed as she remained in bed. The light in her room was off, the curtain was drawn, and her side of the room was darkened. She stared at the bare, blank wall. On 7/9/24 at 1:26 p.m., Resident 3 was observed as she remained in bed. The light in her room was off, the curtain was drawn, and her side of the room was darkened. She stared at the bare, blank wall. Resident 3 was in bed for the remainder of the day on 7/9/24. On 7/10/24 at 9:20 a.m., Resident 3 was observed. She remained in her bed in a hospital gown. The room was dark. Her roommate's TV was on, but hers was off. There was no music. There was no aromatherapy, and her baby doll was out of reach at the end of her bed. She stared at her bare, blank wall. On 7/10/24 at 12:09 p.m., the Activity Director (AD) indicated, she was newer to the building and had not been there a year yet. Since she started, she had been told, Resident 3 didn't get up very often, and when she went to check, Resident 3 was never dressed or gotten up to be brought down to activities. The AD indicated Resident 3 was on one-to-one activities. On 7/10/24 at 3:00 p.m., Resident 3 remained in		assessment to ensure interests and preferences are being met through meaningful activity program. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? • Social Enrichment Director/ Staff was educated by Regional Social Wellness & Enrichment Support on engagement and including meaningful activity program for residents who are totally dependent/ inability to participate in programs.To ensure their interests and preferences are being met. • Social Enrichment Director/ Designee will review participation records weekly to ensure meaningful activities are being provided to residents who are totally dependent or are unable to participate in group activities How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? • To ensure compliance, the SED /Designee is responsible for the completion of the Meaningful Day Program & Engagement QAPI tool weekly times 4 weeks, monthly times 6 and then quarterly. The results of these audits will be reviewed by the CQI committee overseen by	

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	bed. At that time, Laundry Assistant 16 entered Resident 3's room, and proceeded to put clothes away for Resident 3 and 40. Laundry Assistant 16 indicated she had worked at the facility for many years and knew Resident 3 very well. This was demonstrated as Laundry Assistant 16 approached Resident 3's bed, held her hand and gave her affectionate baby kisses on her cheek. Resident 3 smiled broadly, and wrapped her arm around the staff member's neck and did not want to let go. Laundry Assistant 16 indicated, Resident 3 used to get up every day and would always be in or around activities. She loved to hold hands, blow kisses, hug, and watch people come and go. She did not know why Resident 3 no longer got out of bed. Resident 3 was in bed for the remainder of the day on 7/10/24. On 7/11/24 at 10:03 a.m., Resident 3 was observed in bed. The light in her room was off, the curtain was drawn, and her side of the room was darkened. She stared at the bare, blank wall. During an interview on 7/11/24 11:09 a.m., the Regional Director of Clinical Services (RDCS) indicated, she did not know of any reason why Resident 3 should not be up on a routine basis. The RDCS indicated, Resident 3 had always enjoyed being up and socializing, despite her intellectual disability, she loved to engage with other residents and staff. During an interview on 7/11/24 at 11:56 a.m., the Executive Director (ED) indicated, since she had been at the facility, she had seen Resident 3 up every now and then, but she mostly stayed in bed. The ED indicated she did not know Resident 3 too well yet. When Resident 3's activity		the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance By what date the systemic changes will be completed: 8.2.24	

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	participation log was reviewed, the ED indicated there needed to be more variety and rotating 3 simple things and she would talk with the Interdisciplinary team (IDT) to establish a more meaningful and engaging routine and program for Resident 3. On 7/11/24 at 12:10 p.m., Resident 3's medical record was reviewed. She was a long-term care resident with diagnoses which included, but not limited to, cerebral palsy (a congenital disorder of movement, muscle tone, or posture), severe intellectual disability, and down syndrome. Resident 3's nursing progress notes between 1/1/24 and 7/11/24 were reviewed and revealed. There was a total of 36 entries. 8 entries noted that she was in bed, while only one indicated she had been gotten up in her chair. On 7/11/24 at 11:00 a.m., the RDCS provided a copy of Resident 3's activity participation logs for 6/1/24-7/11/24. There were three activities logged for the timeframe: 1. "Resident enjoys listening to Disney channel/music in her room." 2. "Resident enjoys calming music and lotion applied to her hands." 3. "Resident enjoys cuddling with childlike toys." There were two entries where the Daily chronicle was read. There was no other variety of activities or participation engagement.			

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	Further, of the 6 weekends reviewed for the timeframe above, Resident 3 only received one-on-one engagement on 6/8/24 and 6/15/24. There was no documentation of additional weekend engagement for Resident 3. An annual assessment, titled "Preferences for Customary Routine and Activities," dated 1/8/24 indicated, information was obtained from the staff as Resident 3 was unable to answer for herself. The assessment indicated, Resident's 3 preferred time to get out of bed was after breakfast. Every other item was coded, "No response or non-responsive." A quarterly assessment, titled "Preferences for Customary Routine and Activities," dated 4/12/24 indicated, "Resident is 1:1 enjoys lotion applied to hands, calming music, childlike toy animals." Resident 3's comprehensive care plans were reviewed: She had a care plan dated 1/8/24 which indicated, "Resident requires individualized activity programming due to having the inability to participate in daily programming. Previous/current interests include lotion applied to hands, listening to calming, soft music, stuffed animals." The only intervention listed for this plan of care was, "one-to-one visits, Monday, Wednesday and Friday." She had a care plan dated 5/1/2013 which indicated, "Female resident with diagnosis of MR [mental retardation]. Her mental/emotional age is that of a 5-year-old or less. She enjoys have her room decorated in a juvenile theme such as "Hello Kitty" and princess theme, as evidenced by her			

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	smile and laughter when she sees the decorations. Will be involved in activities of interest that promote socialization with others and sensory stimulation. Not eligible for OBRA services. This care plan included the following three interventions, all dated 5/1/2013: 1. "Resident will be involved in sensory activities such as having her nails done, lotions and massage, music." 2. "Resident will be encouraged to socialize i.e. make eye contact and allow staff to interact with her by holding her hand to promote psychosocial wellbeing." 3. "Resident's room to be decorated with comforter, pillow cover, wall decor and accessories in "Hello Kitty" and princess theme." No additional goals or interventions had been added/revised to her care plan for cognitive abilities, preferences, routines and activity engagement. On 7/11/24 at 1:00 p.m., the Regional Social Enrichment Support Specialist provided a copy of current, but undated facility policy titled, "Domains of Wellness & the Social Enrichment Program." The policy indicated, "the wellness and enrichment of our residents is a large part of our mission to compassionately serve each resident with quality of care and excellence...for a resident who does not or cannot engage in a meaningful way in either group or independent activities, a One on One program of engagement is required...One on One programs should be individualized based on the resident's life story, preferences and historical activity pursuits...residents who are able should also be considered for other types of group activities such as sensory groups. This will allow some socialization in addition to their One on One			

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	engagement...." 3.1-33(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure residents environment remained free of accident hazards when medications were not secured for 2 of 8 residents reviewed for secured medication (Resident E and 12). Findings include: 1. On 7/8/24 at 12:20 p.m., Resident E was observed to have her albuterol rescue inhaler in the dining room. The MCSS (Memory Care Support Specialist) indicated to the resident she needed the resident to give her the albuterol inhaler. The resident indicated she could not have it. The MCSS did not get the albuterol inhaler before Resident E went to her room. During a conversation, in her memory care (MC) room, on 7/8/24 at 12:28 p.m., Resident E indicated she still had her albuterol inhaler in her room. She showed the inhaler in her pocket. During an interview, on 7/8/24 at 12:32 p.m.,	F 0689	F689-Based on observation, interview, and record review, the facility failed to ensure residents environment remained free of accident hazards when medications were not secured for 2 of 8 residents reviewed for secured medication. The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. The building is requesting paper compliance for this citation. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? Identified residents' rooms were checked for meds at bedside and if found, Resident 12 was assessed for self administration of	08/02/2024

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	Regional Support Services indicated she was getting agitated in the dining room, so they would re-approach her later. During an interview, in her MC room, on 7/10/24 at 9:24 a.m., Resident E indicated she had her albuterol inhaler, and it was observed in her right pocket. She indicated she had it yesterday too. She showed the inhaler had 66 puffs left in it. During an interview, on 7/10/24 at 11:29 a.m., the Interim Director of Nursing (DON) indicated she talked with the MC nurse this morning and she told the DON she got the albuterol inhaler back from the resident this morning. She indicated she was not aware of the resident had another albuterol inhaler in her pocket. She would go back to MC and try and get the second albuterol inhaler from Resident E. On 7/10/24 at 11:34 a.m., the DON indicated she got the second albuterol inhaler from the resident. On 7/10/24 at 11:45 a.m., Resident E's record was reviewed. She was admitted on 5/24/24 with severely impaired cognition. Her diagnoses included, but were not limited to, Alzheimer's disease with early onset (brain disorder with loss of memory and thinking skills), epilepsy (brain disorder of sensory disturbance, loss of consciousness), chronic obstructive pulmonary disease (COPD) with hypoxia (respiratory failure). Her physician order, dated 5/29/24, for albuterol sulfate inhaler indicated to provide every 4 hours as needed for shortness of breath. Her respiratory care plan, dated 5/16/24, indicated		medications. IDT ensured orders, CP, labels, lockbox, and self-administration observation were in place by 8/2/2024. Resident E albuterol inhaler was removed from resident room. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. All residents' rooms will be checked for medications at bedside and if found, IDT will ensure orders, CP, labels, lockbox, and self-administration observation is in place by 8/2/2024. What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur? Nurses will be educated on the process for self-administration and not leaving medication at bedside by 8/2/2024. DNS/Designee will conduct rounds each shift to ensure medications are not left at bedside, unless resident is able to self administer per protocol. How the corrective action(s) will be	

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	Resident E had the potential for impaired gas exchange related to COPD, chronic bronchitis, and respiratory failure. A nursing approach indicated to administer her medications as ordered. 2. On 7/8/24 at 11:22 a.m., a pill was observed on Resident 12's over the bed table. She indicated it was a potassium pill. She got it with her morning medications and did not want to take it then. She was saving it for lunch time when she would have more food on her stomach. On 7/9/24 at 11:47 a.m., Resident 12 indicated she had folic acid pills in a easy-to-open, unlabeled prescription bottle on her bedside table and an over-the-counter bottle of folate (folic acid) was observed in the bedside table drawer. The unlabeled prescription bottle had 4 whole pills and 3 half pills. On 7/10/24 at 9:03 a.m., Resident 12 was observed to have the folic acid pills in an unlabeled prescription bottle on her bedside table and a bottle of folate pills observed in her top drawer of her bedside table. On 7/10/24 at 12:08 p.m., Resident 12's record was reviewed. She was admitted on 11/17/23. Her diagnoses included, but were not limited to, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and bipolar disorder (psychiatric illness with both manic and depressive episodes). Her physician orders included, but were not limited to, potassium chloride 20 mEq (milliequivalent), dated 2/7/24, by mouth, once a day, between 7:00 a.m. to 11:00 a.m. Her order for folic acid 1 mg by mouth was added on 7/10/24.		monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The DNS/Designee will utilize QA tool-'F689 Meds @ Bedside/Self Administration' to audit a minimum of 10 residents' rooms for meds at bedside; if any noted, audit for-label, order, care plan, and locked compartment in place. Complete weekly x 4 weeks, monthly x 6 months, and then quarterly until compliance is maintained. The Regional Consultant/Designee will provide ongoing training, oversight, resources, and competencies as needed upon identifying on-going areas of concern or areas not meeting threshold. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update, and make changes to the POC as needed with input and oversight from the Regional Consultant for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit. Date of compliance: 8/2/2024	

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	During an interview, on 7/10/24 at 12:08 p.m., Regional Director of Clinial Services (RDCS) indicated the folic acid (folate) would be added to the self-administration assessment. During an interview, on 7/11/24, the Interim Director of Nursing (IDON) indicated medications should not be in resident rooms unless they have a medication self-administration assessment. A current policy, titled, "Self-Administration of Medications," dated 8/98, was provided by the RDCS, on 7/10/24 at 11:04 a.m. A review of the policy indicated, " ...It is the policy of this facility to respect the wishes of alert, competent resident to self-administer prescribed medications, as allowable under state regulations ...A physician order will be obtained specifying the resident's ability to self-administer medications and , if necessary, listing which medications will be included in the self-administration plan ...Storage of self-administered medications will apply with state federal regulations. All bedside medications will be maintained in a secured location in the resident's room ...." 3.1-45(a)(1) 3.1-45(a)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.			

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	§483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observations and record review, the facility failed to ensure appropriate mediation storage was implemented when single-dose vials were labeled and dated, stored external medications from internal medications and dated inhalers once opened for 2 of 4 medications carts observed (Carts 100 hall and 300 hall). Findings include: 1. On 7/8/24 at 9:45 a.m., the 300-hall medication cart was observed. The following was observed inside the cart: a. Hydrophilic wound care dressing (a topical ointment) was observed in a drawer with oral inhalers. b. Lidocaine injectable solution was in the cart and did not have a label or date on the vial. c. Resident 208 had an albuterol HFA 90mcg (microgram) inhaler. It lacked a date to indicate when it was opened. She also had an incruse	F 0761	F761-Based on observations and record review, the facility failed to ensure appropriate medication storage was implemented when single-dose vials were labeled and dated, stored external medications from internal medications and dated inhalers once opened for 2 od 4 medications carts observed. The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. The building is requesting paper compliance for this citation. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?	08/02/2024

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	ellipta 62.5 inhaler. It lacked a date to indicate when it was opened. d. Resident 21 had a breziri aerosol inhaler. It lacked a date to indicate when it was opened. e. Resident 46 had an albuterol sul inhaler 90mcg. It lacked a date to indicate when it was opened. 2. On 7/8/24 at 10:10 a.m., the 100-hall medication cart was observed. The following was observed inside the cart. a. Resident 43 had diclofenac sodium gel in the medication cart with oral inhalers. b. Resident 44 had a Ventolin inhaler 90mcg inhaler in the cart. It lacked a date to indicate when it was opened. A policy titled, "Storage and Expiration of Medications, Biologicals, Syringes and Needles" was provided by the Regional Director of Clinical Services (RDCO) on 7/9/24 at 1:34 p.m. It indicated, "... Facility should ensure that medications and biologicals have not been retained longer than recommended by the manufacturer or supplier guidelines or ... returned to the pharmacy or supplier... Facility should ensure that external use medications and biologicals are stored separately from internal use medications and biologicals..." 3.1-25(j) 3.1-25(m) 3.1-25(n)		Identified medications not stored correctly were removed from medication cart for destruction and replacements ordered from the pharmacy by 8/2/2024. This included oral inhaler, hydrophilic topical ointment, lidocaine injectable solution, albuterol inhaler, breziri aerosol inhaler, diclofenac sodium gel, Ventolin inhaler. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. All medication carts will be audited for expired/undated medications by 8/2/2024. Expired/undated medications will be pulled for destruction and replacements ordered by 8/2/2024. What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur? All nurses and QMA's will be educated on the 'Label/Store Drugs & Biologicals' policy by 8/2/2024. All medication cart binders will have a copy of the Medication Expiration Dates in place by	

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			8/2/2024. DNS/Designee will round each day to review medication carts to ensure expired meds are disposed of and medications are properly labeled. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The DNS/Designee will utilize QA tool to audit medication carts for a minimum of 10 medications per cart. Complete weekly x 4 weeks, monthly x 6 months, and then quarterly until compliance is maintained. The Regional Consultant/Designee will provide ongoing training, oversight, resources, and competencies as needed upon identifying on-going areas of concern or areas not meeting threshold. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update, and make changes to the POC as needed with input and oversight from the Regional Consultant for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit. Date of compliance: 8/2/2024	

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F 0883 SS=D 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 administer a pneumococcal vaccination to a resident who gave consent to receive the vaccination for 1 of 4 residents reviewed for vaccinations (Resident 35). Findings include: On 7/11/24 at 10:25 a.m., a record review was completed for Resident 35. She had the following diagnoses which included but were not limited to unspecified dementia, unspecified protein-calorie malnutrition, type 2 diabetes, and asthma. On 3/26/24, the resident's responsible party signed a consent for Resident 35 to receive a pneumococcal vaccination. It was not administered. On 7/11/24 at 11:25 a.m., the Regional Director of Clinical Services (RDCO) indicated the vaccination was not administered and she would	F 0883	F883-Based on record review and interview, the facility failed to administer a pneumococcal vaccination to a resident who gave consent to receive the vaccination for 1 of 4 residents reviewed for vaccinations. The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. The building is requesting paper compliance for this citation. 1. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? Pneumococcal vaccine administered per consent and	08/02/2024

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	get it scheduled today. A policy was provided by the RDCO on 7/10/24 at 2:02 p.m. It indicated, "...On admission resident(s) will be screened for pneumococcal vaccination. If a resident meets criteria ...will be offered the vaccination ..." 3.1-18(b)(5)		physician order. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. An audit of all residents pneumococcal vaccine administration and consent forms for eligibility of pneumococcal vaccinations will be completed by the Infection Preventionist/designee by 8/2/24. Those residents who have consented and are eligible to receive pneumococcal vaccinations will have the appropriate vaccination ordered through the pharmacy by 8/2/24 and administered when available. 3. What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur? The clinical IDT team will be educated on the Pneumococcal Vaccination policy including consents and administration by 8/2/24 by the Infection Preventionist/designee. The Infection Preventionist/Designee will review all new admission paperwork to ensure pneumococcal vaccinations are being reviewed for eligibility, provided education,	

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			consent/declination is obtained, vaccines ordered if applicable and administered in a timely manner. The Infection Preventionist/designee will keep a tracking list of vaccinations that were ordered from pharmacy and update in the daily clinical meeting to ensure vaccines are administered timely when they are delivered from pharmacy. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The DNS/Designee will utilize Resident Pneumococcal Immunization QA tool will be Completed weekly x 4 weeks, monthly x 6 months, and then quarterly until compliance is maintained. The Regional Consultant/Designee will provide ongoing training, oversight, resources, and competencies as needed upon identifying on-going areas of concern or areas not meeting threshold. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update, and make changes to the POC as needed with input and oversight from the Regional Consultant for sustaining	

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			substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit. Date of compliance: 8/2/2024	
F 9999 Bldg. 00	3.1-14 Personnel (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test. (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure all staff were screened for tuberculous (TB) according to policy upon hire for 3 of 5 newly hired employees reviewed. (Dietary Manager, LPN 46 and CNA 19)	F 9999	**F999** **The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.** **The building is requesting paper compliance for this citation.** **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** **All new hire employees will receive a tuberculosis skin testing/ chest x-ray per company policy.** **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** **All new hires have the potential to be affected by the alleged deficient practice.**	08/02/2024

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	Findings include: On 7/10/24 at 10:00 a.m., employee TB records were reviewed. a. The Dietary Manager (DM) was hired on 3/13/24. She had a first-step TB screening, but it was not read. A second step was not done. b. Licensed Practical Nursing (LPN) 46 was hired on 6/13/24. She had a first-step TB screening on 5/21/24 but it was not read. A second step was not done. c. Certified Nursing Aide (CNA) 19 was hired 3/13/24. She had a first-step TB screening completed on 2/12/24. A second step was not done. On 7/11/24 at 11:23 a.m.., the Regional Director of Clinical Services (RDCS) provided documentation of the DM and CNA 19 receiving new TB screenings on 7/10/24, with LPN 46 receiving her new TB screening on 7/11/24. She indicated they had other employees to provide new TB screenings. During an interview, on 7/11/24 at 11:28 a.m., the RDCS indicated the previous Director of Nursing Services (DNS) had told the staff they only needed one TB screening upon hire. So, all the new hires records were being reviewed to ensure they were screened correctly for TB. The RDCS had created a binder with a calendar enclosed to help follow-up with the additional employee TB screenings that needed to be redone. During an interview, on 7/11/24 at 12:00 p.m., the Interim Director of Nursing (IDON) indicated when a new person was hired, they need to complete the first and second step for TB screening.		**What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** **ADNS/or designee will monitor PPD testing for all new employees in employee PPD binder. PPD's will be added to the orientation checklist for all new employees.** **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** **To ensure compliance, the ADNS/Designee is responsible for the completion of the PPD QA tool weekly times 4 weeks, monthly times 6 and then quarterly. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 100% is not achieved an action plan will be developed to ensure compliance.** **Date of compliance: 8/2/2024**	

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	A current policy, titled, "Tuberculosis (TB) Screening for Employees," dated 11/2023, was provided by the RDCS, on 7/11/24 at 1:05 p.m. A review of the policy indicated, " ...To promote resident and employee safety and well-being by screening employees for tuberculosis and initiating appropriate follow-up in accordance with state and federal regulations and guidelines ...pre-employment screening is required for all hires ...A two-step screening is required ...."			