STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	05/17/2024

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CYPRESS GROVE REHABILITATION CENTER	4255 MEDWELL DR NEWBURGH, IN 47630

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 13, 14, 15, 16, & 17, 2024 Facility number: 000173 Provider number: 155273 AIM number: 100290920 Census Bed Type: SNF/NF: 79 Total: 79 Census Payor Type: Medicare: 3 Medicaid: 37 Other: 39 Total: 79 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 30, 2024.	F 0000	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective June 17, 2024. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after June 17, 2024.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons 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			

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

Brandon Burns | Executive Director | 06/10/2024

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	enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to maintain a resident's dignity for 1 of 1 residents viewed during a random observation. (Resident 75) Finding includes: During an observation on 5/17/24 at 8:58 A.M., Resident 75's bedroom door was fully opened and Resident 75 was observed laying in bed and body	F 0550	CNA was noted to provide a brief to resident 75 in findings. Resident 75 no longer resides at facility. All residents have the potential to be affected by the alleged deficient practice. Education provided to nursing staff related to resident rights and ensuring residents are suitably	06/17/2024

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	was fully exposed. Resident 75 was not wearing pants, an incontinence brief, or covered with a bedsheet. QMA (Qualified Medication Aide) 22 was standing at the medication cart directly across the hall from Resident 75's room. She then took the medication cart towards the opposite end of the hall. At 9:01 A.M., CNA (Certified Nurses Aide) 15 responded to Resident 75's call light and placed an incontinence brief on Resident 75. On 5/15/24 at 11:07 A.M., Resident 75's clinical record was reviewed. Resident 75 was admitted on 3/19/24. Diagnoses included, but were not limited to, acute respiratory failure with hypoxia, dysphagia, pneumonitis due to inhalation of food and vomit, and sepsis. The most recent Admission MDS (Minimum Data Set) Assessment, dated 3/25/24, indicated Resident 75 was cognitively intact, was completely dependent on staff for toileting, bathing, and transfers, and was receiving nutrition through a feeding tube. During an interview on 5/17/24 9:53 A.M., RN (Registered Nurse) 11 indicated residents should not be left exposed and CNA's should come get a nurse to pause feedings before performing incontinence care. On 5/17/24 at 10:51 A.M., a current policy titled Resident's Rights, dated 11/15, was provided by the Administrator and indicated "Residents shall be assured of at least visual privacy in multi-bed rooms. Each resident shall be treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs.		dressed at all times. Staff to be educated to check that residents are suitably dressed as they traverse the units. Re-education to be provided to nursing staff as needed. Education provided to nursing staff related to resident rights and ensuring residents are suitably dressed at all times. Staff to be educated to check that residents are suitably dressed as they traverse the units. Re-education to be provided to nursing staff as needed. DNS/Designee to round each shift to ensure residents are suitably dressed and are not exposed. The DNS/designee will be responsible for the completion of a resident rights QA Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. 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. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	

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	Residents have the right to be suitably dressed at all times". 3.1-3(t)			
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending,			

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	pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner			

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	responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.			
	Based on observation, interview, and record review, the facility failed to ensure that documents were sent to the hospital upon transfer for 1 of 2 residents reviewed for hospitalization. (Resident 80) Finding includes: On 5/15/24 at 3:30 P.M., Resident 80's clinical record was reviewed. Diagnoses included, but were not limited to, epilepsy and COPD (Chronic Obstructive Pulmonary Disease). The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 1/16/24, indicated Resident 80 was severely cognitively impaired, needed partial to moderate assistance for bathing, transferring, and mobility, and had epilepsy. Physician orders included, but were not limited to: Keppra (seizure medication) 750 mg (milligrams) 1 by mouth 2 times a day for seizures, dated 2/1/24. Namenda (a cognition-enhancing medication) 5 mg 1 by mouth twice a day for psychotic disturbance, dated 11/1/23. The most recent seizures care plan, dated	F 0622	Resident 80 no longer resides at the facility. All residents being transferred to the hospital have potential to be affected by the deficient practice. Education provided to nursing staff related to proper documentation being sent with resident during hospital transfers. Education provided to nursing staff related to proper documentation being sent with resident during hospital transfers. Staff to be educated to ensure proper documentation is sent with resident prior to hospital transfer. Re-education to be provided to nursing staff as needed. DNS/designee will review paperwork sent to hospital to ensure all necessary transfer paperwork and bed hold policy are included. The DNS/designee will be responsible for the completion of a	06/17/2024

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	10/25/23, indicated Resident 80 had a seizure disorder and interventions included, but were not limited to, administer medications as ordered, notify MD (Medical Doctor) of any seizure activity, and provide oxygen as ordered. A nursing progress note, dated 2/23/2024 at 4:38 P.M., indicated "... Resident on his way to the hospital for evaluation." The nurse's noted lacked documentation of sending transfer paperwork and bed hold policy. On 5/16/24 at 10:30 A.M., the Medical Records for Resident 80 was received from [Hospital Name]. The records indicated that EMS (Emergency Medical Services) arrived at 4:14 P.M. and the resident was taken to the ER (Emergency Room) at [Hospital Name]. The medical and clinical records lacked documentation of transfer information and a bed hold policy. The hospital record indicated [Hospital name] had called the facility and the medical transfer paperwork lacked code status information. The clinical record lacked transfer and bed hold paperwork for the hospital transfer on 2/23/24. During an interview on 5/16/24 at 9:29 A.M., RN (Registered Nurse) 3 indicated when residents were sent to the hospital, an order was received, and face sheet, lab work, current orders, and bed hold policy was sent. The staff would notify the family, DON (Director of Nursing), and ED (Executive Director). During an interview on 5/16/24 at 10:08 A.M., RN 3 indicated the facility could not find proof that the packet was sent with the resident on the requested day.		hospital transfer QA Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. 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. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	

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	During an interview on 5/16/24 at 2:30 P.M., the DON indicated the transfer and bed hold paperwork was not in the medical records. On 5/17/24 at 10:51 A.M., the Administrator provided a current "Hospital Transfer" policy, dated 11/15, that indicated "... staff at the Community has the responsibility of ensuring pertinent information about the resident and the actions taken to receive treatment at a hospital are properly documented...Copies of all information sent with the resident shall be placed in the resident record under the "miscellaneous" tab...". 3.1-12(a)(6)(A) 3.1-12(a)(9)(D)			
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview, observation, and record review, the facility failed to ensure residents who required assistance with Activities of Daily Living (ADLs) received showers for 6 of 7 residents reviewed for ADLs. (Resident 40, Resident 46, Resident 20, Resident 12, Resident 19, Resident 75) Findings include: 1. On 5/13/24 at 2:04 P.M., Resident 40 indicated he only got a shower once a week, but he would prefer to take a shower three times a week. At that time, Resident 40 was observed to have dandruff on his shirt.	F 0677	Residents 40, 46, 20, 12, and 19 who were affected by the alleged deficient practice have been offered bathing according to their preference. Resident 75 no longer resides at facility. All residents have potential to be affected by the deficient practice. All residents were interviewed to ensure residents are receiving bathing per resident preferences. Resident profiles have been updated.	06/17/2024

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	On 5/16/24 at 9:39 A.M., Resident 40's clinical record was reviewed. Diagnoses included, but were not limited to, primary hypertension and overactive bladder. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 4/30/24, indicated Resident 40 had mild cognitive impairment, had no behaviors, and required partial to moderate assistance (staff does less than half) of staff for bathing. A current ADL (Activities of Daily Life) care plan, dated 11/14/19, included an intervention to offer showers two times per week and that the resident preferred showering in the evening. A January 2024 Point of Care (POC) (a charting system for CNAs [Certified Nurse Aide]) history indicated Resident 40 received a shower on 1/4/24, 1/14/24, 1/18/24, and 1/28/24. There were no complete bed baths documented in January. Resident 40 refused his shower on 1/9/24, 1/10/24, and 1/13/24. A February 2024 POC history indicated Resident 40 received a shower on 2/4/24, 2/8/24, 2/11/24, 2/22/24, and 2/29/24. There were no complete bed baths documented in February. Resident 40 refused his shower on 2/15/24 and 2/18/24. A March 2024 POC history indicated Resident 40 received a shower on 3/3/24, 3/10/24, 3/14/24, 3/24/24, and 3/28/24. There were no complete bed baths or refusals documented in March. An April 2024 POC history indicated Resident 40 received a shower on 4/4/24, 4/7/24, 4/19/24, 4/21/24, and 4/25/24. There were no complete bed		Education provided to staff related to bathing residents according to their preferences as well as proper documentation of ADLs. IDT to audit ADL documentation during daily clinical meeting to ensure ADL bathing documentation is accurate and completed as scheduled according to resident preference. DNS/Designee to round each day to ensure residents are receiving bathing per preference. The DNS/designee will be responsible for the completion of an ADL bathing QA Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. 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. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	

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	baths documented in April. Resident 40 refused his shower on 4/11/24 and 4/28/24. A May 2024 POC history indicated Resident 40 received a shower on 5/5/24 and 5/16/24. There were no complete bed baths or refusals documented in May. A Shower assignment sheet, updated 5/14/24, indicated Resident 40 received showers on Thursday and Sunday during the day. 2. On 5/13/24 at 11:50 A.M., Resident 46 indicated she rarely got showers, but was supposed to get them twice a week. On 5/15/24 at 2:51 P.M., Resident 46's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease, major depressive disorder, and anxiety disorder. The most current Significant Change MDS Assessment, dated 2/27/24, indicated Resident 46 had mild cognitive impairment, had no behaviors, and required substantial/maximal assistance (staff does more than half) of staff for bathing. A current ADL care plan, dated 7/24/23, included an intervention to offer showers two times per week and that the resident preferred showering in the evening. A January 2024 POC history indicated Resident 46 received a shower on 1/3/24, 1/6/24, 1/20/24, 1/24/24, and 1/31/24. There were no complete bed baths documented in January. Resident 46 refused her shower on 1/14/24. A February 2024 POC history indicated Resident 46 received a shower on 2/10/24, 2/18/24, and			

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	2/26/24. There were no complete bed baths or refusals documented in February. A March 2024 POC history indicated Resident 46 received a shower on 3/3/24, 3/13/24, and 3/16/24. Resident 26 received a complete bed bath on 3/27/24. There were no refusals documented in March. An April 2024 POC history indicated Resident 46 received a shower on 4/3/24. There were no complete bed baths documented in April. Resident 46 refused her shower on 4/13/24. A May 2024 POC history indicated Resident 46 received a shower on 5/4/24. There were no complete bed baths or refusals documented in May. A shower assignment sheet, updated 5/14/24, indicated Resident 46 received showers on Monday and Thursday during the day.3. During an interview on 5/15/24 at 2:30 P.M., Resident 20 indicated showers were not received on a regular basis. On 5/16/24 at 10:24 A.M., Resident 20's clinical record was reviewed. Diagnoses included, but were not limited to, unspecified dementia, without behavioral disturbance, and vascular dementia. A current Quarterly MDS Assessment, dated 5/10/24, indicated Resident 20 was moderately cognitively impaired and needed set up assistance with bathing and dressing. Current physician orders included, but were not limited to: Activity level of resident - up ad lib (as desired) with walker, dated 12/8/21.			

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The current ADL care plan, dated 12/8/21, indicated the resident required help with the ADL. Interventions included, but were not limited to, assist with bathing as per resident preference, offer showers two times a week, in the evenings.

On 5/16/24 at 2:00 P.M., Human Resources (HR) 4 provided a copy of the weekly shower sheets for [Unit Name] which indicated the resident received evening showers on Tuesdays and Fridays.

On 5/15/24 at 3:00 P.M., the POC charting in Resident 20's EMR (Electronic Medical Records) indicated that, on the following days, Resident 20 received showers from January 2024 to May 2024:
January 2, 6, 9, 13, and 20. The POC only recorded one refusal on 1/30/24.
February 13, 20, 23, and 27. The POC only recorded one refusal on 2/2/24.
March 5,12, and 5
April 9, 14, and 26
May 3 ,7, and 104. On 5/15/24 at 8:09 A.M., Resident 12's clinical record was reviewed. Diagnoses included, but were not limited to, vascular dementia, osteoarthritis, and osteoporosis.

The most recent Quarterly MDS Assessment, dated 2/16/24, indicated Resident 12 was severely cognitively impaired, was dependent on staff for transfers, and required maximal assistance from staff for toileting.

A care plan included, but was not limited to: (Resident) requires assistance with ADL's; Assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between. Start date: 3/29/22.

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(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
	On 5/17/24 at 10:52 A.M., Resident 12's shower record from 1/1/24 to 5/17/24 indicated Resident 12 received a complete bed bath or shower for that time period, with one refusal of care documented on 2/28/24, for the following dates: January: 1/4, 1/11, 1/25, 1/31 February: 2/4, 2/7, 2/8, 2/11, 2/13, 2/25 March: 3/6, 3/10, 3/31 April: 4/15, 4/17, 4/21 May: 5/5, 5/12, 5/15 5. On 5/14/24 at 2:42 P.M., Resident 19's clinical record was reviewed. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following other cerebrovascular disease affecting right dominant side and chronic pain. The most recent Significant Changes MDS Assessment, dated 4/22/24, indicated Resident 19 was cognitively intact, was dependent on staff for bathing and toileting, and required maximal assistance for transfers. A care plan included, but was not limited to: Assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between. Start date: 6/4/19. Hospice Aide visits three times per week to provide ADL's, nursing facility will provide scheduled Hospice care in the event Hospice unable to make visit. Start date: 4/16/24. On 5/17/24 at 10:29 A.M., Resident 19's shower record from 1/1/24 to 5/17/24 indicated Resident 19 received a complete bed bath or shower for that time period, with no refusal of care documented, for the following dates:			

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	155273	A. BUILDING 00 B. WING	05/17/2024

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	January: 1/18, 1/22, 1/30 February: 2/3, 2/19, 2/22, 2/26 March: 3/1, 3/15, 3/18, 3/20, 3/22, 3/25, 3/27 April: 4/1, 4/3, 4/5, 4/27 May: 5/6, 5/9 6. On 5/15/24 at 11:07 A.M., Resident 75's clinical record was reviewed. Resident 75 was admitted on 3/19/24. Diagnoses included, but were not limited to, acute respiratory failure with hypoxia, dysphagia, pneumonitis due to inhalation of food and vomit, and sepsis. The most recent Admission MDS Assessment, dated 3/25/24, indicated Resident 75 was cognitively intact, was completely dependent on staff for toileting, bathing, and transfers, and was receiving nutrition through a feeding tube. A care plan included, but was not limited to: Assist with bathing as needed per resident preference. Offer showers (prefers complete bed baths) two times per week, partial bath in between. Start date: 3/19/24. On 5/17/24 at 11:07 A.M., Resident 75's shower record from 3/19/24 to 5/17/24 indicated Resident 19 received a complete bed bath or shower for that time period, with no refusal of care documented, for the following dates: March: none April: 4/14, 4/17, 4/22 May: none On 5/16/24 at 2:53 P.M., the Director of Nursing (DON) indicated residents received a shower or complete bed bath 2 days a week. Partial bed baths were not an acceptable substitution because every resident received a partial bed bath			

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	during morning care every day. Some residents preferred showers three times a week which would be accommodated and documented in the care plan. Showers, complete bed baths, and refusals should be documented in the POC. She indicated shower sheets were to be used as a communication tool between the aide and nurse and did not necessarily need to be filled out. On 5/17/24 at 10:06 A.M., the Administrator indicated the QAPI (Quality Assurance and Performance Improvement) committee was aware there was an issue with residents getting their showers. They had been working on that issue for at least a year and it had improved. Now that they had staff documenting in POC, they needed to work on the accuracy of the documentation. At that time, he indicated there was no policy related to ADL care or showers. On 5/17/24 at 10:51 A.M., the Administrator provided a current "Resident Care/ADL Sheet" policy, dated 11/15, that indicated "The Daily Living Flow Chart shall be used to document resident's daily care provided". On 5/17/24 at 11:21 A.M., the Administrator indicated that the facility did not have daily living flow charts. 3.1-38(a)(2)(A) 3.1-38(a)(3)(B) 3.1-38(b)(2) 3.1-38(b)(3)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic			

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	gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review, and interview, the facility failed to ensure physician orders were followed and resident's nutritional feedings were administered for 2 of 2 residents reviewed for tube feedings. (Resident 75, Resident 68) Findings include: 1. During an observation on 5/17/24 at 8:58 A.M., Resident 75's bedroom door was fully opened and Resident 75 was observed laying in bed and body was fully exposed. Resident 75's feeding pump was running at a rate of 75 mL (milliliters) per hour, and the bottle containing the nutritional formula was dated 5/16/24 6:00 A.M. The gauze surrounding the base of the feeding tube was dated 5/15. On 5/15/24 at 11:07 A.M., Resident 75's clinical	F 0693	Resident 75 no longer resides in the facility. Resident 68 is receiving nutritional feedings per MD orders. All residents with a feeding tube have the potential to be affected by the deficient practice. Other residents with feeding tubes were reviewed by DNS/designee to ensure resident physician orders were followed. Nursing staff will be in-serviced on proper procedures related to tube feeding, providing incontinence care to a resident with orders for tube feeding, and to follow orders related to tube feedings. DNS and/or designee to	06/17/2024

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	record was reviewed. Resident 75 was admitted on 3/19/24. Diagnoses included, but were not limited to, acute respiratory failure with hypoxia, dysphagia, pneumonitis due to inhalation of food and vomit, and sepsis. The most recent Admission MDS (Minimum Data Set) Assessment, dated 3/25/24, indicated Resident 75 was cognitively intact, was completely dependent on staff for toileting, bathing, and transfers, and was receiving nutrition through a feeding tube. Current physician orders included, but were not limited to: Elevate HOB (head of bed) 30 degrees at all times every shift; start date 3/19/24. Cleanse G-tube (feeding tube) site with soap and water, pat dry, and apply gauze every shift; start date 3/19/24. Continuous feeding x22 hours formula: Jevity 1.5 mL per hour: 75 mL; twice a day 5/9/24. During an interview on 5/17/24 9:53 A.M., RN (Registered Nurse) 11 indicated CNA's (Certified Nursing Aide) should alert a nurse to pause feedings before laying a resident flat to perform incontinence care, and that she had not been notified to pause Resident 75's feeding during that day. During an interview on 5/17/24 at 9:55 A.M., CNA 15 stated she had paused the continuous feeding machine herself while performing incontinence care for Resident 75. 2. On 5/13/24 at 10:04 A.M., Resident 68 was observed in her room laying on her bed with enteral nutrition running through a feeding tube at 38 mL/hr (milliliters per hour). The head of the bed was flat, and the nutrition was not labeled or		complete feeding tube observations daily. The DNS/designee will be responsible for the completion of a feeding tube QA Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. 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. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	

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	dated. On 5/14/24 at 10:15 A.M., the enteral nutrition was observed turned off in Resident 68's room. Resident 68 was not in her room at that time. On 5/14/24 at 1:24 P.M., Resident 68 was observed in the Gardens lounge in her wheelchair and was not hooked up to enteral nutrition. On 5/15/24 at 2:06 P.M., Resident 68 was observed in the main lounge with a family member and was not hooked up to enteral nutrition. On 5/13/24 at 1:29 P.M., Resident 68's clinical record was reviewed. Diagnoses included, but were not limited to, spastic quadriplegic cerebral palsy, dysphagia, Barrett's esophagus, and profound intellectual disabilities. The most current Quarterly MDS Assessment, dated 3/21/24, indicated Resident 68 was rarely or never understood, was dependent on staff for eating and bed mobility, did not have weight loss, and received 51% or more of calories through a feeding tube. A current enteral feeding care plan, dated 6/28/23, included interventions to elevate the head of the bed and give tube feedings as ordered. Physician orders included, but were not limited to: Continuous Feeding Jevity 1.5 (a calorically dense liquid food) - 38 mL per hour x 22 hours, turn off daily between 2:00 A.M. and 4:00 A.M., dated 9/02/23. Elevate HOB 30 degrees at all times, dated 6/27/23. The MAR (Medication Administration Record)			

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	and TAR (Treatment Administration Record) for May did not include documentation of the Jevity 1.5 being turned on or off except for as it was ordered at 2:00 A.M. and 4:00 A.M. The clinical record lacked documentation that the enteral nutrition was turned off outside off the times ordered by the physician. On 5/16/24 at 11:50 A.M., Licensed Practical Nurse (LPN) 7 indicated that when the nutrition got turned off during the day it should be documented in the progress notes. On 5/17/24 at 10:57 A.M., the Administrator provided a current Enteral Therapy policy, revised 1/2016, that indicated "a licensed nurse will take, note, and implement physician orders for enteral therapy". 3.1-44(a)(2)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.			

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	§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to ensure routine medications were available and dispensed according to physician's orders for 1 of 5 residents reviewed for unnecessary medications. (Resident 71) Finding includes: On 5/15/24 at 8:45 A.M., Resident 71's clinical record was reviewed. Diagnosis included, but was not limited to, gastro-esophageal reflux disease (GERD). The most current Admission Minimum Data Set (MDS) Assessment, dated 2/14/24, indicated Resident 71 had mild cognitive impairment, had no behaviors, and required setup assistance for eating. A current GERD care plan, dated 2/16/24, included an intervention to administer medications as ordered.	F 0755	Resident 71 is receiving medications as ordered by MD. All residents have the potential to be affected by this alleged deficient practice. All medications were reviewed by DNS/Designee to ensure medications were available per MD order. Nursing staff will be in-serviced on proper procedure as it related to medications being available including following up with the pharmacy or pulling medication from the EDK. When a medication is not available, the DNS/Designee will be contacted to determine if available in EDK. Licensed nursing staff will be instructed to obtain medication from EDK.	06/17/2024

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	Physician's orders included, but were not limited to: omeprazole (medication to treat acid reflux) capsule, delayed release (DR) 20 mg (milligrams) orally once a day, dated 5/10/24. pantoprazole (medication to treat acid reflux) tablet, DR 40 mg orally once a day, dated 5/10/24. The May 2024 MAR (Medication Administration Record) indicated omeprazole and pantoprazole was not administered from 5/12/24 through 5/16/24 because the drug was unavailable. A review of the order administration indicated omeprazole and pantoprazole was reordered from the pharmacy on 5/10/24. A list of medications in the EDK (Emergency Drug Kit) indicated the following drugs were available: omeprazole DR, 20 mg - 15 available pantoprazole DR, 40 mg - 5 available On 5/16/24 at 11:50 A.M., Licensed Practical Nurse (LPN) 7 indicated medications ordered usually arrived on the same day because pharmacy came to the facility twice daily. If the medication didn't come, then staff should call the pharmacy. If the medication was in the EDK, it should be given from the EDK. On 5/16/24 at 2:53 P.M., the Director of Nursing (DON) indicated if a medication was unavailable, it should be given from the EDK. Staff should document why the medication was unavailable and should follow up with the pharmacy if it was not received by the next day. At that time, she indicated documentation related to the unavailability of Resident 71's omeprazole and pantoprazole was not in the clinical record like it		The DNS/designee will be responsible for the completion of a medication availability QA Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. 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. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	

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	should have been. On 5/17/24 at 10:52 A.M., the Administrator provided a current Reordering, Changing, and Discontinuing Orders policy, revised 1/1/22, that indicated "facility staff should review the transmitted re-orders for status and potential issues and Pharmacy response". 3.1-25(a)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable			

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	law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic			

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	services reports as required under §483.50. Based on interview and record review, the facility failed to maintain accurate medical records for 1 of 5 residents reviewed for unnecessary medications and 1 of 2 residents reviewed for tube feeding. (Resident 14 and Resident 75) Findings include: 1. On 5/16/24 at 10:01 A.M., Resident 14's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's, anxiety disorder, and recurrent depressive disorders. The most recent Significant Change MDS (Minimum Data Set) Assessment, dated 3/12/24, indicated Resident 14 was mildly cognitively impaired, required partial assistance with toileting and transfers, and was receiving antianxiety and antidepressant medications during the seven day lookback period. A social service note dated 2/21/24 12:16 P.M., indicated (Resident) participated in psychotherapy that day. During an interview on 5/17/24 08:47 A.M., Social Services indicated Resident 14 was in the hospital from 2/18/24 through 2/23/24, and the psychotherapy visit was documented in error. 2. On 5/15/24 at 11:07 A.M., Resident 75's clinical record was reviewed. Resident 75 was admitted on 3/19/24. Diagnoses included, but were not limited to, acute respiratory failure with hypoxia, dysphagia, pneumonitis due to inhalation of food and vomit, and sepsis. The most recent Admission MDS (Minimum Data	F 0842	Resident 75 no longer resides in facility. Resident 75 medical record was amended to indicate resident was not in the facility on 5-15 and 5-16 from medical appointments. Resident 14 medical record was corrected related to the provision of psychotherapy by the social services director. All residents have the potential to be affected by the deficient practice. Social services and nursing staff will be educated related to the accuracy of documentation of ancillary services and documentation of when residents depart and return to the facility. Social services and nursing staff will be educated related to the accuracy of documentation of ancillary services and documentation of when residents depart and return to the facility. IDT will review appointment departure and return documentation during daily clinical meeting to ensure resident appointments are appropriately documented in the resident medical record. IDT will review psychotherapy documentation to ensure accuracy of dates. The DNS/designee will be responsible for the completion of an appointment documentation QA Tool weekly times 4 weeks,	06/17/2024

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	Set) Assessment, dated 3/25/24, indicated Resident 75 was cognitively intact, was completely dependent on staff for toileting, bathing, and transfers, and was receiving nutrition through a feeding tube. On 5/17/24 at 9:52 A.M., the DON (Director of Nursing) provided procedure documents that indicated Resident 75 was out of the building from 9 A.M. to 2:30 P.M. on 5/15/24 for an endoscopy, and from 9:15 A.M. to 2:30 P.M. on 5/16/24 for a colonoscopy. The clinical record from 5/15/24 to 5/17/24 lacked documentation of the departure from the facility and arrival back to the facility for Resident 75 on 5/15/24 and 5/16/24. On 5/17/24 at 10:52 A.M., the Administrator provided a document titled Documentation Guidelines for Nursing, revised date 6/23, that indicated the purpose: (is) to accurately document in an organized manner all information related to the resident in the medical record. On 5/17/24 at 10:52 A.M., the Administrator provided a document titled Leave of Absence, revised date 6/19, that indicated The licensed nurse will document resident status upon leave from the facility and upon return from leave, and any other pertinent information. 3.1-50(a)(2)		bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The SSD/Designee will be responsible for the completion of an ancillary services documentation QA Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. 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. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	
F 9999 Bldg. 00	3.1-13 ADMINISTRATION AND MANAGEMENT	F 9999	ED and DNS will be in-serviced on proper reporting procedures and will provide SSD	06/17/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING 00 B. WING	05/17/2024

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	(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (D) major accidents. This State Rule is not met as evidenced by: Based on interview and record review, the facility failed to accurately report dates of incidences or report unusual occurrences in the required report time to the Indiana Department of Health (IDOH) for 2 of 2 residents reviewed for facility related incidences including falls with major injuries. (Resident 12, Resident 183) Findings include: 1. On 5/15/24 at 8:09 A.M., Resident 12's clinical record was reviewed. Diagnoses included, but were not limited to vascular dementia, osteoarthritis, and osteoporosis. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 2/16/24, indicated Resident 12 was severely cognitively impaired, was dependent on staff for transfers, and required maximal assistance from staff for toileting. An IDT (interdisciplinary team) note, documented		and additional nursing manager with the ability to submit a reportable incident in their absence. All reportables were reviewed to ensure timely submission to IDOH. A document explaining the delay in submission has been added by the ED/designee to any file that was not submitted timely. All reportables will be reviewed by IDT to ensure timely submission to IDOH. The ED/designee will be responsible for the completion of a reportable incidences QA Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. 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. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	

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	on 1/2/24 at 9:46 A.M., indicated Resident 12 had a fall on 12/30/23 at 4:00 P.M. A radiology report dated 1/1/24 at 9:40 A.M., indicated Resident 12 had tibia and fibula fractures. A facility incident report, submitted by the Administrator on 1/2/24 at 5:42 P.M., indicated Resident 12 experienced a fall in her bathroom resulting in fracture that occurred on 1/2/24 at 3:01 P.M. The report was inaccurate regarding date and time of the fall. During an interview on 5/17/24 at 1:27 P.M., the Administrator indicated he did not report the incident that happened on 12/30/23 until after the fact because he was on vacation. It was a holiday weekend so staff was at a minimal, and he could not submit it remotely. 2. On 5/17/24 at 11:16 A.M., Resident 183's clinical record was reviewed. Diagnoses included, but were not limited to, hypertension. The most recent Admission MDS Assessment, dated 12/12/23, indicated Resident 183 was cognitively intact and required partial assistance of staff for transfers. An IDT note, dated 12/15/23 at 10:13 A.M., indicated Resident 183 had a fall on 12/14/23 at 2:45 P.M., was sent to the hospital immediately for shoulder and hip pain, and did not return to the facility. A facility incident report, submitted by the DON (Director of Nursing) on 12/15/24 at 2:45 P.M., indicated Resident 183 experienced a fall on 12/15/24 at 2:45 P.M. in his bedroom resulting in			

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	multiple fractures. The report was inaccurate regarding the date of fall. During an interview on 5/17/24 at 1:27 P.M., the Administrator indicated he and the Director of Nursing were on vacation during the time the fall with fracture occurred and nobody in the building was able to report the incident.			