STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155691	A. BUILDING 00 B. WING	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORRISTOWN MANOR	868 S WASHINGTON ST MORRISTOWN, IN 46161

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaints IN00428482, IN00425957, and IN00430923. Complaint IN00428482 - No deficiencies related to the allegations are cited. Complaint IN00425957 - Federal/State deficiencies related to the allegations are cited at F690. Complaint IN00430923- No deficiencies related to the allegations are cited. Survey dates: March 22, 25, 26, 27, and 28, 2024 Facility number: 000422 Provider number: 155691 AIM number: 100291030 Census Bed Type: SNF/NF: 104 SNF: 5 Total: 109 Census Payor Type: Medicare: 9 Medicaid: 70 Other: 30 Total: 109 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 4, 2024	F 0000	**This plan of correction is to serve as Morristown Manor's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Morristown Manor or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this provision constitute an agreement or admission of the survey allegations.** **The facility respectfully requests desk review for the following citations.** **/b>**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Andrew Buzzard		04/19/2024

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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F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to protect a resident's right to be free from physical abuse by another resident for 1 of 4 residents reviewed for abuse. (Resident D) Findings include: The clinical record for Resident D was reviewed on 3/22/24 at 10:40 a.m. Resident D's diagnoses included, but not limited to, dementia and mood (affective) disorder (marked disruption in emotions; extreme highs/severe lows). An interview with Resident D conducted on 3/22/24 at 10:40 a.m. indicated she was going to be discharged from the facility on April 1, 2024. When asked why she was going to be discharged, she indicated she had been abusive to another resident. An interview with SSD (Social Services Director)	F 0600	I. The corrective action to be accomplished for those residents found to have been affected by the practice. Resident D's behaviors have improved and has had no physical contact with other residents. Resident D's medication regimen has been adjusted since the altercation and is being followed by Psych. Non-pharmaceutical interventions are in place for behavior monitoring. Resident P no longer resides at the facility. II. The facility will identify other residents that may potentially be affected by the practice. Current residents have the potential to be affected. Current resident's behavior documentation has been reviewed for any documented	04/23/2024

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	conducted on 3/26/24 at 3:55 p.m. indicated Resident D was being discharged to another facility once her granddaughter had chosen one that is closer to her. When asked if Resident D's discharge was related to abuse, SSD indicated "yes" and Resident D had "body slammed" another resident to the floor then tried to deny that she knew anything about how the other resident came to be resting on the floor. An Indiana State Department of Health reportable incident report was received on 3/27/24 at 1:56 p.m. The report indicated, Resident D and Resident P, who both resided on the memory care unit, had a resident-to-resident altercation on 11/7/23. The Brief Description of Incident indicated, "11/7/23 [Resident P's first name] claimed [Resident D's first name] pushed her but there were no witnesses. It was in a common area, so we were able to access a camera and verify the incident." The type of injury added indicated, "[Resident P's first name] has a knot to the back of her head and a skin tear." The immediate actions included: separation of the two residents; Resident D was placed on one-on-one supervision; pain and skin assessments were completed; social services was to provide 72 hours of psychosocial support; and families, doctors and the administrator were notified. Resident D was sent to a psychiatric facility for evaluation and treatment. The follow-up dated 11/13/23 indicated, no signs/symptoms of distress were noted for Resident P and Resident D had gone to a psychiatric facility. The investigation file for the resident-to-resident altercation between Resident D and P was received on 3/27/24 10:10 a.m. from CS (Clinical Specialist). Within the file, was a typed statement which indicated, "There was not witness to the		behaviors that could pose as a potential problem leading to resident abuse. Any concerns noted have been addressed as necessary. III. The facility policy on Resident abuse was reviewed with no changes made to the policy. The facility will put into place the following systematic changes to ensure that the practice does no recur. Facility staff will receive re-education regarding resident behaviors and abuse and the facility procedures regarding resident abuse. IV. The facility will monitor the corrective action by implementing the following measures: ="" p=""> ="" p=""> The DON/Designee will review the facility behavior documentation to review any resident behaviors that may show signs of a risk for resident abuse daily 5x a week for 4 weeks, then 3x weekly for 4 weeks, then weekly for 36 weeks or as deemed by the Quality Assurance Committee. The results of the daily audit will be addressed with the IDT team for further interventions. The audit results will be reviewed at the monthly quality assurance meeting. Changes may be made to the auditing process, based upon the results of the audits.	

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	actual incident. The resident [sic, Resident P's full name] was found on the floor and she stated she was pushed. The camera footage was pulled and the entire incident was viewed. [sic, name of Resident P] was attempting to sit at the empty seat at the dining room table. [sic, Resident D's name] grabbed the chair not allowing [sic, Resident P's name] to sit down. Then [sic, Resident D's name] stood up, threw a metal drinking cut at [sic, Resident P] hitting her in the abdomen area. Then [sic, Resident D's name] came around the side of the table and forcefully shoved [sic, Resident P] onto the floor. [sic, Resident D] picked up her cup and quickly sat back down in her spot at the table. The staff within approx.[sic, approximately] 30 seconds who were in the pantry of the dining area came to [sic, Resident P] who was on the floor to assess and care for her. The video footage was viewed by the DON [sic, Director of Nursing], SSD [sic, Social Services Director], and the clinical specialist. 11/7/23" A nursing note in Resident D's clinical record dated 11/7/23 at 12:27 p.m. indicated Resident was seen on the video footage shoving another resident. Resident P indicated she was shoved onto the floor by Resident D. Resident D stated, she didn't do anything. A nursing note in Resident P's clinical record dated 11/7/23 at 2:34 p.m. indicated Resident P was shoved down in the dining room and sustained a skin tear to her right hand and a hematoma to the back of her head. A Social Services note dated, 11/7/2023 at 3:17 p.m. indicated social services had spoken to Resident D who indicated, she had pushed Resident P because she did not want "that lady to			

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	sit with her at the table". When Resident D was told she would be going to a psychiatric facility, she replied, "I don't give a f***, send me the f*** anywhere". A nursing note dated, 11/8/2023 at 10:01 a.m. indicated, "IDT [sic, Interdisciplinary Team] met and reviewed recent aggressive behaviors from 11/07/2023. resident [sic, Resident D] was not triggered or instigated by any other residents. behaviors[sic] were very aggressive that resulted in injuries to other resident. Resident[sic, Resident D] was removed from situation and immediately placed on 1 on 1 supervision until resident left for [sic, name of psychiatric facility] for in patient psych stay. no [sic] further behaviors once 1 on 1 initiated. resident [sic] did leave this am [sic, a.m.] for hospital". A Social Services note dated, 1/29/2024 at 12:08 p.m. in Resident D's clinical record indicated, a care plan meeting with Resident D, Resident D's family, SSD (Social Services Director), IP (Infection Preventionist) and ED (Executive Director) had occurred, and they discussed Resident D's behaviors and stated, "we are not able met her needs here at this facility. [sic, Resident D] is physically and verbally aggressive towards others, hiding knifes [sic] and scissors in her bra and under her bed". An Abuse, Neglect, and Misappropriation Prohibition and Prevention policy was received on 3/22/24 at 3:38 p.m. from ED. The policy indicated, it is the policy of the facility to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse...Reporting to the Administrator...Our facility will not condone resident abuse by anyone, including...other residents...Abuse is "the			

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	willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish....Physical abuse is defined as hitting, slapping, pinching, kicking, etc..." 3.1-27(a)(1)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate			

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	corrective action must be taken. Based on interview and record review, the facility failed to timely report a reportable incident for 2 of 4 residents reviewed for abuse. (Resident 94 and Resident E) Findings include: 1. The clinical record for Resident 94 was reviewed on 3/25/24 at 10:30 a.m. The diagnoses for the resident included, but were not limited to, dementia with psychotic disturbance and hallucinations. The resident was admitted on 2/6/24. The 2/9/24 Admission Minimum Data Set (MDS) Assessment for Resident 94 indicated she was severely impaired. 2. The clinical record for Resident E was reviewed on 3/22/24 at 3:11 p.m. The diagnoses for the resident included, but were not limited to, dementia with psychotic disturbance and hallucinations. The 1/8/24 Quarterly Minimum Data Set (MDS) Assessment for Resident E indicated he was severely impaired. A reportable incident that was reported to the Indiana Department of Health was provided by the Clinical Specialist on 3/25/24 at 9:00 a.m. It indicated "...Incident date: 2/27/24 Incident Time: 3:01 p.m....Brief Description of Incident...[Resident 94] touched [Resident E] on the outside of his pants in his lap area..." An event for Resident 94 dated 2/26/24 indicated the resident on 2/26/24 at 10:00 a.m., had "touched	F 0609	I.The corrective actions to be accomplished for those residents found to have been affected by the practice. Resident 94 and resident E's inappropriate contact was reported to IDOH. Resident 94 and Resident E were monitored for psychosocial distress and neither resident had any negative outcome from the untimely reporting. II. The facility will identify other residents that may potentially be affected by the practice. Current residents have the potential to be affected. All other reportable incidents that have occured in the last 30 days were reviewed. Any concerns noted have been addressed as necessary. III. The facility policy on resident abuse and reportable guidelines was reviewed with no changes made to the policy. The facility will put into place the following systematic changes to ensure that practice does not recur. The administrator, DON, and nurse managers will receive re-education regarding abuse, and reportable guidelines/ timely reporting to IDOH and the facility procedures regarding reporting. The DON was educated on reporting to IDOH as a back up to the facility administrator should it be necessary.	04/23/2024

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	male resident in private area." A Social Services note for Resident E dated 2/26/24 at 2:41 p.m., indicated "Visited with [Resident E] and asked if anything happened this morning. He said he couldn't remember. I asked if a female resident touched his private area. [Resident E] stated yeh (sic). I asked if that bothered him, he said no it was fine with me." A Social Services note dated 2/26/24 at 2:54 p.m., indicated "spoke with [Resident 94] today regarding this morning incident. [Resident 94] did not recall doing that. I explained to her that she cannot go up to another resident and touch them. She replied okay." An interview was conducted with the Executive Director on 3/26/24 at 3:46 p.m. He indicated when the incident between Resident E and Resident 94 was first reported to him; it was not presented to him as something he thought at that time needed to be reported. After realizing the incident did need to be reported; he reported on 2/27/24. An abuse policy was provided by the Executive Director on 3/22/24 at 3:38 p.m. It indicated "...It is the policy of Cardon & Associates, Inc. and its member Communities to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion and misappropriation of their property...Policy Interpretation and Implementation...C. Reporting to State Agencies...1. Allegations of abuse and any neglect, mistreatment or injury of unknown source that results in serious injury will be reported immediately to the State licensing/certification agency through that agency's approved method of incident		IV. The facility will monitor the corrective action by implementing the following measures: The DON/designee will review all reportable incidents to IDOH to ensure that the incident was reported timely. The audit will be reviewed daily 5x a week for 4 weeks, then 3x weekly for 4 weeks, then weekly for 36 weeks or as deemed by the quality assurance committee. The audit results will be reviewed at the monthly quality assurance meeting. Changes may be made to the auditing process, based upon the results of the audits.	

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	reporting...2. Allegations of mistreatment, neglect, or injury of unknown source that do not result in serious injury will be reported within a reasonable amount of time not to exceed 24 hours to the State licensing/certification agency through the approved method of reporting..." 3.1-28(c)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to thoroughly investigate a reportable incident for 2 of 4 residents reviewed for abuse. (Resident E and Resident 94) Findings include: 1. The clinical record for Resident 94 was reviewed on 3/25/24 at 10:30 a.m. The diagnoses for the	F 0610	=" b="">**b="">** **=" b="">** =" b="">**b="">** =" b="">=" b="">**b="">** =" b="">=" b=""	04/23/2024

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	resident included, but were not limited to, dementia with psychotic disturbance and hallucinations. The resident was admitted on 2/6/24. The 2/9/24 Admission Minimum Data Set (MDS) Assessment for Resident 94 indicated she was severely impaired. 2. The clinical record for Resident E was reviewed on 3/22/24 at 3:11 p.m. The diagnoses for the resident included, but were not limited to, dementia with psychotic disturbance and hallucinations. The 1/8/24 Quarterly Minimum Data Set (MDS) Assessment for Resident E indicated he was severely impaired. A reportable incident that was reported to the Indiana Department of Health was provided by the Clinical Specialist on 3/25/24 at 9:00 a.m. It indicated "...Incident date: 2/27/24 Incident Time: 3:01 p.m....Brief Description of Incident...[Resident 94] touched [Resident E] on the outside of his pants in his lap area..." An investigation involving Resident 94 and Resident E was provided by the Clinical Specialist on 3/27/24 at 10:30 a.m. The investigation included but was not limited to: a written statement by Certified Nursing Assistant (CNA) 5. It indicated the following: "To Whom This May Concern: I walked out of a Resident's room, and there was [Resident 94], in the hallway in front of the nurse's station holding another resident's private area. I quickly asked her to stop, saying you can not do that, and I asked the nurse to help because she's (sic) wouldn't let		**b="">** ="" b="">**b="">** ="" span="">**span="">** **="" span="">** ="" span="">**span="">** ="" span="">**span="">** ="" span="">**span="">** ="" span="">**span="">** I.The corrective actions to be accomplished for those residents found to have been affected by the practice. Resident 94 and resident E were monitored for psychosocial distress and neither resident had any negative outcome. Resident 94 has had medication changes, she has not touched anyone else inappropriately, and she is being treated by the facility Psych services. A statement from RN10 and any other staff that was on duty was received and put in the investigative file for residents 94 and E's abuse investigation. II. The facility will identify other residents that may potentially be affected by the practice. Current residents have the potential to be affected. All other reportable incidents that have occured in the last 30 days were reviewed to ensure thorough investigation. Any	

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	go so the nurse grabbed her, and I grabbed him, and took him to his room immediately!!!..." The investigation did not include any additional statements from the staff that were present during the incident between Resident 94 and Resident E. An interview was conducted with CNA 5 on 3/27/24 at 11:55 a.m. She indicated Resident E was clothed and standing in the hallway. Resident 94 had ambulated up to Resident E and grabbed his genitalia through his clothing. CNA 5 had intervened to separate the residents, but Resident 94 would not let go of Resident E's private area. She hollered for assistance from Registered Nurse (RN) 10. RN 10 had assisted with separating the residents. Resident E did not voice any pain during that time. An interview was conducted with the Clinical Specialist on 3/27/24 at 1:33 p.m. She indicated the investigation between Resident 94 and Resident E provided was complete. An interview was conducted with RN 10 on 3/28/24 at 9:29 a.m. She indicated she was at the nurse's station and Resident 94 and Resident E were in the hallway. CNA 5 had hollered for her assistance. She had assisted CNA 5 with the separating of the two residents, but when she approached them Resident 94 was not touching Resident E's private area at that time. She had provided assistance with removing Resident E away from Resident 94 by taking him to his room. She then performed an assessment on Resident E and did not observe any injuries to him. RN 10 indicated she could not recall being asked for a written statement about the incident. She works PRN (as needed) and did not return to the facility for approximately a week after the incident.		concerns noted have been addressed as necessary. III. The facility policy on resident abuse and reportable guidelines was reviewed with no changes made to the policy. The facility will put into place the following systematic changes to ensure that the practice does not recur. IV. The facility will monitor the corrective action by implementing the following measures: The administrator/designeee will review all reportable incidents to IDOH to ensure that the incident was investigated thoroughly. The audit will be reviewed daily for any abuse investigation that has occured 5x a week for 4 weeks, then 3x weekly for 4 weeks, then weekly for 36 weeks or as deemed by the quality assurance committee. The audit results will be reviewed at the monthly quality assurance meeting. Changes may be made to the auditing process, based upon the results of the audits.	

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	An abuse policy was provided by the Executive Director on 3/22/24 at 3:38 p.m. It indicated "...It is the policy of Cardon & Associates, Inc. and its member Communities to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion and misappropriation of their property...Policy Interpretation and Implementation...V. Abuse Investigations. 1. Should an incident or suspected incident of resident abuse, neglect, injury of an unknown source or misappropriation of resident property be reported, the Administrator or designee ensure the immediately protection and safety of the involved resident(s) and then will appoint a member of management to investigate the alleged incident while retaining ultimate responsibility for ensuring a timely and thorough investigation. 2. The Administrator or designee will provide to the person in charge of the investigation a complete copy of any supporting documents relative to the alleged incident. 3. The individual conducting the investigation will, at a minimum...g. Interview staff (on all shifts) who have had contact with the resident before, during, and immediately after the period of the alleged incident..." 3.1-28(d)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to accurately complete the cognitive assessment portion of the MDS (Minimum Data	F 0641	I. The corrective action to be accomplished for those residents found to have been affected by the practice. Resident 28, 54 and 78	04/23/2024

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	Set) Assessment for 3 of 5 residents reviewed for Resident Assessment (Resident 28, 54, and 78). Findings include: 1a. The clinical record for Resident 28 was reviewed on 3/27/24 at 1:30 p.m. The Resident's diagnosis included, but was not limited to, dementia. A Quarterly MDS Assessment, completed 1/29/24, indicated that Resident 28 was usually able to make herself understood and was able to understand others. The BIMS (Brief Interview for Mental Status) of the MDS was not completed. 1b. The clinical record for Resident 54 was reviewed on 3/27/24 at 1:40 p.m. The Resident's diagnosis included, but was not limited to, dementia. A Quarterly MDS Assessment, completed 1/29/24, indicated that Resident 54 was usually able to make herself understood and was able to understand others. The BIMS (Brief Interview for Mental Status) of the MDS was not completed. 1c. The clinical record for Resident 78 was reviewed on 3/27/24 at 1:50 p.m. The Resident's diagnosis included, but was not limited to, dementia. A Significant Change of Status MDS Assessment, completed 2/29/24, indicated he was usually able to make himself understood and was usually able to understand others. The BIMS (Brief Interview for Mental Status) of the MDS was not completed. During an interview on 3/27/24 at 2:40 p.m., the SSD (Social Services Director) indicated that		MDS/BIMS was corrected and completed. II. The facility will identify other residents that may potentially be affected by the practice. Current residents have the potential to be affected. Residents who had a MDS in the last 30 days were reviewed to ensure completion of the BIMS. Any concerns noted have been addressed as necessary. III. The RAI was reviewed. The facility will put into place the follwing systematic changes to ensure that the practice does not recur. The administrator, DON, MDS Coordinators, and social servises will receive re-education regarding MDS and completion of the BIMS, and the facility procedures regarding MDS. The MDS coordinator will discuss the scheduled MDS due with the SS department in the IDT meeting held each mornging 5 days per week. IV. The facility will monitor the corrective action by implementing the following measures: The MDS coordinator/designee wil review all MDS that were due for completion after the ARD date to ensure that the BIMS assessment was completed before submission. The audit will be completed daily 5x a week for 4 weeks, then 3x	

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	Residents 28, 54, and 78 were capable of answering questions for the BIMS Assessment, and that the assessments should have been completed for them. During an interview on 3/27/25 at 2:51 p.m., the MDSC (Minimum Data Set Coordinator) indicated the BIMS Assessment should have been completed on the MDS for Residents 28, 54, and 78. The facility used the RAI (Resident Assessment Instrument) as the policy for completing the MDS Assessments.		weekly for 4 weeks, then weekly for 36 weeks or as deemed by the quality assurance committee. The audit results will be reviewed at the monthly quality assurance meeting. Changes may be made to the auditing process, based upon the results of the audits.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services			

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	to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to ensure a resident with an indwelling urinary catheter received appropriate treatment and services to prevent urinary tract infections and to monitor the urine characteristics of a resident being evaluated for a urinary tract infection for 2 of 3 residents reviewed for urinary catheter. (Resident H and Resident L). Findings include: 1. The clinical record for Resident H was reviewed on 3/26/24 at 10:06 a.m. Resident H's diagnoses included, but not limited to, urinary tract infection, acute pyelonephritis (infection of the kidneys), extended spectrum beta lactamase resistance (ESBL, a multi-drug resistant organism), and neuromuscular dysfunction of the bladder (lack of bladder control). A nursing note dated 1/14/2024 at 11:39 p.m. indicated Resident H had an anchored catheter for urinary drainage. The urine was very foul smelling and dark. His urine was tested in-house with a urine analyzer and had numerous abnormal values. Resident H's urine was to be sent to the lab in the morning for a urinalysis with culture and sensitivity.	F 0690	=" span="">**span="">**="" span="">**="" bresident="">**span="">**="" span="">="" span="">**span="">**="" span="">="" span="">**span="">**="" span="">**span="">**="" span="">I.The corrective actions to be accomplished for those residents found to have been affected by the practice. Resident H's order for catheter care was corrected and verification documentation was added to the order to indicate that catheter care was being done every shift. Resident L had no negative outcome from the nurse not documenting the assessment for her urine. The direct caregivers did document that her urine was normal straw yellow in color. The residents urinalysis results were received and she did not require	04/23/2024

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	A physician's note dated 1/15/24 indicated, Resident H was seen in follow up rounds to review/discuss recent urinalysis with culture and sensitivity lab/diagnostic testing from 1/15/24 due to malodorous urine. The results noted the urine was positive for leukocytes, nitrites and bacteria while the culture was still pending. A new order for Keflex (an antibiotic) 500 mg (milligrams) twice a day for 7 days was to be started and possibly adjusted once the culture came back. A physician's note dated, 1/18/2024 indicated, Resident H's urine culture showed mixed flora which indicated, a contaminated sample and the lab recommended a repeat sample. "The antibiotic did not meet McGreer's criteria" but was continued as his urine was reported as cloudy with large sediment and a foul odor. Resident H was also noted to have had increased behaviors recently. No repeat urinalysis with culture and sensitivity labs were to be completed at that time as Resident H was currently on oral antibiotics, and this could have resulted in a false negative urine culture. A physician's order dated 9/28/23 indicated, to provide urinary catheter care every day and night shift. Resident H's care plan dated 4/3/23 and last revised on 2/17/24 indicated; he had an indwelling urinary catheter related to a neuromuscular dysfunction of bladder. Interventions included, but not limited to, provide catheter care every shift and as needed (start date 5/17/23). An interview with CS (Clinical Specialist) conducted on 3/26/24 at 4:14 p.m. indicated, a review of Resident H's MAR (medication administration report) and TAR (treatment		any treatment. II. The facility will identify other residents that may potentially be affected by the practice. Current residents have the potential to be affected. Residetns who have had a urinalysis completed in the last 30 days were reviwed. III. The facility policy on bed bath /perineal care which includes catheter care was reviewed with no changes made to the policy. The skills validation for catheterizing the urinary bladder with an in and out straight catheter was reviewed, with no changes made. The facility will put into place the follwoing systematic changes to ensure that the practice does not recur. The licensed nurses will receive re-education regarding collecting a urinalysis, assessment of urine, documentation, and the facility procedures regarding catheterization of the bladder with a straight cath. The nursing staff was provided re-education regarding residents with a catheter, and that the catheter care not only needs to be done every shift, but must be documented in the resident record as completed. IV. The facility will monitor the corrective action by implementing the following measures: The DON/designee will review all	

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	administration report) for January and February 2024 did not contain verification documentation that indwelling urinary catheter care had been performed every shift from 1/15/24 to 2/5/24. A Bed Bath/Perineal procedure was provided by CS on 3/27/24 at 10:19 a.m. CS indicated, the facility does not have an indwelling urinary catheter care policy. The Bed Bath/Perineal care procedure indicated, "Catheter care: 22. If resident has catheter, check for leakage, secretions or irritation. Gently wipe four inches of catheter from meatus out...Perineal Care...For Males...Pull back foreskin if male is uncircumcised. Wash and rinse the tip of penis using circular motion beginning with urethra. Continue washing down the penis to the scrotum and inner thighs. Rinse off soap and dry. Return foreskin over the tip of the penis." 2. The clinical record for Resident L was reviewed on 3/22/24 at 10:52 a.m. The Resident's diagnosis included, but were not limited to, cerebral infarct (stroke) and dysuria (painful urination). She was admitted to the facility on 3/11/24. An Admission Assessment, dated 3/11/24, indicated Resident L was occasionally incontinent at night and had no symptoms of burning, frequency, pain with urination, or urgency. She wore incontinent pads or briefs to assist with controlling incontinence. A care plan, initiated 3/12/24, indicated Resident L had urinary incontinence. She required staff to assist with toileting and toilet hygiene. The goal was for her not to develop skin breakdown related to incontinence. The interventions included, but were not limited to, assist with toileting and personal hygiene as needed, provide incontinent care after each episode, and weekly skin		residents daily in the morning IDT meeting to ensure that any resident that has had a urinalysis completed, has documentation of the catheterization and assessment of the urine present in the resident record. The audit will be completed daily 2x a week for 4 weeks, then weekly for 4 weeks, then every other week for 36 weeks or as deemed by the quality assurance committee. The audit results will be reviewed at the monthly quality assurance meeting. Changes may be made to the auditing process, based upon the results of the audit.	

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	assessments. A BIMS (Brief Interview for Mental Status) Assessment, completed 3/19/24, indicated she was cognitively intact. A Nurse Practitioner Progress Note, dated 3/20/24, indicated that Resident L had complaints of dysuria on exam. A UA C&S (Urinary Analysis with Culture and Sensitivity) was ordered. During an interview on 3/22/24 at 10:52 a.m., Resident L indicated she thought she was getting a urinary tract infection. She had told the facility, and they were testing her. It took a long time for the staff to take her to the bathroom and she was having urinary accidents. A Nursing Progress Note, dated 3/22/2024, indicated urine was collected for UA C&S and sent to the lab. A Nursing Progress Note, dated 3/25/2024, indicated that the urine sample previously sent to the lab was reported as possibly contaminated. The Nurse Practitioner had been made aware. During an interview on 3/26/24 at 3:19 p.m., Resident L indicated she was beginning to have burning with urination and that "it seems to run every 15 minutes." During an interview on 3/26/24 at 3:57 p.m., the Director of Nursing indicated the Nurse Practitioner had been informed of possible contamination of the previous urine sample and had ordered to repeat the UA. A Nursing Progress Note, dated 3/27/2024, indicated that urine had been obtained and sent to			

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	the lab that morning. A urine culture was pending at that time and the nurse practitioner was aware. During an interview on 3/27/24 at 11:11 a.m., the Director of Nursing indicated a urine sample that had been sent to the lab that morning had been collected by using an in and out catheter. The Nursing Progress notes did not contain any assessment of Resident L's urine color, characteristics, any odor present in the urine, or how the urinary sample was obtained. On 3/28/24 at 12:16 p.m., the Clinical Specialist provided the current Catheterizing the Urinary Bladder with an In and Out Straight Catheter Skills Validation which read "...Document...Document the procedure: Documentation should include a detail of the procedure, the resident's tolerance of the procedure, the color, character and amount of the urine noted in the drainage bag..." This citation relates to Complaint IN00425957. 3.1-41(a)(2)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview and record review, the facility failed to provide adequate supervision for an ambulatory cognitively impaired resident that resided on the memory care unit for 3 of 4 residents reviewed for abuse.	F 0744	I.The corrective actions to be accomplished for those residents found to have been affected by the practice. Resident 94 is being seen by the facility psych services. Her medications have	04/23/2024

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	(Resident 15 and Resident 94, and Resident E) Findings include: 1a. The clinical record for Resident E was reviewed on 3/22/24 at 3:11 p.m. The diagnoses for the resident included, but were not limited to, dementia with psychotic disturbance and hallucinations. The 1/8/24 Quarterly Minimum Data Set (MDS) Assessment for Resident E indicated he was severely cognitively impaired. 1b. The clinical record for Resident 94 was reviewed on 3/25/24 at 10:30 a.m. The diagnoses for the resident included, but were not limited to, dementia with psychotic disturbance and hallucinations. The resident was admitted on 2/6/24. The 2/9/24 Admission Minimum Data Set (MDS) Assessment for Resident 94 indicated she was severely cognitively impaired. A care plan for Resident 94 dated 2/7/24 indicated "...[Resident 94] has a diagnosis of dementia with behaviors and at times exhibits the following signs and symptoms attempting to hit staff, yelling out. [Resident 94] also has a current dx [diagnosis] of hallucinations and is at risk of experiencing certain behaviors regarding...Approach...New or worsening behaviors will be monitored and new interventions will be considered in order to promote the highest level of quality of life for this resident...Allow for hoarding or wandering in a controlled environment with acceptable limits..." A care plan dated 2/27/24 indicated "...Resident		been adjusted. She has not had any physical contact with others, and her behavior episodes have decreased. Nursing staff and activities are utilizing redirection and also other non-pharmaceuitical interventions to help decrease her behaviors. Resident 15 and resident E have had no psychosocial distress or negative outcome. II. The facility will identify other residents that may potentially be affected by the practice. Current residents have the potential to be affected. Residents behavior notes will be reviewed on all residents for the last 30 days. Any concerns noted will be discussed by the IDT and addressed. III. The facility policy on behavioral health management was reviewed with no changes made to the policy. The facility will put into place the following systematic changes to ensure thaht the practice does no recur. The SS staff, administrator and DON will receive re-education regarding dealing wih behaviors for residents with dementia, necessary steps when behaviors occur and the facility procedures for monitoring. The staff was provided re-education regarding dementia residents with behaviors and ways to manage and redirect behaviors that occur. IV. The facility will monitor the corrective action by implementing	

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	touching another resident inappropriately. Increased interest in touching self, masturbation...Approach...Give resident privacy in own room when desires to masturbate or touch self...Resident on 15 min [minutes] check until deemed necessary to remove per IDT [Interdisciplinary Team.]..." A care plan dated 3/6/24 indicated "Entering another residents room and taking their belongings...Approach...Goal. Resident will not go into other residents rooms and take their belongings...Approach. Encourage resident to join in scheduled activities to keep her busy...See [Psych Provider] as needed...Stop sign placed on other residents door, 15 min checks to continue until deemed appropriate to remove by IDT...Try self directed activities to help keep resident busy, walk with resident in hallway..." A care plan dated 3/6/24 indicated "...Resident is at risk for psychosocial distress from physical contact from another resident...Approach...Monitor for any signs of distress, withdraw, change in mood...." A care plan for Resident 94 dated 3/14/24 indicated "Behavioral symptoms. Resident is at risk wandering, exit seeking, history of elopement from home, expresses the need to go home or leave, , and/or expresses anger or frustration about being in the community. wander guard to L [left] ankle. Resident cuts off wanderguard at times...Approach...3/14/24 Increase staff monitoring as needed...Redirect resident if wandering in unsupervised areas...When resident begins to wander, provide comfort measures for basic needs..." A physician order dated 2/6/24 indicated Resident		the following measures: The DON/designee will review behavior dcoumentation and progress notes daily in the morning IDT meeting to ensure that any resident that has had increased, behaviors that cannot be improved or controlled are addressed and monitored. The audit tool will be completed daily 5x a week for 4 weeks, then 3x weekly for 4 weeks, then weekly for 36 weeks or as deemed by the quality assurance committee. The DON or designee will do facility observation rounds 2x a day 5x a week for 4 weeks, then 2x a day 3x a week for 4 weeks, then 2x a day weekly for 36 weeks to ensure residents with behaviors are being re-educated appropriatley and that staff is managing behaviors. The audit and observation results will be reviewed at the monthly quality assurance meeting. Changes may be made to the auditing process, based upon the results of the audits.	

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	94 was to receive 10 milligrams of memantine daily for a diagnosis of dementia with psychotic disturbances that included hallucinations. A physician order dated 2/6/24 indicated the resident was to receive 2 milligrams of diazepam in the morning daily for combative behavior. The medication was discontinued on 2/7/24. A physician order dated 2/6/24 indicated the resident was to receive 2 milligrams of diazepam at bedtime daily for combative behavior. A nursing progress note for Resident 94 dated 2/6/24 indicated "Unable to complete admission PPD [Purified Protein Derivative] testing at this time. Patient is being extremely combative, yelling, swinging arms/attempting to strike nursing staff, screaming and unable to redirect. Will continue w/ [with] plan of care." A Social Services note for Resident 94 dated 2/7/24 indicated "Nursing staff did report that on the evening of 2/6/24, resident was combative with nursing staff during admission process/care; attempting to hit nursing staff, verbal aggression. Staff also report that on the morning of 2/7/24, resident was yelling out/screaming at others during care. Staff will continue to reassure resident of her safety during care, and will continue to cue and assist resident as necessary." A physician note dated 2/7/24 indicated "...behaviors in hospital requiring prn [as needed] zyprexa. Consult psych if needed. Cont [continue] memantine, diazepam....reports of anxiety and behaviors. Add hydroxyzine 25 mg [milligrams] bid [twice a day] prn x 14 days. May need to increase diazepam dosage..."			

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	A physician order dated 2/8/24 indicated the resident was to receive 25 milligrams of hydroxyzine twice a day as needed. A physician note dated 2/9/24 indicated Resident 94 was confused, but mood was stable. A nursing progress note for Resident 94 dated 2/23/24 indicated "Resident wandering throughout the entire morning. She had to be redirected from 3 other resident rooms. In the last room she was found unclothed in another residents bed and had ripped her brief off. She does not take direction well and is not able to understand what you're asking d/t [due to] dementia. Will continue to redirect." An event for Resident 94 dated 2/26/24 indicated the resident on 2/26/24 at 10:00 a.m., had "touched male resident in private area." Interventions that were put in place after the incident was one on one interaction, reassurance from staff, 15-minute monitor checks, and psych provider was notified. A reportable incident that was reported to the Indiana Department of Health was provided by the Clinical Specialist on 3/25/24 at 9:00 a.m. It indicated "...Incident date: 2/27/24 Incident Time: 3:01 p.m....Brief Description of Incident...[Resident 94] touched [Resident E] on the outside of his pants in his lap area...Follow up: 3/5/24 [Resident 94] was seen by psych and new med [medication] added to help with behavior. 15-minute checks continue for [Resident 94]. Interdisciplinary team will evaluate circumstances to decide when they can be discontinued. Neither resident is showing any s/s [signs and symptoms] of psychosocial distress from incident." An investigation involving Resident 94 and			

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	155691	A. BUILDING 00 B. WING	03/28/2024

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	Resident E was provided by the Clinical Specialist on 3/27/24 at 10:30 a.m. The investigation included but was not limited to: a written statement by Certified Nursing Assistant (CNA) 5. It indicated the following: "To Whom This May Concern: I walked out of a Resident's room, and there was [Resident 94], in the hallway in front of the nurse's station holding another resident's private area. I quickly asked her to stop, saying you cannot do that, and I asked the nurse to help because she's (sic) wouldn't let go so the nurse grabbed her, and I grabbed him, and took him to his room immediately!!!..." An interview was conducted with CNA 5 on 3/27/24 at 11:55 a.m. She indicated she was the staff present during the incident on 2/26/24 between Resident E and Resident 94. Resident E was clothed and standing in the hallway. Resident 94 had ambulated up to Resident E and grabbed his genitalia through his clothing. CNA 5 had intervened to separate the residents, but Resident 94 would not let go of Resident E's private area. She hollered for assistance from Registered Nurse (RN) 10. RN 10 had assisted with separating the residents. Resident E did not voice any pain during that time. Resident 94 was then placed on every 15-minute checks. An interview was conducted with RN 10 on 3/28/24 at 9:29 a.m. She indicated she was at the nurse's station and Resident 94 and Resident E were in the hallway. CNA 5 had hollered for her assistance. She had assisted CNA 5 with the separating of the two residents, but when she approached them Resident 94 was not touching Resident E's private area at that time. She had provided assistance with removing Resident E away from Resident 94 by taking him to his room.			

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	She then performed an assessment on Resident E and did not observe any injuries to him. A Post Behavioral/Emotional IDT Form dated 2/26/24 indicated "...resident went to common area and touch a male resident in his private area...New interventions that will be added to prevent a reoccurrence; make sure resident does not sit next to male resident in common area..." A 2/28/24 Behavior IDT follow up for Resident 94 indicated resident was on 15-minute monitoring checks and psych provider ordered 10 milligrams of Paxil (antidepressant) daily. A physician order dated 2/28/24 indicated the resident was to receive 10 milligrams of Paxil daily. A Social Services note dated 3/6/24 at 7:49 a.m., indicated "On 3-5-24 at 11:12 p.m., [Resident 94] was having trouble sleeping, up walking and going in/out of other residents rooms taking their personal belongings. Staff did try the following redirection, one-on-one, toileted, provided a calm environment, given food/fluids, was not effective. IDT team reviewed behaviors. Staff will continue to redirect resident as needed." 1c. The clinical record for Resident 15 was reviewed on 3/25/24 at 1:11 p.m. The diagnosis for the resident included, but was not limited to, dementia. The 1/29/24 Admissions Minimum Data Set (MDS) Assessment for Resident 15 indicated she was severely cognitively impaired. A nursing progress note dated 3/6/24 at 8:13 a.m., indicated "Res [resident] 94 in [Resident 15]'s room trying to take res in room belongings. Res			

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	[94] was struck in the back with a closed fist before staff could intervene. Res was not injured by this contact. Res skin was assessed and found to have no redness or bruising to area....Res does not seem to have any memory of this incident and continues to try and go into others rooms and take things out of rooms that are not hers. Res redirected several times without effectiveness." A reportable incident that was reported to the Indiana Department of Health was provided by the Clinical Specialist on 3/25/24 at 9:01 a.m. It indicated "...Incident date: 3/6/24 Incident Time: 9:01 a.m....Brief Description of Incident...[Resident 94] wandered into [Resident 15]'s room and before staff could reach [Resident 94] and redirect her [Resident 15] touched her back with her hand...Immediate Action taken...Residents were immediately separated. Skin and pain assessment has been initiated...Stop sign was placed at [Resident 15]'s door...Follow up...[Resident 94] was seen by psych [provider] and new order added to care. 15 - minute checks continue with [Resident 94] IDT team met and reviewed behaviors. Staff will continue to redirect as needed. They will try and engage her in self-directed activities along with scheduled activities." An investigation involving Resident 94 and Resident 15 was provided by the Clinical Specialist on 3/27/24 at 10:30 a.m. The investigation included but was not limited to: a written statement by License Practical Nurse (LPN) 2. It indicated, "3/6/24 at 8:05 a.m. Res [94] was in [Resident 15's room] and had taken some belongings from res [15]. Res in [Resident 15's room] was distressed about [Resident 94] in her room. Res [94] had belongings in her hand. Retrieved res belongings and got her to head to			

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	the door. As were coming through the door [Resident 15] hit her in the back. Removed res [94] from [Resident 15's room] & assessed for injury. Res in [Resident 15's room] went back to her chair and was upset about her being in her room..." A Social Services progress note dated 3/7/24 at 7:37 a.m., indicated "On 3-6-24 at 8:00 a.m., [Resident 94] was rummaging through other residents's belongings. Staff did try the following redirection, one-on-one, offered food/fluids was not effective. On 3-6-24 at 9:47 p.m., [Resident 94] was having trouble sleeping, wondering into other residents rooms, taking their belongings, waking them up and yelling at them about her husband. Staff did try the following redirection, one-on-one, food/fluids, toileted, returned to her room, position change, was not effective. On 3-7-24 at 2:56 a.m., [Resident 94] was having trouble sleeping and wandering. Staff did try the following redirection, one-on-one, toileted, returned to her room, position change, was not effective. IDT team met and reviewed behaviors. Staff will continue to redirect resident as needed. Resident just had a recent increase in her Paxil." A physician order dated 3/6/24 indicated Resident 94 was to be increased to 20 milligrams of Paxil daily. An observation behavior note for Resident 94 dated 3/8/24 indicated "...follow up behavior and resident altercation/contact...Root cause: Resident with altercation with other female resident and also previously touched male resident in hallway in his lap area on outside of his pants/increased pleasing self-masturbation. Current status: resident conts [continues] to wander however no aggression or physical contact with others. Resident has had no psychosocial distress from			

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	physical contact to back when she roamed into other residents room to take her items. Intervention(s): Paxil was increased by psych earlier this week, and it does seem to be helping. Psych evaluated resident this week. This resident is on 15 min checks, and a stop sign is on the door for the female resident whos room she entered and that is effective at this time. Staff gives redirection as needed and engages in appropriate activities..." A psych visit note dated 3/8/24 indicated "...The patient reports no difficulty with sleeping at night. Staff notes she is having trouble with some difficulty with being up wandering at times. If she continues to have difficulty we will add melatonin....She denies difficulty with anxiety and no symptoms are observed. She is more restless than anxious, probably due to her confusion...She is having difficulty with behaviors, including stealing belongings from peers and going in their room. She also has had some sexual behaviors. She was started on Paxil for these, and her dose was increased recently...Staff are obtaining UA on her today. Her recent one was negative for UTI [Urinary Tract Infection]. The patient's cognition is significantly declined. She is currently receiving memantine for cognition decline, which we will probably discontinue once her behavior issues are stabilized....Follow up 1 month..." An observation behavior note for Resident 94 dated 3/15/24 indicated "follow up behaviors...Root cause: resident with behaviors, wandering into others rooms, taking belongings, recently having hypersexual behaviors, such as masturbating. Current status: residents sexual behaviors have decreased, no touching others, conts to roam in to others rooms, and is taking down stop signs. They are not effective. Intervention(s): psych is following resident, and			

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	[Medical Provider]. U/A [Urinalysis] ordered. Paxil was started and also increased which has helped resident some..." A Social Services note for Resident 94 dated 3/18/24 indicated "On 3/15/24 at 9:16 p.m., [Resident 94] was repetitive asking questions. Staff did try to redirect, was not effective. On 3/16/24 at 1:00 a.m., [Resident 94] was having trouble sleeping and going into other residents rooms while they were sleeping. She would uncover them and tell them it was time to get up. She also pulled their clothing out of the closet and put them on top of them. Staff did try the following redirection, offered food/fluids, toileted and returned to her room, was not effective. On 3/17/24 at 7:31 p.m., [Resident 94] was wondering about the unit. Staff did try the following redirection, backrub and provided calm environment, was not effective. IDT team met and reviewed behaviors. Staff will continue to redirect resident as needed through out her daily routine. They will also try to have her do self directed activities and join in scheduled activities." A medical provider note dated 3/19/24 indicated "...Resident with pacing and restlessness at night...Start low dose melatonin 3 mg q hs [every night". A physician order dated 3/20/24 indicated the resident was to receive 3 milligrams of melatonin daily at bedtime. A behavior follow up note dated 3/22/24 indicated "Root cause: resident with ongoing behaviors. sexual behaviors have decreased some, not touching others. Conts to wander into other areas. Current status: stable. Conts to wander into others space, non pharm [nonpharmacological]			

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	interventions attempted. Staff attempting to engage in activities and keep resident busy. Staff reported to NP [Nurse Practitioner] resident not sleeping well. Intervention(s): Melatonin started, cont ss [social services] follow up, psych, and NP to follow...no further IDT monitoring needed at this time..." Resident's 94 staff monitoring documents were provided by the Clinical Specialist on 3/26/24 at 12:55 p.m. The monitoring documents indicated Resident 94 was on staff 15-minute monitoring checks on 2/26/24, 2/27/24, 2/28/24, 2/29/24, 3/1/24, 3/2/24, 3/3/24, 3/5/24, 3/6/24, 3/7/24, 3/8/24, 3/9/24 and 3/10/24. An observation was made of Resident 94 on 3/25/24 at 10:55 a.m. During a scheduled activity on the memory care unit, Resident 94 was observed wandering. The resident had wandered into Residents' 68 and 79's room. The residents that reside in the room were not present in the room at that time. Resident 94 was observed going to one of the resident's bed and messing up blankets; rummaging through the closet, and the bathroom. There was no observation of staff redirecting the resident at that time. The resident then left the room and ambulated to the nurse's station. Resident 94 indicated at that time; she needed her, "dirty white clothes." During an interview with CNA 5 on 3/27/24 at 11:55 a.m., she indicated Resident 94 wanders in and out of residents' rooms, and it upsets other residents. A stop sign was placed on Resident 15's door after the incident occurred on 3/6/24, with Resident 15. Resident 15 gets upset when Resident 94 takes her belongings. Resident 94 goes into other residents' rooms; messes up their covers and belongings. The stop signs do not			

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	help. The resident removes the stops signs. The resident does like her room to be set at a warmer temperature. She will occupy her time in her room at times if the temperature in her room was set to her liking. During an interview with RN 10 on 3/28/24 at 9:29 a.m., she indicated Resident 94 does wander in and out of other residents' rooms. They utilize stop signs on the doors to detour her from entering. An interview was conducted with LPN 2 on 3/28/24 at 11:06 a.m. She indicated she was the staff person present during the incident on 3/6/24 with Resident 94 and Resident 15. She was assisting a resident; assuring that resident was not going to fall and had observed Resident 15 getting aggravated with Resident 94 in her room taking her belongings. She heard Resident 15 yelling "get out!" Then, LPN 2 entered the room to intervene and redirect. LPN 2 was able to get Resident 94 to head to the doorway of the room. During that time, Resident 15 hit Resident 94 in the back prior to getting Resident 94 to exit the room. LPN 2 indicated stops signs do not stop Resident 94 from entering other residents' rooms. She removes them. "Does not help at all; nothing works." She wanders everywhere. A Behavioral Health Management Program was provided by the Director of Nursing on 3/28/24 at 11:50 a.m. It indicated, "Behavior policy...Cardon communities provide services to our residents with specific diseases and disorders. Some of our residents have medical disabilities that can lead to disruptive behaviors and these behaviors have the potential to create a negative effect on the resident, other residents, visitors, and the staff. It is Cardon's policy that each community will have a			

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	behavior program that: identifies, monitors, manages, and disseminates (whenever possible) all behavioral events by utilizing the least invasive approach based on the individual resident affected. Our goal is to provide the highest level of functioning and well being for each resident we serve. Cardon believes in a person-centered care approach and tailors all considerations for the individual affected, including physical and psychosocial aspects of well being when it comes to managing maladies that manifest behavioral disturbances..." 3.1-37(a)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and			

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	following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and			

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	transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on interview and record review, the facility failed to ensure transmission-based precautions (TBP) were initiated timely for a resident with COVID-19 for 1 of 3 residents reviewed for TBP. (Resident 255) Findings include: The clinical record for Resident 255 was reviewed on 3/25/24 at 1:55 p.m. The diagnoses included, but were not limited to, COVID-19, cough, and hypertension. A progress note, dated 3/16/24 at 12:54 p.m., indicated Resident 255 admitted to the facility from the hospital and admitted with COVID-19. A physician order, dated 3/18/24, indicated the following,"...droplet/contact isolation, with no roommate. All meals, activities, therapy and services must be provided in room with isolation precautions followed...." There was no indication in the progress notes or the physician orders that the resident was in TBP until 3/18/24. A policy titled "COVID-19 Policy and Procedure", dated 8/6/23, was provided by Clinical Specialist on 3/26/24 at 12:55 p.m. The policy indicated the following, "...Additional PPE [personal protective equipment] and Other Precautions...A. Face	F 0880	**="" span="">** ="" bresident="">**span="">** ="" span="">**span="">** ="" span="">="" bthe="">I.The corrective actions to be accomplished for those residents found to have been affected by the practice. Resident 255 was placed in isolation on 3/18/2024 and an order was put into place. II. The facility will identify other residents that may potentially be affected by the practice. Current residents have the potential to be affected by the practice. No other residents were affected by Resident 255 going into isolation on 3/18/2024. All residents who had infections requiring isolation in the last 30 days were reviewed. III. The facility Policy on Covid 19 was reviewed with no changes made to the policy. The facility will put into place the following systematic changes to ensure that the practice does not recur. The nursing staff was educated on immediate isolation, and timely physician order for isolation upon	04/23/2024

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	Shield/Goggles, N95 Respirator, and a Gown must be worn by healthcare personnel (HCP) who provide essential direct care within 6 feet of the resident when...1. Caring for a Resident in a Red Zone...." 3.1-18(b)(2)		a resident being diagnosed with or being admitted with covid 19. The DON, and nurse managers were re-educated on potential admissions who have Covid-19 and ensuring isolation is in place. IV. The facility will monitor the corrective action by implementing the following measures: The DON/designee will review all residents daily in the morning IDT meeting to ensure that any resident that has a new diagnosis of Covid-19 or who is admitted with Covid 19 was placed in appropriate isolation and has orders in place for droplet/contact isolation. The audit will be completed daily 5x a week for 4 weeks, then 3x weekly for 4 weeks, then weekly for 36 weeks or as deemed by the qaulity assurance committee. The audit results will be reviewed at the monthly quality assurance meeting. Cahnges may be made to the auditing process, based upon the results of the audits.	
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			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORRISTOWN MANOR	868 S WASHINGTON ST MORRISTOWN, IN 46161

(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
	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; (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:			

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	(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 interview and record review, the facility failed to ensure annual influenza immunization was administered per physician orders for 1 of 5 residents reviewed for immunizations. (Resident 82) Findings include: The clinical record for Resident 82 was reviewed on 3/25/24 at 1:50 p.m. The diagnoses included, but were not limited to, heart failure, diabetes mellitus, and weakness. An immunization consent form, undated, indicated consent was given to administer the influenza vaccine. A physician order, dated 11/3/23, was noted for Fluzone Quad 2023-2024 (flu vaccine) intramuscular injection. The electronic medication administration record (EMAR), dated November of 2023, indicated the dose of Fluzone Quad was not signed off, as administered, on 11/3/23. An interview conducted with the Infection Preventionist (IP), on 3/26/24 at 4:50 p.m., indicated she reached out to the physician and obtained an order to administer the influenza vaccine since it was still within the window to	F 0883	=" " span=" "> **span=" "> **=" " span=" "> =" " bresident=" "> **span=" "> =" " span=" "> =" " span=" "> **span=" "> =" " span=" "> =" " bthe=" "> I.The corrective actions to be accomplished for those residents found to have been affected by the practice. Resident 82's nurse practitioner was contacted to inform her that the resident did not get her influenza vaccine on 11/2/23. The nurse practitioner gave an order to administer the vaccine and that was completed, and her immunization record was updated. II. The facility will identify other residents that may potentially be affected by the practice. Current residents have the potential to be affected. All residents were reviewed to ensure they were given the vaccine if they consented to administration. Any findings were addressed as necessary. III. The facility policy on influenza	04/23/2024

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	receive the annual influenza vaccine. A policy titled "Influenza Immunization Policy - Residents", revised 9/23/20, was provided by the Executive Director on 3/22/24 at 1:30 p.m. The policy indicated the following, "...All residents will be offered an influenza vaccination as appropriate when residing in a [name of Corporation] Community. Annually [name of Corporation] will offer the influenza vaccination beginning on October 1 unless the vaccinations have not yet been received in stock by [name of pharmacy] and continue through the influenza season...This policy is created with the intention to follow current CDC [Centers for Disease Control and Prevention] recommendations for influenza vaccination...." A document from the Centers for Disease Control and Prevention (CDC) titled "Key Facts About Flu Vaccines", last reviewed March 22, 2024, indicated the following, " ...When should I get vaccinated...For most people who need only one dose of influenza vaccine for the season, September and October are generally good times to be vaccinated against influenza. Ideally, everyone should be vaccinated by the end of October ...."		immunization policy was reviewed with no changes made to the policy. The facility will put into place the following systematic changes to ensure that the practice does not recur. The DON and infection preventionist will be re-educated on influenza vaccines, consents for immunizations and timely administration. The licensed nurses were re-educated on administration of vaccines when on the MAR. IV. The facility will monitor the corrective action by implementing the following measures: The infection preventionist will create a facility tracking of residents who consent to the influenza vaccine. The DON/designee will review all residents daily in the morning IDT meeting to ensure that any current resident or new admission that consents to the influenza vaccine is given the vaccine timely, during the dates recommended by the CDC. The audit will be completed daily 5x a week for 4 weeks, then 3x weekly for 4 weeks, then weekly for 36 weeks or as deemed by the quality assurance committee. The audit results will be reviewed at the monthly quality assurance meeting. Changes may be made to the auditing process, based upon the results of the audits.	