STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155404	A. BUILDING 00 B. WING	09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESSEX NURSING AND REHABILITATION CENTER	301 W ESSEX ST LEBANON, IN 46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00405260, IN00412676 and IN00416159. Complaint IN00405260 - Federal/state deficiencies related to the allegations are cited at F725, F727, F759, F880 and F921. Complaint IN00412676 - Federal/state deficiencies related to the allegations are cited at F725, F727 and F761. Complaint IN00416159 - Federal/state deficiencies related to the allegations are cited at F609, F610, F684, F689, F725, F727, and F921. Survey dates: September 20, 21, 22, 25 and 26, 2023. Facility number: 000291 Provider number: 155404 AIM number: 100286710 Census Bed Type: SNF/NF: 20 Total: 20 Census Payor Type: Medicaid: 18 Other: 2 Total: 20 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 5, 2023.	F 0000	**Preparation and or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and or executed solely as required**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Mace	Consultant	10/30/2023

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 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview, and record review, the facility failed to ensure a call light was within reach for 2 of 8 dependent residents observed for call light placement (Residents G and R). Findings include: 1. On 9/20/23 at 11:35 a.m., Resident G was observed. The call light cord was a thin red piece of string coming from a light switch above the head of the bed and was draped out of reach and out of the resident's line of sight. The cord was draped over the window blinds, located behind the bed. On 9/20/23 at 2:05 p.m., Resident G's thin call light string continued to hang from the blinds out of sight and out of reach from the resident. On 9/21/23 at 9:53 a.m., Resident G's thin call light string was observed hanging down behind the head of resident's bed, out of sight and out of reach of the resident. Resident G's record was reviewed on 9/21/23 at 10:38 a.m. Diagnoses on Resident G's profile included, but were not limited to epilepsy (disorder in which nerve cell activity in the brain is disturbed, causes seizures), bipolar disorder (episodes of mood swings ranging from	F 0558	**Preparation and or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and or executed solely as required** The facility will ensure call lights are in reach for dependent residents. Residents G and R now have their call light in reach when in room/bed. All dependent residents were at risk from this alleged deficient practice. Rounds were made to make sure all dependent residents had their call lights in reach at time of the survey. All staff in serviced by the DON/Designee on call light placement for dependent residents when in their room. The Administrative staff are making rounds and visually observing for call light placement during their	11/17/2023

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	depressive lows to manic highs), dementia, and history of traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head), right side hemiplegia (paralysis), and borderline intellectual functioning. A care plan dated 7/2/21, indicated Resident G had potential for falls. Interventions included, but were not limited to, the resident needed a working and reachable call light, a call light placed within easy reach, and call light answered promptly. A progress note, dated 8/6/23 at 6:01 a.m., indicated staff went to Resident G's room where resident had transferred himself to the extra bed in the room and turned on call light to be changed after having had a large bowel movement. A quarterly Minimum Data Set (MDS) assessment, completed on 9/8/23, assessed Resident G as having unclear speech, rarely/never able to make himself understood, and sometimes had the ability to understand others. Resident G was unable to participate in the Brief Interview for Mental Status (BIMS). Resident G required limited assistance of 1-person physical assist for bed mobility, extensive assist of 1-person physical assist for transfers, dressing, toilet use, and personal hygiene. He did not walk in the room or corridor, and mobility devices included a wheelchair. A fall risk assessment, dated 9/26/22, Resident G's score of 31 indicated a high risk for falls. During an interview on 9/20/23 at 11:43 a.m., Certified Nursing Assistant (CNA) 12 indicated she provided almost all care for Resident G, and he was "light happy" with the call light. During an interview on 9/22/23 at 1:10 p.m., CNA		rounds. Any call light found to be out of reach will be corrected immediately. The Admin/DON/Designee will do unannounced walking rounds 5 x week x 1 month; 3 times a week for 1 month and then weekly x 4 months to observe for call light placement for dependent residents. Corrections will be made immediately if needed with further staff education as needed. The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	18 indicated that Resident G was able to use his call light if it was close to where he could reach. She had no idea how the call light string could have gotten in the blinds. It was normally the CNA's responsibility to make sure call lights were within reach. 2. On 9/25/23 at 10:09 a.m., Resident R was observed resting in bed with eyes open verbally requesting assistance to get up. He was unable to reach his call light that was located on his left paralyzed side hanging down between the bed and the wall. On 9/21/23 at 2:56 p.m., Resident R's record was reviewed. Diagnoses on Resident R's profile, included but not was not limited to, hemiplegia and hemiparesis of left side (paralysis, unable to move), muscle weakness, lack of coordination, need for assistance for personal care, and history of falls. On 9/22/23 at 1:20 p.m., the Administrator (ADM) provided a Call Light policy, dated 10/2014, and indicated the policy was the one currently being used by the facility. The policy indicated, "Policy: Resident's call light is to be within reach and answered promptly by facility personnel... 6 ...ensure call light is within reach ... 8. Call lights must remain functional and within reach of each resident. call lights shall not be removed from resident's reach unless this is a therapeutic intervention documented in a resident specific behavior management plan set forth by the physician and/or mental health clinician in response to problematic and/or mental health clinician in response to problematic and/or attention seeking behavior." 3.1-3(v)(1)			

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F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a			

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	temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview, and record review, the facility failed to provide a home-like environment for 2 of 15 residents reviewed for home-like environments (Residents G and R). Findings include: 1. On 9/20/23 at 9:45 a.m., Resident G was observed in his wheelchair in the hallway outside of his room. The wheelchair was heavily soiled with unknown debris and an unidentified light brown substance on the wheels and left arm rest. Resident G had unknown dark soilage in palm of right hand. Splint in place on right hand/forearm, splint frayed with metal showing near palm. On 9/20/23 at 11:50 a.m., observation of Resident G's communication binder with pictures, words, letters and numbers on dresser next to bed. His personal digital clock was upside down on top of the binder. The binder was observed to be heavily soiled, sticky, and molded. Binder rings and binding metal were heavily rusted. The pages, dividers, and vinyl were all heavily soiled and had dark mold. On 9/21/23 at 9:53 a.m., a second observation of Resident G's communication binder in his room on the bedside table that was heavily soiled, had sticky and molded pages, dividers, vinyl sheets, and heavily rusted rings and binding. A second observation of Resident G's wheelchair in his room at the foot of his bed that was heavily soiled with unidentified substances. On 9/25/23 at 10:47 a.m., a third observation of	F 0584	The facility will provide a home like environment. Resident G's wheelchair has been cleaned and has a new communication binder. A new splint has been ordered and is in use. His clock was placed right side up. Resident R's wheelchair has been replaced as well as the anti rollbacks. All residents were at risk of this alleged deficient practice. Facility rounds were made to identify any other potential affected items and corrected as needed. Nursing staff in serviced by DON/Designee on the Facility's wheelchair cleaning schedule and the expectation that it is to be followed. In-service included discussion on homelike environment for all residents and their responsibility to keep items clean. The Housekeeping staff were in serviced as well on the responsibilities of providing a homelike environment. The Admin/DON/Designee will do unannounced walking rounds 5 x week x 1 month; 3 times a week	11/17/2023

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	Resident G's communication binder that was open and laying on bedside table with personal digital clock upside down on top of it. The binder had rusted binding, rusted rings, paper pages and communication pages inside plastic covered in sticky unidentified substance to the extent several pages were unable to be separated. Most of the binder pages were covered in dark mold. On 9/21/23 at 10:38 a.m., Resident G's record was reviewed. Diagnoses on Resident G's profile included, but was not limited to, dementia, history of traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head), right side hemiplegia (paralysis), and borderline intellectual functioning. A progress note, dated 8/28/2023 at 2:10 p.m., indicated Resident G continues to attempt to put inappropriate items in his mouth, also licked his snack wrappers, plates, drinks, refused to use utensils provided, liked to lick his food. Attempted to eat off of other residents' plates. Continued to pick lint or whatever was on floor and throw it over the nurse's station. Several attempts had been made to redirect resident without success. A quarterly Minimum Data Set (MDS) assessment, completed on 9/8/23, assessed Resident G as having unclear speech, rarely/never able to make himself understood, and sometimes had the ability to understand others. Resident G was unable to participate in the brief interview for mental status. Resident G required limited assistance of 1-person physical assist for bed mobility, extensive assist of 1-person physical assist for transfers, dressing, toilet use, and personal hygiene. He did not walk in the room or corridor, and mobility devices included a		for 1 month and then weekly x 4 months to observe for call light placement for dependent residents. Corrections will be made immediately if needed with further staff education as needed. The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	wheelchair. A care plan, dated 7/2/23, indicated Resident G was at risk for falls and indicated he was bed/chair bound and intervention included but not limited to using a wheelchair when out of bed. Resident G displays socially inappropriate and maladaptive behavior. Symptoms and problems were manifested by resident attempting to manipulate or smear fecal matter on walls and bed and throw onto the floor and would rub face and mouth with hands after smearing bowel movement on walls, bed, etcetera. Interventions included, but were not limited to, reminding the resident it was not acceptable and to frequently check for incontinence. Resident G had an activity of daily living (ADL) Self Care Performance Deficit related to old traumatic brain injury with residual hemiparesis and communication/cognitive deficits, lack of coordination, deafness, aphasia (loss of ability to understand or express speech) and required up to extensive to total assistance with ADL care. Interventions include, but are not limited to, the use of a communication binder in his room to help determine what he was trying to express. During an interview on 9/25/23 at 1:38 p.m., the Interim Director of Nursing (IDON) indicated the Administrator (ADM) told her it was the responsibility of Social Services to manage the communication binder and that person was currently not available. During an interview on 9/25/23 at 11:08 a.m., in Resident G's room, the IDON indicated she was not sure if the resident used the communication binder. She indicated the binder looked like it had			

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	syrup on it, picked it up with one hand pinched between finger and thumb and said it needed to be taken out of the room and redone. The IDON turned to look for gloves, said she could not put them on now, turned back around to sit the binder back down, stopped and said she did not know what to do with it, but it could not stay in the room. The IDON indicated the binder should be clean and, in this condition, should be completely replaced. She thought it was the responsibility of Social Services or Activities. The IDON indicated there were concerns with the binder because it looks like mold, and she had been told he puts things in his mouth. She had witnessed Resident G putting his hands in his mouth and had witnessed him putting his hands in cups and then in his mouth. The IDON indicated she had to be truthful, the binder was just unacceptable, and she was going to take care of it and go wash her hands. During an interview on 9/25/23 at 3:45 p.m., ADM indicated he was unaware Resident G had a communication binder. Acknowledged the resident routinely picked up items and put into his mouth, or touched items around him then put his fingers into his mouth or licked them. It was the responsibility of nursing to assure resident equipment and personal items were kept clean, or to notify the appropriate department. The resident should not have had a molded communication binder left at bedside. 2. During a random observation on 9/25/23 at 10:09 a.m., Resident R's wheelchair, located at the foot of his bed, was found to have rusted bars at the bottom of the arm rests, rust on brake handles, rusted nuts and bolts that held the front wheels on, the arm rest pads were cracked, and large pieces of vinyl were missing on the left arm pad.			

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	The anti-roll back bar springs were rusted. The back of chair had cracked vinyl. Certified Nursing Aide (CNA) 14 had indicated the wheelchair belonged to Resident R. On 9/21/23 at 2:56 p.m., Resident R's record was reviewed. Diagnoses on Resident R's profile included but not was not limited to hemiplegia and hemiparesis of left side (paralysis, unable to move), muscle weakness, lack of coordination, need for assistance for personal care, and history of falls. On 9/25/23 at 1:40 p.m., IDON provided Wheelchair Canes and Walkers Cleaning List, dated for June, July, August, and September of 2023. The calendar form has specific rooms assigned each day for cleaning of wheelchairs, canes, and walkers. Staff initials were documented indicating completion for those rooms, there were unsigned areas on dates 9/20/23, 9/10/23, 9/9/23, 8/27/23, 8/13/23, 8/12/23, 7/30/23, 7/28/23, and 7/27/23, indicating the tasks were not completed on those days. On 9/25/23 at 1:40 p.m., the IDON provided a Wheelchair Cleaning Policy and Procedures, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, " ...Wheelchairs will be cleaned with a disinfectant solution at least once per week, and as often as necessary to provide the Resident, employees, and visitors with a safe environment including equipment that is as free as possible of pathogenic organisms ...11. Record cleaning in appropriate area on a nursing unit ..." 3.1-19(f)(5)			

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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 corrective action must be taken. Based on observation, interview and record review, the facility failed to ensure an unusual occurrence was reported to the Indiana Department of Health after a resident (Resident F) tested positive for a controlled medication for which she did not have a prescription for 1 of 1 resident reviewed for incident reporting.	F 0609	The facility will report unusual occurrences to the Indiana Department of Health as required. Resident F will have any defined unusual occurrences reported to the IDH as required.	11/17/2023

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	Findings include: On 9/22/23 at 9:00 a.m., Resident F's medical record was reviewed. Resident F was a long-term care resident who had diagnoses which included, but were not limited to, incomplete quadriplegia from C1-C4 (partial to severe paralysis from the neck down), neuromuscular dysfunction of the bladder and contractures (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of right and left knees and ankles. A nursing progress note dated, 7/27/23 at 6:44 a.m., indicated Resident F had to be reminded to wake up several times to take her medication. A nursing progress note dated 7/27/23 at 8:38 a.m., indicated, Resident F continued to be confused and fell asleep easily. She was due to have her nephrostomy renal tubes changed, and her medication was withheld due to sedation and fear of choking. A nursing progress note, dated 7/27/23 at 12:55 p.m., indicated, Resident F was unable to focus and would fall back asleep within seconds. She was unable to answer questions and only repeated, "ok." She had been scheduled to go to one local hospital to have her renal tubes changed, however, the appointment was rescheduled, and a new order was given to send her to a closer local hospital emergency department. A drug test conducted at the hospital, dated 7/28/23, indicated Resident F tested positive for benzodiazepines, a controlled medication for which she did not have a prescription. The test		All resident's with unusual occurrences are at risk for this alleged deficient practice The Administrator and Director of Nursing were in serviced by a RDO/Designee on the IDH reportable requirements. The Administrator will phone the facility RDO/Designee any time a potential unusual occurrence has happened to assist in making the determination to report to the IDH based on requirements. The RDO/Designee will meet with the Administrator and Director of Nursing weekly x 2 months, then monthly x 4 mo. They will review the notes of any potential unusual occurrence deemed unreportable to verify it indeed did not meet reportable requirements. Any occurrence not reported that did meet the requirements will be reported immediately when noted. The RDO/Designee will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155404	A. BUILDING 00 B. WING	09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESSEX NURSING AND REHABILITATION CENTER	301 W ESSEX ST LEBANON, IN 46052

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	was also negative for opioids, for which she did have a prescription for. During an interview on 9/22/23 at 1:22 p.m., the Administrator (ADM) indicated he had not reported the incident after discussion with her cooperate supervisor as they had determined it did not need to be reported, but to keep a "soft file." During an interview on 9/22/23 at 1:07 p.m., the interim Director of Nursing (IDON) indicated the incident did meet the criteria to report to the state because a drug was found in her system that should not have been there. On 9/26/23 at 5:46 p.m., the ADM indicated the facility followed state and federal guidelines for reporting incidents and provided a copy of Indiana Department of Health policy titled, "Long-Term Care Abuse and Incident Reporting," dated 12/6/22. The policy indicated, " ...Purpose: to facilitate compliance with state and federal law and regulation, as applicable, related to reporting of abuse and incidents in licensed long-term care facilities in Indiana ... 14. Unusual Occurrence: An unusual occurrence includes but is not limited to ... d. major accidents ... B-11. Medication errors resulting in outcomes that require medical treatment beyond an ER/physician evaluation or monitoring vital signs ...." This Federal tag relates to Complaint IN00416159. 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,			

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	155404	A. BUILDING 00 B. WING	09/26/2023

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	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 observation, interview, and record review, the facility failed to ensure an unusual occurrence was investigated when a resident tested positive for a controlled medication for which she did not have a prescription for reoccurrence for 1 of 1 resident reviewed for incident reporting and investigation (Resident F). Findings include: Upon survey entrance on 9/20/23 at 9:50 a.m., the Administrator (ADM) indicated there was only one resident out at the hospital at that time, Resident F, who had been sent out the night before after she was found unresponsive. On 9/21/23 at 10:00 a.m., Resident F was visited in a local hospital. She was observed lying in bed and although she was alert, she was confused to the place and time, and exhibited paranoid thoughts. She did not know why she was in the hospital, or how long she had been there.	F 0610	The facility will ensure an unusual occurrence is investigated when occurs. Resident F's investigation completed. Based on the investigation results the resident will continue with supervised visits at this time. Resident F does receive psychosocial follow up. All residents with unusual occurrences are at risk for this alleged deficient practice. The Administrator and Director of Nursing were in serviced by RDO/Designee on investigation of unusual occurrences and the facility abuse policy. The Administrator will phone the facility RDO/Designee any time a potential unusual occurrence has happened to assist in investigation recommendations and guidance.	11/17/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155404	A. BUILDING 00 B. WING	09/26/2023

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	On 9/21/23 at 10:30 a.m., a copy of Resident F's emergency room summary dated 9/19/23, was provided by the local hospital and reviewed at that time. The hospital record indicated, " ...presents to the emergency department (ED) for evaluation of altered mental status. Coming from group home. EMS reports that patient has a known history of accidental overdose with both narcotics and benzodiazepines. Reportedly she had visitors yesterday, 1 of which was labeled suspicious by the group home. They found patient increasingly somnolent this morning, responsive only to painful stimuli. Total of 2.4 mg of Narcan given with 0 improvement. EMS was having trouble with blood pressure in route ... on arrival, patient's not responsive, not responsive to verbal or painful stimuli, sonorous respirations with airway gurgling ...." During an interview on 9/20/23 at 4:02 p.m., Resident F's family member indicated, Resident F had lived at the facility for many years and never had an issue of drug abuse or overdose. The family member indicated they were upset because the facility automatically blamed Resident F, her family, and friends instead of considering the possibility she had been given the wrong medication by staff. After the benzodiazepine had been found in her system, the Resident was put on supervised visits. When Resident F was sent out on 9/19/23 they believed she had overdosed again and was given her Narcan, but the family member questioned how that could have happened since she was supposed to have supervised visits. It turned out not to be medication, but she had a UTI and pneumonia. During an interview on 9/22/23 at 1:07 p.m., the Interim Director of Nursing (IDON) indicated there had not been any issues or history with Resident		The RDO/Designee will meet with the Administrator and Director of Nursing weekly x 2 months, then monthly x 4 months They will review any unusual occurrences and assure a full investigation was completed. The RDO/Designee will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	F until a couple months ago. Staff started to notice a particular visitor who would always come in the evenings when staff were busy with dinner duties around 6:00 p.m. Then they would start to notice issues with Resident F after the visitor left, and the IDON "speculated" Resident F may have been pocketing her pills and swapping them with her visitor. The IDON indicated she did not believe there had been an investigation since the staff assumed the issues were due to her visitor, so she was placed on supervised visits. During an interview on 9/22/23 at 1:22 p.m., the ADM indicated, he was advised not to report the incident and keep a soft file. At that time, he provided a copy of the sift file which consisted of a filed police report, and the following timeline, "Police Report- responding officer was [name] with [local police department] and [case number]. Call Ombudsman- the Social Service Director (SSD) called the Ombudsman 8/18/23 and had to leave a message. Return call made the next day. She explained the situation and what they did. The Ombudsman agreed that we did everything right and did not violate [Resident F's] rights in the process. Call [Name of Contract Psychiatric Practice] SSD called Psych on 8/23/23 after speaking with [Resident F] and getting her consent for psych services. Resident F agreed and psych was to see her the next time they were in and saw her on 9/11/23. Supervised Visitation- on 8/23/23 the ADM, SSD and MDS Coordinator had a meeting with Resident F upon her return, explaining that her visits in the facility would be supervised from now on. Resident F denied taking anything she was not prescribed and said the toxicology report must be incorrect ...." The investigation lacked resident or staff interviews.			

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	The investigation lacked a plan on how to ensure visits were supervised. The investigation lacked psychosocial follow up with Resident F in the following days. The investigation lacked audit/review/reconciliation of any other resident's medications that may have been accidently given to Resident F. During an interview on 9/26/23 at 10:44 a.m., Certified Nursing Assistant (CNA) 14 indicated Resident F had a friend that would come and visit and described her as, "zooming," meaning she exhibited signs of drug use. The staff suspected that maybe Resident F and her friends were trading medications. During an interview on 9/26/23 at 11:05 a.m., the ADM indicated, they had never had a problem with Resident F until a few months ago when this "friend" started visiting her. She was put on supervised visits only because the staff reported she had a visitor that would come later in the evenings and only stay 5-10 minutes. Resident F had been drug tested in the previous months because of unresponsiveness but which corresponded with the friend's visits. The ADM indicated he had never seen the friend, and there was not record or way to tell when she had been in the facility to visit. When asked why staff suspected a drug overdose on 9/19/23 if she was supposed to be supervised when taking her medication, and was supposed to have supervised visits, the ADM indicated there was no way to prove if she had a visitor or not. On 9/26/23 at 5:46 p.m., the ADM indicated the			

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	155404	A. BUILDING 00 B. WING	09/26/2023

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	facility followed state and federal guidelines for reporting incidents and provided a copy of Indiana Department of Health policy titled, "Long-Term Care Abuse and Incident Reporting," dated 12/6/22. The policy indicated, " ...Purpose: to facilitate compliance with state and federal law and regulation, as applicable, related to reporting of abuse and incidents in licensed long-term care facilities in Indiana ... 14. Unusual Occurrence: An unusual occurrence includes but is not limited to ... d. major accidents ... B-11. Medication errors resulting in outcomes that require medical treatment beyond an ER/physician evaluation or monitoring vital signs ...." On 9/26/23 at 5:46 p.m., the ADM provided a second facility policy titled, "Abuse & Neglect," dated 8/1/23. The policy indicated, "Each resident has the right to be free form abuse, neglect, and misappropriation of resident property ... Identification: The staff will identify events, occurrences, patterns and trends that may constitute abuse and to determine the direction of the investigation. Investigation: the facility will designate someone to investigate the allegations and report the results of the investigation to the administrator or his/her designated representative and to other officials in accordance with state law (including to the state survey certification agency) within 5 working days of the incident or sooner if required by state law. The investigator will review relevant documentation, including relevant parts of the medical records and interview witnesses. The facility will document the findings of the investigation on an investigation form developed by the facility unless a different form is required by state law. The documentation will include the identity of the staff member responsible for the initial reporting, investigation of alleged violation and reporting of results to the			

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	155404	A. BUILDING 00 B. WING	09/26/2023

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	proper authorities ... Protection: the facility will implement action to prevent further potential abuse while the investigation is in progress. If a suspected perpetrator can be identified that person will be suspended pending investigation in accordance with progressive discipline policy ...." Cross reference F684. This Federal tag relates to Complaint IN00416159. 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 code the Minimum Data Set (MDS) for a Preadmission Screening and Resident Review (PASRR) for 2 of 2 residents reviewed (Residents 16 and M). Findings include: 1. On 9/21/23 at 10:32 a.m., a comprehensive record review was completed for Resident 16. She had diagnoses which included but were not limited to peripheral neuropathy (the nerves that are located outside of the brain and spinal cord are damaged), migraine (headaches), hyperlipidemia (high cholesterol), paranoid schizophrenia (delusions and hallucinations), bipolar disease, vitamin B deficiency, COPD, and dementia. Her MDS, dated 5/26/23, indicated she did not require a level II. She required a level II based on	F 0641	The facility will ensure they accurately code the Minimum Data Set (MDS) for Preadmission Screening and Reviews (PASRRs). Resident 16s MDS was modified on 9-26-23 to accurately reflect that she did require a level II. Resident Ms MDS was modified on 9-26-23 to accurately reflect that he did require a level II All residents requiring level II screening were at risk for this alleged deficient practice. The remaining residents medical records and MDS were audited to ensure accurate coding of level II.	11/17/2023

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	155404	A. BUILDING 00 B. WING	09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	her diagnosis of paranoid schizophrenia. On 9/25/23 at 12:02 p.m., the Corporate Minimum Data Set (MDS) Coordinator provided a copy of the corrected MDS for Resident 16. 2. On 9/21/23 at 10:42 a.m., a comprehensive record review was completed for Resident M. His diagnoses included but were not limited to hypothyroidism, hyperlipidemia, anxiety, chest pain, insomnia, major depression, and pain in left knee. His MDS dated 5/5/23 indicated he did not require a level II. He required a level II based on diagnoses of major depression and anxiety. On 9/25/23 at 12:02 p.m., the Corporate MDS Coordinator provided a corrected copy of the MDS for Resident M. A policy titled "Resident Assessment Instrument," was provided by the Corporate MDS Coordinator on 9/25/23 at 11:25 a.m. It indicated, " ...All persons who have completed any portion of the MDS assessment form must sign such document attesting to the accuracy of such information.		Facility MDS Coordinator in serviced by the Regional MDS Coordinator on accurate coding of the MDS assessment, including PASRR, level II. The Regional MDS Coordinator will review 2 comprehensive assessment weekly x 2 months and then 2 monthly x 4 months (the most current for selected resident), dated after completed audit on 9-26-23 to review for accurate coding of level II. The Regional MDSC/Designee will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan,			

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	155404	A. BUILDING 00 B. WING	09/26/2023

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	and the residents' choices. Based on observation, interview and record review, the facility failed to identify and thoroughly assess a resident's change of condition and failed to thoroughly investigate a possible drug overdose for 1 of 1 resident reviewed for a change of condition (Resident F). Findings include: Upon survey entrance on 9/20/23 at 9:50 a.m., the Administrator, (ADM) indicated, there was only one resident out at the hospital at that time, Resident F, who had been sent out the night before after she was found unresponsive. During an interview on 9/20/23 at 12:55 p.m., the Licensed Practical Nurse, (LPN) 23 indicated Resident F had been sent to the hospital after they thought she might have overdosed on an unknown medication. At that time, she remained in the hospital but had been extubated (Extubating is the removal of an endotracheal tube [ETT], when removing a person from a ventilator). On 9/21/23 at 10:00 a.m., Resident F was visited in a local hospital. She was observed lying in bed and although she was alert, she was confused to the place and time, and exhibited paranoid thoughts. She did not know why she was in the hospital, or how long she had been there. When asked if she had taken any medication she was not supposed to have, she indicated, "no." During an interview on 9/21/23 at 10:09 a.m., Resident F's hospital nurse indicated she had come in a couple nights ago and was in pretty bad shape. Her "neph tubes" (nephrostomy- is a medical procedure where tubes are inserted through the skin into the kidney to drain urine)	F 0684	The facility will ensure that a change of condition is fully identified and assessed as well as fully investigating an unusual occurrence. Resident F's investigation completed. Resident F does receive psychosocial follow up. Resident F does receive comprehensive assessment when a baseline change of condition is now noted. Resident Fs care plan has been updated to include person-centered, individualized approaches and/or goals to manage her recurrent UTIs. Resident Fs care plan was updated to include person-centered, individualized approaches and/or goals to address her preferred activities while on LOA and/or when receiving visitors. Resident F's care plan has been updated to reflect supervised visits. All residents with unusual occurrences and/or change in condition are at risk for this alleged deficient practice. The Administrator and Director of Nursing were in serviced by a Regional Director of Operations on investigation of unusual occurrences and the facility abuse policy. Licensed Nursing staff in serviced by the DON/Designee regarding assessment, intervention and documentation when a change in condition has	11/17/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155404	A. BUILDING 00 B. WING	09/26/2023

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	were "gunky and crusty," and her urine output was very decreased. She had to be intubated but was able to get the breathing tube out yesterday. She was still unable to eat or drink anything by mouth until speech therapy could evaluate her. On 9/21/23 at 10:30 a.m., a copy of Resident F's emergency room summary, dated 9/19/23, was provided by the local hospital and reviewed at that time. The hospital record indicated, " ...presents to the emergency department (ED) for evaluation of altered mental status. Coming from group home. EMS reports that patient has a known history of accidental overdose with both narcotics and benzodiazepines. Reportedly she had visitors yesterday, one of which was labeled suspicious by the group home. They found patient increasingly somnolent this morning, responsive only to painful stimuli. Total of 2.4 mg of Narcan given with 0 improvement. EMS was having trouble with blood pressure in route ... on arrival, patient's not responsive, not responsive to verbal or painful stimuli, sonorous respirations with airway gurgling ...." During an interview on 9/20/23 at 4:02 p.m., Resident F's family member indicated Resident F had lived at the facility for many years and never had an issue of drug abuse or overdose. The family member indicated they were upset because the facility automatically blamed Resident F, her family, and friends instead of considering the possibility she had been given the wrong medication by staff. She did have a friend that came to visit every now and then, but she did not believe that friend would give Resident F anything that could hurt her. When the family member was notified benzodiazepine had been found in Resident F's system and that she would be put on supervised visits, the family member		been noted. The Administrator will phone the facility RDO/Designee any time a potential unusual occurrence has happened to assist in investigation recommendations and guidance. The RDO/Designee will meet with the Administrator and Director of Nursing weekly x 2 months then monthly x 4 months. They will review any unusual occurrences and ensure a full investigation was completed. The DON/Designee will review Facility 24 HR shift reports during each morning meeting (M-F) X 6 months to review for potential change in status. Any potential change in status will be followed up by the DON/Designee to ensure investigation, intervention and documentation were completed as needed The RDO/DON/Designee will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	indicated it was not fair. Then, when she was sent out on 9/19/23 they automatically believed she had overdosed again and gave her Narcan. The family member questioned how this could have happened since she was supposed to have supervised visits. It turned out not to be anything wrong with her medication, but she was in septic shock with a UTI and had pneumonia. In all the years Resident F had been at the facility, she never had a problem with drugs or was drug seeking and the family member did not believe she would take anything she should not because she knew her medications and could tell you what each one was. Even if they changed the medications and forget to tell her, she could look in that cup and immediately knew there was a change. The family member indicated Resident F got tired, or out of it, and "tanks" quickly when she has an infection, and UTIs were often overlooked for her. During an interview on 9/22/23 at 1:07 p.m., the Interim Director of Nursing (IDON), indicated there had not been any issues or history of drug abuse with Resident F until a couple months ago. Over the last couple of months Resident F had been found lethargic or unresponsive. There was one week, she went out 2-3 times back-to-back. Staff reported Resident F had a particular visitor who would always come in the evenings when staff was short, or too busy with dinner duties, usually around 6:00 p.m. She would come in and then leave again within 5-10 minutes, and the IDON thought that was odd and "speculated," Resident F may have been pocketing her pills and swapping them with her visitor. The IDON indicated she did not believe there had been an investigation since the staff assumed the issues were due to her visitor and because of that she was placed on supervised visits. The IDON			

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	155404	A. BUILDING 00 B. WING	09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESSEX NURSING AND REHABILITATION CENTER	301 W ESSEX ST LEBANON, IN 46052

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	indicated there was no record of her having a visitor in the days leading up to her last hospitalization on 9/19. During an interview on 9/22/23 at 1:22 p.m., the ADM indicated there had never really been an issue with Resident F. She had lived at the facility for many years, and never exhibited drug seeking behaviors. In the previous months however, she had started to act different than normal and was found unresponsive on several occasions. The doctor ordered drug testing. The first couple were negative, but then in August one came back positive for Benzodiazepines, and she did not have a prescription for that medication. He notified his corporate supervisor who advised him not to report the incident, but that he should keep a "soft file." At that time, he provided a copy of the soft file which consisted of a filed police report, (a detective's card with a case number) and a timeline/summary of events. On 8/23/23 the ADM, SSD and MDS Coordinator had a meeting with Resident F upon her return, explaining that her visits in the facility would be supervised from now on. Resident F denied taking anything she was not prescribed and said the toxicology report must be incorrect. The investigation lacked resident or staff interviews. The investigation lacked a plan on how to ensure visits were supervised. The investigation lacked psychosocial follow up with Resident F in the following days. The investigation lacked audit/review/reconciliation of any other resident's medications that may have been accidently given to Resident F. The investigation lacked documentation of Resident F's signed consent to receive supervised visits. On 9/26/23 at 9:29 a.m., Resident F was observed in her room after she had been readmitted to the			

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	facility the night before. She indicated she felt much better. She had been diagnosed with pneumonia and a UTI (urinary tract infection). When asked if she remember if she had taken any medicine she was not supposed to have, Resident F indicated no. She indicated the staff told her they thought her friend was bringing her medication she should not have. Resident F trusted her friend and she never brought her anything. Even if she had, Resident F indicated she would not have taken it. During an interview on 9/26/23 at 9:57 a.m., Licensed Practical Nurse (LPN) 13 indicated Resident F had a "suspicious" friend who would visit about once every 2 to 3 weeks. She would slip in through the side door and go right to Resident F's room and then be gone before staff were aware. When asked if there was a way to ensure Resident F's visits were supervised, LPN 13 indicated there was none. During an interview on 9/26/23 at 10:44 a.m., Certified Nursing Assistant (CNA) 14 indicated Resident F had a friend that would come and visit and described her as, "zooming," meaning she exhibited signs of drug use. The staff suspected that maybe Resident F and her friends were trading medications but there was no way to prove it except drug tests. During a follow up interview on 9/26/23 at 11:05 a.m., the ADM indicated they had never had a problem with Resident F until a few months ago when this "friend," started visiting her. She was put on supervised visits only because the staff reported Resident F's friend was "suspicious." The ADM indicated he had never seen or met the visitor. When asked how the facility was supposed to ensure Resident F received			

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	supervised visits, he indicated, a plan had not been implemented to ensure all her visits were supervised besides he just told the staff it was supposed to happen. When asked why staff suspected another drug overdose on 9/19/23 if she was supposed to have supervised visits and there was no record of a visitor, the ADM indicated there was no way to prove if she had a visitor or not. On 9/22/23 at 9:00 a.m., Resident F's medical record was reviewed. She was a long-term care resident who had resided at the facility since 2019. She had diagnoses which included, but were not limited to, incomplete quadriplegia from C1-C4 (partial to severe paralysis from the neck down), neuromuscular dysfunction of the bladder and contractures (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of right and left knees and ankles and chronic pain syndrome. The record lacked evidence the facility comprehensively assessed and address a baseline change of condition as Resident F experienced an increase in lethargic and unresponsive episodes. Resident F's nursing progress notes were reviewed from 1/1/2023-6/16/23. She had been treated for a couple recurrent UTIs without complications. However, from June-September, she had unusual changes in her condition when she experienced several episodes of increased confusion/tiredness/lethargy and was found unresponsive on 2 separate occasions as evident by the following: 1. On 6/16/23 at 5:27 p.m., Resident F was noted to be very sleepy and was difficult to arouse with verbal stimulation. Several attempts were made to			

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	give her medication, but she would fall asleep while taking the medication. She appeared less alert than usual. She was noted to call staff she knew well by the wrong names which was unusual for her. At that time, she was already on an antibiotic for a UTI, so the doctor gave a new order to collect urine for a drug screen. She had decreased urine output and only a small sample was collected. 2. On 6/23/23 at 2:54 p.m., Resident F was noted to be very sleepy through the day. Staff attempted to wake her with verbal stimuli. She was able to be aroused with a lot of encouragement but immediately fell back to sleep. Medications/pills/tablets were found on the resident's bed and one on the floor. The progress note lacked documentation the medication had attempted to be identified. 3. On 7/27/23 at 6:44 a.m., Resident F "had to be reminded to wake up several times to take medications." She was noted to be very sleepy that morning and nodded off while in conversation. The progress note lacked documentation the physician was notified. 4. On 7/27/23 at 8:38 a.m., Resident F continued to be lethargic and confused. Her morning medications were held due to sedations. The doctor was notified but gave no new orders. She was due to have her nephrostomy tubes changed that afternoon, but by 12:55 p.m., (nearly 6 hours later) Resident F's condition had deteriorated significantly, her nephrostomy tube exchange was cancelled, and she was sent to the ED. A nursing progress note dated 7/27/23 at 12:55 p.m., indicated, Resident F was unable to focus and would fall back asleep within seconds. She			

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	was unable to answer questions and only repeated, "ok." She had been scheduled to go to one local hospital to have her renal tubes changed, however, the appointment was rescheduled, and a new order was given to send her to a closer local hospital emergency department. A drug test conducted at the hospital dated, 7/28/23 indicated, Resident F tested positive for benzodiazepines, a controlled medication for which she did not have a prescription. The test was also negative for opioids, for which she did have a prescription for. 5. She returned on 7/29/23 with a diagnosis of a UTI. 6. On 8/16/23 at 2:57 p.m., Resident F had a change in her level of consciousness when she was found to be very difficult to arouse with intermittent levels of consciousness where she would be sound asleep one minute then yelling out nonsensical and disjointed thoughts. She was sent to the ED. 7. On 9/7/23 at 5:49 p.m., Resident F was noted to be very groggy and sleepy since her return from a doctor's appointment. She required extensive assistance to take her medication which was unusual for her. Dietary staff indicated they could not wake her up for her dinner tray. The nurse went to her room and had to yell loudly. The Resident was able to open her eyes but continued to look groggy and sleepy. The nurse asked Resident F if she "met anyone at the doctor's office," to which Resident F denied meeting anyone. Resident F's family member called and was very upset that Resident F had been accused of something suspicious. The progress note			

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	lacked documentation the physician had been notified. 8. On 9/8/23 at 4:20 a.m., Resident F was noted to be very lethargic again. She opened her eyes but did not say anything, her narcotic pain medication was withheld due to her sluggish appearance and actions. The progress note lacked documentation the physician had been notified. 9. On 9/19/23 at 9:10 a.m., indicated an aide came to notify the nurses Resident F was breathing very shallow. The nurse immediately went to assess her and found Resident F to be unresponsive to verbal or painful stimuli. The nurse was unable to obtain an oxygen saturation level or blood pressure. The doctor was immediately notified and gave an order to administer Narcan. Narcan was administered with no effect. Resident F remained unresponsive and was incontinent of a large liquid stool. 911 was called and she was sent to the ED. The record lacked documentation of a comprehensive nursing assessment to evaluate the Resident's increased episodes of lethargy. The record lacked documentation of interdisciplinary assessment/evaluation. The record lacked documentation of a visitor seeing Resident F in the days leading up to her hospitalization. The record lacked documentation of any attempt to identify or contact Resident F's friend for additional information or questioning. Resident F's comprehensive care plans were reviewed and lacked implementation/revision to			

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	include person-centered, individualized approaches and/or goals to manage her recurrent UTIs. Resident F's comprehensive care plans were reviewed and lacked implementation/revision to include person-centered, individualized approaches and/or goals to address her preferred activities while on LOA and or when receiving visitor, or that her visits should be supervised. This Federal tag relates to Complaint IN00416159. 3.1-28(d)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observations, interview and record review, the facility failed to ensure splint assistance and passive range of motion for 2 of 2	F 0688	The facility will ensure splint assistance and passive range of motion	11/17/2023

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	residents reviewed for range of motion (Residents 3 and Q). Findings include: 1. On 9/20/23 at 10:23 a.m., Resident Q was observed sitting up in a Broda chair with her eyes closed. She responded when her name was called. Her right hand to be positioned like a fist. When she was asked to open her hand, she attempted but was unable to open her closed fist position. On 9/21/23 at 9:40 a.m., Resident Q was observed sitting up in a Broda chair with her eyes closed. She had her right hand closed like a fist. On 9/22/23 at 11:20 a.m., Resident Q was observed sitting up in a Broda chair with her eyes closed. Her right hand was closed like a fist. On 9/25/23 at 10:12 a.m., Resident Q was sitting up in her Broda chair. She responded when her name was called. She attempted to open her right hand but was unable to straighten her fingers. On 9/21/23 at 11:00 a.m., a record review was completed. Resident Q had diagnoses which included but were not limited to schizoaffective disorder (a mental illness that can affect your thoughts, mood and behavior, pseudobulbar effect (Inappropriate involuntary laughing and crying due to a nervous system disorder), dysphagia (difficulty swallowing), dementia, anxiety, depression, and dyspnea (difficulty breathing). Resident Q's care plans did not address her right-hand contracture. Her MDS, dated 9/13/23, indicated she had		Resident Qs Care Plan has been updated to reflect her right hand contracture. Order for lamb skin palm protecter has been received as well as PROM. Staff now document when ROM performed. Resident 3 is currently on skilled PT and OT at this time All residents with impaired mobility are at risk for this alleged deficient practice. The facility therapist has screened each resident with impaired mobility (not already on caseload) to assist in determining range of motion recommendations for these residents and/or splint assistance. Nursing staff in-serviced by therapist on splint use and range of motion including documentation The DON/Designee will select 1 resident weekly with splint and/or range of motion recommendations/orders x 6 months and ensure either the splint is being applied as ordered and/or the range of motion is completed and documented. The DON/Designee will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	limitations in her upper extremity (arm). The MDS indicated she did not receive range of motion to her right hand. Her therapy notes, dated 9/15/22, indicated she would wear a resting hand splint on her right hand for up to and/or greater than 8 hours per day with minimal signs and symptoms of redness, swelling, discomfort or pain. Her range of motion assessment, dated 8/23/23, indicated she was unable to move her extremities on command. During an interview on 9/25/23, CNA 14 indicated she will put a soft splint on resident's hand when she requests to have it on. She provided range of motion to resident during care. She applied lotion to resident's skin and provides range of motion during the application of lotion. She indicated while transferring resident in a mechanical lift, she would exercise her legs. During an interview with the IDON (Interim Director of Nursing) on 9/25/23 at 1:45 p.m., she indicated Resident Q was receiving hospice services. Hospice discontinued the splint, and she was unsure why it was discontinued. The facility was unable to provide documentation to indicate Resident Q was receiving passive range of motion and splint assistance. 2. On 9/20/23 at 9:41 a.m., Resident 3 was observed lying in bed. When asked to move his left arm, he had difficulty. On 9/22/23 at 11:29 a.m., Resident 3 was observed lying in bed. He was alert and was unable to fully move his left hand and arm.			

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	On 9/23/23 at 9:22 a.m., a comprehensive record review was completed for Resident 3. He had diagnoses that included but no limited to bipolar disorder, hemiplegia, and hemiparesis of left side (weakness and paralysis), hyperlipidemia (high cholesterol), hypertension, insomnia, depression, and dementia. An OT (Occupational Therapy) note dated 9/20/23 indicated Resident 3's current left upper extremity strength was 3+/5 (part moves through full range against gravity, takes minimal resistance then breaks/relaxes suddenly, muscle holds test position against slight pressure). A care plan indicated Resident 3 had an ADL (Activities of Daily Living) self-care performance deficit related to dementia, hemiplegia, pain, COPD (chronic obstructive pulmonary disease) indicated the resident used left ankle brace in shoe and calf. Resident 3's MDS (Minimum Data Set) indicated Resident 3 had limitations on one side. The MDS indicated he did not receive range of motion during the assessment period. On 9/22/23 at 2:08 p.m., the Corporate MDS Coordinator indicated range of motion was completed in the morning by the aides. She indicated there was no documentation to indicate range of motion was completed for resident 3. During entrance conference on 9/20/23 at 9:50 a.m., a copy of the Facility Assessment was requested and provided by the ADM. The assessment was 4/8/23. Section 2 titled, "Services and Care Based on Resident Needs," indicated, " ...Services and care we offer based on our resident's needs ... mobility and fall/fall with injury			

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	prevention ... restorative nursing, contracture prevention/care ...." A policy, dated 10/2014, titled, "Range of Motion, Passive" was provided by the Regional Director of Operations (RDO) on 9/22/23 at 2:53 p.m., it indicated, " ...Range of motion (ROM) exercises are indicated for resident with temporary or permanent loss of mobility, sensation, or consciousness, and as a restorative measure to prevent loss of function, muscle contractures and/or deformity...." 3.1-42(a)(1) 3.1-42(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observations, interviews and record reviews, the facility failed to assess residents to ensure they could safely administer their own medications and failed to prevent the potential for accidents when medications were left at bedside for 2 of 2 residents (Resident M and H). Findings include: 1. On 9/20/23 at 12:42 p.m., Resident M was observed lying in bed. He had 3 pills in a clear medication cup.	F 0689	The facility will assess residents prior to allowing self administration of medications and will prevent the potential for accidents by not allowing medications to be left at the beside. Resident Ms medications are no longer left at the bedside. Resident M does not self administer medications.	11/17/2023

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	On 9/21/23 at 10:42 a.m., a comprehensive record review was completed for Resident M. His diagnoses included but were not limited to hypothyroidism, hyperlipidemia, anxiety, chest pain, insomnia, major depression, and pain in left knee. A medication self-administration assessment was not completed for Resident M to have medications in his room unsupervised. The 3 medications in the cup were Prozac capsule 20 milligrams (mg) daily, losartan potassium table 25 mg daily, and aspirin delayed release 81mg daily. During an interview on 9/25/23 at 2:35 p.m., the Interim Director of Nursing (IDON) indicated, Resident M should not have his medications at bedside. 2. On 9/20/23 at 9:53 a.m., Resident H was randomly observed. There was a clear medication cup, with at least 11 unidentified pills observed on the over the bed table beside the resident's bed. The resident indicated she could not take her medications as she had dropped her breakfast tray but would take them later with a snack. On 9/20/23 at 10:20 a.m., a second observation of a medication cup on Resident H's over the bed table with unidentified pills. Licensed Practical Nurse (LPN) 15 was observed walking back into the resident room and indicated she had just stepped away. Resident H's record was reviewed on 9/22/23 at 9:54 a.m. Diagnoses on Resident H's profile included, but were not limited to, Parkinson's disease (central nervous system disorder that		Resident Hs medications are no longer left at the bedside. Resident H does not self administer medications This alleged deficient practice had the potential to affect any resident taking medications. No residents self administer medications. Licensed Nurses and QMAs in serviced by the DON/Designee on medication administration that includes not leaving medications at the bedside. Medication administration must be observed. Any resident wishing to self-administer must first be assessed as capable of safely doing so. DON/Designee will do unannounced walking rounds 5 X wk x 1 month then 3 x weekly x 1 month and then weekly x mo 4 months and observe for medications left at the bedside. Non-compliance will be corrected immediately with further education and/or disciplinary action as needed. The DON/Designee will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	155404	A. BUILDING 00 B. WING	09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESSEX NURSING AND REHABILITATION CENTER	301 W ESSEX ST LEBANON, IN 46052

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	affects movement, often including tremors), vascular dementia (brain damage caused by multiple strokes, causes memory loss), hypertension (high blood pressure), gastro esophageal reflux disease (GERD - acid reflux), transient cerebral ischemic attack (stroke), type 2 diabetes mellitus (high blood sugar), atrial fibrillation (rapid, irregular heart rate), congestive heart failure (heart doesn't pump blood as well as it should), anxiety disorder, depression, and chronic pain syndrome. A medication administration record (MAR), dated 9/20/23, indicated LPN 26 signed as having administered Resident H's morning medications to include, Bactrim 400/80 milligrams (mg) 1 tablet daily for chronic urinary tract infection (UTI), Bupropion ER (extended release) 150 mg 1 tablet daily for depression, Furosemide 40 mg 1 tablet daily for a-fib, letrozole 2.5 mg 1 tablet daily for cancer, levothyroxine 150 microgram (mcg) 1 tablet daily for hypothyroidism, senna-s 8.6-50 mg 1 table in the morning for constipation, Zoloft 25 mg 1 tablet daily for depression, PreserVision 1 tablet twice daily as a supplement, Carbidopa-Levodopa 2 tablets three times daily for Parkinson's, Gabapentin 800 mg 1 tablet three times daily for polyneuropathy, and Tramadol 50 mg 1 tablet three times daily for pain. Resident H's record lacked a physician's order for the resident to self-administer her medications, documentation a self-administration assessment had been completed, or a care plan for the resident to self-administer medications. The quarterly MDS (Minimum Data Set) assessment, completed 7/1/23, assessed Resident H as having the ability to make herself understood and to understand others. BIMS (Brief Interview			

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	for Mental Status) score 15/15 indicated cognitively intact. A care plan for Resident H, dated 11/10/22, indicate the resident used antidepressant medication related to depression and anxiety. Interventions included, give antidepressant medications ordered by physician. A care plan for Resident H, dated 11/10/22, indicated the resident had Parkinson's complications. Focus: The resident has Parkinson's complications. Interventions included to give medications as ordered by the physician. During an interview on 9/22/23 at 11:42 a.m., the interim Director of Nursing (IDON) indicated Resident H had not been identified as being able to self-administer her medications. During an interview on 9/22/23 at 1:57 p.m., LPN 15 indicated the facility did not allow medications to be preset or to be left a resident bedside. There was no reason medications should have been left at Resident H's bedside, and she did not have an explanation. All residents were supposed to have a self-administration assessment completed, and the assessment should be found in the resident paper chart. Resident H was not allowed to self-administer her own medications. On 9/22/23 at 8:10 a.m., the Administrator (ADM) provided an Administering Medications policy, dated August 2006, and indicated the policy was the one currently being used by the facility. The policy indicated, "Medications will be administered in a timely manner and in accordance with the attending physician's written/verbal orders...Medications may not be prepared in advance and must be administered within one[1]			

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	hour of their prescribed time...The individual administering the medication must ensure that the right medication, right dose, right time, and right method of administration are verified...Should a drug be withheld, refused, or given other than at the scheduled time, the individual administering the medication must initial and circle the MAR space provided for that particular drug...Self-administration of drugs is permitted only when approved by the attending physician and the interdisciplinary care planning team..." This Federal tag relates to Complaint IN00416159. 3.1-45(a)(1)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to ensure a post dialysis assessment was completed upon a residents return from Dialysis for 1 of 1 resident reviewed for Dialysis (Resident J). Findings include: During a confidential interview, it was indicated, some things like blood sugar checks, weekly assessments and/or other routine nursing tasks were not getting done, or were, "being fudged." During a confidential interview, it was indicated, some, but not everyone, really needed to be held	F 0698	The facility does ensure a post dialysis assessment is completed upon residents return from dialysis. Resident J does receive pre and post dialysis assessments before and after scheduled dialysis treatment. Her shunt is checked as ordered per the physician. This alleged deficient practice had the potential to affect any resident on dialysis. No other residents receive dialysis.	11/17/2023

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	accountable for the work that needed to be done, and because they weren't, a lot of things fell through the cracks or didn't get done at all. During an interview on 9/21/23 at 11:40 a.m., Resident J indicated she received Dialysis and sent out every Monday, Wednesday and Friday. Resident J indicated, some of the nurses were good about checking her before or after Dialysis, but most of the time, they didn't. During a continuous observation on 9/22/23 from 9:40 a.m., until 12:07 p.m., the following was observed. At 9:40 a.m., Licensed Practical Nurse (LPN) 15 was seated at the nurses' station computer and charted. At 10:55 a.m., Resident J returned from Dialysis and entered the building through the side door near the nurse's station. Resident J thanked her transportation assistant and independently wheeled herself to the main dining room for a worship church service. At 11:13 a.m., after the worship service was over, Resident J returned to the nurse's station. LPN 15 asked Resident J if she was ready and got up from the desk to meet her in the doorway of the medication room. LPN 15 left the door open and Resident J remained seated in her wheelchair in the entrance of the door, directly across from the nurse's station so that their conversation could be heard. Resident J yawned and indicated she was very tired. LPN 15 asked why, and Resident J indicated, she usually got up around 4:00 a.m. on her Dialysis days to be ready. LPN 15 indicated, "yea, you left early today, you were gone before I got		Licensed nurses in serviced by DON/Designee on performing pre and post dialysis assessments completely and checking shunts as ordered per the physician. DON/Designee to review pre and post dialysis assessments on resident J after each dialysis visit x 1 month and then 1 x weekly x 5 months. Non compliance will be addressed immediately with further education as needed. The DON/Designee will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	here, who picked you up, was it the lady?" Resident J indicated, no, it had been the usual older man who picked her up and the lady dropped her off. LPN 15 checked Resident J's blood sugar level with a finger stick, indicated, "all done." Resident J left the nurse's station/med room area and wheeled herself back to her room and LPN 15 returned to the nurse's station. At 12:07 p.m., LPN 15 remained at the nurse's station. During an interview on 9/26/23 at 12:50 p.m., the Interim-Director of Nursing (IDON) indicated, pre and post dialysis assessments should include a full set of vital signs, such as blood pressure, pulse and respirations. The nurse should also assess the dialysis access site to ensure no issues or complications were present, and if there was a fistula, (an access made by joining an artery and vein, usually in the arm, which created a large, robust blood vessel that can be needled regularly for use during hemodialysis [a procedure where a dialysis machine and a special filter called an artificial kidney, or a dialyzer, are used to clean the blood]), the nurse should check for bruit and thrill, ('Bruit' is a whooshing-like sound near the fistula incision site and 'thrill' is like a vibration caused by blood flowing through the fistula and can be felt by placing fingers just above the incision line). On 9/21/23 at 11:55 a.m., Resident J's medical record was reviewed. She was a long-term care resident who had diagnoses which included, but were not limited to, hypertensive chronic kidney disease, stage 5 or end stage renal disease, and dependence on hemodialysis. She had a current physician's order dated 7/15/22			

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	to check her shunt for bruit and thrill every 8 hours for bruit and thrill, and for signs/symptoms of infection or bleeding. Resident J's Medication Administration Record (MAR) was reviewed and revealed the following: a. On 9/22/23 at 6:00 a.m., Resident J's fistula/shunt site was assessed as instructed by the above physician order. Initialed by Registered Nurse, (RN) 27. b. On 9/22/23 at 2:00 p.m., Resident J's fistula/shunt site was assessed as instructed by the above physician order. Initialed by LPN 11. c. On 9/22/23 at 10:00 p.m., the site was not assessed, and the MAR was left blank. On 9/22/23 at 2:00 p.m., the IDON provided a copy of Resident J's pre and post dialysis assessment for that day. a. the pre-assessment was dated 9/22 but lacked the time of the assessment, and lacked initials of the nurse who completed the assessment. b. the post assessment was dated 9/22 but lacked documentation of the time the assessment was competed, condition of the access site, whether or not bruit and thrill were present and the nurse's initials for who completed the assessment. On 9/22/23 at 2:18 p.m., the IDON provided a revised copy of Resident J's pre and post assessment for that day and indicated, nurses should date and time the assessment and ensure all areas are completed. The pre-assessment was revised and included the signature of LPN 15 and dated 9/22/23 at 6:00 a.m. The post-assessment was revised and included the signature of LPN 15 and dated 9/22/23 at 10:45 a.m.			

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	During an interview on 9/22/23 at 2:13 p.m., a Transportation Technician indicated, Resident J was a regular 6:00 a.m. pick up and he often arrived a little early to ensure she was on time for her appointment. He had picked her up just before or right around 6:00 a.m. that morning. On 9/27/23 at 12:36 p.m., the Administrator, (ADM) provided a copy of current facility policy titled, "Dialysis, Renal" revised, 11/2015. The policy indicated, " ...the resident's Vascular Access will be routinely monitored for swelling, redness, pain, warmth, and/or drainage to identify potential complications. Physician will be notified as indicated. Residents with an AV fistula will have the site checked every shift for bruit and thrill-notify the primary care physician immediately of negative findings ...." 3.1-37(a)			
F 0725 SS=F Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the			

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	following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, interview, and record review, the facility failed to maintain a sufficient amount of nursing and ancillary staff to ensure day to day tasks, responsibilities and upkeep of the building and grounds were maintained. This deficient practice had the potential to effect 20 of 20 residents who resided in the facility. Findings include: Upon survey entrance on 9/20/23 at 9:50 a.m., the Administrator (ADM) was informed, the facilities Certification and Survey Provider Enhanced Reports, (CASPER) had triggered in two areas; low weekend staff and required Registered Nurse (RN) coverage. At that time the ADM indicated, the facility was having a very difficult time keeping staff. Even though there was only one "official" vacant position, the Activities Director's position, the remaining staff filled in for and covered several areas of responsibility and were stretched thin. The ADM indicated the staff they did have tried to make it work with what they had. On 9/20/23 at 4:15 p.m., the grievance/concern logs for past 90 days were requested. At that time, the ADM indicated the Social Service Director (SSD) was in the hospital, and he would most	F 0725	The facility will ensure a sufficient amount of nursing and ancillary staff to ensure day to day tasks, responsibilities and upkeep of the building and grounds are maintained. A grievance log is now in place to track grievances and grievance forms are available for residents, family, visitors… to complete. The Facility now has a Full Time Director of Nursing The Facility has an assigned employee covering the SSD spot while the current SSD is on FMLA The Facility does make efforts to schedule sufficient clinical staff on each shift. Advertisements continue to run. The Facility does not “sugar coat” when hiring new staff. The orientation process does include review of dealing with residents	11/17/2023

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	likely not be able to provide the grievance log. It had probably been kept up with in her absence. During an interview on 9/21/23 at 10:41 a.m., the Resident Council President (RCP) indicated the facility was short staffed and could use more aides. The staff they did have were doing more than just their one job, and because of that they could not get everything done that needed to be. During a follow up interview on 9/22/23 at 1:35 p.m., the facilities staff roles and responsibilities were reviewed with the ADM. a. Director of Nursing (DON). The facility had not been successful in hiring a full time Director of Nursing, (DON) because no one was applying for the position. Currently they had a part-time "Interim" DON, (IDON), even though she was considered the full time DON, she had to work regular night shifts throughout the week to help cover the floor. b. Social Service Director (SSD). The facility's long-time SSD had experienced some medical issues and had recently been out for long periods of time. At the time of the survey, the SSD was in the hospital, and they were not sure when she would return. In her absence, there was supposed to be a corporate liaison to assist but they were only able to come once a month or so. Additionally, the Business Office Manager, (BOM) had a Social Service designee certification and would be used as needed. c. Licensed Practical Nurse (LPN) 23, had been a long-time floor nurse, but had recently taken over as the Minimum Data Set Coordinator (MDSC). Additionally, she was the Medical Record Director, Infection Preventionist and would also help cover the floor as a nurse as needed. d. The Maintenance Director was responsible for the building and grounds as well as filling in as a		and behaviors. The Facility has hired a FT Activity Director The activity calendar has been reviewed to ensure there was more than bingo and church available for the residents. The Facility MDSC has received training on the IC program and medical records. Staff are now putting work orders into TELS and the maintenance director is checking at least daily on his scheduled shifts. As opposed to the reported average census of 26 in 2022, the average census for 2023 has been 21 residents and a current census of 20 residents. All residents at risk for this alleged, deficient practice. Administrator and Interim SSD in serviced on facility grievance policy and tracking log by RDO/Designee. Administrator and DON in serviced by RDO/Designee on maintaining sufficient staffing, as best as possible, to ensure the needs are met of all residents and residents are provided with a safe, homelike environment. All staff in serviced by Admin/Des	

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	Transportation technician. He would take residents to outings or appointments as needed. e. Business Office Manager (BOM). The BOM, as mentioned above, had a social service designee certification, and would fill in for the SSD as needed. She also had an Activity Director's (AD) certification and was supposed to fill in for AD as needed. f. Certified Nursing Assistant, (CNA) 14 worked a full time CNA schedule, served as the Medical Supply Coordinator, Staffing Coordinator, and as of the next week would also be filling in part time as an SSD designee. During an interview on 9/22/23 at 12:00 p.m., the IDON indicated it was very difficult to work night shifts on a regular basis and keep up with all the responsibilities of a full-time office DON. During a confidential interview, it was indicated, there was not enough nurse coverage, and the nurses that were working were stretched too thin. They were also short at least one more CNA as there was usually only 1 CNA on the schedule, but they really needed 2. It was indicated some nursing staff were not completing assessments as required and mainly stayed at the nurse's station instead of making rounds and helping out. During a confidential interview, it was indicated the Maintenance Director was sweet and good to the residents but did not care for a lot of the hard work. When work needed to be done, it was done on his schedule and not any sooner. There used to be a maintenance log, but they didn't know what happened to it. Now if requests were made to the Maintenance Director, staff had to hope he remembered it since it was not written down. During a confidential interview, it was indicated		on use of TELS for placing work orders for the maintenance director. The Administrator/Designee will review the grievance forms and grievance tracking log 1 x weekly x 6 month, to ensure grievances are investigated with resolution and grievances are being tracked. The Administrator/Designee will review TELS weekly to ensure work orders are being completed in a timely manner x 6 month. The RDO/Designee will review staffing with the Admin and/or DON, via phone call or in person, weekly x 6 months. The Admin/DON/Designee will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	there needed to be more CNAs and the new CNAs that were hired needed to be trained for the type of resident population they had. Often times, it was though the hiring and training process was "sugar coated" and by the time they get to the floor, they did not realize what they signed up for. A lot of the residents had mental health conditions and took up a lot of staff time. Especially since there was no activity program besides Bingo and church, the residents needed social interaction and came to the nursing staff for it. During an interview on 9/26/23 at 11:21 a.m., the MDSC indicated the ADM approached her one day in March and indicated she was going to be the facility's IP and oversee the infection control and prevention program (IC). She indicated she had no corporate resources or assistance in developing/maintaining the IC program. The MDSC had also been appointed to oversee Medical Records but had been given no training. In addition to coordinating/submitting resident MDS assessment, overseeing the IC program, and being the Medical Records Director, she also still worked as a floor nurse about once a month, unless a nurse was on vacation, and she would have a pickup more floor shifts. She indicated she was not able to adequately juggle all her administrative responsibilities as well as help with residents daily and it was a struggle to get everything done. During an interview on 9/26/23 at 1:00 p.m., the Staffing/Scheduling Coordinator (SC) indicated she had worked there for 10 years as the Scheduler and the best combination of nursing floor staff was to have at least 1 nurse, 1 Qualified Medication Aid (QMA) and 2 CNAs on the day and evening shift. For night 1 nurse and 2 aids. If			

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	155404	A. BUILDING 00 B. WING	09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESSEX NURSING AND REHABILITATION CENTER	301 W ESSEX ST LEBANON, IN 46052

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	nurses had QMAs for the day/evening shift to help with medication pass, the nurses would more efficiently be able to do assessments, new admission, charting etc. The need for at least 2 CNAs for day and evening shift was essential since there were 7-8 residents who were totally dependent or required extensive staff assistance. The weekend nursing staff was very sparce, and they could only have 2 CNAs on every other weekend. During an interview on 9/26/23 at 2:25 p.m., the ADM indicated his biggest concern was facility census, and because census was so low, he could not approve more nursing staff hours. He had repeated conversation with the SSD about marketing, and other strategies for advertising and promoting the facility to increase the census, but she had gotten sick and been out several times. Currently, the facility was budgeted to have 38 residents and they were down to 20 and were essentially losing money every day. One issues with staffing it seemed was that almost every time they hired new CNAs, they were younger, and had not demonstrated an appropriate work ethic often clashed with some of the more "old school" nurses. During entrance conference on 9/20/23 at 9:50 a.m., a copy of the Facility Assessment was requested and provided by the ADM. The assessment was dated 4/8/23. "The intent of the assessment is to determine resources necessary to care for the residents competently during both day to day operations and in emergencies, to determine resources we have and the resources we may need, to assess and analyze the resident population and resources to competently determine the resources needed to care for residents ... Essex holds a Comprehensive License			

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	by the Indiana Department of Health for 38 residents and the average daily census in 2022 was 26 residents or 77% occupancy ... Part Three: Facility Resource and Staffing require the following: 1 full time DON, 2 CNAs between the hours of 6:00 a.m. and 10:30 p.m., 1 full time medical records and MDS, 1 full time qualified nutritional professional to serve as the Director of Food and Nutrition Services, 3 cooks, 1 full time SSD, 1 full time BOM, 1 full time AD and part time activity assistant ... staffing patterns and competencies are appropriate to meet the needs of residents. Facility resources are adequate supplemented by agreements with third parties, health information technology resources and systems, and coordinated Emergency Operation Plans. Areas of opportunity exist in identifying staff competencies and personalized training as the resident population varies by admission. Challenges exist in recruitment and retention of competent employees. Current efforts include aggressive recruiting tactics and facility-specific retention program ...." Cross Reference F550, F881, F882 and F921. This Federal tag relates to Complaints IN00405260, IN00412676, and IN00416159. 3.1-17(a) 3.1-17(b)(1) 3.1-17(b)(4)			
F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days			

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	a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to ensure the required minimum Registered Nurse (RN) coverage was available for 8 consecutive hours, 7 days a week. This deficient practice had the potential to effect 20 of 20 residents who resided in the facility. Findings include: Upon survey entrance on 9/20/23 at 9:50 a.m., the Administrator (ADM) was informed the facilities Certification and Survey Provider Enhanced Reports, (CASPER) had triggered in two areas; low weekend staff and required Registered Nurse (RN) coverage. At that time the ADM indicated the facility was having a very difficult time keeping staff. Even though there was only one "official" vacant position, the Activities Director's position, the remaining staff filled in for and covered several areas of responsibility and were stretched thin. The ADM indicated the staff they did have tried to make it work with what they had. During a follow up interview on 9/22/23 at 1:35 p.m., the Administrator indicated the facility had not been successful in hiring a full time Director of Nursing, (DON) because no one was applying for the position. Currently they had a part-time "Interim" DON, (IDON), even though she was	F 0727	The facility will ensure the required minimum RN coverage is available for 8 consecutive hours, 7 days a week. The facility does now have a Full Time Director of Nursing. The Facility does have advertisements currently running for RN positions. All residents at risk from this alleged deficient practice DON and Administrator in-serviced by RDO/Designee on requirement for an RN, 8 consecutive hours per day, 7 days per week. The DON and Administrator will review daily staffing at each morning meeting X 6 months, to ensure RN coverage is available 8 consecutive hours per day, 7 days per week. All efforts will be made to fill any vacant spot. The DON/Designee will report the findings to the QAPI meeting monthly for review. After 6	11/17/2023

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	considered the full time DON, she had to work regular night shifts throughout the week to help cover the floor. During an interview on 9/22/23 at 12:00 p.m., the IDON indicated it was very difficult to work night shifts on a regular basis and keep up with all the responsibilities of a full-time office DON and she needed more RN coverage. During an interview on 9/26/23 at 1:00 p.m., the Staffing/Scheduling Coordinator (SC) indicated, there were only two RNs to stretch across the schedule. During an interview on 9/26/23 at 2:25 p.m., the ADM indicated, there were only two RNs on staff and there was no way two RNS could cover 8 hours 7 days a week. Due to limited RN coverage and limited CNAs working over the weekends, it also effected the low weekend staffing rating. During entrance conference on 9/20/23 at 9:50 a.m., a copy of the Facility Assessment was requested and provided by the ADM. The assessment was dated 4/8/23. The intent of the assessment was to determine resources necessary to care for the residents competently during both day to day operations and in emergencies, to determine resources we have and the resources we may need, to assess and analyze the resident population and resources to competently determine the resources needed to care for residents ... Essex holds a Comprehensive License by the Indiana Department of Health for 38 residents and the average daily census in 2022 was 26 residents or 77% occupancy ... Part Three: Facility Resource and Staffing require the following: 1 full time DON, 2 CNAs between the hours of 6:00 a.m. and 10:30 p.m., 1 full time		months, the IDT will determine the need and /or frequency of continued monitoring.	

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	medical records and MDS, 1 full time qualified nutritional professional to serve as the Director of Food and Nutrition Services, 3 cooks, 1 full time SSD, 1 full time BOM, 1 full time AD and part time activity assistant ... staffing patterns and competencies are appropriate to meet the needs of residents. Facility resources are adequate supplemented by agreements with third parties, health information technology resources and systems, and coordinated Emergency Operation Plans. Areas of opportunity exist in identifying staff competencies and personalized training as the resident population varies by admission. Challenges exist in recruitment and retention of competent employees. Current efforts include aggressive recruiting tactics and facility-specific retention program ...." Cross reference F725. This Federal tag relates to Complaints IN00405260, IN00412676, and IN00416159. 3.1-17(b)(2)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or			

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	§483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on interview and record review, the facility failed to ensure pharmacy recommendations were followed up with by the physician and failed to respond to pharmacy recommendations for gradual dose reductions (GDR) for 3 of 5 residents reviewed for unnecessary medications (Residents Q, U, and G). Findings include: 1. On 9/21/23 at 11:00 a.m., a record review was completed. Resident Q had diagnoses which included but were not limited to schizoaffective disorder (a mental illness that can affect your thoughts, mood and behavior, and inappropriate involuntary laughing and crying due to a nervous system disorder), dysphagia (difficulty swallowing), dementia, anxiety, depression, and dyspnea (difficulty breathing). Resident Q had a pharmacy recommendation dated 6/8/23. The pharmacist made a recommendation for the physician to evaluate and perform a gradual dose reduction for her psychotropic drugs. Her orders included Ativan (an antianxiety medication) 1 milligrams (mg) every morning (a.m.), and 0.5 mg at bedtime, Zyprexa 10 mg every	F 0757	The facility will ensure pharmacy recommendations are followed up with by the physician Resident Q's pharmacy recommendations was faxed to her physician with response received. Resident U now has pharmacy recommendations sent to his physician for review in a timely manner. Resident G now has pharmacy recommendations sent to physician for review in a timely manner All residents with pharmacy recommendations are at risk from this alleged deficient practice. An audit was completed of all pharmacy recommendations for the past 3 months to ensure no other has been missed. DON/MDS in serviced by RDO/Designee on the Pharmacy	11/17/2023

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	a.m. (an antipsychotic medication), Invega (an antipsychotic medication) 6 mg every evening (p.m.) and Zoloft (an antidepressant medication) 50 mg every bedtime (HS). Her behavior management record for May through September 2023 indicated her behaviors exhibited were yelling out because she was attention seeking. The physician did not sign the recommendation. During an interview with the Interim Director of Nursing (IDON) on 9/25/23 at 1:53 p.m., she indicated she faxed the physician on 9/25/23 to get a response for the recommendations. 2. On 9/21/23 at 10:18 a.m., a record review was completed for Resident U. His diagnoses included but were not limited to benign prostatic hypertrophy, reflux uropathy (urine flows back to the kidney), bipolar disorder (psychiatric illness characterized by both manic and depressive episodes, or manic ones only, chest pain, dementia), and COPD (chronic obstructive pulmonary disease). Resident U had a pharmacy recommendation dated 8/11/23. The pharmacist recommended a gradual dose reduction for the physician to evaluate and perform a gradual dose reduction for his psychotropic drugs. His orders included klonopin 0.5 mg at HS, Zyprexa 7.5 mg at HS, and Prozac 10 mg daily. His behavior management record for May through September indicated his behaviors exhibited were continually transferring self without assistance, inappropriate use of wheelchair, continually		consultant recommendation process. DON or MDS to keep a copy of the recommendations and review at least every 2-3 days to ensure that the physician has responded to each one. If the physician has not responded in a timely manner, the recommendation should then be sent again until each one has been completed. The Admin/Designee will review pharmacy recommendation 2 X monthly x 6 month to ensure each one was sent to the physician timely and that each one has been addressed by the physician. The Admin/Designee will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	ringing call bell; unable to verbalize need when answered and demanding to go out to smoke unscheduled or early. The documented reason for behavior was confusion. The physician did not sign the recommendation until 9/22/23 and declined to reduce the medications indicating Resident U had failed GDRs in the past. 3. Resident G's record was reviewed on 9/21/23 at 10:38 a.m. Diagnoses on Resident G's profile included, but were not limited to, epilepsy (disorder in which nerve cell activity in the brain is disturbed, causes seizures), bipolar disorder (episodes of mood swings ranging from depressive lows to manic highs), dementia, and history of traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head) . A Physician's order, dated 6/19/23, Depakote delayed release 250 milligrams (mg) give 1 tablet by mouth at bedtime for seizures. A physician's order, dated 6/14/23, Aptiom 800 mg give 1 tablet by mouth in the morning for seizures. A Consultant Pharmacist Recommendation to Physician form, dated 8/14/23, indicated Resident G was down to Depakote 250 mg at bedtime. Staff indicated had not had a seizure in a long time. His last level was 10 mg/dl (milligrams per deciliter). He has been started and tapered up on Aptiom. Please consider stopping Depakote 250 mg at bedtime. The form lacked documentation the physician had addressed the pharmacy recommendation. Medication administration records (MAR's), dated August and September 2023, indicated the resident was administered both Depakote and			

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	Aptiom, until 9/22/23 when Depakote was discontinued. A laboratory report, dated 6/9/23, Valproic acid level was 10 mg/dl (therapeutic level for Valproic acid free 6-22, therapeutic range for Valproic acid total is 50 - 125). The resident record lacked documentation a follow-up Valproic acid level had been completed. A care plan for Resident G, dated 7/2/23, indicated the resident had seizure disorder related to an old traumatic brain injury. The goal was for the resident to be free from seizure activity. Interventions include give seizure medications as ordered, monitor labs, and report any sub therapeutic or toxic results to physician. A quarterly MDS (Minimum Data Set) assessment, completed on 9/8/23, assessed the resident as having an active diagnosis of traumatic brain dysfunction and seizure disorder/epilepsy. During an interview on 9/26/23 at 12:12 p.m., Licensed Practical Nurse (LPN) 13 and the MDS Coordinator indicated the consulting pharmacist visited at least monthly and made recommendations regarding medications. Quality assurance (QA) meetings were held monthly, and those in attendance included the Administrator (ADM), Registered Pharmacist (RPh), physician (MD) and his nurse, the MDS Coordinator, Social Service Director (SSD), and psychologist. During the QA meeting the MD and psychologist reviewed, responded, and signed the pharmacy recommendations. The recommendations were then handed to nursing to process right away, the expectation was for the pharmacy recommendations to be addressed and not wait			

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	and lay the paper around to potentially get lost. During an interview on 9/26/23 at 1:05 p.m., the ADM indicated the RPh was in the facility monthly to provide pharmacy recommendations, the ADM usually received an electronic copy by Friday. Monthly QA was then held monthly to include the ADM, RPh, psych nurse practitioner (NP), MD and his nurse, MDS nurse and SSD. Meetings were generally held the same day the MD visited for the day. All pharmacy recommendations were reviewed during the meeting and addressed. Nurses then processed the pharmacy recommendations the same day, if there were questions, they had the opportunity to question the MD during his visit. Indicated he was upset to hear there had been pharmacy recommendations either missed or not completed timely, there was no reason they weren't done. ADM indicated he was not medical, so relied on the MD, psych NP and RPh to make recommendations on necessary medication orders. On 9/26/23 at 2:30 p.m., the ADM provided a Medication Regimen Review (MRR) policy, dated 12/1/07, and indicated the policy was the one currently being used by the facility. The policy indicated, " ...1. The consulting pharmacist will conduct MRRs ...3. Facility should inform the consulting pharmacist of any physical and/or mental conditions of the resident which are likely to affect his/her medication therapy outcome ...5. Facility should independently review each resident's medication regimen directly from the resident's medical chart and with Interdisciplinary Care Team [IDT] members, resident or responsible party as needed. 6. Facility should ensure that facility physician's/prescribers are provided with copies of MRR's. 7. Facility should encourage			

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	physicians/prescribers or other responsible parties receiving the MRR and the Director of Nursing to act upon the recommendations contained in the MRR. For those issues that require physician/prescriber intervention, facility should encourage physician/prescriber to either a) accept and act upon the recommendations contained within the MRR, or b) reject all or some of the recommendations contained in the MRR or provide an explanation to why the recommendation was rejected. 8. Facility should provide the Medical Director with a copy of the MRR and should alert the Medical Director where MRR's require follow-up. 9. Facility should maintain copies of MRR's on file in facility, either as part of the resident's permanent medical record or in a special file ..." 3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(b)(2)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5%, when 3 errors were observed during 25 opportunities resulting in an error rate of 12% for 2 of 3 residents observed for insulin administration (Resident J and H). Findings include: 1. On 9/21/23 at 12:26 p.m., LPN 13 was standing in the doorway of Resident B's room. She was facing	F 0759	The facility will ensure a medication error rate of less than 5% Resident B now has her blood sugar results verified by review of the medical record or device history. Her insulin pen is now primed prior to administrator and left in for at least 6 seconds before withdrawal. As per order, resident	11/17/2023

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	the medication cart, so her back was to the resident. She called out in a loud voice, 'What was your blood sugar?' Resident H responded with 106. LPN 13 did not observe the glucometer reading or review the history on the glucometer device. She took the resident's word for the BS reading. She did not do a standby supervision as needed per the physician's order or see the actual glucometer reading. LPN 13 dialed-in 8 units on the Novolog Flex Pen per the sliding scale (standing physician orders to provide insulin). She did not prime the insulin needle, administered the insulin, and she withdrew the needle immediately. It was unknown if the glucometer was cleaned prior to use. On 9/22/23 at 10:22 a.m., Resident B's record was reviewed. Her diagnoses included but were not limited to chronic obstructive pulmonary disease (COPD) and diabetes mellitus (blood sugar disorder). She had a physician's order, dated 7/26/23, for Novolog Flex pen 100 unit/mL, inject 8 unit subcutaneously one time a day for insulin dependent diabetes mellitus (IDDM). A physician's order, dated 8/9/21, to do accu-checks, three times a day before meals. A physician's order, dated 5/19/23, indicated she may do her own accu-checks (glucometer readings) with standby supervision, as needed as the resident desires every 6 hours. An IDDM care plan, date 4/28/22, did not indicated Resident B could take her own glucometer readings and provide the results to the nurse.		will have stand by supervision when performing her own blood sugar check. Resident H insulin pen is now primed prior to administration and left in for at least 6 seconds before withdrawal. As per Care Plan, there is now a witness to verify insulin given. The glucometer is disinfected after each use. Resident J's glucometer is now disinfected after each use All residents with insulin pens and/or blood sugar checks are at risk for this alleged deficient practice. Licensed nurses to be in serviced by DON/Designee on proper procedure for insulin pen use and cleaning of glucometers. Inservice will also include assuring the nurses visualize resident blood sugar results and do not rely solely on word of mouth. DON/Designee will observe 2 insulin pen administrations and 2 blood sugar checks weekly x 1 month and then 2 insulin pen administrations and 2 blood sugar checks monthly x 5 months to ensure proper cleaning procedure is followed. Non-compliance will be corrected immediately. The DON/Designee will report the	

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	155404	A. BUILDING 00 B. WING	09/26/2023

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	2. On 9/21/23 at 12:11 p.m., LPN 13 put Resident H's glucometer on top of medication cart. She indicated it came out of the glucometer case already clean. She took Resident H's BS, it was 182. LPN 13 dialed in 25 units on the Lispro insulin pen, injected it into Resident H's abdomen, and pulled it out immediately. LPN 13 indicated she had not primed an insulin needle since she started working at the facility. On 9/22/23 at 11:08 a.m., Resident H's record was reviewed. Her diagnoses included, but were not limited Parkinson's disease (degenerative, progressive neurological disease) and diabetes mellitus. She had a physician's order, dated 11/29/22, it indicated she needed accu-checks before meals and at bedtime. Another physician's order, dated 3/15/23, for Lispro pen injector 100 units/mL, inject 25 units subcutaneously three times a day for IDDM. A care plan, dated 8/31/23, indicated Resident H forgets that she has had her insulin and targets the nurse. A nursing intervention indicated for the nurse to take a witness in with her when giving insulin. 3. On 9/21/23 at 11:56 a.m., Licensed Practical Nurse (LPN) 13 was observed to put on disposable gloves. She indicated all the diabetic residents have their own glucometers so that means the nursing staff did not have to clean them. She did not clean the glucometer before she took Resident J's BS. It was 220. She removed her gloves and did not clean the glucometer before putting it back in its case. She pulled up 4 units of Humalog from a vial. She inserted the needle to		findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155404	A. BUILDING 00 B. WING	09/26/2023

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	administer the insulin, she depressed the plunger and pulled the needle out immediately. On 9/22/23 at 1:13 p.m., Resident J's record was reviewed. Her diagnoses included but were not limited end-stage renal disease (kidney failure) and diabetes mellitus. She had a physician's order, dated 11/18/22, for Humalog solution 100 units/mL, give per standing sliding scale. Give 30-40 minutes before meals. "Novolog FlexPen Instruction for Use," with no date, was provided by the Regional Director of Operations (RDO), on 9/22/23 at 2:11 p.m. A review of the instructions indicated, "Giving an airshot before each injection. Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: Turn the dose selector to select 2 units ...Hold your Novolog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge ...Keep the needle pointing upward, press the push-button all the way in ...The dose selector return to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. If you do not see a drop of insulin after 6 times, do not use the Novolog FlexPen ...Insert the needle into the skin ...Keep the needle in the skin for at least 6 seconds, and keep the push-button depressed all the way in until the needle has been pulled out of the skin ...This will make sure that the full dose has been given ...This Instructions for Use has been approved by the U.S. Food and Drug Administration ...." A current policy, titled, "Glucometer			

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	155404	A. BUILDING 00 B. WING	09/26/2023

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	Disinfection," was provided by the Administrator, on 9/22/23 at 8:10 a.m. A review of the policy indicated, " ...Procedure ...Obtain capillary blood sampling ...Recommended Disinfectant Wipe: PDI sanitation wipes ...Cleanse the glucometer with the disinfectant wipe ...Discard disinfectant wipe in waste receptacle ...Allow device to air dry for minimum of five (5) minutes ...Wash hands or use alcohol gel as appropriate ...." A current policy, titled, "Insulin Administration," was provided by the Administrator, on 9/22/23 at 8:10 a.m. A review of the policy indicated, " ...with the use of insulin pens, the needle should be embedded within the skin for 5 seconds after complete depression of the plunger to ensure complete delivery of the insulin dose ...." A current policy, titled, "Administering Medications," was provided by the Administrator, on 9/22/23 at 8:10 a.m. A review of the policy indicated, " ...The Director of Nursing Services is responsible for the supervision and direction of all personnel with medication administration duties and functions ...." This Federal tag relates to Complaint IN00405260. 3.1-48(c)(1)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.			

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	§483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure safe and secure storage and failed to ensure that all drugs and biologicals were labeled, stored, and destroyed properly in accordance with professional standards in 1 of 2 medication carts, 1 of 1 treatment carts, and 1 of 1 medication storage rooms observed (Residents 5, 18, P, B, K, H, Findings include: On 9/20/23 at 10:08 a.m., 2 medication carts and 1 treatment cart were observed stored in an unlocked resident room being used for medication cart storage, to include: a. Door to room was unlocked and treatment cart was observed to be unlocked. b. Resident 5 had two tubes of Biofreeze (pain relief gel) both opened and not dated. c. Resident 18 had Nystatin 100000 units/gram powder (topical powder to treat skin fungus)	F 0761	The facility will ensure a safe and secure storage and ensure all drugs and biologicals are labeled, stored and destroyed properly in accordance with professional standards. The room where the medication and treatment carts are stored is now kept locked unless the Licensed Nuse or QMA are in direct eyesight of the room. Resident 5s Biofreeze was discontinued Resident 18s Nystatin has been discontinued Resident Ps Hydrocortisone was discontinued. Their MediHoney is now labeled and dated when opened. The unlabeled Lispro pen belonged	11/17/2023

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	opened and not dated. d. Resident P had 3 tubes of hydrocortisone 1% cream (treats skin conditions that cause swelling, redness, or itching) opened and not dated. e. Unlabeled tube of Medihoney (wound gel) stored amongst Resident P items. On 9/20/23 at 10:25 a.m., during an observation of back hallway medication cart the following was observed: a. Lispro insulin pen (injection for diabetes that lowers blood sugar) without label, unidentifiable smeared handwritten name, opened, not dated, no packaging or directions for use. b. Resident B had an Aspart insulin pen (injection for diabetes that lowers blood sugar) without label, unidentifiable smeared handwritten name, opened, not dated, no packaging or directions for use. c. Resident K Albuterol oral inhaler (treats and prevents breathing difficulties) opened and not dated. In an interview on 9/20/23 at 10:25 a.m., Licensed Practical Nurse (LPN) 15 indicated that the Aspart insulin pen without a label was for Resident B, the Lispro insulin pen without a label was for Resident H, and both insulin pens came out of the emergency drug kit (EDK). When asked how to determine how much to give and who to give it to, LPN 15 indicated she knew by reading the order. When asked how others would know how much to give and who to give it to, she indicated she hoped they read the orders. On 9/21/23 at 10:12 a.m., during observation of medication refrigerator located in the nurse's station medication room. Temperature read by LPN 13 indicated the thermometer read at 45 degrees Fahrenheit (F) and she thought it was		to Resident H. His Lispro pens are now labeled properly when pulled from the eKit. Resident Bs Aspart pens are now labeled properly when pulled from the eKit Resident Ks Albuterol inhalers are dated when opened Resident Ws medications are no longer disposed of in trash cans, when not taken All facility refrigerators now have temperature tracking logs in place, with temperatures checked daily. All residents at risk from this alleged, deficient practice. All medication and treatment carts were audited to ensure no further issues identified. All Licensed Nurses/QMAs in serviced by DON/Designee on the proper storage, labeling, dating and disposal of drugs and biologicals. Nurses/QMAs/Housekeepers in serviced by Admin/Des on ensuring daily temperature checks are performed on all facility refrigerators. The DON/Designee will audit all medication and treatment carts weekly x 1 month and then monthly x 5 months to observe for proper storage, labeling and dating of drugs and biologicals.	

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	supposed to be between 38 to 46 degrees F. Refrigerator temperature logs used to document the temperature of the medication refrigerator and staff refrigerator located in the nurse's station, indicated documentation of temperatures for July 1-6, 2023. There were no temperature logs available for the remainder of July, August, or September 2023. LPN 13 and Certified Nursing Assistance (CNA) 14 indicated, all refrigerator temperatures were to be documented daily, including the employee refrigerator located at the nurse's station. On 09/22/23 at 8:18 a.m., Housekeeping Supervisor brought 2 small pink unidentified pills to the medication cart. She indicated she found them in Resident W's trash can. Resident W indicated the nurse threw the pills away due to his blood pressure being too low and he did not need them. LPN 15 indicated the pills were Midodrine 5 milligrams three times per day (to treat low blood pressure) and the order indicated to hold if the resident's blood pressure was below 110. LPN 15 indicated the pills should have not been placed in the trash can, demonstrated putting pills in sharps box on side of medication cart. LPN 15 was not observed to document destruction of the medication. On 09/25/23 at 10:15 a.m., during a random observation of room used for medication storage the door was closed. The treatment cart was unlocked, and no licensed staff were within sight of the carts. On 9/25/23 at 10:50 a.m., random observation of medication and treatment carts in the room. The door to the hallway was open, no staff was in the		Non-compliance will be addressed immediately. The Admin/Designee will audit all facility medication, resident and staff refrigerators weekly x 1 month and then monthly x 5 months to ensure temperature checks are being completed as required. Non-compliance will be addressed immediately. The Admin/DON/Designee will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	room. The Maintenance Supervisor was standing at nurses' station with his back to the room. The back hall medication cart, in room and closest to the door, was observed unlocked. Two residents were outside of the room door. No licensed staff were within sight of the carts. On 9/25/23 at 10:53 a.m., LPN 13 came from around the corner, walked past the room with the medication carts. When she noticed a medication cart was unlocked, she gasped, went in to lock it, then left the room without closing the door. During an interview on 9/20/23 at 2 :35 p.m., LPN 11 indicated they kept the medication carts in the empty room to keep from having medication errors, and because the residents like to "hover a lot." During an interview related to medication storage, on 9/22/23 at 1:57 p.m., LPN 15 indicated nursing staff were not allowed to preset medications and medications were not allowed to be left at bedside. Medications should have been labeled with resident name, date issued, date expired, directions for administration, time, dose, and route of medication administration. To figure out who the medications belonged to when they were without labels, without names that were legible, and to determine what the directions were for administration, LPN 15 indicated her solution was to go by the computer. The nurse was responsible for making sure residents got medications as ordered by the physician. LPN 15 indicated she was not responsible for disposing of resident W's two pills in his bedside trash can that were found by housekeeping staff. Resident W did not self-administer his own medications and she did not leave it up to him to			

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	decide if he should take the medication, other nurses obviously did since there were two in the trash can. On 9/22/23 at 11:10 a.m., the Administrator (ADM) provided a Storage of Medication policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, " ...Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications .... 2. Medication supplies are locked when not attended by persons with authorized access... 3. All medications dispensed by the pharmacy are stored in the container with the pharmacy label ... Temperature ...5. The Facility should maintain a temperature log in the storage area to record temperatures at least once a day. 6. The Facility should check the refrigerator or freezer in which vaccines are stored, at least two times a day, per CDC guidelines ... Expiration Dating [Beyond-use dating] ... 3. Certain medications or package types, such as IV solutions, multiple dose injectable vials, ophthalmics, nitroglycerin tablets, once opened, require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency ... 4 ...b) Drugs dispensed in the manufacturer's original container will carry the manufacturer's expiration date. Once opened, these will be good to use until the manufacturer's expiration date is reached unless the medication is: i. in a multi-dose injectable vial ... 5. When the original seal of the manufacturer's container or vial is initially broken, the container or vial will be dated. a) the nurse shall place a [date opened] sticker on the medication and enter			

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	the date opened. b) if a vial or container is found without a date opened, the date opened will automatically default to the date dispensed and the expiration date will be calculated accordingly..." On 9/22/23 at 11:10 a.m., the Administrator (ADM) provided a Medication Destruction for Non-Controlled Medications policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, ... "3. Disposing of non-flushable prescription drugs ... c) put the mixture into a disposable container with a lid, such as a 5-gallon bucket, or a sealable bag. Place in an opaque bag and dispose in the trash ... 5. Medication destruction occurs only in the presence of at least two licensed healthcare professionals or according to regulation and applicable law. 6. The licensed healthcare professionals witnessing the destruction insure that the following information is entered on the Drug Destruction form: a) date of destruction b) residents name c) name and strength of medication d) prescription number, if applicable e) amount of medication destroyed f) signatures of witnesses. 7. The Drug Destruction Form is kept on file in the facility according to facility policy, regulations, or applicable law ..." This Federal tag relates to Complaint IN00412676. 3.1-25(j) 3.1-25(k) 3.1-25(m) 3.1-25(s)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements.			

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	The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure meat was thawed correctly, hand hygiene was completed appropriately, and pureed food was completed according to the facility's recipe. These potential deficiencies could have effected 21 of 21 residents who received food from the kitchen. Findings include: 1. On 9/20/23 at 9:50 a.m.,10 cartons of raw, liquid eggs were observed on the bottom of the reach-in refrigerator. On top of the cartons of eggs was a package of bacon, on top of the bacon was 12 pounds of ground beef. No shelf or pan separated these items, they were stacked on top of each other. On 9/20/23 at 9:54 a.m., Cook 8 indicated the 2	F 0812	The facility will ensure meat is thawed correctly, hand hygiene is completed appropriately, and puree food is completed according to the facility's recipes. The eggs, bacon and hamburger were separated and are no longer stored/thawed stacked on top of each other. The 2 compartment sink now has cold running water Kitchen staff now perform proper hand hygiene and at the appropriate times Kitchen staff now follow recipes	11/17/2023

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	compartment sink did not have cold running water. The sink only provided warm or hot water. She wanted to thaw a large plastic bag of pulled pork. It was observed in the sink with warm water running over it. She indicated the issues with the sink only providing warm or hot water had been reported to the Administrator (Admin) and Maintenance Director about 6 weeks ago. On 9/20/23 at 11:24 a.m., the pulled pork was observed in the sink. Cook 8 indicated the internal temperature was 76 degrees F. She indicated it should have been 30-40 degrees and it was a little warm now. She turned the water off and left it in the sink. She indicated the meat had reached room temperature. A continuous kitchen observation, from 11:24 a.m. to 12:25 p.m., showed the pulled pork remained in the sink, without water running on it. On 9/30/23 at 12:25 p.m., Cook 8 indicated the internal temperature of the pulled pork was 70.9 degrees F. She indicated the danger zone was 75 degrees and higher. On 9/20/23 at 12:39 p.m., Cook 8 indicated she called the Dietary Manager (DM) for guidance on thawing the pulled pork in dinner. Cook 8 indicated she was wrong about thawing the pulled pork and would be throwing it out. On 9/21/23 at 9:21 a.m., the DM indicated the kitchen staff could not get cold water from the 2 compartment sink. The faucet only gave hot water. It was hard to work in a kitchen with so many things that didn't work. For meat it was better to thaw it in the refrigerator. The ground beef and bacon should not have been sitting on top of the cartons of liquid eggs. The thawing		when preparing puree food Resident 13 has been referred to SLP for evaluation of swallow abilities. All residents were at risk from this alleged, deficient practice. Dietary staff to be in serviced by the Dietary Manager/Designee on proper storage and thawing of food items, hand hygiene (including proper procedure and when to perform), and following recipes for puree foods. The DM/Designee will check the refrigerator daily, 5x week x 1 month then 2x weekly x 5 month to be sure foods are being stored/thawed properly. This schedule will also include checking to verify the 2 compartment sink has cold, running water and observing 1 staff member perform hand hygiene as well as observation of performing hand hygiene at the appropriate times and observing 1 staff member make a puree dish. Non-compliance will be corrected immediately and further education provided. The DM//Designee will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of	

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	ground beef should have been on the bottom and the bacon should be thawing inside a stainless steel pan. A current policy, titled, "Proper Storage of & Thawing of Meats/Eggs/Potentially Hazardous Foods," dated 06/2018, was provided by the Administrator (Admin), on 9/22/23 at 8:10 a.m. A review of the policy indicated, " ...Foods should be placed in the refrigerator to allow for maximum air circulation ...Meat may be thawed using any of the following methods: place in refrigerator (<41 F)for three days or less; place under cold running water at 70 F [sic] or below for two hours or less; and/or placed in the microwave ...Never thaw potentially hazardous foods at room temperature ...Meat should be stored so that juices cannot drip onto other foods ...Each food item will be placed on their own respective tray for refrigerator defrosting ...." 2. On 9/20/23 at 11:02 a.m., Cook 9 was observed washing her hands. She turned the faucet off with her bare hands, then dried her hands on paper towels. On 9/20/23 at 11:57 a.m., Cook 8 was observed washing her hands. She turned the faucet off with her bare hands, then dried her hands on paper towels. On 9/20/23 at 12:04 p.m., Cook 8 was observed washing her hands. She turned the faucet off with her bare hands, then dried her hands on paper towels. On 9/20/23 at 12:29 p.m., Cook 8 was observed washing her hands. She turned the faucet off with her bare hands, then dried her hands on paper towels.		continued monitoring.	

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	155404	A. BUILDING 00 B. WING	09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESSEX NURSING AND REHABILITATION CENTER	301 W ESSEX ST LEBANON, IN 46052

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	On 9/21/23 at 9:26 a.m., the DM indicated hand hygiene should be done when staff enter the kitchen, after touching dirty dishes, after touching food, and when they take their gloves off. The procedure was to turn on the water, soap up for 20 seconds, dry off with paper towels, and turn the faucet off with paper towel. On 9/22/23 at 11:31 a.m., Cook 8 was observed to scratch her head with her right hand while wearing black gloves, then she touched the lid of the trash can. No did not complete hand hygiene before going to the stove to put foil over the Capri vegetables. On 9/22/23 at 11:34 a.m., Cook 8 touched the trash can lid again. She did hand hygiene but turned the faucet off with her bare hands, then drying them with paper towels. On 9/22/23 at 11:44 a.m., Cook 19 was observed washing her hands. She turned the faucet off with her bare hands, then dried her hands on paper towels. On 9/22/23 at 11:54 a.m., Cook 19 was observed washing her hands. She turned the faucet off with her bare hands, then dried her hands on paper towels. A current policy, titled, "Handwashing/Hand Hygiene," dated August 2015, was provided by the Admin, on 9/22/23 at 8:10 a.m. A review of the policy indicated, " ...Washing hands ...Vigorously lather hands with soap ...Rinse hands thoroughly ...Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel ...Discard towels into trash ...."			

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	155404	A. BUILDING 00 B. WING	09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	3. On 9/22/23 at 11:54 a.m., Cook 8 was observed to puree pizza burgers for 4 residents. She put 5 pizza burgers in the blender with 1 ½ cups of beef base liquid, 2 teaspoons (tsp) thickener and blended the food. She had no recipe out to follow. On 9/22/23 at 11:57 a.m., she indicated for Resident 13 if the puree was too thick he could not swallow it, and she would have to re-do his foods. On 9/22/23 at 11:58 a.m., Cook 8 indicated she had not made enough pizza burger puree. After washing the blender, she added one pizza burger. She did not measure the beef base liquid, but indicated it was about 1 cup. She added 2 heaping tsp of thickener and blended. The puree was too thick, so she added about 1/3 cup beef base and another tsp of thickener. On 9/22/23 at 12:09 p.m., Cook 8 added to the blender four 4 ounce Capri vegetable mix. Then, added 4 partially full ladles of the juice the vegetables came in, one tablespoon (T) of thickener. After blending, she indicated she added about a ¼ cup of beef base liquid, then added more. She indicated she did not know how much beef base liquid she used. She indicated the vegetable were hard to puree because of the skin on the vegetables. A current recipe, titled, "Vegetable Blend California Pureed Thick," with no date, was provided by the Admin, on 9/22/23 at 12:36 p.m. A review of the recipe indicated for 5 servings: 2 ½ cups California vegetable blend, 2 tablespoons (T) margarine, and 1 1/3 T thickener. Remove the vegetable portions required and drain liquid. Add drained vegetables with melted margarine to food processor and process until			

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	smooth in texture. Add food thickener. Process briefly until mixed, scraping sides of bowl. Pour into steam table pan and cover. The facility was unable to provide a recipe for pureed pizza burgers. A recipe for, "Cheeseburger Pureed Thick," was provided as a substitute. The ingredients were different, but the process at the bottom of the page indicated to add ingredients to the food processor and process until fine in consistency. Gradually, add beef base liquid until a smooth consistency. Add food thickener and process briefly until mixed. Scrape downside of processor with a rubber spatula and process for 30 seconds. 3.1-21(i)(2) 3.1-21(i)(3)			
F 0867 SS=F Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.			

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	§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions			

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	that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.			

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	§483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. Based on observation, interview, and record review, the facility failed to ensure an effective Quality Assurance and Performance Improvement (QAPI) program was in place to identify systemic, reoccurring, and/or tending issues with the day to day operations of the facility, which resulted in repeat deficiencies cited at F812 and F725 as well as the lack of opportunity to identify, address and potentially prevent additional systemic failures. This deficient practice had the potential to effect 20 of 20 residents who resided in the facility. Findings include: Upon survey entrance on 9/20/23 at 9:50 a.m., a copy of the QAPI policy/plan/program and a list of its members was requested. On 9/22/23 at 2:32 p.m., a copy of the QAPI	F 0867	The facility will ensure an effective QAPI program is in place to identify systemic, reoccurring, and/or trending issues with the day to day operations of the facility, This alleged, deficient practice had the potential to affect all residents. The Administrator has been educated by the RDO/Designee on the Facility QAPI process and expectations involved, including identifying systemic, reoccurring and/or trending issues as well as taking minutes at each meeting and review of PIPs.	11/17/2023

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	155404	A. BUILDING 00 B. WING	09/26/2023

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	policy/plan/program was requested a second time. On 9/26/23 at 3:00 p.m., the Administrator (ADM) provided a single page document QAPI Minutes. It was explained the minutes were an internal documentation tool, and the comprehensive QAPI policy was still needed. On 9/26/23 at 3:17 p.m., the ADM was interviewed regarding the facilities QAPI process. At that time, he pulled a copy of the QAPI policy from a large stack of loose-leaf papers from the previous years annual survey. The ADM indicated all the department heads, a pharmacist and the medical director met monthly to talk about the residents. Each month they would meet and talk one by one about each resident as a comprehensive review of their current status. When asked if there was a scheduled list of items for review, and/or if the facility staff were actively working to identify areas of concern for each department, he indicated, that was not how their meetings worked. The ADM indicated he had never done a performance improvement plan (PIP) before. He did not know the purpose of the PIP and thought they were only disciplinary plans for staff members. The ADM indicated staffing, pharmacy recommendations, and transportation were the top three facility-identified areas of opportunity for improvement. The following were actions that had been taken to address those areas of concern: a. Pharmacy Recommendations- there had been no previous action/plan to address this issue because he had not been made aware that pharmacy recommendations were not being followed up with and was not sure if it was		The RDO/Designee will attend and/or review the minutes from the QAPI meetings for the next 6 months to ensure an effective QAPI program is in place. The RDO will provide the Administrator with guidance as needed.	

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	something the Director of Nursing, pharmacist and/or the medical director should communicate with him. b. Staffing- although staffing had been identified as a concern and was discussed daily with the SSD, the ADM had not seen any improvement. It was the SSD responsibility to market and recruit in order to increase the facility census, so that the PPD expenses could be expanded. SSD had unfortunately experienced some medical issues and had been absent from the facility on several occasions and there was not process to address census/staffing in her absence. c. Transportation- the ADM had been made aware the Southeast Transportation requirement was going to be discontinued and the facility needed to address how they would fill that void. The ADM appointed the Maintenance Director (MD) as the facilities Transportation Technician and made sure the facility van was serviced. The ADM did not have a secretary and did not take notes himself, so the identified areas were not documented or recorded in the QAPI program. He was more of a "fix it in the moment" type of leader and fixed things as they came up. The ADM indicated there had probably been a communication breakdown related to clinical/nursing issues between himself and the Interim Director of Nursing (IDON), as she had not been able to attend any QAPI meetings since she started because she worked the night shifts and would be asleep during the day when QAPI was held. The ADM indicated there many concerns that could have been identified before the survey to			

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	put a plan in place to prevent repeat citations. He had continued to run the QAPI program the way he had observed during his training. He looked forward to working on making the program more effective moving forward. On 9/26/23 at 3:17 p.m., the ADM provided a copy of current facility policy titled, "QAPI- Quality Assurance and Performance Improvement Protocol," revised 10/2017. The policy indicated, "Reason for Policy: To provide a continuous, systemic, comprehensive and data driven approach to daily operations, which monitors the overall environment of the community, ensures the highest quality of care is provided and opportunities for improvement are identified for its residents ..." The policy outlined and provided comprehensive details on how to implement and maintain a beneficial QAPI program which included but was not limited to: "Policy Interpretation and Implementation," which outlined general guidelines of the program, the program procedure, the process of a meeting, areas which should be reviewed monthly, quarterly reports and annual reports and reviews. Cross references F684, F725, F757, F812, F880, F881 F882 and F883. 3.1-52(a)(1) 3.1-52(b)(1) 3.1-52(b)(2)			
F 0880 SS=F 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			

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	155404	A. BUILDING 00 B. WING	09/26/2023

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	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 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			

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	155404	A. BUILDING 00 B. WING	09/26/2023

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	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 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 observation, interview, and record review, the facility failed to ensure an infection prevention and control program was in place to track, trend, and analyze infections, antibiotics, and lab results for 21 of 21 residents who resided in the facility, failed to clean individual glucometers (device to measure blood sugar) before use for 3 of 3 residents reviewed for glucometer use (Resident B, H, and J), and failed to appropriately test and document monthly checks for Legionella that could affect 21 of 21 residents in the building. Findings include:	F 0880	The facility will ensure an infection prevention and control program is in place to track, trend and analyze infections, antibiotics and lab results. The facility will ensure glucometers are cleaned properly before use. The facility will follow it's water management program and test as determined necessary. The IP nurse now tracks, trends and analyzes infections, antibiotic use and lab results. The information is now kept in an IC	11/17/2023

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	155404	A. BUILDING 00 B. WING	09/26/2023

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	1. On 9/26/23 at 11:09 a.m., the MDS Coordinator (MDSC) indicated she was in charge of Infection Control (IC). She indicated her task was to attend a meeting once a month, after the Quality Assurance and Performance Improvement (QAPI) meetings, which included the Medical Director and the Administrator (Admin), therapy, and a nurse if possible, and discuss IC. She indicated they discussed personal protective equipment (PPE): donning and doffing, and when to use it. She indicated she did not track, trend, or analyze infections, antibiotic use, or lab results for any residents in the building and did not have an IC binder with documentation of the same. She had not communicated with any physicians regarding infections, antibiotic use or labs since she started the position in March. She was not using Loeb's criteria (a minimum set of signs and symptoms to determine infection) or McGreer's criteria (used retrospectively counting true infection with diagnostic information). She indicated to her knowledge the current infections in the building were Resident F had a urinary tract infection (UTI), Resident K had an infection of cellulitis in his left lower leg, and Resident Q may have an infection. She overhead some staff talking yesterday and believed Resident Q may be getting a peripherally inserted central catheter (PICC) line to deliver antibiotics. But it may not be her. She indicated Resident K was on an antibiotic. On 9/26/23 at 11:21 a.m., the MDSC indicated the Admin came to her one day in March and indicated she was going to be the facility's IP and be in charge of IC. She had no corporate resources for IC. She was not only the MDS Coordinator and IP for IC, but now she was also		binder with accompanying documentation. The results of the tracking, trending and analyzing are now reported to the Medical Director at least monthly. Loeb's and McGreer's criteria are now used. The IP nurse will provide and/or schedule IC in-services as need when issues or concerns have been identified and to ensure staff are performing best practices. The IP nurse meets with the maintenance director monthly to discuss the facility water management program and findings. Resident B, H and J's glucometers are now cleaned after each use. The facility does follow it's Water Management Program and makes observations and tests as indicated per the program. All residents at risk from these alleged, deficient practices. The IP Nurse has been in-serviced by the RDO/Designee on policy and procedure for the Infection Prevention and Infection control programs as well as any other associated expectations. Licensed Nurses/QMAs in serviced by the DON/Designee on proper cleaning of glucometers after use.	

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	the Medical Records Director, and worked as a floor nurse about once a month, unless a nurse was on vacation and then she would have to pick up more floor shifts. She received zero training to be the Medical Records Director. She indicated on a daily basis that she helped with residents' needs: getting resident drinks, towels, or take them to the restroom, and she answered a lot of call lights. She started as MDSC on 2/16/23, started IP doing IC on 3/4/23, and started as Medical Records Director on 9/22/23. On 9/26/23 at 11:30 a.m., the MDSC indicated she had not completed any staffing in-services as the IP regarding IC. She indicated she wanted to do an in-service on hand hygiene and PPE, but no one in the facility was on isolation. On 9/25/23 at 3:59 p.m., the Admin indicated he realized that a lot of staff were working several different jobs because he didn't want anyone on staff to say, "that is not my job." A current policy, titled, "Policies and Practices - Infection Control," dated July 2014, was provided by the Admin, on 9/26/23 at 2:30 p.m. A review of the policy indicated, " ...This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections ...The objectives of our infection control policies and practices are to ...Prevent, detect, investigate, and control infections in the facility ...Maintain records of incidents and corrective actions related to infection ...provide guidelines for the safe cleaning and reprocessing of reusable resident-care equipment ...The Quality Assurance and Performance Improvement Committee, through the Infection Control Committee, shall		Maintenance Director in serviced by Admin/Designee on the Facility Water Management Program; including observations and testing per the requirements of the plan. The RDO/Designee will review the Facility Infection Control processes, tracking, surveillance, and all other portions monthly x 6 months to be sure the processes are being completed per protocol and policy. Non-compliance will be corrected immediately with further education as needed. DON/Designee will observe 2 blood sugar checks weekly x 1 month and then 2 monthly x 5 months to ensure proper cleaning procedure is followed. Non-compliance will be corrected immediately. The Administrator will meet with the Maintenance Director monthly to ensure that the Protocol for the Water Management Program is being followed. This will continue indefinitely. Non compliance will be corrected immediately. The Admin/DON/Designee will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	155404	A. BUILDING 00 B. WING	09/26/2023

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ESSEX NURSING AND REHABILITATION CENTER	301 W ESSEX ST LEBANON, IN 46052

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	oversee implementation of infection control policies and practices, and help department heads and managers ensure that they are implemented and followed ...All personnel will be trained on our infection control policies and practices ...." A current policy, titled, "Surveillance for Infections," dated July 2016, was provided by the Admin, on 9/26/23 at 2:30 p.m. A review of the policy indicated, " ...The Infection Preventionist will conduct ongoing surveillance for Healthcare-Associate Infections (HAIs) and other ...infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions ...The purpose of the surveillance of infections is to identify both individual cases and trends of ...significant organisms and Healthcare-Associate Infections, to guide appropriate interventions, and to prevent future infection ...Infections that will be included in routine surveillance include those with ...Evidence of transmissibility ...available processes and procedures that prevent or reduce the spread of infection ...Infections that may be considered in surveillance include those with limited transmissibility ...Nursing Staff will monitor residents for signs and symptoms that may suggest infection, according to current criteria and definitions of infections, and will document and report suspected infection to the Charge Nurse as soon as possible ... The Charge Nurse will notify the Attending Physician and the Infection Preventionist of suspected infections ...The Infection Preventionist and the Attending Physician will determine if laboratory tests are indicated ...If transmission-based precautions or other preventative measures are implemented to slow or stop the spread of infection, the Infection Preventionist will collect data to help determine			

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	the effectiveness of such measures ...." A current policy, titled, "Infection Preventionist," dated July 2016, was provided by the Admin, on 9/26/23 at 2:30 p.m. A review of the policy indicated, " ...The Infection Preventionist is responsible for coordinating the implementation and updating of our established infection prevention and control policies and practices ...The Infection Preventionist (or designee) shall coordinate the development and monitoring of our facility's established infection prevention and control policies and practices ...The Infection Preventionist shall keep abreast of changes in infection prevention and control guidelines and regulation to ensure our facility's protocols remain current and aid in preventing and controlling the spread of infections ...The Infection Preventionist will collect, analyze and provide infection and antibiotic usage data and trends to nursing staff and health care practitioners; consult on infection risk assessment and prevention control strategies; provide education and training; and implement evidenced-based infection prevention and control practices ...." 2a. On 9/21/23 at 12:26 p.m., LPN 13 was standing in the doorway of Resident B's room. She was facing the medication cart, so her back was to the resident. She called out in a loud voice, 'What was your blood sugar?' Resident H responded with 106. LPN 13 did not observe the glucometer reading or review the history on the glucometer device. She took the resident's word for the BS reading. She did not do a standby supervision as needed per the physician's order or see the actual glucometer reading. LPN 13 dialed-in 8 units on the Novolog Flex Pen per the sliding scale (standing physician orders to provide insulin), she did not prime the insulin needle, and			

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	administered the insulin, she withdrew the needle immediately. It was unknown if the glucometer was cleaned prior to use. On 9/22/23 at 10:22 a.m., Resident B's record was reviewed. Her diagnoses included but were not limited to chronic obstructive pulmonary disease (COPD) and diabetes mellitus (blood sugar disorder). A physician's order, dated 8/9/21, to do accu-checks (glucometer readings), three times a day before meals. A physician's order, dated 5/19/23, indicated she may do her own accu-checks with standby supervision, as needed, as the resident desires every 6 hours. An IDDM care plan, date 4/28/22, did not indicated Resident B could take her own glucometer readings and provide the results to the nurse. 2b. On 9/21/23 at 12:11 p.m., LPN 13 put Resident H's glucometer on top of medication cart. She indicated it came out of the glucometer case already clean. LPN 13 did not clean glucometer after use. On 9/22/23 at 11:08 a.m., Resident H's record was reviewed. Her diagnoses included, but were not limited Parkinson's disease (degenerative, progressive neurological disease) and diabetes mellitus. She had a physician's order, dated 11/29/22, it indicated she needed accu-checks before meals and at bedtime.			

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	2c. On 9/21/23 at 11:56 a.m., Licensed Practical Nurse (LPN) 13 was observed to put on disposable gloves. She indicated all the diabetic residents have their own glucometers so that means the nursing staff does not have to clean them. She did not clean the glucometer before she took Resident J's BS. It was 220. She removed her gloves and did not clean the glucometer before putting it back in its case. On 9/22/23 at 1:13 p.m., Resident J's record was reviewed. Her diagnoses included but were not limited end-stage renal disease (kidney failure) and diabetes mellitus. A current policy, titled, "Glucometer Disinfection," was provided by the Administrator (Admin), on 9/22/23 at 8:10 a.m. A review of the policy indicated, " ...Procedure ...Obtain capillary blood sampling ...Recommended Disinfectant Wipe: PDI sanitation wipes ...Cleanse the glucometer with the disinfectant wipe ...Discard disinfectant wipe in waste receptacle ...Allow device to air dry for minimum of five (5) minutes ...Wash hands or use alcohol gel as appropriate ...." 3. On 9/20/23 at 10:19 a.m., the ice room was observed with Cook 8. A wet blanket was on floor from the leaking ice machine, the floor was warped from previous water issues, a streak of lime was down the front of the ice machine. Cook 8 indicate she believed the ice machine was the Maintenance Director (MM) responsibility. On 9/21/23 at 9:39 a.m., the DM indicated the inside of the ice machine was the dietary staff responsibility and the outside was housekeeping responsibility. Six weeks ago, she cleaned ice machine and ice room. The ice machine had leaked			

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	a lot. The facility staff used to put a pan under it to catch the dripping water. She did not know if there was a plan to fix the ice machine or the floor in the ice room. The dietary staff got most of the lime off the ice machine last month, it was built-up. The ice machine was a constantly leaking issue. On 9/21/23 at 10:04 a.m., the wall water fountain, in the resident hallway, was observed to be unplugged, the plug was laying on the floor. It was partially covered with dark plastic. The fountain bowl was observed to have standing water in it. The water was brownish with black specks in the bottom. On 9/22/23 at 9:31 a.m., the ice machine used for residents was observed to have lime buildup on the front bottom and crusted into the seams/seals. Inside of the ice machine door, from next to the , was observed to have lime buildup, white and brownish gray in color. Some areas were crusted, and some wet and felt slimy with a long black hair stuck to the slimy substance on the inside of the bottom edge of the lid. Water leaking was from behind or under ice machine, standing water observed on the floor. On 9/22/23 at 9:36 a.m., the water fountain, near dining room on front hallway, was observed to be partially cover with black plastic, unplugged. The bowl of the fountain was observed to have standing water, brownish, rusted with unidentified dark substances. On 9/25/23 at 11:19 a.m., the ice room was observed with the Maintenance Director. A puddle of water was in front of the ice machine. He indicated he had no idea who was responsible for cleaning the lime build-up off the ice machine and the outside and inside lid. He thought the last			

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	test for Legionella (measures to prevent the growth of Legionella in the building water systems) had been completed either this month or last month. The water was tested with strips, he did not keep a log of test results. He had never tested the build-up of lime or water in or around the ice machine. On 9/25/23 at 11:26 a.m., the housekeeping supervisor indicated the housekeeping staff was only responsible for the outside of the ice machine. She did not know who was responsible for cleaning the inside and outside of the ice machine. On 9/25/23 at 11:58 a.m., the Admin indicated he had lumped the water temperature testing and the Legionnaire testing together and assumed the Maintenance Director was completing the testing. He indicated the Water Management Program was not talked about during their monthly Quality Assurance Performance Improvement (QAPI) meetings. On 9/25/23 at 12:28 p.m. the housekeeping supervisor indicated the housekeeping staff was responsible for cleaning the outside of the ice machine and dietary was responsible for cleaning the inside of the ice machine. On 9/25/23 at 3:56 p.m., the Admin indicated the Maintenance Director did test strips for Legionella testing. He indicated he did not know how often the Maintenance Director did them. The Maintenance Director used TELS (a building management service) for tasks. The Admin indicated he would get an email from TELS if a task was not done. On 9/26/23 at 11:09 a.m., the Infection			

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	Preventionist (IP) indicated she did not coordinate with the Maintenance Director regarding Legionella testing. On 9/26/23 at 12:25 p.m., the Admin indicated he would provide information from TELS regarding the Maintenance Director Legionella tasks. He indicated he did not know if the Maintenance Director had been doing Legionella testing. If he was, he should have been keeping a logbook of Legionella testing results. The facility monitored for signs of Legionella but did not know what the signs were for monitoring. The most recent TELS documentation regarding, "Testing and Monitoring of Water Management Plan for Legionella," dated 8/31/2020, was provided by the Admin, on 8/26/23 at 12:45 p.m. It was, "Marked done on-time," by the Maintenance Director on 8/31/2020. A review of the document indicated, "You need to test and monitor your water system and supply for Legionella against the 'Water Management Plan' you put together. The 'Water Management Plan' should be stored in TELS on the annual task in your 'Work History' ...It is recommended that weekly you are doing any necessary visual inspections of area such as decorative fountains or ice machine for any 'biofilm' (slime), scale or sediment that could encourage the growth of the Legionella. If any unclean areas are found, follow your equipment owner's manual and 'Water Management Plan' and document, clean and retest and monitor until conditions improve and are then maintained. This may mean increasing your monitoring to daily until condition return ...If you indicated on your 'Water Management Plan' that you are at risk for temperature fluctuation or water stagnation, monitor if conditions fall within the range that would encourage growth of the bacteria by			

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	testing and documenting the water temperatures at the points in your water system you indicated ...All of these inspections, test and measurements need to be documented and recorded. Please contact your TELS Representative to create your custom log that covers all of you points of risk that were labeled on the 'Water Management Plan.' On 9/26/23 at 12:33 p.m., the Maintenance Director indicated he used Legionella test strips once a month. He had no logbook or tracking information of any kind regarding the history of his Legionella testing. He indicated he would look, once a week, for standing water in the ice room or the kitchen. He was looking for standing water, slime, or build-up of lime. He indicated he did not know the ice machine had slime in and on it. The water fountain was unhooked. The facility stopped using it when COVID-19 started. He had not sent any samples of water to any labs to check for Legionella. The Legionella testing strips were used on standing water in the ice room on the puddle on the floor, the ice machine lid, and in the kitchen where water may stand. He indicated he ran out of Legionella strips this month. He had no test strips to demonstrate his process. The facility, "Water Management Program," with no date, was provided by the Admin, on 9/26/23 at 12:45 p.m. A review of this document indicated it did not include information regarding doing visual inspections and what to do when unclean areas were found (slime) or list of any at risk areas of Legionella testing specified by TELS. The order for additional Legionella strips was completed on 9/26/23 at 12:47 p.m. The order was for Lovibond Hydrosense Legionella Field Test Kit (10 Tests). The receipt indicated the Legionella			

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	Field Test Kit is the most basic of the Legionella Detection test kits. The test was easy and fast with results in 25 minutes, the test allowed for immediate understanding and response to the water conditions. Users simply collect a water sample in the provided collection bag, and using the provided exact volume disposable pipet, dispense 100 µL (unit of measure) of sample onto the test strip. After the required reaction time, the test line will turn red if results are positive. On 9/26/23 at 9:00 a.m., the Maintenance Director TELS work history was provided from 6/1/23 to present. The Maintenance Director put the dates in for Legionella testing, but no results were present in an electronic or paper logbook. The testing was to be completed weekly. a. For June: 6/2, 6/9, 6/19, 6/23, 6/28. b. For July: 7/10, 7/29. The first and third week of July were missed. c. For August: 8/4, 8/9, 8/21, 8/28. The third week of August was missed. d. For September: 9/5, 9/7, 9/16, 9/22. A CDC document, from the facility's Water Management Program binder, was titled, "Developing a Water Management program to Reduce Legionella Growth & Spread in Buildings, A Practical Guide to Implementing Industry Standards." It was dated 6/5/2017, and was provided by the Admin, on 9/26/23 at 12:45 p.m. A review of the document indicated, " ...This toolkit will help you develop and implement a water management program ...Biofilm: Protects Legionella from heat and disinfectant: provides food and shelter to germs, grows on any surface that is constantly moist and can last for decades ...Scale and sediment: Uses up disinfectant and creates a protected home for Legionella and other germs ...Your program team should establish			

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	procedures to confirm, both initially and on an ongoing basis, that the water management program is being implemented as designed. This step is call "verification" ...Now, that you have done all of the work required to create your water management program, write it down. This information will be important to improve your program and if you or others want to review your records ...Special Considerations for Healthcare Facilities ...All healthcare facilities should have a Legionella water management program ...." A CMS (Centers for Medicare and Medicaid) document, from the facility's Water Management Program binder, was titled, "Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease." It was dated 6/2/2017, and was provided by the Admin, on 9/26/23 at 12:45 p.m. A review of the document indicated, " ...In manmade water systems, Legionella can grow and spread to susceptible hosts, such as person who are at least 50 years old, smokers, and those with underlying medical conditions ...Legionella can grow in parts of building water system that are continually wet, and certain devices ...water, heaters ...pipes, valves, and fittings ...water filters, electronic and manual faucets ...faucet flow restrictors, showerheads and hoses ...eyewash stations, ice machines ...Expectations for Healthcare Facilities ...Implement a water management program that considers the ASHRAE (American Society of heating, Refrigerating and Air-Conditioning Engineers) industry standard and the CDC toolkit (Centers for Disease Prevention and Control), and includes control measure such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens (bacteria or microorganism that can			

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	cause disease) ...Specify testing protocols and acceptable ranges for control measures and document the results of testing and corrective actions taken when control limits are not maintained ...Healthcare facilities are expected to comply with CMS requirements to protect the health and safety of its patients ...." A current policy, titled, "Legionella Surveillance and Detection," dated July 2017, was provided by the Admin, on 9/25/23 at 4:30 p.m. A review of the policy indicated, " ...Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. Legionnaire's disease will be included as part of our infection surveillance activities ...The Infection Preventionist will meet with the Water Management Team to investigate the possible source of contamination ...." This Federal tag relates to Complaint IN00405260. 3.1-18(b) 3.1-18(b)(1) 3.1-18(b)(2) 3.1-18(b)(3) 3.1-18(b)(4)			
F 0881 SS=F Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.			

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	Based on interview and record review, the facility failed to implement an antibiotic stewardship program, and failed to document 11 of 21 residents with infections that needed antibiotics (Resident B, C, E, F, G, H, K, L, N, Q, and X). This deficient practice had the potential to effect 21 of 21 residents residing in the facility. Findings include: On 9/26/23 at 11:09 a.m., the MDS Coordinator (MDSC) indicated she was in charge of Infection Control (IC). She indicated her task was to attend a meeting once a month, after their Quality Assurance and Performance Improvement (QAPI) meetings, which included their Medical Director and the Administrator (Admin), therapy, and a nurse if possible, and discuss IC. She indicated they discussed personal protective equipment (PPE): donning and doffing, and when to use it. She indicated she did not track, trend, or analyze infections, antibiotic use, or lab results for any residents in the building and did not have an IC binder with documentation of the same. She indicated she had not communicated with any physician's regarding infections, antibiotic use or labs since she started this position in March. She was not using Loeb's criteria (a minimum set of signs and symptoms to determine infection) or McGreer's criteria (used retrospectively counting true infection with diagnostic information). She indicated to her knowledge the current infections in the building were Resident F had a urinary tract infection (UTI), Resident K had an infection of cellulitis in his left lower leg, and Resident Q may have an infection. She overhead some staff talking yesterday and believed Resident Q may be getting a peripherally inserted	F 0881	The facility has implemented an antibiotic stewardship program and will document resident infections that need antibiotics Resident's G, F, K, L, X, H, B, C, N and E now have their infections/antibiotics tracked as per protocol of the antibiotic stewardship program. All residents using antibiotics are at risk for this alleged, deficient practice. The designated facility IP has been in-serviced by RDO/Designee on the Facility Antibiotic Stewardship Program. The RDO/Designee will monitor the facility IC binders monthly x 6 months to be sure the ABT Steward Program is up to date and followed per protocol. Non-compliance will be corrected immediately with further education as needed. The RDO/Designee will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	11/17/2023

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	central catheter (PICC) line to deliver antibiotics. But it may not be her. She indicated Resident K was on an antibiotic. On 9/26/23 at 11:21 a.m., the MDSC indicated the Admin came to her one day in March and indicated she was going to be the facility's IP and be in charge of IC. She indicated she had no corporate resources for IC. She started as Infection Preventionist and doing Infection Prevent and Control on 3/4/23. On 9/26/23 at 3:04 p.m., the IP provided a list of resident who had infections and used antibiotics in the last 7 months, since she started the infection control position. Resident G had several infections that required antibiotics: a. He was on ceftriaxone, 1 gram (gm) intramuscularly (IM) every morning and a bedtime (HS) for urinary tract infection (UTI) for 7 days, from 4/12/23 to 4/19/23. b. He was on vancomycin 1250 mg, intravenously (IV) in the morning for abdominal abscess for 18 administrations, from 6/1/23 to 6/6/23, 6/7/23 to 6/10/23, and again from 6/14/23 to 6/24/23. c. He was on vancomycin 1 gm, IV every 12 hours for abdominal abscess from 6/20/23 to 6/24/23 and 6/25/23 to 7/2/23. d. He was on Zosyn, 3.375 gm , IV every 8 hours for 24 days, for abdominal abscess, from 6/1/23 to 6/25/23. Resident F had several infections that required antibiotics: a. She was on ceftazidime, 2 gm, IV, for UTI three times a day (TID) for 10 days, from 8/24/23 to 9/3/23. b. She was on ciprofloxacin 500 mg, every morning			

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	155404	A. BUILDING 00 B. WING	09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	and HS for 10 days, from 6/7/23 to 6/14/23 and for another 7 days, from 7/29/23 to 8/5/23. c. She was on Keflex (cephalexin) 250 mg by mouth TID for 7 days for UTI, 6/14/23 to 6/21/23 and the same antibiotic four times a day (QID), from 8/12/23 to 8/18/23. d. She was on cephalexin 500 mg TID for 7 days for UTI, from 7/29/23 to 8/5/23. e. She was on ertapenem injection, 1 gm IV one time a day for UTI for 10 days, from 9/26/23 to 10/6/23. Resident K had several infections that required antibiotics: a. He was on Bactrim 800-160 mg 2 times a day for left foot cellulitis for 10 days, from 7/9/23 to 7/19/23. b. He was on doxycycline 100 mg every 12 hours for left ankle cellulitis from 9/23/23 to 9/29/23. Resident Q had infections that required antibiotics: a. She was on ciprodex otic Suspension 0.3-0,1%, instill 4 drops in left ear TID for inner ear infection, from 8/9/23 to 8/14/23. b. She was on azithromycin 500 mg one time a day for pneumonia, from 5/3/23 to 5/4/23. Resident L had infections that required antibiotics: a. He was on ciprofloxacin 250 mg BID for UTI, from 5/30/23 to 6/6/23. b. He was on diflucan 150 mg once a day at HS for yeast infection, from 7/9/23 to 7/12/23. c. He was on diflucan 200 mg once a day for yeast infection, from 7/19/23 to 8/2/23. d. He was on amoxicillin 875 mg BID, from 6/10/23 to 6/15/23. e. he was on ciprofloxacin 250 mg BID for a UTI, from 5/31/23 to 6/6/23.			

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	Resident X had infections that required antibiotics: a. She was on ciprodex otic suspension 0.3-0.1% instill 4 drops in both ears TID for bilateral ear infections, from 8/9/23 to 8/14/23. b. She was on doxycycline 100 mg BID for left foot cellulitis, from 5/18/23 to 5/19/23 and 5/19/23 to 5/25/23. Resident H had infections that required antibiotics: a. She was on Bactrim 400-80 once a day for chronic UTI, starting 8/15/23 with no end date. b. She was on ertapenem 1 gm IM in the morning for UTI for 10 days, from 4/5/23 to 4/15/23. Resident B had infections that required antibiotics: a. She was on Diflucan 100 mg in the evening for yeast infection, take two 100 mg tablets tonight and one tablet on Thursday and Friday, from 5/24/23 to 5/27/23. b. She was on Diflucan 200 mg one time a day for vaginal candidiasis (infection), from 7/7/23 to 7/8/23. c. She was on Diflucan 100 mg in the evening for vaginal candidiasis, take two 100 mg tablets tonight and one tablet on Thursday and Friday, from 7/8/23 to 7/9/23. Resident C had infections that required antibiotics: a. He was on ciclopirox olamine cream 0.77%, apply to toenails topically every 24 hours as needed for fungal infection, from 8/17/23 to 6/13/23. Resident N had infections that required antibiotics:			

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	a. She was on ciprofloxacin otic solution 0.2%, instill 0.25 mL BID for external otitis, from 9/9/23 to 9/15/23. Resident E had infections that required antibiotics: a. He was on Keflex 500 mg once a day QID for ear infection for 7 days, from 8/28/23 to 9/4/23. A current policy, titled, "Policies and Practices - Infection Control," dated July 2014, was provided by the Admin, on 9/26/23 at 2:30 p.m. A review of the policy indicated, " ...This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections ...The objectives of our infection control policies and practices are to ...Prevent, detect, investigate, and control infections in the facility ...Maintain records of incidents and corrective actions related to infection ...provide guidelines for the safe cleaning and reprocessing of reusable resident-care equipment ...The Quality Assurance and Performance Improvement Committee, through the Infection Control Committee, shall oversee implementation of infection control policies and practices, and help department heads and managers ensure that they are implemented and followed ...All personnel will be trained on our infection control policies and practices ...." A current policy, titled, "Surveillance for Infections," dated July 2016, was provided by the Admin, on 9/26/23 at 2:30 p.m. A review of the policy indicated, " ...The Infection Preventionist will conduct ongoing surveillance for Healthcare-Associate Infections (HAIs) and other ...infections that have substantial impact on potential resident outcome and that may require			

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	transmission-based precautions and other preventative interventions ...The purpose of the surveillance of infections is to identify both individual cases and trends of ...significant organisms and Healthcare-Associate Infections, to guide appropriate interventions, and to prevent future infection ...Infections that will be included in routine surveillance include those with ...Evidence of transmissibility ...available processes and procedures that prevent or reduce the spread of infection ...Infections that may be considered in surveillance include those with limited transmissibility ...Nursing Staff will monitor residents for signs and symptoms that may suggest infection, according to current criteria and definitions of infections, and will document and report suspected infection to the Charge Nurse as soon as possible ... The Charge Nurse will notify the Attending Physician and the Infection Preventionist of suspected infections ...The Infection Preventionist and the Attending Physician will determine if laboratory tests are indicated ...If transmission-based precautions or other preventative measures are implemented to slow or stop the spread of infection, the Infection Preventionist will collect data to help determine the effectiveness of such measures ...." A current policy, titled, "Antibiotic Stewardship," dated July 2016, was provided by the Admin, on 9/26/23 at 2:30 p.m. A review of the policy indicated, " ...Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship program ...." A current policy, titled, "Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcome," dated July 2016, was provided by the Admin, on 9/26/23 at 2:30 p.m. A review of the policy indicated, " ...Antibiotic usage and			

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	outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship ...As part of the facility Antibiotic Stewardship Program, all clinical infections treated with antibiotics will undergo review by the Infection Preventionist, or designee ...The IP, or designee, will review all antibiotic starts within 48 hours to determine if continued therapy is justified, justified with needed intervention ...At the conclusion of the review, the provider will be notified of the review findings and recommendation ...All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form ...." A current policy, titled, "Infection Preventionist," dated July 2016, was provided by the Admin, on 9/26/23 at 2:30 p.m. A review of the policy indicated, " ...The Infection Preventionist is responsible for coordinating the implementation and updating of our established infection prevention and control policies and practices ...The Infection Preventionist (or designee) shall coordinate the development and monitoring of our facility's established infection prevention and control policies and practices ...The Infection Preventionist shall keep abreast of changes in infection prevention and control guidelines and regulation to ensure our facility's protocols remain current and aid in preventing and controlling the spread of infections ...The Infection Preventionist will collect, analyze and provide infection and antibiotic usage data and trends to nursing staff and health care practitioners; consult on infection risk assessment and prevention control strategies; provide education and training; and implement			

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	evidenced-based infection prevention and control practices ...." 3.1-18(b)(1)			
F 0882 SS=F Bldg. 00	483.80(b)(1)-(4) Infection Preventionist Qualifications/Role §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. Based on interview and record review, the facility failed to ensure they had a certified Infection Preventionist (IP) on staff this effected 21 of 21 residents residing in the facility. Finding includes: On 9/20/23 at 9:45 a.m., during the entrance conference the Administrator (Admin) indicated the Infection Preventionist was the Interim Director of Nursing (IDON). On 9/25/23 at 2:30 p.m., Licensed Practical Nurse (LPN) 13 indicated the IP was the IDON.	F 0882	The facility will ensure there is a certified IP on staff. The IP finished her certification on 9-25-23 This alleged, deficient practice had the potential to affect all residents The Administrator was in serviced by the RDO/Designee on the requirements to have a designated, certified IP on staff.	11/17/2023

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	On 9/25/23 at 3:54 p.m., the Administrator (Admin) indicated the MDS Coordinator (MDSC) was the IP. He did not have a certificate indicating the MDSC was a certified IP. He indicated he would have her log back into the Centers for Disease Control and Prevention (CDC) website and print her certification. On 9/26/23 at 9:01 a.m., the Admin indicated the MDSC had not completed the final criteria to become certified. He indicated she had been the facility's IP since March. On 9/26/23 at 11:07 a.m., the MDSC indicated she had not completed the final criteria to receive the title of certified IP. On 9/26/23 at 11:21 a.m., the MDSC indicated the Admin came to her one day in March and indicated she was going to be the facility's IP and be in charge of IC. She had no corporate resources for IC. She was not only the MDS Coordinator and IP for IC, but now she was also the Medical Records Director, and worked as a floor nurse about once a month, unless a nurse was on vacation and then she would have to pick up more floor shifts. She received zero training to be the Medical Records Director. She indicated on a daily basis that she helped with residents' needs: getting resident drinks, towels, or take them to the restroom, and she answered a lot of call lights. She started as MDSC on 2/16/23, started IP doing IC on 3/4/23, and started as Medical Records Director on 9/22/23. On 9/26/23 at 11:30 a.m., the MDSC indicated she had not completed any staffing in-services as the IP regarding IC. She indicated she wanted to do an in-service on hand hygiene and PPE, but no		The RDO/Designee will review certification(s) monthly x 6 months to ensure there is a certified IP on staff. The RDO/Designee will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	one in the facility was on isolation. A current policy, titled, "Infection Preventionist," dated July 2016, was provided by the Admin, on 9/26/23 at 2:30 p.m. A review of the policy indicated, " ...The Infection Preventionist is responsible for coordinating the implementation and updating of our established infection prevention and control policies and practices ...The Infection Preventionist (or designee) shall coordinate the development and monitoring of our facility's established infection prevention and control policies and practices ...The Infection Preventionist shall keep abreast of changes in infection prevention and control guidelines and regulation to ensure our facility's protocols remain current and aid in preventing and controlling the spread of infections ...The Infection Preventionist will collect, analyze and provide infection and antibiotic usage data and trends to nursing staff and health care practitioners; consult on infection risk assessment and prevention control strategies; provide education and training; and implement evidenced-based infection prevention and control practices ...." 3.1-18(b)(1)			
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza			

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	155404	A. BUILDING 00 B. WING	09/26/2023

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	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: (A) That the resident or resident's representative was provided education			

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	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 observation, interview, and record review, the facility failed to administer pneumonia vaccinations as recommended by the Centers for Disease Control and Prevention (CDC) for 3 of 5 residents reviewed for vaccinations (Residents F, Q and U). Finding include: 1. Upon survey entrance on 9/20/23 at 9:50 a.m., the Administrator, (ADM) indicated, there was only one resident out at the hospital at that time, Resident F. During an interview on 9/20/23 at 12:55 p.m., the Licensed Practical Nurse (LPN) 23 indicated Resident F remained in the hospital but had been extubated. (Extubating is the removal of an endotracheal tube [ETT], when removing a person from a ventilator). On 9/21/23 at 10:00 a.m., Resident F was visited in a local hospital. She was observed lying in bed and although she was alert, she was confused to the place and time, and exhibited paranoid thoughts. She indicated she had a cough and when she coughed her chest hurt. On 9/21/23 at 10:30 a.m., a copy of Resident F's emergency room summary dated 9/19/23, was provided by the local hospital and reviewed at that time. The hospital record indicated, " ...brought in by Emergency Medical Staff [EMS] for altered mental status. Hypotensive [low blood	F 0883	The facility will administer pneumonia vaccines as recommended by the CDC Residents F, U and Q and/or their legal representative will be offered the pneumonia vaccine and administered and documented if consent is given or documented if refused. All residents are at risk from this alleged, deficient practice. An audit was done of the remaining residents to ensure Pneumonia vaccinations were up to date. Residents not up to date will have the pneumonia vaccine offered and administered (if choose to receive). DON/MDS and Licensed nurses in serviced by RDO/Designee on the policy and procedure for pneumococcal vaccinations. The RDO/Designee will review 5 residents monthly x 6 month to ensure their pneumococcal vaccinations are up to date or that the resident was offered the education and choice to decline. The RDO/Designee will report the	11/17/2023

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	pressure] in the 60's upon arrival. Not easy to obtain initial oxygen saturation ... decision to intubate upon arrival ... chest x-ray with adequate ET tube placement and nonspecific right and left perihilar infiltrates [a sign of lung infection/pneumonia] ... patient did received 30 per kilos bolus fluid while in emergency department. Very fluid responsive, however when pressure bag not running, becomes hypotensive again with systolic usually in the 80's ... Assessment/Plan: hypotensive, blood pressure 69/46 on arrival to emergency department ...." On 9/26/23 at 9:29 a.m., Resident F was observed in her room after she had been readmitted to the facility the night before. She indicated she felt much better. She had been diagnosed with pneumonia and a UTI (urinary tract infection). When asked about the pneumonia vaccination, Resident F indicated she did not know if she had been given the vaccine, but she wanted it now to make sure she didn't get it again if possible. On 9/22/23 at 9:00 a.m., Resident F's medical record was reviewed. She was a long-term care resident who had diagnoses which included, but were not limited to, incomplete quadriplegia from C1-C4 (partial to severe paralysis from the neck down), neuromuscular dysfunction of the bladder and contractures (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of right and left knees and ankles. An "Influenza & Pneumococcal Immunization Informed Consent" record dated, 10/27/2020 indicated, Resident F received an initial pneumonia vaccination in 2016 and was due for the next dose in 2021.		findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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ESSEX NURSING AND REHABILITATION CENTER	301 W ESSEX ST LEBANON, IN 46052

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	She had a discontinued physician's order, dated 9/19/23 (upon her discharge to the hospital), which indicated she may have a "Pneumovax" if not already given. She had a comprehensive care plan, initiated 3/12/2020, which indicated she was at risk for respiratory illness related to the corona virus threat, but lacked revision to include person-centered/individualized status of her covid, flu, and/or pneumococcal consents/refusal or current status. The record lacked documentation of updated informed consent for the pneumococcal vaccine. The record lacked documentation the pneumococcal vaccine had been administered. 2. On 9/21/23 at 10:18 a.m., a comprehensive record review was completed for Resident U. His diagnoses included but were not limited to benign prostatic hypertrophy, reflux uropathy (urine flows back to the kidney), bipolar disorder (psychiatric illness) characterized by both manic and depressive episodes, or manic ones only), chest pain, dementia, and COPD (chronic obstructive pulmonary disease). He had 1 pneumococcal vaccination on 10/21/16. He had a physician's order, dated 5/11/23, indicated to administer pneumovax if he had not had it. 3. On 9/21/23 at 11:00 a.m., a comprehensive record review was completed. Resident Q had diagnoses which included but were not limited to schizoaffective disorder (a mental illness that can affect your thoughts, mood and behavior, pseudobulbar effect (Inappropriate involuntary			

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	155404	A. BUILDING 00 B. WING	09/26/2023

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	laughing and crying due to a nervous system disorder), dysphagia (difficulty swallowing), dementia, anxiety, depression, and dyspnea (difficulty breathing). She had 1 pneumococcal vaccination on 10/1/2016. The record lacked documentation of any additional vaccinations. 3.1-13(a)			
F 0908 SS=F Bldg. 00	483.90(d)(2) Essential Equipment, Safe Operating Condition §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, interview, and record review, the facility failed to ensure the kitchen employees were knowledgeable about correct dishwasher temperatures, the dishwasher and oven equipment worked correctly, and the 2 compartment sink could provide cold water for thawing of foods. This deficient practice had the potential to affect 21 of 21 residents who received food from the kitchen. Findings include: 1. On 9.20.23 at 10:03 a.m., Cook 8 indicated the dishwasher should be washing and rinsing the dishes at 135 degrees F. The first dish rack she ran through, the temperatures gauge did not move for the wash or rinse cycles. The second dish rack was wash 110, rinse 110. The third dish rack was wash 114, rinse 124. The fourth dish rack was wash 122, rinse 129. She indicated they ran all the dish racks through 3 times to get them clean.	F 0908	The facility will ensure the kitchen employees are knowledgeable about correct dishwasher temperatures, the dishwasher and oven work correctly and that the 2 compartment sink provides cold water for thawing foods The facility has signed a lease with it's current food vendor to rent a low temperature dish machine. It will be installed once arrived in 2-3 weeks. Until then, dietary staff are aware they must get the dish machine to the required temperature to run dishes through. The Oven has been fixed. The 2 compartment sink now has	11/17/2023

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	On 9/20/23 at 11:23 a.m., Cook 8 indicated the items in the dishwasher were the large bowl for mixing and cake and utensils. The dishwasher wash cycle was 108 degrees F and the rinse cycle was 108 degrees F. On 9/20/23 at 12:23 p.m., Cook 8 indicated the dishwasher had not been doing what it's supposed to do. The gauge did not move for the wash or rinse cycles. She indicated she had to run the cycles three times for each rack that went into it. On 9/21/23 at 9:08 a.m., the Dietary Manager (DM) indicated the dishwasher was a low temperature machine. It should be running at 130 degrees for wash and rinse. EcoLab was servicing the dishwasher last week, they indicated the seals were dry rotted and removed them. He had changed the temperature gauge at the top. The average temperature was 130-133 degrees F. On 9/21/23 at 9:15 a.m., the DM indicated she did not trust the dishwasher temperature gauge. On 9/22/23 at 11:45 a.m., the first dishwasher temperature gauge read for wash was 129, rinse 101. The next cycle the temperature gauge did not move at all, rinse cycle 110. Then, wash was 110, rinse 120. Then, wash was 118, rinse 120 degrees F. On 9/25/23 at 3:04 p.m., the dishwasher temperature gauge was compared to the water exiting the dishwasher at the end of the cycle with a thermometer. a. For the first 2 cycles, the temperature gauge did not move at all. b. Next, the dishwasher gauge read: wash was 100,		cold, running water. This alleged deficient practice had the potential to affect all residents. Dietary staff to be in serviced by the RD/Designee on dish machine temperatures, oven temperatures and thawing foods. The DM will question 3 dietary staff per week on their knowledge of correct dishwasher temperatures, oven temperatures (what to do if temperatures are not correct) weekly x 1 month and then monthly x 5 months. Staff will be rotated when questioned to include both shifts. Immediate re-education will be given for incorrect responses. The DM/Designee will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	155404	A. BUILDING 00 B. WING	09/26/2023

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	rinse was 116. The thermometer wash temperature was 124, rinse 115. c. Next, the dishwasher gauge read: wash was 116, rinse was 124. The thermometer wash temperature was 119, rinse 128. d. Next, the dishwasher gauge read: wash was 124, rinse was 130. The thermometer wash temperature was 125, rinse 134. On 9/25/23 at 3:11 p.m.. the DM indicated that she runs dishwasher racks through it while empty to get the dishwasher up to temperature. 2. On 9/20/23 at 11:29 a.m., Cook 8 indicated the oven was set at 400 degrees F. There was no internal thermometer in the oven. She estimated the oven temperature was 350 degrees F. The oven had been broken for about 8 months. On 9/20/23 at 11:37 a.m., the Maintenance Director brought a laser thermometer. He indicated the internal oven temperature was 252 degrees F. On 9/21/23 at 9:17 a.m., the DM indicated the left side oven doesn't work at all, it has been out for at least 2-3 months. We had an internal thermometer, but she indicated she doesn't know where it is now. If the right side oven was on, and the oven was turned on 500 degrees F, the actual oven temperature was estimated to be 400 degrees F. On 9/22/23 at 11:36 a.m., pizza burgers were observed baking in the oven. The oven was set at 450, but Cook 8 estimated the actual temperature was 350 degrees F. They stayed in the oven until the internal temperature was above 175 degrees F. On 9/20/23 at 9:54 a.m., Cook 8 indicated the dishwasher was a low temperature machine, but it won't get it to 135 degrees Fahrenheit (F). The			

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	facility had 2 ovens, one oven did not work at all, and the other oven had inconsistent temperatures. Examples of the uncooked foods baked in the oven were ground beef, hamburger patties, pork roast, chicken breast, polish sausage, baked bacon, pizza burgers, French fries, and cake. They used to have an internal thermometer to check the temperatures for foods baking in the oven, but they no longer have it. If they set the partially working oven on 350 degrees F, it cooked the food at 200 degrees F, if it is set at 500 degrees F it goes up to 550 degrees F. 3. On 9/20/23 at 9:54 a.m., Cook 8 indicated the 2 compartment sink did not have cold running water. The sink only provided warm or hot water. She wanted to thaw a large plastic bag of pulled pork. It was observed in the sink with warm water running over it. She indicated the issues with the sink only providing warm or hot water had been reported to the Administrator (Admin) and Maintenance Director about 6 weeks ago. On 9/25/23 at 3:33 p.m., the DM indicated she was not aware of or following the Indiana Department of Health's Retail Food Establishment Sanitation Requirements. On 9/25/23 at 4:14 p.m., the Administrator (Admin) indicated the ovens were not fixed yet, they had to order parts. On 9/25/23 at 4:26 p.m., the Admin indicated the dishwasher repair company representative indicated he had ordered the dishwasher seals and had them for months. He kept forgetting to bring them to the facility. 3.1-21(i)(2)			

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F 0921 SS=F Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a clean and sanitary environment on 2 of 2 hallways (front and back). Findings include: On 9/20/23 at 10:20 a.m. during the initial facility tour, the following was observed: a. Tiled and wood-looking vinyl floors, cove base, and framing around doorways throughout the facility to include hallways, main dining room, staff offices, resident rooms, staff/visitor bathroom, and inside nurse's station all observed to be heavily soiled with unidentified dark sticky substances, food crumbs, and dark soiled build-up and debris. b. Windowsills in resident rooms observed to be covered in dust, dark colored debris, and small dead bugs. c. The bottom foot of two (2) vending machines near room 118 observed to be heavily soiled with unidentified sticky substances, with dust adhered on the sticky substances. The tiles under and around the vending machines were cracked, with rusted tiles, dark sticky buildup, and small dead bugs to include a cockroach. d. Handrails throughout the facility with white paint chipped off. e. Bottom and edges of all wooden doors in the facility observed to have chips of wood splintered and peeled off. f. Staff bathroom floor observed to be littered with debris to include dirt, and paint chips from the baseboards.	F 0921	The facility will maintain a clean and sanitary environment. Facility floors, cove base, framing around doorways, throughout the facility, have been cleaned. Windowsills in resident rooms have been cleaned The bottom foot of the 2 vending machines have been cleaned. The cracked tiles under the vending machine have been replaced and the other tiles cleaned. Handrails throughout the building have been repainted. The bottom of the doors will be covered with kick plates and door edge guards. The staff bathroom has been cleaned Resident room 16 has had the missing section of floor replaced. The kickplate has been repainted. Ice machine on the front hallway has been cleaned of lime down the front.	11/17/2023

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	g. Resident room 16 observed to have sections of flooring missing on the front side of the bed. Wooden closet kick plates observed to have extensive areas of peeling paint. h. Ice machine on the front hallway observed to have a wet blanket on the floor, and lime down the front. Cook 8 indicated she that the ice machine was the responsibility of the Maintenance Director. Two housekeeping personnel observed in the facility this date, 1 pushing a housekeeping cart emptying trash, not observed to be sweeping, mopping, or cleaning. On 9/20/23 at 12:00 p.m., the Housekeeping Supervisor was overheard saying she had a fly in the laundry room that has been bothering her. On 9/20/23 at 2:20 p.m., Resident R was observed in his room lying in bed with his eyes closed. A fly was observed buzzing around his head, landing on his face (he brushed it away), shirt, and blanket. On 9/21/23 at 9:59 a.m. during a random facility tour, the following was observed: a. Resident P was observed lying in bed with her eyes closed. Chunks of unidentified brown food observed under the over the bed table at the foot of her bed. b. Resident R was observed lying in bed with his eyes closed. Unidentified brown colored food observed beside and under the edge of the bed, and under the over the bed table at bedside. c. The water fountain on the wall outside the kitchen observed to be unplugged and partially covered with dark plastic, with standing water on the top. d. The floors inside the nurse's station were		The facility has installed plug in type fly traps to help decrease the fly population Resident Ps room has been cleaned Resident Rs room has been cleaned The water fountain has been removed The Nurse's station has been cleaned A new shower chair has been ordered to replace the cited shower chair that has been removed. Bathroom B has been cleaned; The drip in the sink has been repaired. The cracked tiles have been replaced. The door frame has been repainted. The back hallway medication cart has been cleaned The metal divots, sunken in the middle of the hallways that are used to catch fire doors have been cleaned al all debris The resident ice machine has been cleaned of lime and scale and the long black hair.	

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	observed to be littered with food and paper debris, liquid spillage, and stains. No housekeeper observed cleaning this am. On 9/21/23 at 2:20 p.m., a shower chair was observed sitting in the hallway outside bathroom D in front of the vending machines. The chair legs, caster wheels, footrest support bar, and Velcro all observed to be heavily soiled with unidentified brownish substances. The vinyl seat and back, and Velcro were frayed. On 9/22/23 at 7:55 a.m., a second observation of the shower chair sitting in the hallway outside bathroom D. The chair continued to be heavily soiled. On 9/22/23 at 8:05 a.m., bathroom B was observed to have a pink wash basin positioned on the floor under the sink pipes collecting dripping water. The was bowel movement smeared on the outside and down the front of the toilet bowl, heavily soiled floor with buildup of unidentified sticky dark substances, the tiles were cracked on threshold of the room, and paint chipped off with rust showing down both sides of the door frame. On 9/22/23 at 8:37 a.m., the back hallway medication cart sides and lid of trash can were observed to be soiled with dried white liquid and dark unidentified substances. Licensed Practical Nurse (LPN) 15 indicated it was the responsibility of the night shift nurse to clean the medication carts, which she did at least twice weekly. On 9/22/23 at 9:29 a.m., during observation of the front and back hallways, the following was observed, a. The metal divots sunken in the middle of the hallways that are used to catch fire doors		Standing water removed from in front of the ice machine. Any facility water fountains have been removed. All residents were at risk from this alleged, deficient practice The Admin/Des has reviewed Job Descriptions and expectations for maintaining a clean, sanitary, safe environment with the Housekeeping Supervisor and Maintenance Director. The Administrator reviewed TELS service with the Maintenance Director and the expectation that tasks are completed in full as required. The Administrator/Designee will do rounds 3x weekly with the Maintenance Director and the Housekeeping Supervisor, to include all areas in the facility, x 1 month and then weekly X 5 months. The Administrator will pull a minimum of 5 completed TELS task each month X 6 months, (varying them each month) and check to verify that task completed as per requirement. Non-compliance will be corrected immediately with further education and disciplinary action if needed. The Admin/Designee will report the findings to the QAPI meeting monthly for review. After 6	

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	observed to be filled with small rocks, dirt, food crumbs, and other unidentified debris. b. The ice machine used for residents observed to have lime and scale buildup on the front bottom and crusted into the seams/seals. Inside of ice machine door from next to ice observed to have lime buildup white and brownish gray in color, some areas were crusted, and some wet and felt slimy with a long black hair stuck to the slimy substance on the inside of the bottom edge of the lid. Water leaking from behind or under ice machine, standing water observed on the floor in front of the ice machine. c. A water fountain mounted to the wall between the nurse's station and kitchen on the front hallway observed to be partially cover with black plastic, and unplugged. The top/bowl of the fountain observed to have standing water, rusted, and covered in unidentified dark substances. 9/26/23 at 4:00 p.m., Tammy housekeeper observed in facility this date during survey process, was not observed performing housekeeping duties. Work History Report, dated 6/1/23 - 9/22/23, indicated the Maintenance Director electronically signed as having completed the following tasks: Ice Machines/Ice Bins: check filters, clean coils, sanitize interior, delime as necessary on 6/28, 7/28, 8/28, and 9/22. On 9/21/23 at 9:39 a.m., the Dietary Manager indicate cleaning of the inside of the ice machine was dietary's job, and the outside was housekeeping's job. Dietary Manager indicated, 6 weeks ago she had cleaned the ice machine and ice room. The ice machine had leaked a lot, now they didn't always see the water leaking, staff used to put a pan to catch the dripping. Indicated		months, the IDT will determine the need and /or frequency of continued monitoring.	

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	she did not know if there was a plan to fix the floor in the ice room. Last month they were able to get most of the lime build up out of the ice machine (used a chiseling motion), but it would take more attempts due to the buildup, and constant leaking. On 9/25/23 at 11:19 a.m., observed the interior of facility with the Maintenance Director. He indicated there had been no touch up painting to the walls, door frames or handrails, and the trim, doors, and handrails had not been repainted. He tried to buff the floors weekly as time allowed. Observation of a puddle of water in front of the ice machine, he indicated the puddle of water was from staff dropping ice and not picking it up. He had no idea who was responsible for cleaning lime build up off the ice machine outside and inside the lid, that was the responsibility of the housekeeping department. The Maintenance Director indicated, he did not have enough time to complete all job tasks as he worked in maintenance, drove the bus, helping with activities, helped to pass resident meal trays, and worked on information technology (IT) as needed. On 9/25/23 at 11:26 a.m., observation of the interior of the facility with Housekeeping Supervisor to include dirt and debris on all floors in the facility, along cove base in hallways and resident rooms, the soda machines, and ice machine. She acknowledged concerns with uncleanliness, indicated "after 5 years I guess I just don't see it." Indicated she had just become a supervisor and would get it cleaned up, had 1 other housekeeper who was currently in training. Indicated was only responsible for the outside of the ice machine, did not know who was responsible for cleaning off the inside of the ice			

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	machine. During an interview on 9/25/23 at 12:28 p.m., the Housekeeping Supervisor indicated, the housekeeping department was responsible for cleaning the outside of the ice machine, dietary was responsible for cleaning the inside of the ice machine. On 9/26/23 at 9:00 a.m., the Administrator (ADM) provided a Facility Housekeeper/Laundry Aide job description, undated, indicated this is the current job description being used by the facility. The job description indicted, "Direct Housekeeping: a. Perform all functions necessary to maintain cleanliness in individual resident rooms, hallways, offices, and other common areas, i. Sweep, mop and clean floors, ii. Dust furniture, windowsills, and room accessories, iii. Sanitize furniture, iv. Empty wastebaskets and replace liners, including biohazardous waste containers, v. Clean and sanitize resident, employee, and public restrooms...b. Perform all functions necessary to deep clean newly vacated or contaminated resident rooms and rooms scheduled for routine deep cleaning...ii. Wash walls, ceiling, and woodwork, iii. Wash windows, door panels, and sills..." On 9/26/23 at 9:00 a.m., the ADM provided a Facility Maintenance Director job description, undated, indicated this is the current job description being used by the facility. The job description indicted, "Direct Maintenance...d. Inspect, repair, and maintain building structures throughout the facility and grounds...f. Maintain safety and cleanliness of facility grounds, g. Maintain painting of interior walls for routine painting and [touch up] painting...m. Inspect repair and maintain ice machines...p. Perform			

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	general building repair...t. Water the facility grounds [e.g., lawn, trees, shrubs, and flowers] unless under contract with an outside firm..." On 9/26/23 at 10:26 a.m., Regional Director of Operations (RD) provided a Facility Maintenance Director job description, undated, indicated this is the current job description being used by the facility. The job description indicted, "Maintenance service shall be provided to all areas of the building, grounds, and equipment ...1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times ...The Maintenance Director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner ... This Federal tag relates to Complaints IN00405260 and IN00416159. 3.1-19(f)(5)			