STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155126	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs Valley Meadows	457 S Sr 145 French Lick, IN 47432

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34309 Based on record review and interview, the facility failed to ensure person centered interventions were implemented for dementia related behaviors for 1 of 5 residents reviewed for dementia care. (Resident 5) Findings include: The record for Resident 5 was reviewed on 3/20/24 at 6:35 a.m. The diagnoses included, but were not limited to, dementia with agitation, cognitive communication deficit, and insomnia. The physician's order, dated 5/12/22, indicated the resident may receive psychiatric services. The physician's order, dated 5/17/22, indicated staff were to apply a wanderguard to the resident's right wrist for exit seeking behavior, and to check the device for function daily. The resident was to be monitored for exit seeking behavior every shift. The Activity Assessment, dated 5/18/22, indicated the resident was interviewed by the Activities Director on her activity preferences. She documented the following were somewhat important: -Having coloring books, word searches, and puzzle books. -Listening to gospel music. -Being around animals. -Going outside. Involvement in Christian activities was documented as very important. (continued on next page)

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

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note, dated 3/12/23 at 8:41 a.m., indicated the resident continued to attempt to go into other resident's rooms that morning. Staff attempted to redirect, but the resident continued to attempt to go right back into the rooms. The resident hallucinated, talking to people that were not there. She was talking to a chair like it was her family member. She was in the TV (television) room and attempted to get out of her wheelchair and sit herself on the floor. She kept yelling out for the babies and wanting to feed them. The resident would not sit still or stay in one place. Snacks and activities were offered, to try to keep the resident busy, but the resident was not entertained by these. The care plan, dated 3/14/23 and last reviewed 1/24/24, indicated the resident intrusively wandered at times. The interventions, dated 3/16/23, indicated staff were to call and let the resident speak with a family member, dated 3/14/23, staff were to assess the resident for pain, offer to lay down the resident to rest, offer toileting and snacks, redirect the resident to activities of interest, and take the resident to a quiet environment. The nurse's note, dated 3/15/23 at 9:29 a.m., indicated the resident was wandering around halls attempting to go into other resident's rooms and pushing their wheelchairs up the halls. The resident thought that her family member was sitting in one of the wheelchairs and the resident was talking to her. The resident went to coffee club and went over to the therapy side and was yelling at the other residents and therapy staff. Therapy staff came to get the nurse to come and get her. The resident continued to yell out at staff and was trying to get out of the doors. The nurse's note, dated 3/15/23 at 9:34 a.m., indicated the night shift reported that the resident was asleep in bed until her family member came in and woke her up and then the resident would not stay asleep. The resident was found scooting up the hallway on her bottom and had been awake since yelling at staff and trying to get into other resident's rooms. The nurse's note, dated 3/16/23 at 5:37 p.m., indicated the night shift reported that the resident had been up all night. She was going in and out of other resident's rooms, taking other residents' items. The resident had been confused and asked for a family member. The resident was not easily redirected and crawled out of bed if she was laid down. A family member and the Social Service Director were notified. The nurse's note, dated 3/20/23 at 9:17 a.m., indicated the night shift staff reported that the resident was awake all night just like she had been all weekend. When staff took her to the bathroom in the morning, they found some items that the resident had taken a thermometer, eyeglass case with glasses, nail clippers and a fidget [NAME] all were hidden under the resident's shirt. The resident had then fallen asleep sitting in her wheelchair in the common area. The IDT (Interdisciplinary Team) behavior review note, dated 3/20/23 at 3:47 p.m., indicated the resident was not sleeping. The root cause of the behavioral expression was a BIMS (Brief Interview of Mental Status) score of 0, meaning the resident's cognition being severely impaired. The preventative intervention was for the psychiatrist, who was at the facility, to increase the melatonin, as this was all the family member allowed to be done at this time. The care plan was updated, and the current interventions were revised as applicable. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note, dated 3/26/23 at 3:51 a.m., indicated the resident was up throughout the night, screaming that the facility was on fire. The resident intrusively wandered, screaming about the facility being on fire, telling other residents to get out of bed. All interventions of one-on-one, food, snacks, and redirection, failed. The physician's order, dated 4/6/23, indicated staff were to administer 10 mg (milligrams) of melatonin at bedtime for the resident. The nurse's note, dated 4/12/23 at 9:53 a.m., indicated the night shift reported that the resident had been up since approximately 3:00 a.m. The resident had been wandering throughout the hallways and was trying to get out through the doors. Redirection continued with little to no effectiveness. The nurse's note, dated 4/18/23 at 5:47 p.m., indicated she spoke with the resident's family member about the psychiatric recommendation for the resident to start Zoloft. He did not want this to happen at this time. He said he had been monitoring the resident and would continue to do so and as long as the facility staff abided by the resident's and his wishes, she would be okay. He wanted to make sure that when the resident was in bed, that a light and her TV were left on because the resident did not do well in the dark and got scared. The Annual MDS (Minimum Data Set) assessment, dated 4/20/23, indicated the resident was severely cognitively impaired. The Social Service note, dated 4/21/23 at 11:56 a.m., indicated the psychiatric social worker was at the facility to visit the resident on 4/20/2023. No new orders were received. The Social Service note, dated 5/18/23 at 11:33 a.m., indicated the Psychiatric NP (Nurse Practitioner) was at the facility to visit the resident on 5/16/23. No new orders were received. The Social Service note, dated 6/23/23 at 3:00 p.m., indicated the Psychiatric Social Worker was at the facility to visit the resident on 6/22/23. No new orders were received. The nurse's note, dated 7/2/23 at 2:09 a.m., indicated the resident was rolling herself in her wheelchair, down the hallway, when she bumped into the housekeeping cart. The broom came down and hit the resident. The nurse came and heard the incident after the fact. The resident was mad and was yelling at the cart and rubbing her head and her arm. When she was asked if the broom hit her, she answered that it did. An assessment was performed with no abnormal findings. The Social Service note, dated 7/5/23 at 7:49 a.m., indicated the Psychiatric NP was at the facility to visit the resident on 6/29/23. The nurse's note, dated 7/12/23 at 1:52 p.m., indicated the resident had been up for the past two days. The resident was displaying manic behavior. The night shift reported that they called the family member to come sit with the resident at midnight due to the resident being continuously in and out of other resident's rooms and trying to get out the doors. The family member came in on this day and was requesting that lab work be done. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note, dated 7/19/23 at 6:33 a.m., indicated the resident had a physical altercation with another resident at 5:30 a.m. The CNA (Certified Nurse Aide) heard a noise coming from the resident's room and went to investigate. The CNA saw this resident slapping Resident 6 on the face. The CNA immediately separated this resident and redirected her to the nurse's station. Resident 6 had red marks on the right side of her face. No other injuries were observed. The on-call personnel were called and was informed of the situation. The State Incident report, dated 7/19/23, indicated that Resident 5 was observed making contact with Resident 6. The residents were immediately separated. The residents were both offered a room change. Psychiatric services were to be conducted upon the next visit. The residents were to be monitored for signs or symptoms of psychosocial distress. CNA 6, indicated she had gotten Resident 5 up to her wheelchair and went to the closet to get clothes for Resident 6. She turned around to see Resident 5 smack Resident 6 and say shut up. She immediately told QMA (Qualified Medication Aide) 5 about the incident. The IDT behavior review note, dated 7/20/23 at 10:42 a.m., indicated the resident hit her roommate, Resident 6, on the right cheek when her roommate was hollering out. The immediate intervention was to separate the resident from her roommate and Resident 5 was brought to the nurse's station. Resident 5's family member was contacted, and he took her for a drive. The root cause was that the roommate, Resident 6, was hollering out and potentially caused Resident 5 over stimulation. Resident 5's roommate was hollering out after staff got her up for the morning, and Resident 5 was possibly over stimulated. The preventative intervention was that the nurses gave Resident 6 routine morphine before staff got her up in the a.m. The room move was completed to separate the roommates. Resident 6's family members were to be called if the resident appeared agitated or over stimulated. Resident 5's family member indicated he would take her for a drive. The care plan was updated, and the current interventions were revised. The records lacked documentation of a care plan for aggressive behaviors toward staff or other residents. The nurse's note, dated 7/24/23 at 8:53 a.m., indicated there was no ill effects observed from the recent resident to resident altercation. There was also no increase in moods or behaviors. Nursing would continue to monitor the residents. The nurse's note dated 7/24/23 at 12:07 p.m., indicated the Psychiatric NP was at the facility to visit the resident on 7/20/23. No new orders were received. The Psychiatric note, dated 8/10/23, indicated the resident had symptoms of aggression during care, agitation and restlessness, anxiety, exit-seeking, delusions, functional decline, hallucinations, impulsivity, disinhibition, intrusiveness, irritability, non-adherence behaviors, paranoia, suspiciousness, ruminating thoughts, wandering, and yelling out. The psychiatrist indicated the resident would benefit from ongoing psychotherapy with behavioral health services. The Quarterly MDS assessment, dated 12/20/23, indicated the resident was severely cognitively impaired. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note, dated 1/23/24 at 10:02 p.m., indicated Resident 5 was observed to wheel herself over to Resident 2, who was sitting in her wheelchair next to the South Hall spa door. Resident 2 was drinking her coffee when Resident 5 used her right hand to slap Resident 2 across her left cheek. The residents were immediately separated, and Resident 5 was moved to safety and placed on one-on-one monitoring. The Director of Nursing was notified. The family of Resident 5 was notified and encouraged to call nursing management in the morning with further questions. The IDT behavior review note, dated 1/24/24 11:32 a.m., indicated the resident slapped another resident. The immediate intervention was to separate the residents. The root cause was environmental of over or under stimulation, the approach, positioning, or other resident behavior, the cognitive level of dementia staging, or BIMS assessment. The resident had a diagnosis of dementia with a BIMS score of 3 (severely cognitively impaired). The resident had episodes of being over stimulated. The root cause of behavioral expression was that the resident was up past her usual bedtime. The preventative intervention relating to the above root causes was for staff to attempt to put the resident to bed at 8:00 p.m. The care plan was updated with the current interventions. The care plan, dated 1/24/24 and last reviewed 3/15/24 at 1:54 p.m., indicated the resident had episodes of being aggressive with other residents. The interventions, dated 1/24/24, indicated to call the family member and ask him to visit with the resident, conduct a psychiatric consult, move the resident to a quiet environment, and offer to lay down the resident at 8:00 p.m. The Social Service's note, dated 1/30/24 at 11:41 a.m., indicated the Psychiatric NP visited the resident. The records lacked documentation of provision or attendance to activities of interest to prevent the resident from harming other residents or intrusive behaviors. During an observation of the resident on 3/21/24 at 8:16 a.m., she was sitting in her wheelchair near the nurse's station with her head leaning over and she was asleep. She had a blanket over her upper body. No music was playing. Staff were not in the area. During an observation on 3/21/24 at 9:45 a.m., the activity room was empty. The resident was asleep in bed. The TV was not on and music was not playing in her room. During an observation on 3/21/24 at 11:30 a.m., an exercise activity was going on in the Main Dining Room. There were 10 residents present. The resident was still in her room asleep and was not present for exercises. Her TV was not on and music was not playing in her room. During an observation on 3/21/24 at 1:51 p.m., the activity room had the TV on with one resident sitting on the couch. The resident was asleep in her wheelchair in the nurse's station area. No music was playing. Staff were not in the area. During an observation on 3/22/24 at 8:46 a.m., the resident was asleep in bed. The TV was not on and no music was playing. The activity room had 2 male residents in the room. One was asleep on the sofa and the other was working with a puzzle at the table. There were 5 residents sitting around the nurse's station in their wheelchairs. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/22/24 at 9:09 a.m., RN 7 indicated it depended on the day as to whether the resident would participate in an activity. She liked to toss balloons on her own terms. The resident napped all day and night. The resident's family would take her out to eat at a local restaurant often. The family member refused to let the facility give the resident any psychotropic medications, other than melatonin. The resident would just flip out sometimes or if another resident bumped her wheelchair. A full body mechanical lift was used to get the resident up from bed. The resident would refuse to get up in the mornings sometimes and the family would come in and ask why she wasn't up. There were times when the resident would be up all night and was manic. On July 12, 2023, the resident had an altercation with another resident. It was at 5:30 p.m. The resident had been up all night for 2 nights and the family member had to come in to sit with the resident. The DON (Director of Nursing) indicated the resident slapped was Resident 6. During the altercation, Resident, 5 had just been placed into her chair. The CNA turned to obtain clothes for Resident 6. Resident 5 slapped her roommate, Resident 6 on the face and told her to shut up. The residents were separated by taking Resident 5 out of the room. An assessment was completed. The DON indicated the incident was reported due to the red marks on Resident 6's face. She indicated the other altercation occurred on January 23, 2023. The DON indicated this incident was not reported due to Resident 2 not having any red marks or injuries. The RN indicated Resident 2 was sitting in her wheelchair next to the South Hall spa door, drinking her coffee, when Resident 5 was observed wheeling herself over to Resident 2. Resident 5 used her right hand to slap Resident 2 across her left cheek. A small red spot was observed to the upper left cheek bone on Resident 2. No bruising was observed. The residents were immediately separated, and Resident 2 was moved to safety. When the resident was wandering, she was looking for a bed to lay in. She would forget where her room was. She had a wanderguard on her right wrist and was compliant with wearing it. During an interview on 3/22/24 at 10:58 a.m., the Social Service Director indicated the resident was not interviewable, but could answer some questions. She couldn't remember her family member's name. She had talked with the family member to follow up after the altercation, but he only wanted melatonin used for the resident. He only wanted herbal or homeopathic alternatives. He refused to let her receive Remeron for an appetite stimulant, because he read about the side effects. The resident was seen by the psychiatrist, and they would evaluate her. If she was up and about, they offered her food. She liked music, so they would play it for her. It wasn't every day that they did that. The other residents were protected from her by the staff watching her. They tried to get her involved in activities. The family would be called if behaviors occurred. She didn't know if anyone had talked to the resident's family about how that didn't help other residents if an occurrence had already occurred, such as her slapping another resident. The Behavior Management policy, revised August 2022, included, but was not limited to, . Interventions provided are both individualized and non-pharmacological and part of a supportive physical and psychosocial environment that is directed toward preventing, relieving and/or accommodating the resident's behavioral expressions . 1. Care plans should be initiated for any behavioral expression that is problematic or distressing to the resident, other resident or caregivers. Care plan interventions should include individualized and nonpharmacological interventions which address both proactive and responsive interventions . 3.1-37(a)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 35732 Based on record review and interview, the facility failed to ensure Social Services followed up on residents that exhibited mood and behavior issues, and failure to consult with family members related to behaviors for 4 of 6 residents reviewed for Social Services. (Residents 8, 33, and 54) Findings include, 1. The record for Resident 8 was reviewed on 3/18/24 at 2:10 p.m. The diagnoses included, but were not limited to, vascular dementia with mood disturbance, disorder of adult personality and behavior, and seizures. The Quarterly MDS (Minimal Data Set) assessment, dated 2/13/24, indicated the resident was moderately cognitively impaired. The nurse's note, dated 6/20/23 at 9:13 a.m., indicated the resident told the nurse of his wife's passing. The resident was encouraged to talk about his concerns or feelings. The nurse was able to sit and talk with the resident. The nurse's note, dated 6/20/23 at 11:42 p.m., indicated the resident came back at the beginning of the shift. The resident was tearful at times due to his wife's passing. The resident wanted to go to bed early. The nurse's note, dated 6/26/23 at 9:00 a.m., indicated the resident was sitting at the nurse's station. He was quiet and did not speak very much. The resident was encouraged to express his thoughts and feelings. He thanked the nurse and stated he was just thinking. The nurse's note, dated 7/2/23 at 10:21 a.m., indicated the resident appeared to be more withdrawn. The nurse's note, dated 7/5/23 at 9:10 a.m., indicated the resident continued to be withdrawn. He was not as engaged as prior to his wife's passing. The nurse's note, dated 7/6/23 at 12:56 p.m., indicated the resident continued to be withdrawn from activities. He would eat his meals and then requested to lay down. The resident would get up when his family members were present, but he was not as social as before. The nurse's note, dated 7/7/23 at 10:58 a.m., indicated the resident continued to be withdrawn from activities and other residents. His appetite had been fair at best. The nurse's note, dated 7/9/23 at 9:23 p.m., indicated the resident was observed with increased lethargy, and requested to go to bed almost immediately after dinner. The nurse's note, dated 7/10/23 at 5:30 p.m., indicated the resident continued to be withdrawn from activities. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note, dated 8/31/23 at 6:44 p.m., indicated the resident continued to be withdrawn. He didn't want to get up for meals and refused breakfast and lunch today. He just wanted to stay in his room and lay down. The resident would sleep throughout the day. He did eat one half of a cheeseburger after lunch when offered. He was encouraged to get up and go to activities and meals, but the resident declined. The nurse's note, dated 9/8/23 at 1:45 p.m., indicated the resident continued to show increased signs and symptoms of depression and abnormal behaviors throughout the day. He refused to get out of bed for breakfast and to eat. His appetite was poor. The nurse's note, dated 9/11/23 at 4:42 p.m., indicated the resident continued to be withdrawn and uninvolved in activities, meals or socialization. The resident preferred to stay in bed most of the time when not eating. The Psychiatric notes, dated 8/24/23, indicated the resident had increased depressive symptoms and mood disturbance which may be a symptom of the dementia progression. Orders were placed to start Zoloft 25 mg (milligrams) daily. Psychiatric services would follow up and titrate as needed to address the behavioral and psychological symptoms associated with dementia. The physician orders were placed to start galantamine 4 mg twice daily. The facility staff were to monitor the residents verbal and non-verbal cues, communicate primarily by entering patient's reality, re-orient and re-direct as appropriate, and report acute behavioral disturbances to the provider. The clinical record lacked documentation indicating the facility's Social Services's reassessed the resident for signs and symptoms of/or increased depression or follow up with the resident. 15251 2. The record for Resident 33 was reviewed on 3/22/24 at 9:10 a.m. The diagnoses included, but were not limited to, unspecified dementia, unspecified severity, with other behavioral disturbance, unspecified depression and recurrent major depressive disorder. The Significant Change MDS assessment, dated 2/20/24, indicated the resident was alert and oriented, had occasional little interest in doing things with trouble concentrating, frequently felt down and depressed, had trouble with sleep and felt tired, and a poor appetite with weight loss. The care plan, dated 10/28/19 and last reviewed on 3/2/24, indicated the resident exhibited sexual inappropriate comments towards other female staff. The interventions included, but were not limited to, staff will leave conversation when resident was being inappropriate, education provided and will have psychiatric follow up with resident, educate resident on the inappropriateness of behavior and offer distraction. The care plan, dated 12/1/21 and last reviewed on 3/2/24, indicated the resident had a history of using foul and vulgar language. The interventions included, but were not limited to, educate resident on other people's preference on not hearing foul language and encourage resident to not use foul language. The care plan, dated 1/11/22 and last reviewed on 3/2/24, indicated the resident had a history of refusing care. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note, dated 9/2/23 at 6:10 p.m., indicated that due to the resident being in bed all shift, his clothing was visibly soiled and smelled of urine. When asked by nursing if they may assist him in changing, he told them it was none of their concern and not to worry about his clothes. Education was provided by nursing. The nurse's note, dated 9/18/23 at 11:14 a.m., indicated that while a CNA was assisting another resident in the bathroom, Resident 33 continued to verbalize inappropriate comments about that resident's genitalia and the CNA. He proceeded to laugh when the CNA told him his comments were inappropriate. The nurse's note, dated 9/25/23 at 6:12 p.m., indicated the resident was making obscene gestures at the QMA and told her he was going to grab her a*s. He was also sticking his tongue out and waved it at her. Although the resident was told that his talk and gestures were inappropriate, he did not stop them. The Behavior Communication note, dated 10/28/23 at 11:03 p.m., indicated that at 10:15 p.m. when the resident asked the QMA for some cookies, she informed him there were only graham crackers. The resident then replied he wanted to get his cookies off with her. The QMA informed him this remark was inappropriate. The Behavior Communication note, dated 10/29/23 at 1:15 a.m., indicated that on 10/28/23 at 10:20 p.m., the resident had confrontational behavior with staff when he was given directions. The interventions by nursing were ineffective and his behavior worsened. The nurse's note, dated 12/4/23 at 7:10 a.m., indicated the night shift QMA reported that when she went into resident's room to give his medication to him, he pointed at his penis and asked her if she wanted to play with it? The QMA informed the resident that was inappropriate to talk to staff that way and he knew it. The nurse's note, dated 12/9/23 at 5:03 a.m., indicated the resident was observed to have refused dinner the past few nights, had not eaten his own personal food and indicated he wasn't hungry. The resident had also refused insulin each night. He was observed with increased incontinence during the night and had refused to get up and allow staff to assist him with cleaning up. The resident had not been interacting with staff and other residents in normal ways of talking and joking mannerisms. He was also observed to remain in bed for primarily throughout the shift. The NP (Nurse Practitioner) was updated on his status. The nurse's note, dated 1/10/24 at 11:50 p.m., indicated the resident refused to let staff make his bed this night. He indicated that his bed was airing out, but then he would not let staff make the bed when asked several times. The resident then put himself to bed without sheets on it. The staff attempted to get the resident up, but the resident refused. The resident continued to be incontinent at night as well and refused most times to be checked and changed when asked. The resident had become increasingly more incontinent and required more of staff assistance throughout the day and throughout the night. The resident continued to deny the need for staff assistance. The nurse's note, dated 1/11/24 at 10:46 p.m., indicated the resident had refused medications this night. He did not eat dinner and his blood sugar was low prior to dinner. The resident refused to eat a snack or let this nurse check his blood sugar and insulin was withheld. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note, dated 1/15/24 at 1:06 p.m., indicated the resident continued to refuse to wear his tubi grip (to help with leg swelling) so far on this day. Although he was educated, he continued to not wear them. The resident was in bed at this time and refused to get up for breakfast or lunch. The nurse's note, dated 1/15/24 at 8:59 p.m., indicated the resident was observed to be laying in bed which was saturated in urine. The resident was repeatedly asked by multiple different staff members to allow them to assist him with incontinent care, but he would only yell at staff to leave him alone and to get out of the room. The nurse's note, dated 1/20/24 at 3:47 p.m., indicated the resident refused to get out bed to take his medications this shift. Despite education being given, it had no effect. The nurse had re-attempted multiple times this shift, but he was currently still laying in his soiled bed. Staff had attempted to change the linens and assist the resident out of bed to change him into clean clothes, but it had no effect. The nurse's note, dated 2/4/24 at 12:21 p.m., indicated the resident had continued to refuse neurological checks after he fell out of bed earlier. The resident was also laying in bed covered in urine and refused to allow staff to assist. Multiple staff members had attempted to help the resident with no effect. The nurse's note, dated 2/15/24 at 1:07 p.m., indicated the resident refused to get out of his urine soaked bed. Multiple staff members had tried to get him out of bed with no success and were unable to change the resident's wet bed. The nurse's note, dated 2/28/24 at 2:09 p.m., indicated the resident had been non-compliant with the staff in allowing them to change his bedding. The nurse's note, dated 2/22/24 at 12:34 p.m., indicated the resident spent most of the morning laying in his wet soiled bed and refused to get up or be changed. Multiple staff attempted to get the resident out of his soiled bed but were unsuccessful. When staff told the resident that he was making the hallway stink, he told them to go outside or spray something. The resident would laugh at the staff when they encouraged him to get cleaned up. The nurse's note, dated 3/6/24 at 1:13 p.m., indicated the resident continued to remain in bed at this time with several attempts from staff to get him up and get dry clothes on to change his bedding. The nurse's note, dated 3/12/24 at 10:47 a.m., indicated the resident was in bed at that time and refused to get up and change into clean clothes. He stated he doesn't have to get up if he didn't want to. The nurse's note, dated 3/16/24 at 11:18 a.m., indicated the resident remained in bed with a soiled brief and clothes. The nurse had encouraged the resident multiple times to assist him to get out of bed and change with no effect. Documentation was lacking of the Social Service Director having visited the resident after the behaviors and refusals of care. There was only documentation by the IDT (Interdisciplinary Team) having met to discuss the resident. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The record for Resident 54 was reviewed on 3/20/24 at 8:37 a.m. The diagnoses included, but were not limited to, anxiety disorder, depression, chronic post-traumatic stress disorder (PTSD) and bipolar disorder, current episode depressed, mild. The Quarterly MDS assessment, dated 3/4/24, indicated the resident was alert and oriented, had frequent little interest in doing things, felt down and depressed, had trouble with sleep and appetite issues. The care plan, dated 12/4/23 and last reviewed on 3/15/24, indicated the resident had manic episodes related to her bipolar disorder. The goal was to have no manic episodes. The interventions included, but were not limited to, medication adjustments by psychiatric services, one on one conversations with resident to allow her to voice her feelings, and to redirect her to activities. The care plan, dated 3/8/24 and last reviewed on 3/15/24, indicated the resident had experienced trauma and experienced PTSD due to a family member being abusive. The resident experienced the following expressions in response to trauma: (flashbacks, nightmares and severe anxiety, uncontrollable thoughts about the event.) No triggers were identified by the resident. The resident was also at risk for experiencing re-traumatization, feeling unsafe/untrusting, and or distressed. The goal was to eliminate or mitigate (reduce) triggers that might cause re-traumatization. The approaches included, but were not limited to, allow the resident to talk about her past if she chose to and give comfort and reassurance, Behavioral Health Services, ensure the resident had a sense of environmental and physical safety, establish and encourage open communication between resident and staff, new or worsening behaviors will be assessed to identify additional potential triggers and the need for additional support and behavioral health services, and resident specific approaches. The nurse note, dated 12/3/23 at 6:53 p.m., indicated the resident continued with manic and mania rambling talk without stopping throughout the day. She was also observed to have insomnia for the last couple days. The resident indicated they had tried to put her on seroquel at one point and time for her periods of highs and lows but she didn't want to do that. The resident was observed to be pacing at times. The nurse's note, dated 12/4/23 at 5:48 a.m., indicated the resident was again up throughout the night sitting up at the nurse's station talking with staff for the entirety of the shift non-stop. The IDT Behavior Review note, dated 12/4/23 at 11:36 a.m., indicated the resident continued with manic and mania rambling, talking without stopping throughout the day and had insomnia the last couple days. The resident was also pacing at times. The immediate intervention was to allow the resident to voice her feelings. The root cause of the behavioral expression was thought to be isolation and acute illness due to COVID-19. The nurse's note, dated 12/5/23 at 1:45 p.m., indicated the resident had diagnoses of bipolar, anxiety, and PTSD, and was expressing signs and symptoms of mania. She did sleep the prior night, but was up early, dressed, and ready for the day. The resident was very talkative, pacing back and forth in the hallway and going to each person in the hallway and talking to them. Although the resident was pleasant, her behavior was abnormal. She presented with shaking hands and voiced to this nurse that she knew she was up and down right now. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note, dated 12/6/23 at 3:28 p.m., indicated the resident has had mood swings throughout the shift. She indicated that the CNAs and residents were talking bad behind her back and that the CNAs were texting other residents about how she used to do drugs. The resident got up out of bed at 2:00 a.m. and stayed next to nurse station until 3:30 a.m. The IDT Behavior Review note, dated 12/7/23 at 10:27 a.m., indicated the resident was talking a lot and pacing. The immediate intervention was for staff to listen to the resident. The root cause of the behavioral expression was determined to be that the resident was in a manic phase of disorder as the resident indicated she did this from time to time. The nurse's note, dated 12/28/23 at 5:58 p.m., indicated the resident's mania was somewhat better this day, but was still rambling and had thoughts of people talking about her. The nurse's note, dated 2/24/24 at 10:19 p.m., indicated the resident was observed to be up and ambulating throughout north hall common area this evening. She indicated she was upset and unhappy with her roommate and stated F*** her, I don't care what she says. Staff were uncertain as to why the resident was upset and what she was referring to. The resident was unable to explain why she was upset. The IDT Behavior Review note, dated 2/27/24 at 11:37 a.m., indicated the resident had increased manic mood and behavior. The immediate intervention was to allow the resident to voice feelings and validate. The root cause of the behavioral expression was thought to be a manic episode. The nurse's note, dated 3/1/24 at 10:06 p.m., indicated that when the CNA entered the room to take in new water cups to the resident and her roommate, the resident stated Don't just stand there, if you have something to say, just come on over here and say it. When the CNA asked the resident what she was talking about, the resident indicated she thought the CNA was her roommate. The roommate was observed in bed with her eyes closed. Documentation was lacking of the Social Worker having visited the resident after the behaviors. There was only documentation by the IDT (Interdisciplinary Team) having met to discuss the resident. During an interview with the Social Services Director on 3/22/24 at 10:20 a.m., she indicated that she was not the only one who should have been documenting on the residents as the other disciplines were just as responsible. She indicated she talked to multiple residents everyday and always followed up with them after the IDT meetings on behaviors. She also indicated she did not always chart the visit. During this meeting with the Social Services Director, the DON (Director of Nursing) also indicated only new behaviors were usually documented on. If the behavior was not new, it probably would not be charted on. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Social Services Director Job Description included, but was not limited to, SUMMARY OF POSITION FUNCTIONS: The Social Services Director provides medically-related social services to attain or maintain the highest practicable, physical, mental, and psychosocial well-being of each resident; and shares a responsibility toward creating and sustaining an environment that humanizes and individualizes each resident's living area. ESSENTIAL POSITION FUNCTIONS: Assesses each resident's psychosocial needs and develops a plan for providing care. Reviews resident's needs and care plan with progress notes indicating implementation of methods to respond to identified needs .Mediates and must be able to deal tactfully and professionally with issues that arise among residents and their families and/or assigned ombudsman .Establishes a positive and socially therapeutic environment through staff training and input on policies and procedures. Collaborates with other departments, physicians, consultants, community agencies, and institutions to improve quality of services and to resolve identified problems . 3.1-34(a)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 40240 Based on observation, record review, and interview, the facility failed to ensure accurate documentation of controlled substances on the controlled drug record sheet for 2 of 27 residents reviewed for narcotic storage. (Residents 2 and 28) Findings include: 1. During an observation of the South Short Hall Medication Cart on 3/18/24 at 10:17 a.m., with QMA (Qualified Medication Aide) 3 Resident 2's acetaminophen-codeine number (#)4 medication card contained only 20 tablets of the medication. Resident 2's clonazepam 0.5 mg (milligrams) medication card contained only 22 tablets of the medication. The controlled drug storage record sheet indicated there should be 21 doses of the acetaminophen-codeine #4 and 23 tablets of the clonazepam 0.5 mg remaining. The last doses signed out on the controlled drug storage record sheet were on 3/17/24 at 5:00 p.m. The record for Resident 2 was reviewed on 3/18/24 at 10:20 a.m. The diagnoses included, but were not limited to, generalized anxiety disorder and muscle spasm. The physician's order, dated 11/19/20, indicated the resident received acetaminophen-codeine #4 three times daily for chronic pain. During an interview on 3/18/24 at 10:20 a.m., QMA 3 indicated she had given the medications to the resident that morning and had not signed them out. She did not have a reason why she had not signed it out. She tried to make sure she signed them out when she gave them. She had administered the medications to the resident on 3/18/24 at approximately 8:00 a.m. 2. During an observation of medication administration for Resident 28 on 3/18/24 at 10:32 a.m., QMA 4 indicated she was preparing medications for Resident 28. She obtained one tablet of Ativan 0.5 mg from the narcotic drawer and placed it into a medication cup. She did not have the Resident's MAR (Medication Administration Record) pulled up on her computer. She did not refer to the MAR during any point of the administration observation. She indicated the Resident's MAR would not show any medications as being due to administer. She crushed the medication and placed it into a medication cup before taking it to the resident's room. QMA 4 administered the medication to the resident on 3/18/24 at 10:46 a.m. The record for Resident 28 was reviewed on 3/18/24 at 1:30 p.m. The diagnosis included, but was not limited to, anxiety disorder. The physician's order, dated 3/9/23, indicated the resident received Ativan 0.5 mg three times daily for anxiety at 8:00 a.m., 2:00 p.m., and 8:00 p.m. The controlled substances record sheet indicated the QMA documented the medication as being administered on 3/18/24 at 8:00 a.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/18/24 at 1:59 p.m., QMA 4 indicated the resident's medications had not been showing up on the MAR because she had clicked them off earlier as administered. She had pulled the medications that morning and the resident would not wake up, so she had to dispose of them. She had already documented them as administered earlier. She needed to go back in and amend them. She had tried to wake her up and she was not having it. The resident's Ativan was supposed to be given at 8:00 a.m. She was about to get another Ativan at 2:00 p.m. During an interview on 3/20/24 at 8:16 a.m., the DON (Director of Nursing) indicated with specific timed medications, they had an hour before and an hour after the timed dose to administer them. If it could not be administered in that time frame, they would try again later. If they didn't wake up or they would refuse, staff would attempt again later. With the narcotic, they would probably waste it then. She would expect staff to document medication as administered after the medication was administered. She would expect the nurse to document the time of the narcotic after the medication was administered. She would expect them to document the actual time of the medication administration. The most current Controlled Substances policy, included, but was not limited to, . The staff at the Community must also maintain strict records of the controlled substances stored in the Community as well as the dose given to the resident . When a controlled substance is administered to a resident, it must be recorded on the resident's Medication Sheet as well as a separate Controlled Substance/Schedule II Narcotic Sheet that is created for each prescription . 3.1-25(b)(3)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 40240 Based on observation, record review, and interview, the facility failed to ensure medication errors less than 5% for 3 of 30 medication observations of medication administration. (Resident 28) Findings include: During an observation of medication administration for Resident 28 on 3/18/24 at 10:32 a.m., QMA (Qualified Medication Aide) 4 indicated she was preparing medications for Resident 28. She obtained one tablet of Ativan 0.5 mg (milligram) from the narcotic drawer and placed it into a medication cup. She then obtained two tablets of potassium 10 meq (milliequivalent) and 1 tablet of levothyroxine 150 mcg (micrograms) from the medication cart and dispensed them into the same cup. She did not have the Resident's MAR (Medication Administration Record) pulled up on her computer. She then pulled up a copy of the resident's physicians order, and prepared the rest of the resident's morning medications, which included coreg 6.25 mg, clopidogrel 75 mg, gingko biloba, hydrochlorothiazide (HCTZ) 12.5 mg, imdur 20 mg three one half tablets to equal 30 mg, lisinopril 10 mg, Namenda 10 mg, famotidine 40 mg tablet, sertraline 100 mg, and sertraline 25 mg. She did not refer to the MAR for any of the administration observation. She indicated the Resident's MAR would not show any medications as being due to administer. She crushed the medications and placed them in individual medication cups before taking them to the resident's room. QMA 4 administered the medications to the resident on 3/18/24 at 10:46 a.m. The record for Resident 28 was reviewed on 3/18/24 at 1:30 p.m. The diagnoses included, but were not limited to, dementia, hypokalemia, depressive episodes, osteoarthritis, muscle weakness,, GERD (gastroesophageal reflux disease), hypothyroidism, HTN (hypertension), insomnia, major depressive disorder, hyperlipidemia, heart disease, and dysphagia. The physician's orders indicated the following: -Ativan 0.5 mg give 0.25 mg three times daily for anxiety, which started on 3/9/23. The medication was scheduled in the mornings for 8:00 a.m., with the next dose due at 2:00 p.m. - Levothyroxine 175 mcg once daily at 7:00 a.m., which started on 3/12/24. - Famotidine 40 mg twice daily, which started on 11/12/24. The morning dose was scheduled to be given at 7:00 a.m. During an interview on 3/18/24 at 1:59 p.m., QMA 4 indicated the resident's medications had not been showing up on the MAR because she had clicked them off earlier as administered. She had pulled the medications that morning and the resident would not wake up, so she had to dispose of them. She had already documented them as administered earlier. She needed to go back in and amend them. She had tried to wake her up and she was not having it. The resident's Synthroid and famotidine were due at 7:00 a.m., and the Ativan was supposed to be given at 8:00 a.m. She was about to get another Ativan at 2:00 p.m. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/20/24 at 8:16 a.m., the DON (Director of Nursing) indicated with specific timed medications, they had an hour before and an hour after the timed dose to administer them. If it could not be administered in that time frame, they would try again later. If they didn't wake up or they would refuse, staff would attempt again later. With the narcotic, they would probably waste it then. She would expect staff to document medication as administered after the medication was administered. She would expect the nurse to document the time of the narcotic after the medication was administered. She would expect them to document the actual time of the medication administration. During an interview on 3/20/24 at 10:50 a.m., the RDCO (Regional Director of Clinical Operations) indicated they could not obtain a report to show the exact time of administration documentation on the MAR. The most current Medication Administration Procedure included, but was not limited to, . Medications administered within 60 minutes before and/or after time ordered . 12. Refusal of medication document as appropriate . 19. Medication administration will be recorded on the MAR/EMAR or TAR after given . 33. Administration and inventory of controlled substances were documented according to facility policy . 3.1-48(c)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40240 Based on observation, record review, and interview, the facility failed to ensure appropriate labeling and storage of medications for 3 of 27 residents reviewed for Medication Storage. (Residents 33, 61, and 273) Findings include: 1. During an observation of the South Short Hall Medication Cart on [DATE] at 10:17 a.m., with QMA (Qualified Medication Aide) 3, there was a bottle of lispro, dated [DATE], with Resident 33's first and last name written on it in black marker. The bottle was open and approximately three-quarters full. There was also a Fiasp insulin pen for Resident 33, dated [DATE]. The record for Resident 33 was reviewed on [DATE] at 1:00 p.m. The diagnosis included, but was not limited to, type 2 diabetes mellitus. The physician's order, dated [DATE], indicated the resident received Fiasp FlexTouch U-100 insulin pen per sliding scale four times daily. The order was discontinued on [DATE]. The physician's order, dated [DATE], indicated the resident received insulin lispro U-100 per sliding scale four times daily. The order was discontinued on [DATE]. During an observation on [DATE] at 11:10 a.m. of the South Short Hall with QMA 4, Resident 33's Fiasp and insulin Lispro vial remained in the top drawer of the medication cart. During an interview on [DATE] at 11:11 a.m., QMA 4 indicated Resident 33 did not have current orders for either Fiasp or insulin lispro. The insulins should have been removed when the orders were discontinued. The insulins were only good for 28 days, and they were beyond that. 2. During an observation of the South Short Hall medication cart on [DATE] at 10:17 a.m., the following concerns were observed: a. Resident 61's Breyna (budesonide-formoterol) ,d+[DATE].5 mcg/act (micrograms per actuation) inhaler and his albuterol sulfate 90 mcg/act inhalers were both in the bottom right hand drawer of the medication cart. They were both stored lying on their side. The record for Resident 61 was reviewed on [DATE] at 1:00 p.m. The diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), allergic rhinitis, and asthma. The physician's order, dated [DATE], indicated the resident received budesonide-formoterol ,d+[DATE].5, two puffs twice daily. The Breyna Package Insert Storage instructions indicated to store the medication with the mouthpiece down. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Resident 273's albuterol 90 mcg/act inhaler was lying on its side in the bottom right hand drawer. The medication was opened with 240 doses remaining. The instructions on the side of the package indicated to store the inhaler with the mouthpiece down. The record for Resident 273 was reviewed on [DATE] at 1:05 p.m. The diagnosis included, but was not limited to, single pulmonary nodule. The physician's order, dated [DATE], indicated the resident received albuterol sulfate 90 mcg/act, 2 puffs four times daily as needed. During an interview on [DATE] at 8:16 a.m., the DON (Director of Nursing) indicated the insulins were good for 30 days. She was aware of the policy for some inhalers to be stored upright but wasn't sure which ones. The most current Medication Storage Guidelines included, but were not limited to, . Breyna Inhalation Aerosol (budesonide/formoterol) . store . with the mouthpiece down . Ventolin HFA (High Flow Actuation) Inhalation Aerosol . store the inhaler with the mouthpiece down . Storage Recommendations for Injectable Diabetes Medications . Fiasp . Opened . 28 days . Insulin Lispro . Opened . 28 days . Properly handle and dispose of any expired or unused product in accordance with facility policy or local, state, and federal regulations . 3XXX,d+[DATE](j)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. 35732 Based on record review and interview, the facility failed to promptly obtain dental services for 1 of 2 residents reviewed for dental services. (Resident 23) Findings include, The record for Resident 23 was reviewed on 3/19/24 at 10:34 a.m. The diagnoses included, but were not limited to, functional dyspepsia, constipation, muscle weakness, chronic vascular disorders of the intestine, nausea, and vomiting. The Admission MDS (Minimal Data Set) assessment, dated 2/6/24, indicated the resident was moderately cognitively impaired. The care plan, dated 3/4/24, indicated the resident had some of his natural teeth lost. He did not have dentures or a partial plate. The interventions included, but were not limited to, obtaining dental consult as indicated, and observing chewing or eating difficulties at meals. The nurse's note, dated 7/29/23 at 9:50 a.m., indicated the resident continued to complain of oral pain due to the loss of a filling. Slight redness was observed on the gum. Resident 23 stated, it makes it difficult to chew Staff would continue to monitor the resident. The nurse's note, dated 7/30/23 at 9:37 a.m., indicated the nurse examined the area where the tooth had appeared to have broken off. The sharp part of the tooth was exposed above the gum line. Resident 23 stated, that it's getting tender and hard to chew. The nurse would pass it on to set up a dental appointment. The nurse's note, dated 8/15/23 at 9:08 a.m., indicated the resident complained of discomfort from a broken tooth. No redness or swelling was observed. No signs and symptoms of distress were observed. Nursing would continue to monitor the resident. The nurse's note, dated 8/16/23 at 8:48 a.m., indicated the nurse asked the resident about a dental appointment. The resident stated, he didn't want one at this time. Staff would continue to monitor the resident. The NP (Nurse Practitioner) note, dated 8/25/23 at 5:50 p.m., indicated the resident had some broken teeth which caused him some soreness. Orajel was ordered for dental pain. The nurse's note, dated 8/27/23 at 9:35 a.m., indicated the resident continued to complain of tooth pain when eating. No redness or swelling of the gum was observed but could see where the tooth was broken off. The nurse's note, dated 8/28/23 at 3:52 p.m., indicated the resident denied any tooth pain or discomfort this day. This nurse reported to management that the resident needed a dental appointment to look at the resident's tooth. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155126	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs Valley Meadows	457 S Sr 145 French Lick, IN 47432

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note, dated 8/30/23 at 9:28 a.m., indicated the resident stated his tooth was kind of sensitive when he bit down on things. No redness was observed to the gums, but staff would continue to monitor the resident. The clinical record lacked documentation indicating a dental appointment was made or the family was contacted about making a dental appointment for the resident. During an interview on 3/20/24 at 11:00 a.m., the Social Service Director (SSD) indicated the resident declined the in-house dentist. He had an outside dentist to go to. Social Services or the scheduler could make the appointment for the resident. She would also let the family know if they wanted to make the appointment and take the resident. She indicated there was no information documented that the resident had an appointment to see the dentist, or the family was contacted. During an interview on 3/21/24 at 9:00 a.m., RN 8 indicated when a resident needed to see the dentist, he would inform the scheduler, or Social Services and they would make a dental appointment for the resident or call the family to see if they wanted to make the appointment. The facility's current policy titled Dental Services/Missing Dentures, included, but was not to limited to, The facility obtains needed dental services, including routine and emergency dental services; assist in providing these services and makes prompt referrals for dental services as needed . 3.1-24(a) 3.1-24(a)(1)(2)