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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155330 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/05/2024 |
| NAME OF PROVIDER OR SUPPLIER Salem Crossing | | STREET ADDRESS, CITY, STATE, ZIP CODE 200 Connie Ave Salem, IN 47167 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>34309</p> <p>Based on observation and interview, the facility failed to ensure staff provided the necessary care and services in a timely manner for 2 of 4 residents observed for Activities of Daily care. (Residents D and E)</p> <p>Findings include:</p> <p>1. During an observation on 5/30/24 at 9:40 a.m., Resident D's bed sheet had a 2-foot diameter area of urine with a brown ring around the edges that appeared wet. There were multiple brown dotted areas within the ring.</p> <p>During an observation on 5/30/24 at 10:00 a.m., Resident D's bed sheet still had a circular 2-foot diameter area of urine with a brown ring that appeared to be wet. There were multiple brown spots dotted within the ring.</p> <p>During an observation and interview on 5/30/24 at 12:47 p.m., Resident D indicated she changed her own brief and once weekly the bedding was changed by staff. The bedding still had a 2-foot diameter area with a brown ring around the edges. The area appeared drier.</p> <p>During an observation on 05/31/24 at 9:05 a.m., Resident D was lying in bed with a bedspread pulled up over her body. There was a strong smell of urine in her area of the room. The resident indicated she was not wet.</p> <p>During an observation on 5/31/24 at 9:07 a.m., the MDS (Minimum Data Set) Coordinator entered Resident D's room. The MDS Coordinator asked the resident if she wanted to be changed and dressed. The resident indicated she did not want to be dressed and pulled the bedspread up tighter to her body. The MDS Coordinator indicated the resident was supposed to receive assistance to be checked and changed. The MDS Coordinator left the room to get assistance from a CNA (Certified Nurse Aide).</p> <p>During an observation and interview on 5/31/24 at 9:15 a.m., CNA 4 joined the MDS Coordinator in Resident D's room to check and change the resident. The resident indicated she had already been dressed. The MDS Coordinator asked the resident if she could check her brief to see if it was wet. The brief and sheets were dry, but the odor of urine was still observed. The resident was wearing a night gown. CNA 4 indicated she checked and changed the resident every 2 hours. The last time she had checked Resident D was around 6:30 a.m. It was maybe a little longer than the 2 hours then. The resident was not a heavy wetter, but resident would have some days that were worse than others.</p> <p>(continued on next page)</p> |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The record for Resident D was reviewed on 6/3/24 at 2:09 p.m. The diagnoses included, but were not limited to, acute cystitis without hematuria, severe dementia with psychotic disturbance, delusions, hallucinations, functional urinary incontinence, unsteadiness on feet, abnormalities of gait and mobility, and muscle weakness.</p> <p>The care plan, dated 9/23/22, indicated the resident required assistance with toileting and incontinence care due to acute cystitis, dementia, and urinary incontinence. The interventions, dated 9/23/22, included but were not limited to, assess and document skin condition weekly and as needed, assist with incontinent care as needed, and check every 2 hours for incontinence.</p> <p>The Quarterly MDS assessment, dated 3/18/24, indicated the resident was severely cognitively impaired. She required supervision for toileting and hygiene and was frequently incontinent of bladder and bowel. The resident required limited assistance of one staff for transfer, bed mobility, and walking in her room.</p> <p>The nurse's note, dated 3/21/24 at 5:38 p.m., indicated the resident was alert and oriented to self and room environment. The resident was incontinent and continent at times. Staff were to check and change the resident every 2 hours and PRN (as needed), with perineal care completed at this time also. Provide one person assistance with the use of a gait belt for the resident.</p> <p>During an interview on 6/4/24 at 9:30 am., NA (Nurse Aide) 5 indicated she provided perineal care, feeding, bathing, and interactions with residents when she was rounding. She rounded every 2 hours. A heavy wetter would be checked hourly. When a resident took diuretics, staff would check the resident every 30 minutes. Resident D would be checked, and the NA would ask the resident for permission to provide one person assistance to the bathroom. Staff typically wouldn't let the resident go by herself, due to her falls. The resident's bedding was changed at shower time, if it was dirty or if a resident was a heavy wetter. If she smelled the odor of urine on the resident, she would make sure the resident didn't have a wet bed, and if not, she would let the nurse know because the resident most likely had a UTI (urinary tract infection).</p> <p>During an interview on 6/4/24 at 11:09 a.m., CNA 6 indicated when she entered the building for her shift, she would do walking rounds with the outgoing CNA from the night shift. The walking rounds consisted of checking the residents to see if they were wet and doing bed checks. She would then check the residents' briefs every 2 hours. If she observed an odor of urine in a resident room, she would check the resident's brief to see if they were wet. If they were, she would change them. If they weren't wet, she would check back later and leave them be.</p> <p>During an interview on 6/4/24 at 1:15 p.m., CNA 7 indicated she had on occasion found the draw sheets to be wet on heavy wetting residents' beds when she entered for her shift. She would check the residents every 2 hours for the need to change their briefs.</p> <p>During an interview on 6/4/24 at 1:16 p.m., CNA 8 indicated when she entered the building for the start of her shift, she would get a report from the night shift CNA. She would start with bed checks and change the residents if they needed it.</p> <p>35732</p> <p>(continued on next page)</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>2. During an observation, on 5/30/24 at 12:10 p.m., Resident E was laying in her bed. The CNA took her lunch tray to her and explained to the resident her lunch was ready. The resident was in a wet brief and her bed was wet with urine. The resident's top sheet was wet, and the resident was uncovered. The CNA did not check the resident for bladder incontinence, and she did not cover the resident up. The CNA rolled up the head of the resident's bed and sat her lunch tray in front of her. She proceeded to pass the other residents' trays without providing incontinent care.</p> <p>The record for Resident E was reviewed on 6/5/24 at 10:24 a.m. The resident's diagnoses included, but were not limited to, weakness, kidney failure, arthritis and dementia.</p> <p>The Quarterly MDS (Minimum Data Set) assessment, dated 2/29/24, indicated the resident's cognition was severely impaired. The resident required substantial or maximal staff assistance with her ADL's (activities of daily living).</p> <p>The care plan, dated 5/31/24, indicated Resident E needed assistance with her ADLs including bed mobility, transfers, eating and toilet use. The interventions included, but were not limited to, the resident would participate in ADLs to her maximum potential, a touchpad call light, the resident attempted to self transfer without staff assistance, a Hoyer lift with the assistance of 2 staff for transfers to a wheelchair, assistance with toileting and/or incontinent care as needed. The resident was on a toileting plan program.</p> <p>The nurses note, dated 9/25/23 at 10:14 p.m., indicated the resident was alert to self with staff to anticipate the resident's needs. The resident was incontinent of bowel and bladder and staff were to provide perineal care after each episode.</p> <p>The IDT (Interdisciplinary Team) note, dated 5/30/24 at 12:10 p.m., indicated the resident currently had an intervention to be up in her wheelchair for lunch, however the resident preferred to stay in bed at times for lunch.</p> <p>During an interview on 6/4/24 at 9:50 a.m., CNA 9 indicated the residents were checked and changed every 2 hours. If a resident was incontinent when she took a tray in, she would stop and provide incontinent care before she gave the resident their food tray.</p> <p>The most current Certified Nursing Assistant (CNA) position description, included, but was not limited to, . Provides direct care to residents to improve maintain the resident's abilities according to the resident's plan of care. Assist in activities of daily living including bathing, grooming, dressing, mobility, transferring and feeding of assigned residents by providing set-up assistance, verbal prompts, physical support, or more extensive assistance as more fully described below . Elimination/toileting - Promptly assist resident to bathroom according to toileting schedule or promptly brings clean bedpan or urinal. Opens, removes clothing in preparation, cleans a resident if resident is unable to clean self, adjusts clothing, cleans resident's and own hands. Measures and records output as directed by Unit Charge Nurse and plan of care. Provide catheter care according to facility procedures and infection control policies .</p> <p>This citation relates to Complaint IN00434385.</p> <p>3.1-38(a)(3)</p> | | |

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| <p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>35732</p> <p>Based on record review and interview, the facility failed to schedule 8-hour consecutive RN coverage for 4 of 4 months reviewed. (March, April, May, and June, 2024). This had the potential to affect all 84 residents currently residing in the facility.</p> <p>Findings include:</p> <p>The review of the March to June 2024 licensed nursing schedule indicated the following days were short of 8 consecutive hours in a 24 hour day of RN coverage:</p> <p>March</p> <ul style="list-style-type: none"> - On March 9 no RN coverage for 6a to 6p and 6p to 6a - On March 24 no RN coverage for 6a to 6p and 6p to 6a - On March 31 no RN coverage for 6a to 6p and only 6 hours of RN coverage for 6p to 6a <p>April</p> <ul style="list-style-type: none"> - On April 27 no RN coverage for 6a to 6p and only 6 hours of RN coverage for 6p to 6a - On April 28 no RN coverage for 6a to 6p and only 6 hours of RN coverage for 6p to 6a <p>May</p> <ul style="list-style-type: none"> - On May 12 no RN coverage for 6a to 6p and only 6 hours of RN coverage for 6p to 6a - On May 18 no RN coverage for 6a to 6p and only 6 hours of RN coverage for 6p to 6a - On May 25 no RN coverage for 6a to 6p and only 6 hours of RN coverage for 6p to 6a <p>June</p> <ul style="list-style-type: none"> - On June 1 no RN coverage for 6a to 6p and 6 hours of RN coverage for 6p to 6a - On June 2 no RN coverage for 6a to 6p and 6 hours of RN coverage for 6p to 6a <p>During an interview on 6/4/24 at 9:15 a.m., the Scheduler indicated she agreed there were some days that did not have RN consecutive coverage.</p> <p>During an interview on 6/5/24 at 8:30 a.m., the ED (Executive Director) indicated she thought she had 8 hours of consecutive RN coverage. She was unaware the coverage started at midnight and ended at midnight. The ED agreed the nursing schedule lacked RN coverage on some days.</p> <p>(continued on next page)</p> | | |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>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.</p> <p>34309</p> <p>Based on observation, record review, and interview, the facility failed to ensure appropriate pharmacy labeling for 4 of 13 insulin flexpens observed for medication storage. (Residents 19, 31, 85, and 42)</p> <p>Findings include:</p> <p>1. During an observation of one of the two 100 Hall medication carts on 6/4/24 at 9:55 a.m., Resident 19's lispro flexpen was in a bag marked with her name and the flexpen's open date. There was no pharmacy label. The medication room refrigerator was reviewed with no other lispro flexpens with pharmacy labels for Resident 19.</p> <p>The record for Resident 19 was reviewed on 6/4/24 at 11:00 a.m. The resident's diagnosis included, but was not limited to, type 2 diabetes mellitus with diabetic chronic kidney disease.</p> <p>The physician's order, dated 3/6/24, indicated staff were to administer the resident's lispro per sliding scale subcutaneously three times daily.</p> <p>The Quarterly MDS (Minimum Data Set) assessment, dated 4/24/24, indicated the resident was moderately cognitively impaired. The resident had received 1 injection of insulin during the previous 7 days prior to the assessment.</p> <p>2. During an observation of one of the two 300 Hall medication carts on 6/4/24 at 10:06 a.m., Resident 31's lispro was in a bag marked with her name and the flexpens' open date. There was no pharmacy label. The medication room refrigerator was reviewed with no other lispro flexpens with pharmacy labels for Resident 31.</p> <p>The record for Resident 31 was reviewed on 6/4/24 at 11:08 a.m. The resident's diagnosis included, but was not limited to, type 2 diabetes mellitus.</p> <p>The physician's order, dated 2/5/24, indicated staff were to administer the resident's lispro per sliding scale subcutaneously three times daily.</p> <p>The Quarterly MDS assessment, dated 3/26/24, indicated the resident was cognitively intact. She received 7 injections of insulin during the 7 previous days prior to the assessment.</p> <p>3. During an observation of one of the two 300 Hall medication carts on 6/4/24 at 10:07 a.m., Resident 85's glargine flexpen was in a bag marked with her name and the flexpen's open date. There was no pharmacy label. The medication room refrigerator was reviewed with no other glargine flexpens with a pharmacy label for Resident 85.</p> <p>The record for Resident 85 was reviewed on 6/4/24 at 11:10 a.m. The resident's diagnosis included, but was not limited to, type 2 diabetes mellitus.</p> <p>(continued on next page)</p> | | |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>The physician's orders, dated 4/22/24, indicated the staff were to administer the resident's glargine insulin pen 5 units subcutaneously at bedtime.</p> <p>The Admission MDS assessment, dated 4/29/24, indicated the resident was severely cognitively impaired. She received 6 injections of insulin during the 7 previous days prior to the assessment.</p> <p>4. During an observation of one of the two 400 Hall medication carts on 6/04/24 at 10:30 a.m., Resident 42's Levemir flexpen was in a bag marked with his name the flexpen's open date. There was no pharmacy label. The medication room refrigerator was reviewed with no other Levemir flexpens with a pharmacy label for Resident 42.</p> <p>The record for Resident 42 was reviewed on 6/4/24 at 11:16 a.m. The diagnosis included, but was not limited to, type 2 diabetes mellitus.</p> <p>The physician's order, dated 9/26/22, indicated staff were to administer the resident's Levemir U-100 insulin 10 units subcutaneously for type 2 diabetes mellitus daily.</p> <p>The Quarterly MDS assessment, dated 5/16/24, indicated the resident was moderately cognitively impaired. He received 7 injections of insulin during the 7 previous days prior to the assessment.</p> <p>During an interview on 6/4/24 at 10:26 a.m., LPN (Licensed Practical Nurse) 2 indicated the pharmacy label needed to be with the flexpens for cases of power outages, so that the instructions were present.</p> <p>During an interview on 6/5/24 at 9:57 a.m., the DON (Director of Nursing) indicated they could not locate another policy for pharmacy labeling requirements of medications.</p> <p>The LTC [Long Term Care] Facility's Pharmacy Services and Procedures Manual 5.3 Storage and Expiration Dating of Medications, Biologicals LTC Facilities Receiving Pharmacy Products and Services form Pharmacy, revised on 8/7/23, included, but was not limited to, . 6. Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels or cautionary instructions . 4/5/19. 19. Facility should request that Pharmacy perform a routine nursing unit inspection for each nursing station in Facility to assist Facility in complying with its obligations pursuant to Applicable Law relating to the proper storage, labeling, security and accountability of medications and biologicals .</p> <p>3.1-25(j)</p> |