STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155780	A. BUILDING 00 B. WING	03/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HEALTHCARE CENTER	7465 MADISON AVE INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 resulted in an Extended Survey - Substandard Quality of Care - Immediate Jeopardy. This visit was in conjunction with the Investigation of Complaints IN00374538 and IN00374452. Complaint IN00374452 - Unsubstantiated due to lack of evidence. Complaint IN00374538 - Substantiated. Federal/State deficiencies related to the allegations are cited at F641, F684, F690, F711, and F725. Survey dates: March 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, and 21, 2022 Facility number: 012225 Provider number: 155780 AIM number: 200983560 Census Bed Type: SNF/NF: 75 Total: 75 Census Payor Type: Medicare: 4 Medicaid: 61 Other: 10 Total: 75 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.***	

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

Any deficiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Quality review completed March 29, 2022.			
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 ensure an accurate Minimum Data Set (MDS) assessment was completed for for 1 of 21 residents reviewed. An indwelling urinary catheter was not coded on the MDS assessment. (Resident B) Finding includes: The clinical record for Resident B was reviewed on 3/9/22 at 11:22 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder and neurogenic bladder. The Admission MDS assessment, dated 1/1/22, indicated Resident B was cognitively intact and did not have an indwelling urinary catheter. An Initial Admission Evaluation, dated 12/27/21 at 6:26 p.m., indicated Resident B had a 14f (size) indwelling Foley (urinary) catheter that was draining clear urine. A Nurse Practitioner Progress Note, dated 1/13/22 at 2:08 P.M., indicated ...Resident B had an indwelling Foley catheter and the catheter had been removed three days prior due to irritation. During an interview on 3/14/22 at 8:47 A.M. The MDS Coordinator indicated she was not aware Resident B had an indwelling urinary catheter because there were no orders entered into the	F 0641	**F 641** **1) Resident B no longer resides in the facility.** **2) Any resident who has an indwelling catheter has the potential to be affected by the alleged deficient practice. An audit was conducted on all residents with indwelling catheters to confirm their most recent MDS reflects accurate coding of an indwelling catheter, that catheter care orders are in place, and that the plan of care is updated accordingly. Any findings were immediately corrected and the family and physician were notified.** **3) The Regional Resident Care Coordinator has educated the MDS coordinator reinforcing the need for accurately completing an MDS per the**	04/27/2022

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	electronic medical record. The indwelling urinary catheter should have been documented on the Admission MDS assessment. On 3/21/22 at 3:20 P.M., the facility was unable to provide a policy regarding MDS assessment accuracy by survey exit. This Federal tag relates to Complaint IN00374538. 3.1-31(d)		**guidelines of the RAI manual.** **4) The Regional Resident Care Coordinator will audit 3 resident MDS's weekly x 4 weeks, then 5 resident MDS's monthly x 5 months to ensure the accuracy of the resident MDS assessment.** **MDS coordinator is responsible for the compliance. The results of these audits will be reviewed in the Quality Assurance Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The			

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	comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on interview and record review, the facility failed to develop a person centered care plan for a resident that receives narcotic medications for 1 of 21 residents reviewed for care plans. (Resident 6)	F 0656	**F 656** **1) Resident 6 was not harmed by the alleged deficient practice. Resident 6's plan of care was updated to add the intervention of monitoring of**	04/27/2022

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	Finding includes1 The clinical record for Resident 6 was reviewed on 3/15/22 at 1:45 p.m. The diagnosis included, but were not limited to, bilateral above the knee amputations and chronic pain syndrome. The Physician's Orders included, but were not limited to: Hydrocodone-acetaminophen (narcotic pain medication), 10-325 milligrams (mg), one tablet every 4 hours, as needed for pain, ordered 3/7/22. Resident 6's clinical record lacked a plan of care for the monitoring of narcotic pain medication side effects such as drowsiness, confusion, sedation, lethargy, constipation, and respiratory depression. During an interview on 3/21/22 at 1:30 p.m., the DON indicated Resident 6's care plan did not include the monitoring of narcotic pain medication side effects. On 3/21/22 at 1:30 p.m., the DON provided a policy, dated 5/30/19, titled: Plan of Care Overview, and indicated it was the current policy in use by the facility. A review of the policy indicated, " ...The plan of care...is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care ...it is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. Safety is a primary concern for our residents, staff, and visitors." 3.1-35(a)		**side effects related to narcotic medication use.** **2) All other residents who have physician's orders for narcotic medications have the potential to be affected by the alleged deficient practice. An audit was conducted of all residents' medication administration and if the resident was prescribed a narcotic medication(s) their plan of care was updated to add the intervention of monitoring for side effects of narcotic medications. It is a nursing measure to monitor for side effects of any mediation, whether reflected on the residents' care plan or not and Homestead Healthcare implements and follows that nursing measure.** **3) The DON/MDS Coordinator educated the nursing staff and IDT on the facility's existing policy identified as, "Plan of Care Overview" with emphasis on development of a person-centered care plan for those residents that have physician orders for narcotics. Nursing staff was also reminded that it is a basic nursing measure to monitor residents for the side effects of any mediation that is administered and report any side effects to the attending**	

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			physician. The expectation this policy is followed was reinforced and staff was reminded of the consequences to residents and staff if physicians' orders or facility policy are not followed. **4) The MDS/Designee will audit 5 resident care plans x 4 weeks, then 3 resident care plans x 4 weeks, then 5 resident care plans monthly x 4 months to ensure development of a person-centered care plan for those residents with physician orders for narcotics are in place, accurate, and implemented.** **The MDS/Designee is responsible for the compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive month. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the			

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	necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to ensure ADL (Activities of Daily Living) care was provided for a dependent resident who required assistance with bowel and bladder incontinence care for 1 of 3 residents reviewed for ADL care. (Resident M) Finding includes: During a tour of the facility from 3/10/22 at 10:15 a.m. to 10:20 a.m., a strong urine odor was noticed in the hallway near Resident M's room. Resident M's bed was observed to have a blanket and fitted sheet resting on the mattress. A large brownish colored wet area was observed to have soaked through the blanket, fitted sheet, and onto the mattress. The wet area covered approximately 1/3 of the mattress. On 3/10/22 from 12:09 p.m. to 12:15 p.m., Resident M's bed was observed to have a blanket and fitted sheet resting on the mattress. A large brownish colored wet area was observed to have soaked through the blanket, fitted sheet, and onto the mattress. The wet area covered approximately 1/3 of the mattress. On 3/10/22 at 2:30 p.m., Resident M's bed linens were observed to be clean and no odor noted. During an interview at that time, Resident M indicated staff "just changed the sheets a few minutes ago." On 3/12/22 from 9:32 a.m. to 9:40 a.m., a strong urine odor was noticed in the hallway near	F 0677	**F 677** **1) Resident M was part of a confidential survey and could not be identified.** **2) All residents who require assistance with bowel and bladder incontinence care have the potential to be affected by the alleged deficient practice. An audit was conducted via interview, record review, and observation on all residents who require assistance with bowel and bladder incontinence care to ensure their ADL needs are being met daily. Their care plan was updated if needed to ensure it accurately reflects incontinence needs and interventions to meet the residents' needs.** **3) The DON/Designee has educated the nursing staff on the facility's existing policy identified as, "Routine Resident Care Policy" with emphasis on providing bowel and bladder incontinence care and bed linen changing as needed. The expectation this policy is followed was reinforced and staff was remined of the consequences to residents and staff if physicians' orders or facility policy are not followed.** **4) The DON/Designee will audit random residents, on all**	04/27/2022

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	Resident M's room. Resident M was observed sleeping on his bed. The bed's bottom sheet, which the resident was resting on, was observed to have a brownish yellow wet stain in the middle of the sheet. On 3/12/22 at 11:55 a.m., Resident M's bed was observed. The bottom sheet was observed to have a brownish yellow wet stain. The stained area was approximately 5 inches from the head-board area of the bed to the middle section of the mattress area. Resident M's pillow, located at the head-board area of the bed, was laying on top of the brownish yellow wet stained bottom sheet. On 3/17/22 at 11:38 a.m., Resident M's clinical record was reviewed. The diagnoses included, but were not limited to, benign prostatic hyperplasia with lower urinary tract symptoms (enlarged prostate gland that can cause urination difficulty) and vascular dementia. The Quarterly Minimum Data Set (MDS) assessment, date 2/11/22, indicated Resident M was mildly cognitively impaired, frequently incontinent, and required assistance with hygiene and toileting. Resident M's care plan, initiated on 12/23/21 and valid through 4/4/22, indicated assistance was required for ADLs, "...Resident requires supervision to total assistance with hygiene...Resident requires supervision to total assistance with toileting..." During an interview on 3/21/22 at 10:40 a.m., Resident M indicated he wore an incontinence brief because of not being able to hold his urine and that staff didn't always change his brief when		**shifts, including weekends via observation and interviews to ensure bowel and bladder ADL care is being completed, this will be based on the following schedule: 10 residents weekly x 4 weeks, then 5 residents weekly x 4 weeks, then 10 residents monthly x 4 months. DON/Designee is responsible for the compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA monthly meetings for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	needed. During an interview on 3/21/22 at 10:45 a.m., CNA 9 indicated Resident M was incontinent of bowel and bladder. The resident wore an incontinent brief, was checked every 2 hours, and more often as needed for incontinence care. During an interview on 3/21/22 at 11:04 a.m., the DON indicated staff were to monitor Resident M every two hours and more often as needed for toileting care. On 3/21/22 at 8:20 a.m., the DON provided a copy of the Routine Resident Care policy, dated 4/6/16, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...provide routine daily care by a certified nursing assistant with specialized training in rehabilitation/restorative care under the supervision of a licensed nurse including but not limited to ...toileting, providing care for incontinence with dignity and maintaining skin integrity..." 3.1-38(a)(3)			
F 0684 SS=J 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, and the residents' choices. A. Based on interview and record review, the	F 0684	The facility respectfully request an	04/27/2022

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	facility failed to ensure a physician order was followed for transferring a resident to the hospital. Two days later the resident was found unresponsive for 1 of 3 residents reviewed for hospital transfers. (Resident B) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on, 1/11/22 at approximately 2:32 p.m., when the facility failed to follow a physician's order to send a resident to the hospital. Two days later the resident was found unresponsive. The Administrator, Director of Nursing, and the Regional Director of Nursing were notified of the Immediate Jeopardy on 3/11/22 at 5:00 p.m. The Immediate Jeopardy was removed on 3/16/22 at 4:05 p.m., but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. B. Based on interview and record review, the facility failed to ensure medication for reversal of low blood sugar was available and given per nursing measures to treat an acute episode of hypoglycemia resulting in hospitalization for 1 of 3 residents reviewed for diabetic care. (Resident C) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 2/22/22 at approximately 8:50 a.m., when the facility failed to provided glucagon as a nursing measure to treat a hypoglycemic episode. The resident was sent emergently to the emergency room. The Administrator, Director of Nursing, and the Regional Director of Nursing were notified of the Immediate Jeopardy on 3/11/22 at 5:00 p.m. The Immediate Jeopardy was removed		IDR to lessen the scope and severity for this alleged deficient practice related to the documentation in the citation was not obtained by the treating NP and Glucagon is not indicated for administration for a blood sugar of 62. ***1.*** The facility allegedly failed to ensure physician's orders for transfer to the hospital were followed. Two days later the resident was found unresponsive. (Resident B) Resident B was seen by the Nurse Practitioner (NP) on 1/11/22 for a regular visit. The resident asked to be sent to the hospital and the N P ordered the resident be sent to the hospital. On I /13/22 the resident was found unresponsive at the facility and was sent to the hospital with sepsis, respiratory failure, and acute urinary tract infection. At the hospital the resident was placed on palliative care on 1/14/22. B. The facility allegedly failed to ensure medication to reverse low blood sugar was available and administered in accordance with nursing measures to treat an acute episode of hypoglycemia which ultimately resulted in the resident being hospitalized. (Resident C). Resident C was experiencing seizure activity and hypoglycemia with a blood glucose of 64 on 2/22/22. The	

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	on 3/16/22 at 4:05 p.m., but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. C. Based on observation, interview, and record review, the facility failed to ensure care was provided to maintain the highest practicable well being for 4 of 21 residents reviewed. Physician's orders were not in place for a resident admitted with surgical wounds and dressings on open wounds were not dated, (Resident J, Resident D, Resident E, Resident F) Findings include: A. The clinical record for Resident B was reviewed on 3/9/22 at 11:22 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder and respiratory failure. The Admission MDS (Minimum Data Set) assessment, dated 1/1/22, indicated Resident B was cognitively intact. A Nurse Practitioner Note, dated 1/11/22 at 2:32 p.m., indicated Resident B was seen for increased confusion and fever. The Physical Therapist reported Resident B had increased confusion and agitation. The resident requested to go to the hospital. An order to send the resident to the emergency room for evaluation was written. A Nurse's progress note, dated 1/13/22 at 3:49 p.m., indicated Resident B was found unresponsive. Resident B's blood pressure was 80/39 mm/Hg (millimeters/Mercury), temperature 101.2 degrees Fahrenheit, pulse 139 beats per minutes, and the blood sugar was 154.		resident could not drink and the staff could not find Glucagon to administer to increase the blood glucose. The nurse obtained an order from the physician to transfer Resident C to the hospital. C. Resident J, D, E, and F were part of a confidential complaint survey and could not be identified. ***2.*** A facility-wide audit will be completed to ensure all physician's orders for transfer to the hospital for residents who experience a change in condition are followed and the resident is or was transferred to the hospital. This audit will review any residents who experienced a change in condition in the past 3 days to ensure that the resident was transferred to the hospital if the resident's physician ordered the resident be transfer to the hospital. Any findings indicating a transfer order was not followed will be reported to the family and physician and any follow-up orders are implemented. The DON validated on 03/11/2022 the facility has 3 glucagon injection kits in the Emergency Drug Kit (EDK). All licensed nurses will be educated on the existing facility policy and procedure for hypoglycemia and know the location of medications needed in an emergency situation. This education will be	

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	Emergency services were called to transport the resident to the emergency room for evaluation. During an interview on 3/9/22 at 3:13 p.m., the Director of Nursing indicated there was no order written to send Resident B to the hospital nor was an order entered into the electronic medical record. The Nurse Practitioner note, dated 1/11/22 at 2:32 p.m., was not actually signed until 1/14/22 at 10:22 a.m., so the staff wouldn't have been aware Resident B needed to be sent to the hospital. During an interview on 3/11/22 at 11:01 a.m., the Nurse Practitioner indicated she had written an order to send Resident B to the Emergency Department and had not reported that to a nurse because it wasn't emergent at that time. The Nurse Practitioner put the order in a mailbox outside the Assistant Director of Nursing's (ADNS) office which was the standard practice used when the Nurse Practitioner wrote new orders for any residents. When the Nurse Practitioner saw him on 1/13/22, she was going to follow up on labs because he was never sent to the hospital as per the 1/11/22 written order. She does not remember Resident B reporting he had refused to go to the Emergency Department nor the staff reporting that Resident B refused to go to the Emergency Department. Resident B should have been sent to the Emergency Department on 1/11/22. During an interview on 3/11/22 at 2:47 p.m., RN (Registered Nurse) 1 indicated she had been working at the facility for several weeks. The Assistant Director of Nursing (ADNS) had been entering the new orders into the electronic medical record and would give a verbal report to the staff to notify them of the new orders. The		completed by the DON/Designee with all nurses at the beginning of each shift until all licensed nurses have been educated. All licensed nurses will be educated in orientation on the location of glucagon. This education will reinforce the expectation that physician's orders for transfer to the hospital are implemented immediately and that residents requiring emergency medication from the EDK receive those medications as well as the potential consequences to the residents and staff if physician's orders are not followed or residents are not promptly administered medications from the EDK. A facility-wide audit was conducted on all residents requiring wound care to ensure that all physician's orders were documented and implemented. ***3.*** The DON/Designee will educate all licensed nurses on the facility's existing policy of following physician's orders for transfer to the hospital, and ensure all staff and physician service staff are aware of how to communicate new orders from physicians to staff. All licensed nurses will be educated on the existing facility policy and procedure for treating hypoglycemia and know the location of medications needed in	

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	Nurse Practitioners sometimes entered the orders for themselves, but most of the time it had been the ADNS. During an interview on 3/11/22 at 3:07 p.m., the ADNS indicated she had been entering the new orders for the Nurse Practitioners during the month of January. The Nurse Practitioner's would put the new orders in a mailbox outside her office and then she, the DON, or the Infection Preventionist would enter them into the electronic medical record. They did this because the Nurse Practitioner was not able to sign into the electronic medical record to enter the new orders. She was not aware of an order to send Resident B to the hospital. On 3/11/22 at 2:30 P.M., a Hospital Progress Note, dated 1/13/22, indicated Resident B was admitted with sepsis, respiratory failure, an acute urinary tract infection. On 3/11/22 at 2:30 P.M., a Hospital Discharge Summary, dated 2/8/22, indicated on 1/28/22 Resident B was comfort measures only. Resident B's respirations had ceased. On 3/11/22 at 4:21 p.m., the Administrator provided a copy of a facility policy, titled "Physician Orders," dated 8/2010, and indicated this was the current policy used by the facility. A review of the policy indicated "...The provider may write the order in the medical record... place orders in electronic medical record... print copy for Physician to sign and place in paper chart unless they are being signed electronically... the nurse that takes the Physician order will be responsible for executing the order or provide for the safe hand-off to the next nurse... contact...outside venders as required to execute		an emergency. This education will be completed by the DON/Designee with all nurses at the beginning of each shift until all licensed nurses have been educated. The DON/Designee has educated all licensed nurses on the existing facility policy identified as, “Skin Care and Wound Management Overview” with emphasis on transcribing and completing wound care and dating the dressing. This education will reinforce the expectation that facility policies and nursing measures be followed and the potential consequences to both residents and staff if facility policies and nursing measures are not followed. ***4.*** The DON/Designee will complete an exit conference with any provider who treats residents to confirm that orders to transfer a resident to the hospital are implemented, that there is a progress note indicating an order to transfer a resident to the hospital has been obtained, and that the transfer order has been communicated to the licensed nurse. This will remain an ongoing practice of the facility. The DON/Designee will audit all residents’ progress notes daily to confirm any order to transfer a resident to the hospital has been timely implemented . This will	

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	the medical order... notify internal staff of changes/updates as appropriate. document contacts in the medical record." B. The clinical record for Resident C was reviewed on 3/11/22 at 12:50 p.m. The diagnoses included, but were not limited to, diabetes mellitus and schizophrenia. The Annual MDS (Minimum Data Set) assessment, dated 12/24/21, indicated Resident C was cognitively intact and had received insulin every day. A Nurse's progress note, dated 2/22/22 at 1:52 p.m. indicated "I was informed by the QMA (Qualified Medication Aide) on 700-hallway that [Resident C] was having seizure activities at 0850. I immediately rushed to the room knowing that a QMA was on that hallway. When I got to the room [Resident C] was sitting up in the wheelchair dressed. Both QMA and CNA (Certified Nursing Aide) were in the room. [Resident C] was lethargic but could respond to voices... While observing [Resident C] for seizure activity, I did not see any activity going on. Then I asked the QMA what [Resident C's] blood sugar was. QMA reported that [Resident C's] blood sugar was 70 this morning... when she rechecked the blood sugar, it reads 64. [Resident C's] unresponsiveness continues to worsen. The QMA brought orange juice but [Resident C] was not able to drink. Then I rushed to get glucagon [a prescription medication to treat hypoglycemia] to administer and there is none on the cart or EDK [Emergency Drug Kit] on both sides. Then I called 911. When the ambulance arrived, I reported to them what the situation was and asked for glucagon. During their assessment, [Resident C's] blood sugar went down to 36. [Resident C] was transported to the hospital."		remain an ongoing practice of this facility. The DON/Designee will audit the EDK five times a week for 4 weeks to confirm that glucagon kits are available, then three times a week for 4 weeks, then weekly for 4 weeks. The DON/Designee will interview 5 licensed nurses a week to confirm they know the location of glucagon kits in the facility for 4 weeks, then 5 nurses a month for 2 months. Any findings from the audits will be addressed with staff immediately. The DON/Designee will review and observe random residents' wound care dressings to ensure the dressings indicate the date applied on the following schedule: 10 residents weekly x 4, then 5 residents weekly x 4, then 10 residents monthly x 4 months. The DON/Designee will reconcile all new admission orders to ensure accuracy in transcription including ensuring that treatment orders are entered in the resident's clinical record. This will remain an ongoing facility practice. It will be a documented audit for 6 months and remain a regular practice thereafter. The DON/Designee is responsible for compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6	

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	The February 2022 MAR (Medication Administration Record) indicated Resident C's blood sugar reading, on 2/22/22 at 7:30 a.m., was 70. During an interview on 3/11/22 at 3:15 p.m., RN (Registered Nurse) 1 indicated she was unable to locate the glucagon for when a resident becomes hypoglycemic. She was unsure where to find the EDK. During an interview on 3/11/22 at 3:30 p.m., LPN (Licensed Practical Nurse) 1 indicated nurses ask each other where to find the glucagon for when a resident's blood sugar declines. LPN 1 was observed to search through the east and west wing medication room refrigerators and was unable to find the glucagon in either refrigerator. During an interview on 3/12/22 at 10:25 a.m., the Director of Nursing indicated the facility did not have standing orders for an emergency reversal medication for hypoglycemia (low blood sugar). A physician's order would be required before the nurse could administer the medication. During an interview on 3/13/22 at 10:00 a.m., UM 1 indicated that if a resident was admitted with insulin orders she would call the physician to see if they would like to add an order for glucagon because a resident's blood sugar could drop with insulin. During an interview on 3/13/22 at 1:54 p.m., the Medical Director indicated that if a nurse would have called and asked for an order for glucagon, he would have given it. On 3/11/22 at 3:00 p.m., the Director of Nursing provided a copy of a facility policy, titled "Blood		months or until 100% compliance is achieved x 3 consecutive month. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	Glucose Point of Care Testing," dated 12/2014, and indicated this was the current policy used by the facility. A review of the policy indicated "It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents...Extremely low blood glucose levels (hypoglycemia) may result in confusion, unusual behaviors, coma, and even death if left untreated." C1. During an interview on 3/14/22 at 10:08 A.M., Resident J indicated his surgical wound treatment to his left ankle had not been completed as ordered by the physician when he initially admitted to the facility. The clinical record for Resident J was reviewed on 3/10/22 at 9:40 A.M. The diagnoses included, but were not limited to, stress fracture of left ankle and fracture of lower left tibia. The Admission MDS (Minimum Data Set) assessment, dated 10/30/21, indicated Resident J was cognitively intact, did have surgical wounds, but did not require surgical wound care. An Initial Admission Evaluation, dated 10/23/21, indicated "Skilled services/reason for admission: wound care... skin intact, resident will remain free of skin breakdown...nurse completing this section [the wound nurse]." A hospital discharge summary, dated 10/23/21, indicated collagenase ointment (a prescription ointment used to debride wounds) apply 1 application topically 2 times a day. A Wound Nurse Practitioner Note, dated 10/25/21 at 9:06 A.M., indicated "location - left medial ankle...follow surgeon's orders and			

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	scheduled follow up appointments-wet to dry dressings daily." A Physician's orders, dated 11/16/21, indicated cleanse left medial foot and lateral ankle with normal saline, apply wet to dry dressing, cover with pad and secure every day shift for wound care with a start date of 11/17/21. The November 2021 TAR (treatment administration record) indicated on 11/17/21 Resident J started receiving the wet to dry dressing to the left foot and ankle that was ordered on 10/25/21. On 3/18/21 at 2:00 P.M., the Activity Director provided a document, titled "Resident Council Minutes," dated December 2022. A review of the document indicated concerns with wound care and medication administration were discussed. Residents in attendance for that meeting included, but were not limited to, Resident J, Resident C and Resident F as indicated by the document. During an interview on 3/21/22 at 9:25 A.M., the Wound Nurse indicated she could not explain why the treatment order from 10/25/21 was not entered into the electronic medical record until 11/17/21 because she didn't work for the facility at that time. However, the Initial Admission Evaluation, dated 10/23/21, indicated she completed the skin section of the evaluation. She was able to recall Resident J admitted with an infection in his wounds. On 3/11/22 at 4:21 P.M. The Administrator provided a copy of a facility policy, titled "Physician Orders," dated 8/3/2010, and indicated this was the current policy used by the			

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	facility. A review of the policy indicated "Medical Orders Transcription...the provider may write the order in the medical record...a provider may give a medical order over the phone...verbal orders are accepted but will be input into [the electronic medical record] by the nurse as soon as practicable. The practitioner will need to sign off on these orders..." C2. During a random observation on 3/13/22 at 10:00 a.m., Resident D was observed in his room. The resident was lying in his bed. A soiled, undated dressing was noted on his mid-abdomen. The resident was observed to expose the wound. The wound had a moderate amount of thick, dark red, and whitish drainage. During an interview the resident indicated his dressing did not get changed every day. On 3/14/22 at 9:30 a.m., Resident D was observed in his room. An undated dressing was noted on his mid-abdomen. During a wound care observation on 3/15/22 at 10:00 a.m., the Wound Nurse was observed at the resident's bedside. The Wound Nurse removed an undated dressing. During an interview, at that time the Wound Nurse indicated the dressing should be dated at the time the dressing was changed. On 3/15/22 at 10:30 a.m., the clinical record of Resident D was reviewed. The diagnosis included but were not limited to, open wound of abdominal wall. A Quarterly MDS (Minimum Data Set) assessment, dated 2/21/22, indicated Resident D was cognitively intact.			

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	A Physician's Order Summary Report, dated March 17, 2022, indicated "Cleanse surgical site to mid abdomen with NS [normal saline], pat dry, apply xeroform in wound bed and lastly cover with a bordered gauze Q [every] night shift for surgical wound." A Care Plan, dated 4/30/21 and current through 3/28/22, indicated Resident D was at risk for altered skin integrity related to impaired mobility. The resident had a surgical wound. The interventions included but were not limited to administer treatments as ordered by a medical provider. A Nurse Practitioner note, dated 3/7/22, indicated to encourage nursing staff to change dressings as ordered. A wound evaluation, dated 3/14/22, indicated to change the dressing daily. C3. During an interview on 3/18/22 at 2:30 p.m., Resident E indicated his dressings did not get changed every day as ordered by the physician. On 3/21/22 at 8:30 a.m., the clinical record of Resident E was reviewed. The diagnoses included but were not limited to, acquired absence of right toe and dependence of renal dialysis. The Annual MDS assessment, dated 12/17/21, indicated Resident E was cognitively intact. The physician orders, dated 3/17/22, indicated Right plantar/heel eschar: Cleanse area with wound cleanser or normal saline. Paint the areas with Betadine daily, secure with dry gauze/kerlix daily.			

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	During a wound care observation on 3/17/22 at 2:33 p.m., the Wound Nurse was observed completing Resident E's dressing change. The dressing on Resident E's right foot was undated. During an interview at that time, the Wound Nurse indicated the dressing should have been dated. On 3/18/21 at 2:00 P.M., the Activity Director provided a document, titled "Resident Council Minutes," dated December 2022. A review of the document indicated concerns with wound care and medication administration were discussed. Residents in attendance for that meeting included, but were not limited to, Resident J, Resident C and Resident F as indicated by the document. C4. During an interview on 3/13/22 at 11:30 a.m., Resident F indicated the areas on his legs were getting worse and sometimes the dressings on this legs do not get changed for days. On 3/15/22 at 2:33 p.m., the clinical record of Resident F was reviewed. The diagnosis included but were not limited to, Type 2 diabetes mellitus with diabetic neuropathy. The Annual MDS assessment, dated 3/12/22, indicated Resident F was cognitively intact. A Physicians Order, with a start date of 12/27/21, indicated to wrap the bilateral lower extremities with kerlix and ace wraps from toes to knees every day for lymphedema. A care plan, undated, indicated Resident F was at risk for further skin breakdown. The interventions included, but were not limited to: evaluate existing wound daily.			

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	During a wound care observation on 3/18/22 at 2:00 p.m., the ADON was observed providing wound care. The ADON removed the undated dressing. During an interview at that time, the ADON indicated the dressing should have been dated indicating the date of the previous dressing change. A wound evaluation, dated 3/14/22, indicated to change the dressing daily. On 3/18/22 at 2:15 p.m., a policy/procedure was requested from the ADON for dating the dressing at the time it was changed. On 3/18/21 at 2:00 P.M., the Activity Director provided a document, titled "Resident Council Minutes," dated December 2022. A review of the document indicated concerns with wound care and medication administration were discussed. Residents in attendance for that meeting included, but were not limited to, Resident J, Resident C and Resident F as indicated by the document. On 3/21/22 at 4:00 p.m., a policy/procedure for dating dressings was not provided from the facility by the end of the exit date. The Immediate Jeopardy, that began on 1/11/22 and 2/22/22, was removed on 3/16/22 when the facility inserviced the facility staff on following physician's orders and emergency diabetic medications, but the noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because a systemic plan of correction had not been developed and implemented to prevent recurrence.			

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	This Federal tag is related to Complaint IN00374538. 3.1-37(a)			
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 observation and interview, the facility failed to ensure and environment free from accident hazards for 1 of 21 resident rooms observed. Medications were left at bedside. (Resident E) Finding includes: During initial tour on 3/10/22 at 10:33 a.m., Resident E's room door was observed to be open. The resident was discharged to the hospital. No staff were observed to be in the room. The following was observed: 1. One clear plastic pill cup. The pill cup contained 6 calcium acetate 667 mg (milligram) capsules. 2. One clear plastic pill cup that contained 1 ibuprofen tablet 400 mg (used to treat pain). 3. One box of Fluticasone Nasal spray (used to	F 0689	**F 689** **1) Resident E was part of a confidential complaint survey and could not be identified.** **2) All residents have the potential to be affected by the alleged deficient practice. Upon being notified of unattended medications in a resident's room, a complete sweep of residents' rooms was conducted through the facility to ensure no other residents had medications left unattended, unless they had a physician's order to self-administer, an assessment completed for self-administration, and a care plan to reflect self-administration of medications. Any medications**	04/27/2022

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	relieve symptoms of allergies). 4. One clear plastic drinking cup full of sugar packets. The drinking cup included a providone iodine packet (antiseptic used for skin disinfection). 5. A dresser was observed in the room, next to the door. The top drawer of the dresser was unlocked and easily opened. The drawer contained a bisacodyl suppository (used treat constipation) and 6 pouches of providone iodine. 6. A dresser across from the bed was observed to have 3 lidocaine patches (used to treat pain) in the top drawer. The top drawer was unlocked and easily opened. During in interview at that time, the ADON indicated the medication should have been kept behind locked doors. Resident E was sent to the hospital "5 days ago." On 3/10/22 at 1:33 p.m., the DON provided a policy titled Medication Administration, dated 8/3/10, and indicated it was the current policy being used by the facility. A review of the policy indicated "...b. vi. Do not leave medication at bedside." 3.1-45(a)(1)		**found left unattended were appropriately destroyed per the facility policy.** **3) The DON/Designee has educated licensed nursing staff and qualified medication aides on the facility's existing policy identified as, "Medication Administration" with emphasis on not leaving medications at bedside unless an order is in place for self-administration and the residents has been assessed as able to self-administer safely. The expectation this policy is followed was reinforced and staff was reminded of the consequences to residents and staff if physicians' orders or facility policy are not followed.** **4) The DON/Designee will audit via observation random residents and residents' rooms on all shifts including weekends to ensure medications are not left at bedside on the following schedule: 10 residents and residents' rooms weekly x 4 weeks, then 5 residents and residents' rooms weekly x 4 weeks, then 10 residents and residents' rooms monthly x 4 months.** **DON/Designee is responsible for the compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
			reviewed in the monthly QA monthly meetings for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0690 SS=G Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to			

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	155780	A. BUILDING 00 B. WING	03/21/2022

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	restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to ensure urinary catheter care was provided for 1 of 2 residents reviewed for catheter care. This resulted in a resident being diagnosed with sepsis and a urinary tract infection. (Resident B) Finding includes: The clinical record for Resident B was reviewed on 3/9/22 at 11:22 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder and neurogenic bladder. The Admission MDS (Minimum Data Set) assessment, dated 1/1/22, indicated Resident B was cognitively intact and did not have an indwelling urinary catheter. An Initial Admission Evaluation, dated 12/27/21 at 6:26 p.m., indicated Resident B had a 14f (size) indwelling Foley catheter that was draining clear urine. A Nurse Practitioner Progress Note, dated 1/11/22 at 2:32 p.m., indicated Resident B was seen for increased confusion and fever. The Physical Therapist reported Resident B had increased confusion and agitation. The resident requested to go to the hospital. An order to send the resident to the emergency room for	F 0690	**F 690** **1.) Resident B no longer resides in the facility.** **2.) Any resident who has an order for an indwelling Foley catheter has the potential to be affected by the alleged deficient practice. An facility-wide audit was conducted to identify those residents currently using an indwelling Foley catheter to ensure catheter care orders and a plan of care were in place and implemented accurately and timely.** **3.) The DON/Designee educated the nursing staff and IDT on the existing facility policy identified as, "Catheter Care" with emphasis on ensuring orders were documented, followed, and that catheter care was provided in accordance with nursing practice and physician's orders. The expectation this policy is followed was reinforced and staff was**	04/27/2022

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	evaluation was written. A Nurse Practitioner Progress Note, dated 1/13/22 at 2:08 P.M., indicated ...Resident B had an indwelling Foley catheter and the catheter had been removed three days prior due to irritation. A Nurse's progress note, dated 1/13/22 at 3:49 p.m., indicated Resident B was found unresponsive. Resident B's blood pressure was 80/39 mm/Hg (millimeters/Mercury), temperature 101.2 degrees Fahrenheit, pulse 139 beats per minutes, and the blood sugar was 154. Emergency services were called to transport the resident to the emergency room for evaluation. The clinical record lacked physician's orders for the care and management of the indwelling urinary catheter. The clinical record lacked a care plan for the indwelling urinary catheter. The clinical record lacked documentation that urinary catheter care had been provided. During an interview on 3/11/22 at 9:45 a.m., the DON indicated Resident B should have had physician's orders and a care plan for the urinary catheter. On 3/11/22 at 2:30 p.m., a Hospital Progress Note, dated 1/13/22, indicated Resident B was admitted with sepsis, respiratory failure, an acute urinary tract infection. On 3/11/22 at 2:30 p.m., a Hospital Discharge Summary, dated 2/8/22, indicated on 1/28/22 Resident B was comfort measures only. Resident B's respirations had ceased.		**reminded of the consequences to the residents and staff if physicians' orders or facility policy are not followed.** **4.) The DON/Designee will audit 5 residents with indwelling Foley catheters weekly x 4 weeks, then 3 residents weekly x 4 weeks, then 3 residents monthly x 4 months to ensure catheter care is being completed, is being documented appropriately in the clinical record, and the residents' care plans reflect the use of an indwelling Foley catheter with appropriate interventions. All admissions will be reviewed in the clinical morning meeting for the use of an indwelling Foley catheter and audited to ensure catheter care orders and a plan of care is in place, this is an ongoing facility practice. Audits/observation will be conducted randomly, across all 3 shifts, and will include weekends. DON/Designee is responsible for the compliance. Audit findings will be presented to the QA Committee monthly meeting x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x3 consecutive months. The QA**	

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	On 3/14/22 at 10:00 a.m., a urinalysis result, dated 1/17/22, indicated the urinalysis that had been collected on 1/13/22 had greater than 100,000 CFU/ML (colony-forming unit per milliliter) of Proteus vulgaris (bacteria) in the urine. On 3/14/22 at 10:30 a.m., the DON provided a copy of a facility policy, titled "Catheter Care," dated 10/13/13, and indicated this was the current policy used by the facility. A review of the policy indicated "catheter care is performed at least twice daily on residents that have indwelling catheters, for as long as the catheter is in place...the risk of bacteremia (bacteria in the blood) is 3 to 36 times more likely than residents without an indwelling catheter." This Federal tag relates to Complaint IN00374538. 3.1-41(a)(2)		**Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
F 0692 SS=G Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences			

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	indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review, the facility failed to ensure nutritional supplements recommended by a dietician were implemented for 1 of 2 residents reviewed for nutrition. (Resident X) Resident X experienced a significant weight loss before intervention was recommended. Finding includes: On 3/11/22 at 10:49 A.M., Resident X's medical record was reviewed. The diagnoses included, but were not limited to, bipolar disorder, Type 2 diabetes mellitus, and generalized muscle weakness. The Annual MDS (Minimum Data Set) assessment, dated 2/15/22, indicated Resident X had moderate cognitive impairment and required set up assistance and supervision for eating. The care plan indicated goals and interventions were in place for increased nutritional risks and that Resident X had "a history of weight changes". The weights included, but were not limited to: 3/1/22-108.2 pounds 2/15/22- 105.2 pounds The 2/15/22 weight struck out in the medical	F 0692	**F 692** 1) The facility respectfully request an IDR for this deficiency related to the documentation does not reflect a true weight loss as indicated in the cited deficient practice, additionally there was no harmed sustained by the resident. Resident X was readmitted to the facility and the documentation from the hospital indicated the resident weighed 110 lbs upon discharge from hospital. The facility did not obtain an admission weight on 2/1 the next weight was obtained on 3/1 and the resident weighed 108.2 lbs. Resident has been reweighed and the resident's weight has remained stable and consistent. The weights obtained in January appear to be incorrectly documented. 2) All residents have the potential to be affected by the alleged deficient practice. A facility-wide audit was conducted of dietary recommendations made over the last 30 days to ensure that the recommendations were	04/27/2022

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	record on 2/26/22 as "incorrect documentation". 1/2/22-148 pounds 1/1/22-147 pounds The clinical record lacked any other weight documentation from February 2022 through March 2022. A Progress Note, dated 3/4/22, indicated a weight change was recorded. The note included, but was not limited to, a recommendation from the Registered Dietician for "Ensure (a nutritional supplement) TID (three times daily) at this time to promote weight maintenance." A review of the current physician orders indicated there were not any current orders for nutritional supplements. On 3/17/22 at 9:30 A.M., an interview with LPN 7 indicated on 2/8/22 Resident X had readmitted after a fall with a fracture. No weight was recorded for resident's readmission date. LPN 7 indicated she would get a current weight on Resident X and also check on nutritional supplement orders. On 3/17/22 at 11:01 A.M., the DON indicated Resident X was reweighed at 110.2 pounds; this was a loss of 37.8 pounds since the 1/2/22 weight, or a 25.5% weight loss. An order for Ensure three times daily was placed in the eMAR (electronic medication administration record) at 10:29 A.M. On 3/17/22 at 1:35 P.M., a Resident Height and Weight policy, dated 5/19/16, was provided by the DON who indicated this was the policy currently being used. The policy indicated that reweight parameters included a plus or minus of		reviewed by the physician and implemented as recommended and ordered. Residents have been reweighed and their weights were reviewed by a Registered Dietician. Any resident who needed to be reweighed was reweighed and appropriate dietary recommendations, if any, were made, reviewed and verified by the physician, and transcribed and implemented accordingly. 3) The Regional Director of Clinical Operations has educated the DON/Designee on the existing facility protocol for receiving, transcribing, and implementing dietary recommendations. The DON/Designee has educated the staff on obtaining weights and reweights per the existing facility policy. This education reinforced the expectation that facility protocols and policies will be followed and the potential consequences to both the residents and staff if they are not followed. 4) The RDCO/Designee will audit residents' medical records to confirm transcription of dietary recommendations on the following schedule: 5 residents weekly x 4 weeks, then 3 residents weekly x 4 weeks, then 5 residents monthly x 4 months. The DON/Designee will confirm all resident reweights are obtained based the RD's recommendation on the following schedule: 5 residents weekly x 4	

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	5 pounds of weight in one week and that this would result in a reweight within 24 hours, validation with nurse for an accurate weight, and the notification of the IDT (interdisciplinary) team, doctor, and family if indicated. On 3/21/22 at 8:47 A.M., an interview with the DON indicated that Resident X should have been reweighed and had orders for Ensure or other nutritional supplements prior to 3/17/22. 3.1-46(a)(2)		weeks, then 3 residents weekly x 4 weeks, then 5 residents monthly. **The DON/Designee is responsible for the compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive month. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate			

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	treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, interview, and record review, the facility failed to provide care for a resident's enteral feeding (tube feeding) for 1 of 1 residents reviewed for enteral feeding. The enteral feeding was not administered as ordered and the equipment was not labeled and dated. (Resident N) Findings include: During the initial facility tour on 3/10/22 from 10:10 a.m. to 10:15 a.m., Resident N was observed resting in bed. Next to the bed was an IV pole. Attached to the IV pole was an IV electronic pump, an unlabeled plastic bottle that was 3/4 full of a tan colored liquid, and a clear plastic bag labeled "flush bag". The "flush bag" was observed to be connected to the unlabeled plastic bottle. The unlabeled plastic bottle was connected to a long plastic tube that contained a tan colored liquid and was attached to the IV electronic pump. The IV electronic pump was observed to not be turned to the on position. The tubing was observed to not be attached to Resident N. The "flush bag" and unlabeled plastic bottle lacked a label to indicate what was contained within the containers, when it was prepared, and who administered the contents. On 3/11/22 from 9:35 a.m. to 9:45 a.m., Resident N was observed resting in bed. Next to the bed was an IV pole. Attached to the IV pole was an IV electronic pump, an unlabeled plastic bottle that was 3/4 full of a tan colored liquid,	F 0693	F 693 1) Resident N was part of a confidential complaint survey. 2) All residents who require enteral nutrition have the potential to be affected by the alleged deficient practice. A facility-wide audit was conducted for residents who require enteral nutrition to ensure physician orders were implemented and followed as written and that equipment necessary to implement physician's orders was labeled and dated. Any non-compliance was immediately corrected. 3) The DON/Designee has educated the licensed nursing staff on the facility's existing policies identified as, "Enteral Nutrition With Continuous Pump", "Physician Order", and "Medication Administration" with emphasis on implementing and following physician orders as written, and labeling and dating of enteral nutrition. This education reinforced the expectation that facility policies and procedures are followed and the potential consequences to both residents and staff if the policies and procedures are not followed as expected.	04/27/2022

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	and a clear plastic bag labeled "flush bag". The "flush bag" was observed to be connected to the unlabeled plastic bottle. The unlabeled plastic bottle was connected to a long plastic tube that contained a tan colored liquid and was attached to the IV electronic pump. The IV electronic pump was observed to not be turned to the on position. The tubing was observed to not be attached to Resident N. The "flush bag" and unlabeled plastic bottle lacked a label to indicate what was contained within the containers, when it was prepared, and who administered the contents. On 3/12/22 at 9:50 a.m., Resident N was observed resting in bed. Next to the bed was an IV pole. Attached to the IV pole was an IV electronic pump, a ¾ filled plastic bottle of Jevity 1.2 cal (a prescribed liquid nourishment administered through a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications), and a clear plastic bag labeled "flush bag". The "flush bag" was observed to be connected to the Jevity 1.2 cal plastic bottle. The Jevity 1.2 cal plastic bottle had a long plastic tube that contained a tan colored liquid and was attached to the IV electronic pump. The IV electronic pump was observed to be turned to the off position. The tubing was observed to not be attached to Resident N. The "flush bag" lacked a label to indicate what was contained within the container, when it was prepared, or who administered the contents. The Jevity 1.2 cal plastic bottle lacked a label to indicated when it was prepared and who administered its contents. On 3/13/22 at 9:50 a.m., observed Resident N resting in bed. Next to the bed was an IV pole. Attached to the IV pole was an IV electronic pump, a plastic bottle of Jevity 1.2 cal and a clear		4) The DON/Designee will audit all residents receiving enteral nutrition via observation to ensure the appropriate enteral nutrition is provided in accordance with physician's orders, and the equipment used is labeled and dated on the following schedule: 5 residents weekly x 4 weeks, then 3 residents weekly x 4 weeks, then 5 residents monthly x 4 months. The DON/Designee is responsible for compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive month. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. ="" p="">	

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	plastic bag labeled "flush bag". The "flush bag" was observed to be connected to the Jevity 1.2 cal plastic bottle. The Jevity 1.2 cal plastic bottle had a long plastic tube that contained a tan colored liquid and was attached to the IV electronic pump. The IV electronic pump was observed to be turned to the on position, administering 60 ml/hr (milliliter per hour). The tubing was observed to be attached to Resident N's gtube site, located on her abdomen, and 300 ml of the Jevity 1.2 cal had been administered to the resident. On 3/11/22 at 3:01 p.m., Resident N's clinical record was reviewed. The diagnosis included, but were not limited to, dysphagia following cerebral infarction (trouble swallowing after a stroke). The 5 day Minimum Data Set (MDS) assessment, dated 2/24/22, indicated Resident N had a feeding tube. A Physician order, dated 2/19/22, indicated Resident N was prescribed continuous feeding (uninterrupted tube feeding) of Jevity 1.5 cal strength at 60 ml/hour with a flush at 100 ml/hour every 4 hours. Resident N's current care plan, initiated 1/17/22 and current through 4/21/22, indicated "[Resident N] has nutritional problem/potential nutrition problem...dx [diagnosis] of stroke, dysphagia, requires gtube [tube feeding]...to meet nutrient needs...enteral nutrient as ordered..." During an interview on 3/12/22 at 9:55 a.m., LPN 7 indicated Resident N was to receive Jevity 1.5 cal at 60 ml/hour continuously. LPN 7 indicated the Jevity and "flush bag" were supposed to be labeled to indicate who administered the contents and when.			

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During an interview on 3/13/22 at 10:00 a.m., the DON indicated Resident N's tube feeding was for Jevity 1.5 cal and she was unsure why the Jevity 1.2 cal was administered. The DON further indicated the Jevity and "flush bag" were to be labeled to indicate when and who administered the contents.

During an interview on 3/18/22 at 11:04 a.m., the DON indicated the facility had one resident who received tube feedings.

On 3/14/22 at 11:00 a.m. the DON provided a copy of the Medication Administration policy, dated 12/14/17, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...administer medication only as prescribed by the provider..."

On 3/14/22 at 11:00 a.m., the DON provided a copy of the General Enteral Feeding Guidelines policy, dated 8/12/16, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...A physician/provider order is required to include solution, amount, frequency, rate...a licensed nurse will administer nutritional feeding and care of the enteral tube...label...bottles used for tube care with resident's name and the date and specific use..."

On 3/14/22 at 11:35 a.m., the DON provided a copy of the Medication Storage and Labeling policy, dated 2/2017, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...medications and biologicals labeled...be dated..."

3.1-47(a)(2)

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F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, interview, and record review, the facility failed to ensure a PICC (peripherally inserted central catheter) line dressing was changed for 1 of 1 residents reviewed with a PICC line. (Resident K) Finding includes: During an interview on 3/9/22 at 10:15 A.M., Resident K indicated she didn't think her PICC line had been cared for properly. At that time, the PICC line to Resident K's right upper arm was observed with a dressing dated 2/24/22 and the IV (intravenous) tubing was uncapped and plugged into a port on the tubing. During an interview on 3/9/22 at 10:44 A.M., the Unit Manager indicated she was one of the staff that changed PICC line dressings but was unable to indicate how often a PICC line dressing should be changed. During an interview on 3/9/22 at 10:53 A.M., the Wound Nurse indicated PICC line dressings should be changed every 7 days. The dressing should have been changed. The clinical record for Resident K was reviewed on 3/17/22 at 1:26 P.M. The diagnoses included, but were not limited to, diabetes mellitus and infection following a procedure.	F 0694	F 694 1) Resident K is part of a confidential complaint survey and could not be identified. 2) All residents with intravenous lines have the potential to be affected by the alleged deficient practice. A facility-wide audit was conducted to ensure that all residents with an intravenous line had an assessment of both the insertion site and the dressing to ensure there were no signs of infection and the dressing was clean, dry, intact, and current. 3) The DON/Designee has educated all licensed nursing staff on the existing facility policy's and nursing measure on how to assess, care for and maintain an intravenous line with emphasis on timely intravenous line dressing changes and documenting dressing changes. The expectation the policy and nursing measure are implemented timely was reinforced as well as the potential consequences for both the residents and staff if the policy and nursing measure is not	04/27/2022

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	155780	A. BUILDING 00 B. WING	03/21/2022

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	The Admission MDS assessment, dated 2/23/22, indicated Resident K was cognitively intact. On 3/21/22 at 1:17 P.M., the Regional Nurse provided a copy of a facility policy, titled "Pharmscript," dated 2/09, and indicated this was the current policy used by the facility. A review of the policy indicated "A sterile end cap must be placed on the end of the intermittent tubing in between administrations. The sterile end cap must be discarded when the tubing is reattached to the catheter...a dressing change must be done every 7 days or sooner if compromised." 3.1-47(a)(2)		followed as expected. 4) The DON/Designee will audit residents with an intravenous line to ensure orders for changing the dressing are in place and implemented on the following schedule: 5 residents weekly x 4 weeks, 3 residents weekly x 4 weeks, then 5 residents monthly x 4 months. ="" span="">
The DON/Designee is responsible for compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive month. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. ="" span="">	
F 0711 SS=D Bldg. 00	483.30(b)(1)-(3) Physician Visits - Review Care/Notes/Order §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;			

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	§483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. Based on interview and record review, the facility failed to ensure a physicians orders were obtained for 1 of 21 residents reviewed. Indwelling urinary catheter and oxygen therapy orders were not obtained. (Resident B) Finding includes: The clinical record for Resident B was reviewed on 3/9/22 at 11:22 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder and neurogenic bladder. The Admission MDS (Minimum Data Set) assessment, dated 1/1/22, indicated Resident B was cognitively intact, was receiving oxygen therapy, and did not have an indwelling urinary catheter. An Initial Admission Evaluation, dated 12/27/21 at 6:26 p.m., indicated Resident B had a 14f (size) indwelling Foley catheter that was draining clear urine and was receiving 5 liters per minute of oxygen through a nasal cannula. A Nurse Practitioner Progress Note, dated 1/13/22 at 2:08 p.m., indicated Resident B had an indwelling urinary catheter that had been removed three days prior. The clinical record lacked Physician's orders for the care and management of the urinary catheter	F 0711	**F 711** **1) Resident B no longer resides in the facility.** **2) All residents with indwelling catheters and mechanical oxygen have the potential to be affected by the alleged deficient practice. A facility-wide audit was conducted on all residents with indwelling catheters and mechanical oxygen to ensure a physician's order was in place, appropriate, and implemented. The physician(s) for any resident identified with an indwelling catheter or mechanical oxygen for which there is no physician's order and new orders were obtained and implemented. The resident's family or responsible party and plan of care were updated accordingly.** **3) The DON/Designee has educated the licensed nursing staff on the existing facility policy identified as, "Physician Orders" with emphasis on ensuring there are physician's orders for indwelling catheters and oxygen therapy. The**	04/27/2022

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	and oxygen therapy. During an interview on 3/11/22 at 9:45 A.M., the Director of Nursing indicated Resident B should have had physician's orders for the urinary catheter and oxygen therapy. On 3/11/22 at 4:21 P.M., the Administrator provided a copy of a facility policy, titled "Physician Orders," dated 8/3/10, and indicated this was the current policy used by the facility. A review of the policy indicated "Medical Orders Transcription...the provider may write the order in the medical record...a provider may give a medical order over the phone...verbal orders are accepted but will be input into [the electronic medical record] by the nurse as soon as practicable. The practitioner will need to sign off on these orders..." This Federal tag relates to Complaint IN00374538. 3.1-22(c)(1)		**expectation this policy is followed was reinforced and staff was reminded of the consequences to residents and staff if physicians' orders or facility policy are not followed and implemented.** **4) The DON/Designee will audit the residents' orders to ensure there are physician orders in place for either indwelling catheters and oxygen or both on the following schedule: 10 residents' orders x 4 weeks, 5 residents' orders x 4 weeks, and 10 residents' orders monthly x 4 months.** **The DON/Designee will review all new admissions during the clinical morning meeting to ensure the physician's orders are in place to meet the needs of the resident. Reviewing all new admissions in the clinical morning meeting to ensure orders are received and implemented will remain an ongoing facility practice.** **The DON/Designee is responsible for the compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive month. The QA Committee will identify any**	

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			trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0725 SS=H 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 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 ensure sufficient and competent nursing staff was provided. Treatment orders were not in place, appropriate care for a	F 0725	1) 1) Resident B no longer resides in the facility. Residents Y, E, M, F, D, K, J, and N were part of a confidential	04/27/2022

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	gtube was not provided, dressings were not dated, PICC line dressings were not changed, catheter care was not provided, medications were left in resident rooms, and antibiotics were given longer than prescribed. (Resident B, Resident Y, Resident E, Resident X, Resident M, Resident F, Resident D, Resident K, Resident J, Resident N) Finding includes: 1. During the survey dates of 3/9/22 through 3/21/22 the following interviews were completed. a. The facility does not have enough staff on evenings and weekends. b. The facility does not have enough staff. It takes an hour for call lights to be answered. 2. During an interview on 3/14/22 at 9:10 a.m. the Director of Nursing indicated the facility does not use competencies, instead the facility uses staff in-services for education. 3. On 3/18/21 at 2:00 P.M., the Activity Director provided a documents, titled "Resident Council Minutes". A review of the documents indicated long call light times were discussed at the Resident Council Meetings on 1/31/22 and 2/28/22. During Resident Council Meeting on 3/18/22 at 2:15 p.m., the residents indicated the facility does not have enough staff on third shift. 4. The Facility Assessment Tool, dated 10/1/21, indicated: "...average daily census 72... staffing needs...for direct care needs: 3 or 4 Licensed Practical Nurses (LPN) or Registered Nurses		complaint survey and could not be identified. Resident X was part of a confidential complaint survey. 2) All residents have the potential to be affected by the alleged deficient practice. 3) The facility will continue to staff at or above the minimum staffing requirements for its daily census to ensure sufficient staff to meet residents needs as determined by the updated facility assessment. The scheduler was educated on the existing policy for staffing requirements to ensure sufficient staff to meet assessed residents' needs. 4) The staffing schedule will be reviewed daily with the Executive Director, DON, Human Resource manager, and staffing coordinator to confirm appropriate staffing levels and identify the distribution of staff based on residents' needs. This remains an ongoing facility practice Monday through Friday and the weekend scheduled is reviewed in the Friday staffing meeting. ="" span="">"> The ED/Designee is responsible for compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance	

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	(RN) on day shift, 3 or 4 LPN or RN on evening shift, and 2 LPN or RN on night shift." 5. The as worked nursing schedule, dated 2/23/22 to 3/9/22, indicated: a. On 2/23/22, the facility had 1 Licensed Practical Nurse (LPN) that worked day shift, 1 LPN that worked evening shift, and 1 Registered Nurse (RN) that worked night shift. b. On 2/24/22, the facility had 1 LPN that worked day shift, 2 LPN's that worked evening shift, and 1 LPN that worked night shift. c. On 2/25/22, the facility had 1 LPN that worked day shift, 1 RN that worked evening shift, and 1 RN that worked night shift. d. On 2/26/22, the facility had 1 LPN that worked day shift, 1 LPN that worked evening shift, and 1 LPN that worked night shift. e. On 2/27/22, the facility had 1 LPN that worked day shift, 1 LPN that worked evening shift, and 1 LPN that worked night shift. f. On 2/28/22, the facility had 1 LPN that worked day shift, 2 LPN's that worked evening shift, and 1 RN that worked night shift. g. On 3/1/22, the facility had 2 LPN's that worked day shift, 1 LPN that worked evening shift, and 1 LPN that worked night shift. h. On 3/2/22, the facility had 1 LPN that worked day shift, 1 LPN that worked evening shift, and 1 LPN that worked night shift. i. On 3/3/22, the facility had 1 LPN that worked		is achieved x 3 consecutive month. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	day shift, 1 LPN and 1 RN that worked evening shift, and 1 RN that worked night shift. j. On 3/4/22, the facility had 2 LPN's that worked day shift, 2 LPN's that worked evening shift, and 1 LPN that worked night shift. k. On 3/5/22, the facility had 1 LPN that worked day shift, 1 LPN and 1 RN that worked evening and night shift. l. On 3/6/22, the facility had 2 LPN's that worked day shift, 1 LPN and 1 RN that worked evening and night shift. m. On 3/7/22, the facility had 1 LPN that worked day shift, 1 LPN and 1 RN that worked evening shift, and 1 RN that worked night shift. n. On 3/8/22, the facility had 1 LPN that worked day shift, 1 LPN that worked evening shift, and 1 LPN that worked night shift. o. On 3/9/22, the facility had 1 LPN that worked day shift, 1 LPN that worked evening shift, and 1 LPN that worked night shift. 6. The lack of sufficient nursing staff resulted surgical dressing changes not being completed. Cross reference F684. 7. The lack of sufficient nursing staff resulted care not being provided for a feeding tube. Cross reference F693. 8. The lack of sufficient nursing staff resulted PICC line dressings not being changed.			

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	Cross reference F694. 9. The lack of sufficient nursing staff resulted nutritional supplements not being provided. Cross reference F692. 10. The lack of sufficient nursing staff resulted medications being left in a resident room. Cross reference F689. 11. The lack of sufficient nursing staff resulted a resident receiving unnecessary medications. Cross reference F757. 12. The lack of sufficient nursing staff resulted a lack of urinary catheter care. Cross reference F690. This Federal tag relates to Complaint IN00374538. 3.1-17(a)			
F 0727 SS=D 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 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			

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	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 observation and record review, the facility failed to ensure 8 consecutive hours of RN (Registered Nurse) services 7 days a week for 9 of 28 days reviewed. Finding includes: On 3/9/22 between 8:45 A.M. an 9:00 A.M., during the initial facility tour, no RN was observed to be working the resident units. On 3/9/22 at 10:00 A.M., the daily "as worked" schedule for 3/9/22 indicated there was no RN coverage scheduled for the entire day. On 3/9/22 at 3:00 P.M., the schedule of licensed nurses for 2/10/22-3/9/22 was reviewed. The facility lacked 8 hours of RN coverage on 2/15/22, 2/22/22, 2/24/22, 2/26/22, 3/1/22, 3/2/22, 3/4/22, 3/8/22, and 3/9/22. On 3/9/22 at 3:25 P.M., proof of RN coverage was requested from the Regional Nurse. On 3/21/22 at 4:00 P.M., the facility failed to provide documentation for RN coverage on 2/15/22, 2/22/22, 2/24/22, 2/26/22, 3/1/22, 3/2/22, 3/4/22, 3/8/22 and 3/9/22 by survey exit. 3.1-17(b)(3)	F 0727	F 727 1) The facility allegedly failed to ensure 8 consecutive hours of RN services 7 days a week. 2) All residents have the potential to be affected by the alleged deficient practice. 3) The facility will staff 8 consecutive hours of RN services 7 days a week. The scheduler was educated on the existing facility staffing requirements with emphasis on 8 consecutive hours of RN services 7 days a week. This education emphasized the expectation that the facility would have RN services for 8 consecutive hours 7 days a week and the potential consequences of not staffing in accordance with facility staffing requirements. 4) The Executive Director, DON, Human Resource manager, and staffing coordinator will review the staffing schedule for each day to confirm that 8 consecutive hours of RN services are scheduled daily. This is an ongoing facility practice that will continue Monday through Friday. The weekend schedule is reviewed in the Friday staffing meeting.<br="" p="">	04/27/2022

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			The ED/Designee is responsible for compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive month. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
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 §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			

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	reasons stated in paragraphs (d)(1) through (5) of this section. Based on observation, interview, and record review, the facility failed to ensure residents were free from unnecessary medications for 1 of 6 residents reviewed for unnecessary medications. A resident received an antibiotic medication for two weeks beyond the hospital's discharge orders for the antibiotic. (Resident Y) Finding includes: On 3/14/22 at 11:23 A.M., Resident Y's clinical record was reviewed. A Quarterly MDS (Minimum Data Set) assessment, dated 12/29/21, indicated Resident Y was cognitively intact. The Physician's orders included, but were not limited to: Cefuroxime Axetil (an antibiotic medication), 250 mg (milligram) capsules, take one capsule every 12 hours, for infection. There was no end date for the antibiotic A Hospital Discharge note, dated 2/25/22, indicated Resident Y had been admitted and treated for altered mental status and was found to have a UTI (urinary tract infection) on arrival. She was treated at the hospital with 3 days of Cefuroxime Axetil . The note indicated the resident would be sent back to the facility 2 days of antibiotics to complete a 5 day course. The eMAR (electronic medication administration record) was included, but was not limited to: Cefuroxime Axetil 250 mg capsule had been signed out as given twice daily from 2/25/22 until 3/13/22. The 9:00 A.M. dose was documented as given on 3/14/22.	F 0757	F 757 1) Resident Y is part of a confidential complaint survey and could not be identified. 2) All residents receiving antibiotics have the potential to be affected by the alleged deficient practice. A facility-wide audit was conducted on all residents currently receiving antibiotics to ensure that there was physician's order for a stop date for the antibiotic, if appropriate. If a resident receiving an antibiotic did not have a stop date the resident's physician was notified and the antibiotic order was clarified as either continuous or a stop date was initiated per the physician's recommendation. 3) The DON/Designee has educated the licensed nursing staff on the facility's existing policys identified as, "Physician Orders" and "Medication Administration" with emphasis on accurate transcription of physician's orders and following physician's orders. The DON/Designee also educated the licensed nurses on the medication reconciliation process for new admissions. This education included reinforcement of the potential consequences to the residents and staff if physician's orders are not transcribed or implemented	04/27/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 3/14/22 at 3:11 P.M., during an observation with the ADON, Resident Y's ordered antibiotic medication could not be found in the medication cart. The ADON indicated she would reorder the medication. On 3/15/22 at 8:30 A.M., a progress note dated 3/14/22 at 3:45 P.M. stated, "Received new orders to DC [discontinue] Ceftin [Cefuroxime Axetil] due to completion of ATB (antibiotic). New orders have been noted and family aware of ATB [antibiotic] DC [discontinue]." On 3/21/22 at 8:40 A.M., an interview with the DON indicated that Resident Y's antibiotic orders should have been discontinued two days after her readmission date as stated in her hospital discharge orders. On 3/17/22 at 1:35 P.M., a current Medication Administration policy, dated 8/3/10, was provided by the DON who indicated this was the policy currently in use. The policy indicated "medication will be administered as prescribed." 3.1-48(a)(2) 3.1-48(a)(4)		accurately. 4) The DON/Designee will audit all new admissions and complete a medication reconciliation in the clinical morning meeting to ensure medication orders are transcribed accurately. This audit will be documented on a facility audit tool for 6 months but it remains an ongoing facility practice. The IP nurse/Designee will audit newly prescribed antibiotic orders for accuracy and to ensure a stop date is in place if ordered. This audit will be documented on a facility audit tool for 6 months but it remains an ongoing facility practice. ="" p=""> The DON/Designee is responsible for compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive month. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
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			

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	155780	A. BUILDING 00 B. WING	03/21/2022

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	must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §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 medications and supplies were stored properly for 2 of 2 medication carts observed, 1 of 1 Central Storage Room, and 1 of 1 medication rooms observed. Loose pills were observed in the medication carts, supplies were expired, and resident enteral nutrition was expired. (200 Hall Medication Cart, 600 Hall medication cart, Central Supply Storage Room, West Side Medication Room) Findings include: 1. On 3/18/22 at 10:28 A.M., the 200 Hall	F 0761	**F 761** **1) Resident N was part of a confidential compliant survey and could not be identified.** **2) All residents have the potential to be affected by the alleged deficient practice. A facility-wide audit was conducted of all the medication carts to ensure medications and supplies are stored in accordance with facility policy and are not expired. Any expired medications or supplies were destroyed or discarded in**	04/27/2022

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	Medication Cart drawers were observed to have the following pills loose and unlabeled in the bottoms of the drawers where resident medications were kept. The pills observed included: 3 white round pills, 1 pink round pill, 1 green round pill, 1 beige capsule, and one blue and white capsule. Eighteen residents received their medications from this medication cart on the 200 Hall. 2. On 3/18/22 at 10:45 A.M., the 600 Hall Medication Cart drawers were observed to have the following pills loose and unlabeled in the bottoms of the drawers where resident medications were kept. The pills observed included: 2 beige capsules, 1 oval white pill, 2 blue and white capsules, 4 round white pills, 2 blue round pills, 2 beige round pills, 1 red round pill, 1 orange round pill, 1 yellow round pill, 1 beige oval pill, and 2 round pale green pills. One side drawer was noted to have spilled medication powder and residue. Seventeen residents received their medications from this medication cart on the 600 Hall. On 3/18/22 at 10:55 A.M., an interview with the DON (Director of Nursing) indicated that the medication carts are supposed to be cleaned daily on night shift and as needed and that loose medications should have been properly discarded. 3. On 3/12/22 at 9:50 a.m., observed Resident N resting in bed. Next to the bed was an IV pole. Attached to the IV pole was an IV electronic pump, a ¾ filled plastic bottle of Jevity 1.2 cal (a prescribed liquid nourishment administered through a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications), and a clear plastic bag labeled "flush bag". The "flush bag" was observed to be		**accordance with facility policy, any expired enteral nutrition was discarded in accordance with facility policy, and any loose pills were destroyed in accordance with facility policy. Any non- compliance with facility policy governing medication carts, medication and supply storage, or expired enteral nutrition was immediately corrected, and staff was educated on the spot.** **3) All licensed nursing staff has been educated on the facility's existing policy identified as, "Storage of Medication" with emphasis on disposal of loose pills, expired enteral nutrition aid, and expired supplies. This education reinforced the expectation that facility policy will be followed and the potential consequences to both residents and staff if facility policy is not followed as expected.** **4) The DON/Designee will audit 4 medication carts 1 x weekly x 4 weeks, then 2 medication carts 1 x weekly x 4 weeks, then 2 medication carts monthly x 4 months to ensure there are no loose pills in the bottom of the drawers, that medications are stored properly and in accordance with facility policy. The DON/Designee will audit 2**	

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	connected to the Jevity 1.2 cal plastic bottle. The Jevity 1.2 cal plastic bottle had a long plastic tube that contained a tan colored liquid and was attached to the IV electronic pump. The IV electronic pump was observed to be turned to the off position. The tubing was observed to not be attached to Resident N. "Use by 12/1/21" was printed on the Jevity 1.2 cal bottle. 4. On 3/12/22 at 10:00 a.m., during a tour of the Central Supply Storage room with the DON. The DON was observed to open 4 boxes of Jevity 1.5 cal which contained 6 unopened bottles of Jevity. Each bottle had "use by 12/1/21" printed on the bottle. During an interview at that time, the DON indicated on 2/2/22 the facility supplier delivered the Jevity 1.5 cal boxes. The Central Supply Coordinator was to verify the product's "use by date" at the time of delivery from the supplier. Additionally, the nurses were to verify the status of the "use by date" before administering any medications or tube feedings. 5. During medication storage room observation, on 3/18/22 at 10:42 a.m., the following expired medications and medical supplies in the West Side Medication Room were observed: a. #1 BD 20 gauge insyte autoguard IV (intravenous) catheter (a devise used to draw blood and give treatments.), the label indicated an expiration date of 4/30/19. b. #1 BD 20 gauge insyte autoguard IV catheter, the label indicated an expiration date of 3/31/20. c. #1 BD 24 gauge IV catheter, the label indicated an expiration date of 11/30/20. d. #30 BD Safetyglide needles 21 gauge, the label indicated an expiration date of 10/31/21.		**medication rooms weekly x 8 weeks, then 1 medication room monthly x 4 months to ensure there are no expired supplies and that expired supplies are or have been properly discarded. The DON/Designee will audit the enteral nutrition supply 1 x weekly x 8 weeks, then 1 x monthly x 4 months to ensure there is no expired enteral nutrition and that expired enteral nutrition is or has been properly discarded. DON/Designee is responsible for the compliance. Audit findings will be presented to the QA Committee monthly meeting x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	e. #86 Hemocult single slides (A test used to screen for colorectal cancer), the label indicated an expiration date of 11/2020. f. #90 Hemocult single slides with a label that indicated an expiration date of February 2022. g. #150 Blood Glucose Test strips (used to determine a high or low blood sugar level), with a label that indicated an expiration date of 6/30/21. h. #3 Hydrophilic dressing foam (used on wounds to keep the area moist), with a label that indicated an expiration date of October 2021. During an interview at that time, the ADON indicated the expired medications and medical supplies should have been "pitched" at the time they had expired. On 3/18/22 at 11:35 A.M., a current Medication Storage and Labeling policy, dated February 2017, was provided by the DON who indicated this was the policy being used. The policy indicated that all medications and biologicals should be stored and labeled properly. On 3/21/22 at 11:09 a.m., the DON provided a policy titled Medication Administration, dated 8/3/10 and indicated it was the current policy being used by the facility. A review of the policy indicated "...ii. Check expiration dates 1. Do not administer expired medications." 3.1-25(o)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary			

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	§483.60(i) Food safety requirements. 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 serve food in a sanitary manner during 4 of 4 observations where staff's hair was uncovered. (Dietary Manager, Dietary Aide 1, CNA 2) Findings includes: 1. During the initial kitchen tour on 3/10/22 from 3:35 p.m. to 3:55 p.m., the DM (Dietary Manager) was observed walking through out the kitchen where the evening meal was being prepared. The DM was observed wearing a surgical face mask. Between the DM's ears and the surgical face mask area, facial hair, ½ inch in length, was visible and was observed to not be covered. At the chin area, below the surgical	F 0812	F 812 1) No residents were identified in the alleged deficient practice. 2) All residents have the potential to be affected by alleged deficient practice. 3) The Regional Dietary consultant has educated the dietary staff on facility policy including appropriate staff attire with an emphasis on ensuring facial hair be covered. The DON/Designee has educated the staff on the facility's existing policy requiring appropriate attire in the kitchen with an emphasis on hair coverings and facial hair coverings. This education	04/27/2022

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	face mask facial hair, 2 inches in length, was observed to not be covered. 2. During a follow-up kitchen tour on 3/11/22 from 10:45 a.m. to 11:05 a.m., the following was observed: a. The DM was observed walking near the steamtable area where the noon meal foods were kept. The DM then began placing the lids onto the resident's plated noon meal foods. The DM was observed wearing a surgical face mask. Between the DM's ears and the surgical face mask area, facial hair, ½ inch in length, was visible and was observed to not be covered. At the chin area, below the surgical face mask, facial hair, 2 inches in length, was observed to not be covered. b. Dietary Aide 1 was observed near the steamtable area where the noon meal foods were kept. Dietary Aide 1 began to prepare the resident's food trays. Dietary Aide 1 was observed wearing a surgical face mask. Between the Dietary Aide 1's ears and the surgical face mask area, facial hair, ¾ inch in length, was visible and was observed to not be covered. At the chin area, below the surgical face mask facial hair, 1 inch in length, was observed to not be covered. 3. During a follow-up kitchen tour on 3/11/22 from 12:30 p.m. to 12:37 p.m., the following was observed: a. The DM was observed walking near the steamtable area where the noon meal foods were kept. At the grill, next to the steamtable, the DM prepared a grilled cheese sandwich for a resident. The DM was observed wearing a surgical face		reinforced the expectation that the facility's policies and expectations will be followed and the consequences for failing to do so. 4) The Executive Director/Designee will observe the staff for appropriate attire in the kitchen on random shifts and weekends on the following schedule: 10 staff members weekly x 4 weeks, then 5 staff members weekly x 4 weeks, then 10 staff members monthly. The ED/Designee is responsible for compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive month. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	mask. Between the DM's ears and the surgical face mask area, facial hair, ½ inch in length, was visible and was observed to not be covered. At the chin area, below the surgical face mask, facial hair, 2 inches in length, was observed to not be covered. b. Dietary Aide 1 was observed near the steamtable area where the noon meal foods were kept. Dietary Aide 1 then walked to the dish machine and began washing dishes. Dietary Aide 1 was observed wearing a surgical face mask. Between the Dietary Aide 1's ears and the surgical face mask area, facial hair, ¾ inch in length, was visible and was observed to not be covered. At the chin area, below the surgical face mask, facial hair, 1 inch in length, was observed to not be covered. c. CNA (Certified Nursing Assistant) 2 entered the kitchen area. While conversing with the dietary staff, CNA 2 walked to the steamtable where the noon meal foods were kept and stood at the grill area where a resident's grilled cheese sandwich was being prepared. CNA 2's hair, 6 inches in length, was observed to not be covered. 4. During a follow-up kitchen tour 3/14/22 from 9:15 a.m. to 9:20 a.m., the following was observed: a. Dietary Aide 1 was observed walking through out the kitchen near where the noon meal was being prepared, then walked to the dish machine and began washing dishes. Dietary Aide 1 was observed wearing a surgical face mask. Between the Dietary Aide 1's ears and the surgical face mask area, facial hair, ¾ inch in length, was visible and was observed to not be covered. At the chin area, below the surgical face mask,			

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	facial hair, 1 inch in length, was observed to not be covered. During an interview at that time, Dietary Aide 1 indicated the facial hair under the chin was to be covered but he was unsure if the hair in front of the ears was to be covered. b. The DM was observed walking through out the kitchen area near where the noon meal was being prepared. The DM was observed wearing a surgical face mask. Between the DM's ears and the surgical face mask area, facial hair, ½ inch in length, was visible and was observed to not be covered. At the chin area, below the surgical face mask facial hair, 2 inches in length, was observed to not be covered. During an interview on 3/14/22 at 9:25 a.m., the DM indicated while in the kitchen, all dietary staff's hair, including facial hair, was to be covered. On 3/15/22 at 9:05 a.m., the DM provided a copy of the Staff Attire policy, date 9/2017, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...all staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained..." On 3/14/22 at 2:00 p.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated, "...food employees shall wear hair restraints such as...hair coverings or nets, beard restraints...that are designed and worn to wear effectively keep their hair from contacting...exposed food..." 3.1-21(i)(2) 3.1-21(i)(3)			

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F 0814 SS=C Bldg. 00	483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure the dumpster's sliding side panel door and top lid were kept closed when not in use for 3 of 3 observations. Findings include: During the initial kitchen tour with the Dietary Manager (DM) on 3/10/22 from 4:00 p.m. to 4:05 p.m., the dumpster site area was observed, located near the east wing's north exit door, which contained 2 individual dumpsters. Multiple geese were observed near the dumpster site area. The dumpster, on the left, had 2 top lids and 2 sliding side panel doors. The top lid and sliding side panel door, on the left side of the dumpster, was observed to be not closed. No staff members were observed in the area at that time. During an interview at that time, the DM indicated all dumpster lids and doors were to be kept closed when not in use. On 3/11/22 from 5:10 p.m. to 5:15 p.m., the dumpster site area was observed, located near the east wing's north exit door, which contained 2 individual dumpsters. Multiple geese were observed near the dumpster site area. The dumpster, on the left, had 2 top lids and 2 sliding side panel doors. The top lid, on the right side of the dumpster, was observed to not be closed and filled trash bags were partially hanging outside of the dumpster. No staff members were observed in the area at that time.	F 0814	F 814 1) No residents were identified in the alleged practice 2) All residents have the potential to be affected by alleged deficient practice. 3) The Regional Dietary consultant has educated the dietary staff on the existing facility protocol for the appropriate disposal of waste with an emphasis on closing the side panel door and top lid. The DON/Designee has educated the staff on the existing facility protocol for appropriate disposal of waste with emphasis on closing the side panel door and top lid. This education reinforced the expectation facility sanitation protocols will be strictly followed and discussed the potential consequences to both staff and residents if sanitation protocols are not followed. 4) The Executive Director/Designee will observe the dumpster site during random shifts and weekends to ensure the side panel door and top lid are closed based on the following schedule: 10 observations weekly x 4 weeks, then 5 observations weekly x 4 weeks, then 10 observations monthly. The ED/Designee is responsible	04/27/2022

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	On 3/14/22 from 4:00 p.m. to 4:05 p.m., the dumpster site area was observed, located near the east wing's north exit door, which contained 2 separate dumpsters. Multiple geese were observed near the dumpster site area. The dumpster, on the left, had 2 top lids and 2 sliding side panel doors. The top lid, on the right side of the dumpster, was observed to not be closed and filled trash bags were visible inside the dumpster. No staff members were observed in the area at that time. On 3/15/22 at 9:05 a.m., the DM provided a copy of the Dispose of Garbage and Refuse policy and indicated it was the current policy in use by the facility. A review of the policy indicated, "...all garbage and refuse will be collected and disposed of in a safe and efficient manner....the dining services director will ensure that...appropriately lined containers are available within the food services area for disposal of garbage or other refuse...appropriate lids are provided for all containers..." On 3/14/22 at 10:40 a.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated, "...receptacles and waste handling units for refuse, recyclables and returnables shall be kept covered with tight-fitting lids or doors if kept outside..." 3.1-21(i)(2) 3.1-21(i)(5)		for compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive month. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0838 SS=F Bldg. 00	483.70(e)(1)-(3) Facility Assessment §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what			

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	resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific			

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	155780	A. BUILDING 00 B. WING	03/21/2022

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	rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. Based on interview and record review, the facility failed to thoroughly conduct and document a facility-wide assessment based on the residents needs and the required resources to provide the care and services needed. This had the potential to affect 75 of 75 residents residing in the facility. Finding includes: On 3/18/22 at 3:00 p.m., the Facility Assessment Tool guide was reviewed. A review of the tool indicated, "...Requirement: Nursing Facilities will conduct, document, and annually review a facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents...Purpose: The purpose of the assessment is to determine what resources are necessary to care for residents competently	F 0838	F 838 1) No specific resident was identified as being affected by the alleged deficient practice. 2) All residents have the potential to be affected by the alleged deficient practice. A review of the current facility-wide assessment tool has been complete 3) The Regional Director of Clinical operations has educated the ED, DON and IDT on the existing facility policy identified as, “Annual Facility Assessment” with emphasis on conducting and documenting a thorough facility-wide assessment to include required staff competencies that are necessary to provide the level and types of	04/27/2022

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	during both day to day operations and emergencies." On 3/21/22 at 2:35 p.m., the Administrator provided a copy of the Facility Assessment Tool for Homestead Healthcare Center, dated 11/2020 through 10/2021, and indicated it was the current and completed facility assessment in use by the facility. A review of the document included the following: -The Facility Assessment was completed on 10/1/21. Staff members involved in the completion of the Facility Assessment included the Administrator, Director of Nursing, Governing Body Representative, Human Resources Director, Business Office Manager, Medical Director, and the Admission Director. -Section 3.3 lacked documented description for "how you determine and review individual staff assignments for coordination and continuity of care for residents within and across the staff assignments." -Section 3.4 lacked documented description for "how staff training/education and competencies that are necessary to provide the level and types of support and care needed for the resident population." -Section 3.5 lacked documented description for "how you for evaluate what policies and procedures may be required for the provision of care and how you ensure those meet current professional standards of practice." -Section 3.6 lacked documented description of the plan "to recruit and retain enough medical practitioners (e.g. physicians, nurse		care that have been identified for the resident population. This education reinforced the expectation this comprehensive tool will be utilized as expected and produce accurate and complete responses and overviews, and the potential consequences to both residents and staff if this assessment tool is not utilized properly. 4) The ED/Designee will audit the facility-wide assessment monthly x 6 months to ensure the assessment continues to accurately reflect a comprehensive facility -wide assessment that is based on the resident's assessed needs and identifies the resources required to provide the care and services needed are obtained and available. The ED/Designee is responsible for compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive month. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. ="" span="">	

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	practitioners) who are adequately trained and knowledgeable in the care of the resident population, including how you will collaborate with them to ensure that the facility has appropriate medical practices for the needs and scope of your population." -Section 3.7 lacked documented description for "how management and staff familiarize themselves with what they should expect from medical practitioners and other healthcare professionals related to standards of care and competencies necessary to provide the level and types of support and care needed for the resident population." -Section 3.9 lacked documented "...lists of contracts, memoranda of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies." -Section 3.10 lacked documented "...list of health information technology resources, such as systems for electronically managing resident records and electronically sharing information with other organizations." -Section 3.11 lacked documented evaluation process for the "...infection prevention and control program that included effective systems for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for residents, staff, volunteers, visitors, and other service providers under contractual arrangement that meet accepted national standards." -Section 3.12 lacked documented "...facility-based and community-based risk			

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	assessment, utilizing an all-hazards approach (an integrated approach focusing on capacities and capabilities critical to preparedness for a full spectrum of emergencies and natural disasters)." During an interview on 3/10/22 at 9:30 a.m., the Administrator indicated the facility census was 75. On 3/11/22 at 1:15 p.m., the Administrator provided a copy of the QAPI (Quality Assurance Performance Improvement) Plan, dated 5/30/19, and indicated it was the current policy in use by the facility. A review of the document indicated, "...to identify opportunities for improvement, address gaps in systems or processes, develop and implement an improvement or corrective plan and continuously monitor effectiveness of interventions...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety of residents, staff and visitors is a primary focus of the facility. Regulations require that the facility have a on-going quality assurance process improvement plan to monitor the quality of resident care..."			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.			

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	§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law;			

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	or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on observation, interview, and record review, the facility failed to keep an accurate medical record for 2 of 21 residents reviewed for resident medical records. A resident had an antibiotic medication signed off as given in excess of the number of doses available and a resident had discrepancies noted between the electronic medication administration record (eMAR) and the physical narcotic sign-out sheets on paper. (Resident 56, Resident Y) Findings include: 1. On 3/14/22 at 11:23 A.M., Resident Y's clinical record was reviewed. A Quarterly MDS (Minimum Data Set) assessment, dated 12/29/21, indicated Resident Y was cognitively intact.	F 0842	F 842 1) Resident 56 was not harmed by the alleged deficient practice. The NP was notified of discrepancies between the EMAR and the physical narcotic sign-out sheets. Resident Y was part of a confidential complaint survey and could not be identified. 2) All residents who receive narcotics and antibiotics have the potential to be affected by the alleged deficient practice. A facility-wide audit was conducted to ensure all residents currently receiving antibiotics had accurate medication administration documentation demonstrating	04/27/2022

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	The Physician's orders included, but were not limited to: Cefuroxime Axetil (an antibiotic medication), 250 mg (milligram) capsules, take one capsule every 12 hours, for infection. There was no end date for the antibiotic A Hospital Discharge note, dated 2/25/22, indicated Resident Y had been admitted and treated for altered mental status and was found to have a UTI (urinary tract infection) on arrival. She was treated at the hospital with 3 days of Cefuroxime Axetil . The note indicated the resident would be sent back to the facility 2 days of antibiotics to complete a 5 day course. The eMAR (electronic medication administration record) was included, but was not limited to: Cefuroxime Axetil 250 mg capsule had been signed out as given twice daily from 2/25/22 until 3/13/22. The 9:00 A.M. dose was documented as given on 3/14/22. On 3/14/22 at 3:11 P.M., during an observation with the ADON, Resident Y's ordered antibiotic medication could not be found in the medication cart. The ADON indicated she would reorder the medication. On 3/15/22 at 11:26 A.M., the DON provided the following clarifications from the pharmacy. The pharmacy indicated they sent 4 doses of Resident Y's antibiotic on 2/26/22, 4 doses on 3/2/22, 4 doses on 3/6/22, and 4 doses on 3/7/22 for a total of 16 doses sent. No doses of the antibiotic were noted to be removed from the back up pharmacy supply kit for Resident Y. The total number of doses signed out as given until the 3/14/22 discontinue date was 35 doses given.		implementation of and compliance with the physician's order. A facility-wide audit was conducted to ensure all residents currently receiving narcotics had accurate medication administration documentation in the EMAR demonstrating implementation of and compliance with the physician's order, and that the facility's narcotic sign-out sheet for the past 14 days was accurate and complete. If any discrepancies between residents' records and the narcotic sign-out shee were detected, that resident(s)'s physician was notified for further order, if any. 3) The DON/Designee has educated all licensed nursing staff and qualified medications aides on the facility's existing policies identified as, "Medication Administration" and "Physician Order" with an emphasis on accurate documentation in both the clinical records and facility count and verification tools, as well as following physician's orders. This education including reinforcing the expectation facility policies will be followed and the potential consequences for both residents and staff if this expectation is not met. 4) The DON/Designee will audit residents EMAR and facility's narcotic sheet to ensure accurate documentation of narcotics and antibiotics on the	

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	On 3/21/22 at 8:40 A.M., an interview with the DON indicated, when asked about the number of doses of antibiotic given and the number of times it was signed out for the duration of the active order, that staff had been signing it out at times without administerting the medication. 2. On 3/11/22 at 11:15 A.M., Resident 56's medical record was reviewed. An Admission MDS (Minimum Date Set) assessment, dated 2/2/22 indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, CVA affecting the left/dominant side, high blood pressure, and COPD (chronic obstructive pulmonary disorder). On 3/16/22 at 9:20 A.M., Resident 56's sign-out sheets for her narcotic pain pill indicated that she received her PRN (as needed; resident may have it as needed for pain within order parameters) Hydrocodone-Acetaminophen (an opoid pain pill) 5/325 mg (milligram) tablet at least once daily from 2/3/22 through 2/8/22 and from 2/10/22 to 2/27/22. On 3/16/22 at 9:40 A.M., Resident 56's eMAR for the hydrocodone-acetaminophen order indicated 10 days where she did not receive a tablet of her PRN pain medication at least once daily from 2/3/22 through 2/27/22 including; 2/3/22, 2/5/22, 2/6/22, 2/9/22, 2/10/22, 2/14/22, 2/15/22, 2/20/22, 2/21/22, and 2/23/22. On 3/18/22 at 9:42 A.M., a comparison of Resident 56's paper sign-out sheets for the Norco 5/325mg order and the eMAR for the Norco 5/325mg order indicated there were 17 instances of the paper sign-out sheet having more Norco tabs signed out than were marked as given		following schedule: 10 residents x 4 weeks, then 5 residents x 4 weeks, then 10 residents monthly x 4 months. ="" p=""> The DON/Designee is responsible for compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive month. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	in the eMAR. The discrepancies are as follows for Resident 56's Norco 5/325mg 1 tab every 6 hours PRN order: -On 2/3/22 the narcotic sign-out sheet indicated 2 doses were given and the eMAR indicated none were given, -On 2/4/22 the narcotic sign-out sheet indicated 3 doses were given and the eMAR indicated 1 was given, -On 2/5/22 the narcotic sign-out sheet indicated 3 doses were given and the eMAR indicated none were given, -On 2/6/22 the narcotic sign-out sheet indicated 3 doses were given and the eMAR indicated none were given, -On 2/7/22 the narcotic sign-out sheet indicated 2 doses were given and the eMAR indicated 1 was given, -On 2/10/22 the narcotic sign-out sheet indicated 1 dose was given and the eMAR indicated none were given, -On 2/11/22 the narcotic sign-out sheet indicated 2 doses were given and the eMAR indicated 1 was given, -On 2/13/22 the narcotic sign-out sheet indicated 3 doses were given and the eMAR indicated 2 doses were given, -On 2/14/22 the narcotic sign-out sheet indicated 3 doses were given and the eMAR indicated none were given, -On 2/15/22 the narcotic sign-out sheet indicated 1 dose was given and the eMAR indicated none were given, -On 2/16/22 the narcotic sign-out sheet indicated 2 doses were given and the eMAR indicated 1 dose was given, -On 2/18/22 the narcotic sign-out sheet indicated 2 doses were given and the eMAR indicated 1 dose was given,			

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	-On 2/19/22 the narcotic sign-out sheet indicated 3 doses were given and the eMAR indicated 1 dose was given, -On 2/20/22 the narcotic sign-out sheet indicated 2 doses were given and the eMAR indicated none were given, -On 2/21/22 the narcotic sign-out sheet indicated 2 doses were given and the eMAR indicated none were given, -On 2/23/22 the narcotic sign-out sheet indicated 2 doses were given and the eMAR indicated none were given, -On 2/24/22 the narcotic sign-out sheet indicated 3 doses were given and the eMAR indicated 1 dose was given. On 3/17/22 at 1:35 P.M., a current Medication Administration policy, dated 8/3/10 was provided by the DON who indicated this was the policy being used. A review of the policy indicated, under section VI. Narcotic that staff are to "a. Sign out narcotic controlled substance[s] from narcotic count card when removed" and to "b. Record narcotic in MAR". On 3/18/22 at 9:50 A.M., an interview with the Regional Nurse indicated that the discrepancy was a documentation issue and that staff should be signing it in both the eMAR and on the narcotic sign-out sheets. 3.1-50(a)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent			

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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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	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 COVID-19 infection control measures were implemented to prevent the potential spread of COVID-19 for 1 of 1 residents who received aerosol generating procedures. (Resident 66) Findings include: On 3/9/22 from 11:24 a.m. until 11:29 a.m., Resident 66 was observed in his room with a c-pap (continuous positive airway pressure) mask on his face. The mask was observed to have aerosol mist coming from the face mask.	F 0880	**F 880** **1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident 66 had signage placed on his door to indicate type of isolation and instructions for use during aerosol generating procedure (c-pap). Resident 66 had PPE placed on his door for when aerosol	04/15/2022

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	155780	A. BUILDING 00 B. WING	03/21/2022

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	Resident 66's room mate (Resident 41) was present on his side of the shared room watching television. The privacy curtain, between Resident 66 and Resident 41, was observed to be open, exposing Resident 41 to the aerosol mist from Resident 66's C-PAP. No signage was observed to be on the residents door to indicate a type of isolation and instructions. No PPE (personal protective equipment) was observed outside of the residents door. During an interview at that time, the resident indicated he can use the C-PAP anytime he wants and uses it all the time. During an interview on 3/9/22 at 11:29 a.m., the Wound Nurse indicated Resident 66 should have an isolation sign on his door and PPE outside of this door. On 3/10/22 at 11:10 a.m., the record of Resident 66 was reviewed. The diagnosis included but were not limited to, chronic obstructive pulmonary disease and obstructive sleep apnea. A Physicians order summary, dated March 2022, indicated CPAP Rate 10 with Oxygen at 6 liters at night and as needed, with a start date of 9/8/21 for the diagnosis obstructive sleep apnea. On 3/11/22 from 10:30 a.m. until 10:45 a.m., Resident 66 was observed in his room with c-pap face mask on his face. The mask was observed to have aerosol mist coming from the face mask. Resident 66's roommate was present in the room. The privacy curtain between Resident 66 and Resident 41 was observed to not be pulled shut, exposing Resident 41 to the aerosol mist from Resident 66's C-PAP. During an interview on 3/11/22 at 10:45 a.m., the		generating procedure (c-pap) is in use. Resident 66 will have privacy curtain pulled in his room for when aerosol generating procedure (c-pap) is in use. **2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: Residents who have a physician order for aerosol generating procedures (AGP) will have signage placed on the door to indicate the type of isolation and instructions for use, PPE placed on the door and privacy curtain pulled in the room for when the AGP is in use. The DON or designee will complete the following: · Staff and resident education on proper procedure for Aerosol Generating Procedures (AGP) and Infection Control practices before and after AGP ·Facility Policy: Guidance for Aerosol Generating Procedures ·Indiana Department of Health LTC Covid-19 IP Toolkit – pages 20-22 for AGP **3. Measures put in place and systemic changes made to**	

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	Assistant Director of Nursing indicated she was not sure if the resident should be in isolation. On 3/12/22 at 9:00 a.m., the Director of Nursing provided a policy titled Policies and Standard Procedures, dated 9/2/2020, and indicated it was the current policy being used by the facility. A review of the policy indicated, "**Higher risk Exposure: refers to exposure of ...aerosol-generating procedure. This can occur when staff do not wear adequate personal protective equipment during care..." 3.1-18(b)(1)		**ensure the alleged deficient practice does not recur:** A Root Cause Analysis (RCA) was conducted with the Infection Preventionist (IP) and input from the IDT and the facility Medical Director/IP/DON. The root cause was identified resulting in the facility's alleged failure. Solutions were developed and systemic changes were identified that need to be taken to address the root cause. The Infection Preventionist and IDT reviewed the LTC infection control self-assessment and identified changes to make accurate **4. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** After the IDT and Infection Preventionist completed the RCA and LTC infection control assessment, training identified above was implemented to facility staff. The training will be conducted by the DON, IP or Medical Director with documentation of completion. To ensure Infection Control	

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			Practices are maintained, the following monitoring will be implemented. 1. The IP nurse/DON/Designee will monitor each solution and systemic change identified in RCA and as noted above, daily or more often as necessary for 6 weeks and until compliance is maintained. Ensure residents who have a physician order for aerosol generating procedures (AGP) will have signage placed on the door to indicate the type of isolation and instructions for use, PPE placed on the door and privacy curtain pulled in the room for when the AGP is in use 2. The IP nurse/DON/Designee will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with the solutions identified as above. This will occur for 6 weeks and until compliance is maintained. Ensure residents who have a physician order for aerosol generating procedures (AGP) will have signage placed on the door to indicate the type of isolation and instructions for use, PPE placed on the door and privacy curtain pulled in the room for	

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			when the AGP is in use **5. Quality Assurance and Performance Improvement (QAPI):** The facility through the QAPI program, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.	
F 9999 Bldg. 00	3.1-13 Administration and Management (g) The administrator is responsible for the overall management of the facility but shall not function as a department, for example, director of nursing or food service supervisor, during the same hours, The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any: (D) major accidents If the department cannot be reached, such as on holidays or weekends, a call shall be made to the emergency telephone number (317) 383-6144) of the division. This State rule was not met as evidenced by: Based on observation, interview, and record review, the facility failed to report a major injury	F 9999	**F9999** **1) Resident 10's fall was reported to the Indiana Department of Health Gateway reporting system.** **2) All residents who experienced an injury from a fall that required reporting have the potential to be affected by the alleged deficient practice. An audit was conducted on all residents who experienced an injury from a fall in the last 30 days to ensure appropriate reporting was completed and if any fall with injury had not been reported, that incident was reported to the Indiana Department of Health Gateway reporting system.** **3) The Regional Director of Clinical Operations (RDCO) has educated the Administrator and Director of Nursing on the**	04/27/2022

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	obtained from a resident fall to the Indiana Department of Health (IDOH, a fall which required medical treatment beyond basic first aid for 1 of 2 residents reviewed for falls. (Resident 10) Findings Include: During an interview on 3/14/22 at 9:15 a.m., Resident 10 indicated that he had fallen in his room on 5/13/21 and indicated he started feeling his neck and back hurt that evening and it had worsened by the next day. The next morning the resident let the Nurse Practitioner know about the worsening pain. The resident indicated that he was sent out of the facility to the Emergency Room (ER) in which lab work and a CT scan (computed tomography) were performed. The resident was admitted with the diagnosis of hyponatremia (low sodium level) and traumatic cervical neck fracture. On 3/16/22 at 9:25 a.m., Resident 10's record was reviewed. The diagnoses included, but was not limited to, type 3 traumatic spondylolisthesis of the seventh cervical vertebra (fractured neck), paraplegia, and diabetes mellitus. On 5/13/21 at 2:28 p.m., Resident 10 experienced an unwitnessed fall in his room. According to the Post Fall Evaluation completed on 5/13/21 at 2:27 p.m., there was not an injury that occurred as a result of the fall. The physician and the resident's daughter were notified of the fall. Physician orders for neck and back x-rays were received. The x-rays obtained to the neck and back were negative for injury. On 5/14/22 at 10:02 a.m., Resident 10		**existing "Reportable Incident Policy" from the Indiana Department of Health website with emphasis on reporting falls with major injuries. The RDCO reiterated the expectation this policy is followed and the Administrator and DON were reminded of the consequences of not following facility policy.** **4) The RDCO will audit residents who experienced a fall to ensure that falls with injury are reported to the IDOH Health Gateway reporting system based on the following schedule: all falls x 4 weeks, then 10 falls weekly x 4 weeks, then 10 falls monthly x 4 months.** **The RDCO is responsible for the compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive month. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	complained to the Nurse Practitioner that he was experiencing neck and back pain from the fall he had on 5/13/21. On 5/14/21 Resident 10 was sent out to the ER for evaluation. A CT scan was completed and showed a right fractured cervical vertebra. The resident was admitted for hyponatremia (low sodium level) and a fractured neck. During an interview on 3/21/22 at 11:15 a.m., the Administrator indicated the facility had not reported the fall with resulting neck fracture to the Indiana State Department of Health. The Division of LongTerm Care Reportable Incident Policy, dated 7/15/15, indicated, "...C. Types of incidents reportable ...5. Major accidents - unexpected or unintentional events resulting in any fracture or other outcomes that require medical treatment beyond basic first aid or ER/physician evaluation."			