STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE ARBORS MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 5/30/23. This visit included a PSR to the Investigation of Complaints IN00404726, IN00404823, IN00405200, IN00405707, and IN00405922 completed on 5/30/23. This visit was done in conjunction with the Investigation of Complaints IN00409912, IN00410989, and IN00411376. Complaint IN00404726 - Corrected. Complaint IN00404823 - Not Corrected. Complaint IN00405200 - Not Corrected. Complaint IN00405707 - Corrected. Complaint IN00405922 - Corrected. Complaint IN00409912 - Federal/State deficiencies related to the allegations are cited at F580, F686, and F773. Complaint IN00410989 - No deficiencies related to the allegations are cited. Complaint IN00411376 - Federal/State deficiencies related to the allegations are cited at F686 and F774. Survey dates: July 19 and 20, 2023 Facility number: 000076 Provider number: 155156 AIM number: 100271060	F 0000	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. The facility respectfully requests a desk review for these alleged deficient practices.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Todd Smith	Executive Director	08/01/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Census Bed Type: SNF/NF: 120 Total: 120 Census Payor Type: Medicare: 9 Medicaid: 89 Other: 22 Total: 120 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 7/24/23.			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).			

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	(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on record review and interview, the facility failed to ensure the Physician was notified of a possible fracture for 1 of 3 residents reviewed for notification of change. (Resident B) Finding includes: An Incident Report, dated 5/26/23 at 4:01 p.m. and received from the Administrator, indicated Resident B had a follow up to an initial x-ray for complaints of pain to the left foot. The type of injury was a diffuse prominent osteopenia with	F 0580	**Tag number: F580 – Notify of Changes** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident B's change in condition was communicated with the NP.	08/04/2023

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	linear lucencies that suggested subacute healing fractures of the distal fibula and tibial metaphysis. His lower extremity was immobilized immediately and the physician and responsible party were notified. The follow-up on 6/2/23 indicated the resident returned from the hospital from a CT scan and the results were reported on 5/26/23 which indicated there were no negative acute findings. The record for Resident B was reviewed on 7/19/23 at 10:02 a.m. Diagnoses included, but were not limited to, hemiplegia (one sided weakness) following a stroke affecting the left non-dominant side, heart failure, and dementia. The Annual Minimum Data Set (MDS) assessment, dated 6/22/23, indicated the resident was cognitively intact for daily decision making. The resident required extensive assistance with two persons physical assist for bed mobility, transfer, dressing, toilet use, and personal hygiene. He had an impairment for range of motion on one side on both the upper and lower extremities. A Radiology Results Report, dated 5/19/23 at 11:55 a.m., indicated the resident had a possible distal tibial fracture. The results were reported to the Nurse Practitioner on 5/22/23 at 9:48 a.m. New orders were received for the resident to have a consult with an orthopedic surgeon. An appointment was made for 5/25/23. An Incident IDT Note, dated 5/23/23 at 2:46 p.m., indicated the resident had an area noted to his left sub-medial metatarsal. The root cause of the incident was noted to be due to the resident rubbing his foot up against the footboard of the		II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice. All notifications of pertinent changes in condition will be communicated with all resident physicians and/or NPs 7 days a week.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to educate nursing staff by 8-4-2023 on necessary notifications of changes in condition to resident physician/NP.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct a notification of change audit to ensure notifications of changes are reported to physician/NP per regulation. Audits will be completed 7x/week for 4 weeks, 3x/week for 4 weeks**	

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	bed. Wound care was initiated and a longer bed was given to the resident. Interview with the Director of Nursing, on 7/20/23 at 4:44 p.m., indicated she was made aware of the resident having pain to his left foot by a QMA. She assessed the resident and he had swelling and pain to the left foot so she made the Nurse Practitioner aware. There were new orders to obtain an x-ray of the foot which was completed on 5/19/23. The Nurse Practitioner should have been made aware of the results immediately as they were available. She placed the resident in a new bed as his foot was pushing against the foot board and they were under the impression that this was causing his foot pain. A formal investigation was never started to determine the root cause of the possible fracture because they were waiting on the results from the x-ray and scans to come back to determine the extent of the injury. A Policy titled, "Physician-Family Notification-Change in Condition," noted as current, indicated "...Guidelines: The facility will inform the resident; consult with the resident's physician or authorized designee such as Nurse Practitioner; and if known, notify the resident's legal representative or an interested family member when there is: (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention..." This deficiency was cited on 5/30/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-5(a)(1)		**then weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater 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.** Date of compliance: 8/4/2023	

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F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to ensure neurological checks were thoroughly completed following a fall for 1 of 3 residents reviewed for falls. (Resident D) Finding includes: The record for Resident D was reviewed on 7/20/23 at 9:56 a.m. Diagnoses included, but were not limited to, orthopedic aftercare, lack of coordination, fractured left femur, and dementia without behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 6/2/23, indicated the resident was cognitively impaired for daily decision making and she required extensive assistance with bed mobility and transfers. A Care Plan, dated 5/4/23, indicated the resident had a potential for falls related to confusion, incontinence, and unfamiliar environment due to the diagnosis of dementia. The goal was to have no falls thru the next review. An Initial Fall Occurrence Note, dated 7/9/23 at 8:30 a.m., indicated the resident had an unwitnessed fall. She was found on the floor in	F 0684	**Tag number: F684 – Quality of Care** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident D had no adverse reaction to the missing neurochecks.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice. Moving forward all residents with unwitnessed falls to have neurological checks completed per policy and procedure.** III. What measures will be put into place and what systemic changes will be made to	08/04/2023

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	the common area after breakfast. Neurological checks were initiated and no injuries were observed. Neurological checks were started on 7/9/23 and were completed on 7/12/23. Neurological checks were to be completed every 4 hours times 6. Only 4 assessments were documented. Neurological checks were then to be completed every 8 hours times 6. Only 2 assessments were documented. Interview with the Nurse Consultant on 7/20/23 at 4:10 p.m., indicated some of the neurological check assessments had not been completed per protocol. This deficiency was cited on 5/30/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-37(a)		ensure that the deficient practice does not recur; **DON/designee to re-educate nursing staff on protocols for witnessed/unwitnessed falls, neurological checks, monitoring of bruising utilizing Skin Condition Assessment and Monitoring Pressure and Non-Pressure policy and procedure.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct an accident and incident audit to ensure compliance in monitoring. Updated audits to include shift-to-shift nurse report of all residents requiring neurochecks will be completed 5x/week for 4 weeks, 3x/week for 4 weeks then weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater 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.** Date of compliance: 8/4/2023	

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F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			
	Based on record review and interview, the facility failed to ensure residents with pressure ulcers received the necessary treatment and services to promote healing, related to turning and repositioning and treatments not completed as ordered for 2 of 3 residents reviewed for pressure ulcers. (Residents C and E) Findings include: 1. The closed record for Resident C was reviewed on 7/19/23 at 2:15 p.m. Diagnoses included, but were not limited to, high blood pressure, multiple myeloma, paraplegia, and acute respiratory failure. The resident was admitted to the facility on 4/28/23 and discharged to the hospital on 6/9/23. The resident was admitted to the hospital several times over the course of her stay at the facility as follows: - Hospital admission on 5/8/23 and returned 5/12/23	F 0686	**Tag number: F686 – Treatment/Svcs to Prevent/Heal Pressure Ulcer** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Residents C and E had no adverse reactions to cited alleged deficient practice.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents with pressure areas have the potential to be affected by the alleged deficient practice. The**	08/04/2023

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	- Hospital admission on 5/17 and returned on 5/30/23 The Quarterly Minimum Data Set (MDS) assessment, dated 6/6/23, indicated the resident was cognitively intact and was an extensive assist with a 2 person physical assist for toilet use and bed mobility. The resident had a supra pubic foley catheter and was frequently incontinent of bowel. A Care Plan, dated 5/3/23, indicated the resident had a pressure ulcer. The resident was admitted to the facility with 3 pressure ulcers. The measurements and description were as follows: - sacrum: unstageable and measured 8.5 centimeters (cm) by 10.5 cm with 100% of necrotic tissue. - right ischium: unstageable and measured 4.5 cm by 3 cm with 100% of necrotic tissue. - left ischium: unstageable and measured 6.5 cm by 4.5 cm with 100% of necrotic tissue. The wounds were measured after the first hospital return on 5/16/23 as follows: - sacrum: Stage 4 and measured 8 cm by 6 cm by 1.5 cm with 60% granulation tissue, 20% slough (necrotic tissue) and 20% viable tissue. - right ischium: Stage 3 and measured 2 cm 1.0 by 0.3 cm with 100% granulation tissue. - left ischium: Unstageable and measured 4 cm by 7.5 cm with 40% necrotic tissue, 30% granulation tissue and 30% viable tissue. The Bed Mobility (how resident moved to and from a lying position, turned side to side, and positioned the body while in bed or alternate sleep furniture) in the CNA task section indicated the resident was not turned or repositioned at		**DON/designee will review CNA documentation 5 times a week.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to re-educate nursing staff on treatment of pressure areas and documentation in the TAR. Re-education to also include protocol for turning and repositioning of residents.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct a Pressure Area audit to ensure compliance as follows:** **Audits will be completed 5x/week for 8 weeks, then 3 X week weekly. Updated audit has included auditing of turning and repositioning of residents – 9 residents per week. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any**	

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	least every 2 hours. The Bed Mobility documentation indicated the resident was turned and repositioned only during following times: 4/29 at 1:17 a.m. and 1:29 p.m. 4/30 at 5:59 a.m. and 10:20 a.m. 5/1 at 4:06 a.m., 10:11 a.m., and 9:43 p.m. 5/2 at 1:02 a.m., 1:58 p.m., and 8:25 p.m. 5/3 at 11:58 a.m. and 9:39 p.m. 5/4 at 3:32 a.m., 9:35 a.m., and 8:54 p.m. 5/5 at 12:51 p.m. .and 7:17 p.m. 5/6 at 5:59 a.m., 11:28 a.m., and 9:17 p.m. 5/7 at 12:19 a.m., 1:59 p.m., 7:43 p.m., and 11:06 p.m. Nothing documented 5/8/23 Nothing documented on 5/12/23 5/13 at 3:27 a.m., 1:51 p.m., and 9:59 p.m. 5/14 at 5:59 a.m. and 7:05 a.m. 5/15 at 2:59 a.m., 1:59 p.m., and 9:28 p.m. 5/16 at 2:57 a.m., 10:20 a.m., and 6:44 p.m. 5/17 at 11:38 a.m. and 6:29 p.m. 5/30 at 5:18 p.m. 5/31 at 4:46 a.m., 11:12 a.m., and 9:59 p.m. 6/1 at 9:22 a.m. 6/2 at 3:04 a.m. and 9:47 a.m. 6/3 at 5:59 a.m. and 12:20 p.m. 6/4 at 1:05 a.m., 1:36 p.m., and 9:59 p.m. 6/5 at 3:36 a.m., 1:12 p.m., and 8:10 p.m. 6/6 at 5:59 a.m. and 1:39 p.m. 6/7 at 5:59 a.m., 6:35 a.m., and 7:23 p.m. 6/8 at 2:27 a.m., 1:59 p.m., and 6:50 p.m. 6/9 at 3:08 a.m. and 1:41 p.m. Interview with the Director of Nursing (DON) on 7/20/23 at 4:15 p.m., indicated there was no documentation the resident was turned and repositioned every 2 hours. She indicated staff were to do that, especially for residents with pressure sores. The revised and current 1/15/18 "Pressure Ulcer Prevention" policy, provided by the DON on		**trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 8/4/2023	

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	7/20/23 at 4:10 p.m., indicated to prevent and treat pressure sores whenever possible encourage the resident to change positions at regular intervals. Turn dependent residents approximately every 2 hours or as needed and position the resident with pillows or pads protecting bony prominences.2. Resident E's record was reviewed on 7/20/23 at 10:14 a.m. Diagnoses included, but were not limited to dementia, high blood pressure, and Alzheimer's disease. The Significant Change Minimum Data Set (MDS) assessment, dated 6/14/23, indicated the resident was severely cognitively impaired. She required extensive assistance with two persons physical assist for bed mobility, transfer, and toilet use. She was always incontinent of bowel and bladder. A Care Plan, revised on 6/15/23, indicated the resident had a pressure ulcer present on the coccyx due to limited mobility. Interventions included, but were not limited to, administer treatments as ordered and assess for effectiveness. A Wound Care Physician Note, dated 7/18/23, indicated the resident had a stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle) pressure wound to the coccyx measuring 4.5 centimeters (cm) by 4 cm by 0.5 cm. The wound had undermining (tunneling) at 12 o'clock and moderate serous (clear) exudate (drainage). A Physician Order, dated 6/20/23, indicated cleanse coccyx area with normal saline, pat dry, apply calcium alginate to wound bed and cover with dry dressing one time a day for wound care. The July 2023 Treatment Administration Record (TAR) indicated the treatment of calcium alginate			

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	was not completed as ordered on 7/2/23, 7/5/23, and 7/10/23. Interview with the Director of Nursing on 7/20/23 at 1:34 p.m., indicated the treatment should have been completed as ordered. This deficiency was cited on 5/30/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-40(a)(2)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.			

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	155156	A. BUILDING 00 B. WING	07/20/2023

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	§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on record review and interview, the facility failed to establish and/or maintain a system that accounted for, periodically reconciled, and ensured the disposition of all controlled drugs, related to incomplete and inaccurate documentation of narcotic medications for 2 of 3 residents reviewed for narcotics. (Residents F and G) This had the potential to affect all residents who received narcotic medication. Findings include: 1. The record for Resident F was reviewed on 7/20/23 at 11:35 a.m. Diagnoses included but were not limited to, dementia without behaviors, chronic kidney disease, depressive disorders, bipolar disorder, and acute kidney failure. The Quarterly Minimum Data Set (MDS) assessment, dated 4/27/23, indicated the resident was cognitively intact for daily decision making. Physician's Orders, dated 1/3/23, indicated Norco Tablet 5-325 milligrams (mg) (Hydrocodone-Acetaminophen), give 1 tablet by mouth every 6 hours as needed for moderate pain (4-6 on pain scale). The July 2023 Medication Administration Record (MAR), indicated the Norco was signed out as being administered to the resident on 7/20/23 at	F 0755	**Tag number: F755 – Pharmacy Srvcs/Procedures/Pharmacist/Records** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Residents F and G exhibited no adverse reactions related to the alleged deficient practice.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice. Moving forward the DON/designee will complete a narcotic to MAR reconciliation audit per below specifications in point IV of POC.** III. What measures will be put into place and what	08/04/2023

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	8:30 a.m. There were no other times documented from 7/1-7/20/23 the Norco was signed out as being administered on the MAR. The Controlled Drug Administration Record for the Norco indicated 1 tablet was signed out on 7/4/23 at 5:00 a.m., and another tablet was signed out on 7/4/23 at 3:00 p.m. The MAR and the Narcotic disposition record did not have the same documentation to ensure an accurate reconciliation of the Norco medication was being completed. Interview with the Director of Nursing on 7/20/23 at 4:32 p.m., indicated she was not performing audits of the disposition sheets in comparison to what was signed on the Medication Administration Records, but they should be signed out on both for each medication given. 2. The record for Resident G was reviewed on 7/20/23 at 10:56 a.m. Diagnoses included, but were not limited to, fracture of shaft of the humerus, cirrhosis of the liver, and dependence on renal dialysis. The Quarterly Minimum Data Set (MDS) assessment, dated 7/6/23, indicated the resident was cognitively intact for daily decision making. She required extensive assistance for activities of daily living. A Physician's Order, dated 6/20/23, indicated hydrocodone-acetaminophen oral tablet 5-325 milligrams (mg) one tablet every 8 hours as needed (prn). The July 2023 Medication Administration Record		systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to re-educate nursing staff on proper maintaining, accounting for, periodically reconciled, and disposition of all controlled drugs by 8-4-2023. Education to also include ensuring narcotics are signed out on the MAR.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will reconcile narcotics, to include MAR documentation, on 8 residents a week x 4 weeks, then 4 residents per week for 12 weeks, then weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater 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.** Date of compliance: 8/4/2023	

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	(MAR), indicated the resident received the hydrocodone-acetaminophen oral tablet on 7/2/23 at 12:31 p.m., 7/3/23 at 6:55 p.m., 7/4/23 at 2:22 a.m., 7/6/23 at 9:00 p.m., 7/7/23 at 10:00 p.m., 7/10/23 at 11:23 p.m., 7/12/23 at 7:35 p.m., 7/13/23 at 2:00 a.m., and 7/17/23 at 10:40 p.m. The Controlled Drug Administration Record for July 2023 indicated the resident received the hydrocodone-acetaminophen tablet on 7/2/23 at 7:00 a.m., 7/3/23 at 12:31 p.m., 7/4/23 at 10:35 p.m., 7/6/23 at 2:20 a.m., 7/7/23 at 9:00 p.m., 7/11/23 at 10:00 p.m., 7/12/23 at 3:00 a.m., 7/12/23 at 7:37 p.m., 7/13/23 at 7:37 p.m., 7/14/23 at 2:00 a.m., 7/15/23 at 10:30 p.m., 7/17/23 at 10:00 p.m., 7/17/23 at 4:30 p.m., and 7/19/23 at 10:30 p.m. Interview with the Director of Nursing on 7/20/23 at 4:32 p.m., indicated she was not performing audits of the disposition sheets in comparison to what was signed on the Medication Administration Records, but they should be signed out on both for each medication given. This deficiency was cited on 5/30/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-48(b)(2)			
F 0773 SS=D Bldg. 00	483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or			

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	clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. Based on record review and interview, the facility failed to ensure specimens for laboratory testing were collected as ordered by the Physician for 1 of 3 residents reviewed for laboratory services. (Resident B) Findings include: The record for Resident B was reviewed on 7/19/23 at 10:02 a.m. Diagnoses included, but were not limited to, hemiplegia (one sided weakness) following a stroke affecting the left non-dominant side, heart failure, and dementia. The Annual Minimum Data Set (MDS) assessment, dated 6/22/23, indicated the resident was cognitively intact for daily decision making. The resident required extensive assistance with two persons physical assist for bed mobility, transfer, dressing, toilet use, and personal hygiene. A Physician Order, dated 7/14/23, indicated culture for wound one time only. A Nurse's Note, dated 7/13/23 at 10:31 p.m., indicated there was a new order for labs. A Nurse's Note, dated 7/14/23 at 2:06 p.m., indicated the Nurse Practitioner and the resident's responsible party were made aware of the resident's refusals for lab draws that morning. A Nurse's Note, dated 7/17/23 at 3:52 p.m., indicated the lab called the facility to inform them	F 0773	**Tag number: F773 – Physician Order/Notify of Results** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident B had wound cultured and sent out to the laboratory for testing on 7-20-2023.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents having laboratory tests ordered have the potential to be affected by the alleged deficient practice. The facility DON/designee re-audited residents with laboratory tests ordered to ensure compliance in obtaining labs/cultures and reporting results to physician/NP.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice	08/04/2023

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	the wrong test tube swab color was sent for the wound culture and it would have to be resent. There were no records the wound culture was completed and sent. Interview with the Director of Nursing on 7/20/23 at 1:34 p.m., indicated the correct wound culture was sent out as of today (7/20/23), however it should have been sent out sooner. This deficiency was cited on 5/30/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-49(a)		does not recur; **DON/designee to re-educate by 8-4-2023 nursing staff on obtaining laboratory tests/cultures as ordered and reporting results to physician/NP.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct a laboratory audit to ensure compliance in obtaining and reporting results. Audit to include educational opportunities and explanations for any laboratory tests/cultures that were not able to be obtained timely. Audits will be completed 5x/week for 4 weeks, 3x/week for 4 weeks then weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater 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.** Date of compliance: 8/4/2023	

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F 0867 SS=F Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which			

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	the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice,			

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	and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data,			

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	including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. Based on record review and interview, the facility failed to identify unresolved quality deficiencies, some of which had been cited on previous surveys, and ensure actions were developed and implemented to attempt to correct the deficiencies through the quality assessment and assurance (QAA) process as evidenced by the number of repeated deficiencies cited involving physician notification, quality of care, pressure ulcers, pharmacy services, and ensuring specimens for lab testing were collected. This deficient practice affected 120 of 120 residents residing in the facility. Findings include: Interview with the Interim Administrator on /20/23 at 3:10 p.m., indicated the Quality Assessment and Assurance (QAA) Committee had a meeting on 6/30/23 and the committee consisted of the Medical Director, the Administrator, the DON, the ADON, Infection Control Nurse, the Minimum Data Set (MDS) Nurse, the Food Sanitation Supervisor, the Pharmacist, and Maintenance. The Department Heads met on a monthly basis. The Quality Assurance and Performance Improvement (QAPI) plan was a general outline of how to set up a QAPI committee and what the committee should do. The QAPI plan was a data driven, proactive approach for improving the quality of life, care and services in long term care. The activities of QAPI involved members at all levels of the organization to identify opportunities for improvement, address gaps in systems or processes, develop and implement and	F 0867	**Tag number: F867 – QAPI/QAA Improvement Activities** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Moving forward all QAPI/QAA audits and plans for improvement will be audited by the facility Nurse Consultant/designee.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice. Administrator reviewed QAPI plan and all POCs for the Survey Cycle that continued on 7-20-2023 with all department managers by 8-2-2023.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administrator/Nurse Consultants to re-educate QAPI**	08/04/2023

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	improvement or corrective plan and continuous monitoring of interventions. The following deficiencies were cited on this survey at an isolated or pattern scope with potential for more than minimal harm and had been cited previously: a. F580 Physician Notification cited on Recertification survey on 5/30/23. b. F684 Quality of Care cited on Recertification survey on 5/30/23. c. F686 Pressure Ulcers cited on Recertification survey on 5/30/23. d. 755 Pharmacy Services cited on Recertification survey on 5/30/23. e. 773 Laboratory cited on Recertification survey on 5/30/23. There was no evidence the facility had identified, developed, or implemented action plans and/or continued to monitor any corrective actions taken when these deficiencies were cited previously. Interview with the Interim Administrator 7/20/23 at 3:10 p.m., indicated last QAPI meeting was on 6/30/23 and the majority of the focus was the survey and the plan of correction. He had to initiate an ad hoc plan of correction for skin assessments and employee files after realizing through audits things were not being done as stated in the plan of correction. The Unit Managers and Director of Nursing were responsible for auditing physician notification, treatments and medications being administered and completed, follow up assessments after a fall		**team/department managers on the QAPI process and audit tools for the Survey Cycle that continued on 7-20-2023 by 8-2-2023.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **Administrator/Nurse Consultant/designee will conduct an audit of all POC audits for this survey cycle as follows: QA minutes will be reviewed weekly for 3 months then monthly for 3 months - and signed off by Regional/corporate staff for 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater 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.** Date of compliance: 8/4/2023	

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	and labs being completed. This deficiency was cited on 5/30/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-52(b)(2)			
F 9999 Bldg. 00		F 9999	POC Completed	08/04/2023