STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155653	A. BUILDING 00 B. WING	07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARBOR HEALTH & REHAB	5025 MCCOOK AVE EAST CHICAGO, IN 46312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00403073, IN00404782, IN00408677, and IN00413252. This visit resulted in Immediate Jeopardy. Complaint IN00403073 - Federal/state deficiencies related to the allegations are cited at F561. Complaint IN00404782 - Federal/state deficiencies related to the allegations are cited at F925. Complaint IN00408677 - Federal/state deficiencies related to the allegations are cited at F622 and F689. Complaint IN00413252 - Federal/state deficiencies related to the allegations are cited at F805. Survey dates: July 24, 25, 26, 27, and 28, 2023 Facility number: 000108 Provider number: 155653 AIM number: 100267410 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 3 Medicaid: 59 Other: 2 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rosa McGowen	VP of Operations	08/20/2023

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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	Quality review completed on 8/2/23.			
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on observation, record review, and interview, the facility failed to ensure the resident's preference was honored for the number of medications received for 1 of 1 residents reviewed for choices. (Resident C)	F 0561	p paraid="1251450714" paraeid="{dc177bb1-db8f-4d43-b596-6aafa0dd5141}{179}" >Please accept the following as the facility's credible allegation of	08/22/2023

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	Finding includes: On 7/24/23 at 10:08 a.m., Resident C was observed sitting up in bed and indicated she had asked the nurses numerous times to spread out her medications because she takes too many pills at one time. The record for Resident C was reviewed on 7/25/23 at 9:44 p.m. Diagnoses included, but were not limited to, heart failure, hypertension (high blood pressure), hemiplegia left side (left side paralysis), hyperlipidemia (high cholesterol), seizure disorder, acid reflux, and overactive bladder. The Quarterly Minimum Data Set (MDS) assessment, dated 5/6/23, indicated the resident was cognitively intact. A Care Plan, dated 6/6/23, indicated the resident had a behavior of being non-compliant with medication. Approaches included, nursing to educate resident on any medications that she may not be familiar with or any new medications prescribed, resident would vocalize any medication concerns and staff would explain what every medication was and the purpose upon medication administration. A Physician note dated, 3/10/23, at 11:17 a.m., indicated the resident denied refusing medications and requested frequency adjustment and the resident was re-educated on the importance of medication adherence. Interview with LPN 2 at 7/27/23 11:01 a.m., indicated the resident took almost all her medications and refused a couple. The resident		compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this citation. F561 Self Determination What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident preferences were reviewed with focus on the number of medications that Resident C takes at one time. Medication administration times adjusted so that the resident does not need to take so many medications at one time. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;	

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	did complain about how many pills she had to take at once. Interview with the Nurse Consultant on 7/27/23 11:17 a.m., indicated she was unaware of any requests to change the resident's frequency and time of medication. She will follow up now with the nurses. A follow up interview with the Nurse Consultant on 7/27/23 at 1:33 p.m., indicated she called LPN 3 for a phone interview and LPN 3 indicated the resident did mention that she wanted a frequency change a month ago. The Interim Director of Nursing (DON) was calling the physician to see if he could review the resident's medication times and frequency. This Federal tag relates to Complaint IN00403073. 3.1-3(u)(1)		All take have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Clinical staff were educated on providing medications per resident's self- determined preferences. This includes changing medication times if residents feel as though they take too many medications at one time. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Activities Director/designee will audit the 5 residents with an admission and/or quarterly MDS due weekly, for 4 months, to identify/review residents' self-determined preferences. Preferences related to medications will be relayed to the DON/Designee.	

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			Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 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 by which systemic corrections will be completed: 8/22/2023	
F 0577 SS=C Bldg. 00	483.10(g)(10)(11) Right to Survey Results/Advocate Agency Info §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3			

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	preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents.			
	Based on observation and interview, the facility failed to ensure residents and/or visitors could access the survey inspection results without having to ask. This had the potential to affect 64 of the 64 residents who resided in the facility. Finding includes: During the Resident Council Meeting on 7/27/23 at 2:00 p.m., the 10 residents in attendance were not able to indicate where the survey inspection results were located. After the meeting, there was no signage in the lobby area indicating where the survey inspection results were located. The survey book was also not observed in the area. On 7/27/23 at 3:10 p.m., the Administrator in Training was not able to locate the survey book. At 3:35 p.m., she indicated she had found the survey book and a sign would be posted with its location and the residents would be informed. 3.1-3(b)(1)	F 0577	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this citation. F577 Right to Survey results/Advocate Agency info What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The Facility Survey result binder was immediately updated and made available for residents, visitors, and staff.	08/22/2023

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			How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; reviewed survey result regulations and will be audited monthly to ensure that the survey book is available for observation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Administrator/designee will visualize survey binder is in designated area and available for viewing monthly for 6 months.	

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			Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 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 by which systemic corrections will be completed: 8/22/23	
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility			

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	would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this			

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	section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.			
	Based on record review and interview, the facility failed to ensure appropriate documentation, such as a discharge summary, was completed prior to transferring a resident to the hospital for 1 of 3 residents reviewed for hospitalization (Resident D). Finding includes: Resident D's record was reviewed on 7/26/23 at 9:15 a.m. The resident was admitted to the facility	F 0622	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this citation.	08/22/2023

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	on 9/21/22 and discharged on 2/24/23. Diagnoses included, but were not limited to, one sided weakness/paralysis affecting the right dominant side following a stroke, type 2 diabetes mellitus, and bipolar disorder. The Discharge - Return Anticipated Minimum Data Set (MDS) assessment, dated 2/24/23, indicated the resident had a memory problem and required modified independence for daily decision making. She required extensive assistance with one person physical assist for bed mobility, transfers, dressing, toilet use, and personal hygiene. She was totally dependent with one person physical assist for bathing. A Progress Note, dated 2/24/2023 at 7:45 a.m., indicated a loud thump was heard from the resident's room and upon entrance the resident was observed to be sitting on her buttocks next to the bed on the bedside mat. She had bleeding noted to her forehead. The resident indicated she fell. First aid was provided to the gash on her forehead and she had no change in mental status. The Physician was notified and orders were given to send the resident to the hospital for evaluation and treatment. The record lacked documentation regarding information provided to the receiving facility such as contact information, discharge summary, medication lists, or special instructions/precautions for ongoing care. Interview with the Nurse Consultant on 7/28/23 at 12:42 p.m., indicated she was unable to locate any discharge communication in the chart. The nurse should have documented under an e-Interact Transfer Form that contained the appropriate information to communicate with the receiving		F622 Transfer and Discharge Requirements What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident D no longer resides in the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents that are transferred or discharged have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff were re-educated on providing contact information, discharge summary, medication lists, and any special	

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	facility such as a current medication list and current diagnosis. This Federal tag relates to Complaint IN00408677. 3.1-12(a)(3)		instructions/precautions for ongoing care to the receiving facility when a resident is being transferred/discharged. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; SSD/Designee will audit weekly, for 4 months, to ensure that staff is providing contact information, discharge summary, medication lists, and any special instructions/precautions for ongoing care to the receiving facility when a resident is being transferred/discharged. Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 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 by which systemic	

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			corrections will be completed: 8/22/23	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) 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 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.			

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	(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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on record review and interview, the facility failed to ensure a Care Plan was developed for a resident who had a new Schizophrenia diagnosis for 1 of 19 residents reviewed for Care Plan development. (Resident 10) Finding includes: Resident 10's record was reviewed on 7/27/23 at 2:43 p.m. Diagnoses included, but were not limited to, hypotensive (low blood pressure), depression, bipolar, schizophrenia, restlessness and agitation, and stroke. The Quarterly Minimum Data Set (MDS) assessment, dated 5/4/23, indicated the resident was cognitively intact. A Significant Change Minimum Data Set (MDS) assessment, dated 11/28/22, was completed after emergency detention stay at the hospital. The After-Visit Summary from the hospital, dated 11/21/22, indicated the resident was started on an antipsychotic medication Seroquel (Quetiapine	F 0656	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this citation. F656 Develop/Implement Comprehensive Care Plan What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A Schizophrenia Care plan was	08/22/2023

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	155653	A. BUILDING 00 B. WING	07/28/2023

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	Fumarate) for Schizophrenia. A Physician's Order, dated 11/22/22, indicated Quetiapine Fumarate (Antipsychotic) tablet 50 mg one time a day. A Physician's Order, dated 5/11/23, indicated Quetiapine Fumarate (Antipsychotic) tablet 150 mg every evening. A Physician's Note, dated 7/12/23 at 3:12 p.m., indicated the resident's chief complaint was Schizophrenia, and to continue the current treatment of Seroquel 150 mg at night and 50 mg in the morning. Residual signs of psychotic disorder were noted but the resident was currently stable on the current management. The record lacked a Care Plan for the Schizophrenia diagnosis and treatments. Interview with Nurse Consultant on 7/28/23 at 8:39 a.m., indicated she couldn't find any documentation regarding a care plan for schizophrenia for the resident. 3.1-35(a)		added for Resident 10. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by this alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff responsible for adding Diagnosis' Care Plans were in-serviced to ensure that all relevant resident Diagnosis' have a corresponding care plan. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; MDS/designee will conduct weekly audits, for 4 months, and monthly thereafter of care plans for 10 different residents to ensure that all Diagnosis' have a	

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			corresponding care plan. The DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 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 by which systemic corrections will be completed: 8/22/2023	
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.			

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	(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to provide documentation of care conferences held with the resident or resident's family and facility staff for 7 of 7 residents reviewed for care planning decisions. (Residents 60, 12, 46, 52, 18, 16, and 10) Findings include: 1. During an interview on 7/24/23 at 9:59 a.m., Resident 60 indicated he had not been invited or attended a care conference with facility staff since he had been living at the facility. The record for Resident 60 was reviewed on 7/26/23 at 9:40 a.m. The resident was admitted on 2/10/23. Diagnoses included, but were not limited to acute spinal cord infarction, chronic ischemic heart disease, high blood pressure, type 2 diabetes, major depressive disorder, anxiety disorder, panic disorder, stroke with no residual, and coronary artery bypass graft. The 5/30/23 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was	F 0657	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this citation. F657 Care Plan Timing and Revision What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 60 had a care plan	08/22/2023

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	cognitively intact for daily decision making. There was no documentation of a care plan conference held with the resident since he had been admitted. Interview with the Social Service Director on 7/27/23 at 12:26 p.m., indicated the resident has not had care planning conference since he has been at the facility.2. During an interview on 7/24/23 at 3:33 p.m., Resident 12 indicated he had never been invited or gone to a care plan meeting. Resident 12's record was reviewed on 7/26/23 at 11:29 a.m. Diagnosis included, but were not limited to, end stage renal disease, dependence on renal dialysis, and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 6/27/23, indicated the resident was cognitively intact for daily decision making. Interview with the Social Service Director on 7/27/23 at 12:30 p.m., indicated she was unable to locate previous invitations sent to the resident or care plan meetings that occurred for Resident 12. 3. An interview with Resident 46 on 7/24/23 at 11:02 a.m., indicated he was never invited to any care plan meetings. Resident 46's record was reviewed on 7/26/23 at 9:43 a.m.. Diagnosis included, but were not limited to, stroke, bipolar disorder, and one-sided weakness affecting the left non-dominant side. The Quarterly Minimum Data Set (MDS) assessment, dated 5/30/23, indicated the resident was cognitively intact for daily decision making.		meeting scheduled and resident was invited. Resident 12 had a care plan meeting scheduled and resident was invited. Resident 46 had a care plan meeting scheduled and resident was invited. Resident 52 had a care plan meeting scheduled and was invited. Resident 18 had a care plan meeting scheduled and resident was invited. Resident 16 had a care plan meeting scheduled and resident was invited. Resident 10 had a care plan meeting scheduled and resident was invited. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by the same alleged deficient practice.	

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	Interview with the Social Services Director on 7/27/23 at 12:30 p.m., indicated she was unable to locate invitations to quarterly care plan meetings for the resident since 11/21/2022. 4. An interview with Resident 52 on 7/24/23 at 10:07 a.m., indicated the resident had received no invitations to quarterly care plan meetings since he had been in the facility. The record for Resident 52 was reviewed on 7/26/23 at 8:43 a.m. Diagnosis included, but were not limited to, one sided weakness affecting the right dominant side, stroke, and heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 7/2/23, indicated the resident was moderately cognitively impaired for daily decision making. A Social Services Note, dated 1/11/23 at 12:00 p.m., indicated a quarterly care plan was held with the resident and the Social Services Director. Interview with the Social Services Director on 7/27/23 at 9:54 a.m., indicated she had just spoken with the resident's family members and performed a quarterly assessment on the resident on July 3, 2023, however she was unable to locate an invitation to any care plan meetings. 5. During an interview with Resident 18 on 7/24/23 at 9:50 a.m., the resident indicated he was never involved in a care plan meeting. Resident 18's record was reviewed on 7/26/23 at 9:04 a.m. Diagnoses included, but were not limited to, multiple sclerosis, muscle weakness, tachycardia, high blood pressure, and hyperlipidemia.		What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Management staff having care conference meetings timely and inviting the resident/responsible party to attend. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The administration/designee will audit 10 residents monthly to ensure care conferences are held in a timely manner and that all parties attend. Social Service Director /designee will present a summary of the audits to the Quality Assurance committee monthly for 6 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.	

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	The Quarterly Minimum Data Set (MDS) assessment, dated 5/21/23, indicated the resident was moderately cognitively impaired for decision making. There was no documentation indicating the resident had been invited to or attended a care plan conference. Interview with the Nurse Consultant on 7/28/23 at 10:28 a.m., indicated she had no further information to provide. 6. During an interview with Resident 16 on 7/24/23 at 11:15 a.m., the resident indicated he has never been involved in a care plan meeting. Resident 16's record was reviewed on 7/26/23 at 1:05 p.m. Diagnoses included, but were not limited to, heart failure, hypertension, mild intellectual disabilities, physiological condition, altered mental status, schizoaffective disorder, bipolar, and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 6/26/23, indicated the resident was moderately cognitively impaired for decision making. There was no documentation indicating the resident had been invited to or attended a care plan conference. Interview with the Nurse Consultant on 7/28/23 at 10:30 a.m., indicated she had no further information to provide. 7. Resident 10's record was reviewed on 7/27/23 at 2:43 p.m. Diagnoses included, but were not limited to, hypotensive (low blood pressure), depression, bipolar, schizophrenia, restlessness and agitation, and		Date by which systemic corrections will be completed: 8/22/23	

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	stroke. The Quarterly Minimum Data Set (MDS) assessment, dated 5/4/23, indicated the resident was cognitively intact. The last documented care conference was 10/25/22. Interview with Nurse Consultant on 7/28/23 at 12:46 at p.m., indicated the last care conference meeting for the resident was on 10/25/22. 3.1-35(d)(2)(B)			
F 0660 SS=D Bldg. 00	483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.			

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	(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient			

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	assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. Based on record review and interview, the facility failed to ensure documentation of discharge planning was completed for 1 of 1 closed records reviewed for discharge. (Resident 70) Finding includes: The closed record for Resident 70 was reviewed on 7/28/23 at 10:34 a.m. Diagnoses included, but were not limited to, nontraumatic intracerebral hemorrhage, hypertensive encephalopathy, high blood pressure, gastrostomy, anemia, stroke and hemiplegia on the right side. The Quarterly Minimum Data Set (MDS) assessment, dated 6/16/23, indicated the resident was alert and oriented. There was no documentation related to the resident's discharge in the clinical record. Interview with the Nurse Consultant on 7/28/23 at 12:44 p.m., indicated she was not able to locate the discharge instructions.	F 0660	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this citation. F660 Discharge Planning Process What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 70 no longer resides in the facility.	08/22/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	A facility policy, titled" Discharge Planning", received from the Nurse Consultant as current, indicated, " ...6. The facility will involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final goal. 7. The facility will address the residents' goals of care and treatment preferences. 8. The facility will document that a resident has been asked about their interest in receiving information regarding returning to the community ..." 3.1-12(a)(18)		How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents who are discharged have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Social Services educated to document all discharge planning efforts in the resident record. Licensed Nursing Staff educated to document all pertinent discharge information upon discharge from the facility to include, but not limited to: Discharge instructions given and who they were provided to, assessment of resident upon discharge, who the resident left the facility with and everything the resident took upon discharge.	

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Administration/designee will audit 10 residents monthly, for 4 months, to ensure all pertinent documentation is present upon resident discharge from the facility. Service Director/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 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 by which systemic corrections will be completed: 8/22/23	
F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary			

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	that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.			
	Based on record review and interview, the facility failed to complete the recapitulation of the resident's stay prior to discharge for 1 of 1 closed records reviewed for discharge. (Resident 70) Finding includes: The closed record for Resident 70 was reviewed on 7/28/23 at 10:34 a.m. Diagnoses included, but were not limited to, nontraumatic intracerebral hemorrhage, hypertensive encephalopathy, high blood pressure, gastrostomy, anemia, stroke and	F 0661	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this citation	08/22/2023

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	hemiplegia on the right side. The Quarterly Minimum Data Set (MDS) assessment, dated 6/16/23, indicated the resident was alert and oriented.. There was no documentation related to the recapitulation of stay for the resident prior to discharge. Interview with the Nurse Consultant on 7/28/23 at 12:44 p.m., indicated she was not able to locate the recapitulation of the resident's stay at the facility. A facility policy, titled" Discharge Planning", received from the Nurse Consultant as current, indicated, " ...13. Document, completed on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plane. The results of the evaluation must be discussed with the resident or resident representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delay in the resident's discharge or transfer... " 3.1-12(a)(1)		. F661 Discharge Summary What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 70 no longer resides in the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents who are discharged have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: SSD educated that prior to discharge they are to open the discharge summary so that the IDT can input all of the pertinent discharge information.	

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; SSD/designee will audit 10 residents monthly, for 4 months, to ensure that the discharge summary is completed and provided to the resident upon discharge from the facility. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.¿ Monitoring will be on going. Date by which systemic corrections will be completed: 8/22/23	
F 0684 SS=G Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that			

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	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 observation, record review, and interview, the facility failed to ensure a resident was monitored for signs and symptoms of constipation. The lack of assessment and monitoring resulted in the resident being hospitalized with a severe fecal impaction for 1 of 1 residents reviewed for constipation. (Resident 60) The facility also failed to ensure a fall follow up assessment was completed and an assessment including vital signs was documented prior to hospitalization for 1 of 2 residents reviewed for falls and 2 of 3 residents reviewed for hospitalization. (Residents E and 12) Findings include: 1. During an interview on 7/24/23 at 10:12 a.m., Resident 60 indicated he has horrible constipation issues and sometimes only has 1 bowel movement a week. He did not think he always received his Miralax (a laxative medication) as scheduled. During an interview on 7/26/23 at 10:55 a.m., the resident indicated he was very constipated and had not had a bowel movement yet this week. Staff were supposed to order an enema, but he had not received it. The record for Resident 60 was reviewed on 7/26/23 at 9:40 a.m. The resident was admitted on 2/10/23. Diagnoses included, but were not limited to acute spinal cord infarction, chronic ischemic	F 0684	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this alleged citation. F684 Quality of Care What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 60 was assessed for constipation. Current management for constipation has been effective. Resident E no longer resides in	08/22/2023

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	heart disease, high blood pressure, type 2 diabetes, major depressive disorder, anxiety disorder, panic disorder, stroke with no residual, and coronary artery bypass graft. The resident was admitted to the hospital on 7/16/23 and return to the facility on 7/20/23. The 5/30/23 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making. The resident was an extensive assist with a 1 person physical assist for bed mobility, dressing, toilet use, and personal hygiene. He had an indwelling catheter and was frequently incontinent of bowel. There was no Care Plan for constipation. The bowel movement record in the last 30 days, indicated there was no documented bowel movement on 6/28, 6/30, 7/1, 7/2, 7/3, 7/4, 7/5, 7/6, 7/7, 7/8, 7/9, 7/11, 7/12, 7/14, 7/21, 7/22,7/23, 7/24, 7/25, and 7/26/23. The resident had a small bowel movement on 6/29, 7/10, and 7/13/23, and a medium bowel movement on 7/15/23. Physician's Orders, dated 5/17/23, indicated Norco (a narcotic medication) tablet 7.5-325 milligrams (mg), give 1 tablet by mouth three times a day for pain. Physician's Orders, dated 6/9/23, indicated Polyethylene Glycol 3350 Powder (a laxative medication), give 17 grams orally every other day for constipation and give 17 grams as needed for constipation. Physician's Orders, dated 6/16/23, indicated Docusate Sodium (a stool softener) tablet 100 mg (Docusate Sodium), give 1 tablet by mouth two		the facility. Resident 12 no changes made to medical record at this time related to hospitalization on 7/18/23. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; p paraid="1448548393" paraeid="{de6da46e-091a-4d31-9adf-e4419d147c94}{11}" >All have issues with constipation, falls and hospitalization have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Nurses were educated on monitoring residents for constipation utilizing the PCC dashboard. Nurses were also educated on the bowel management policy which includes any resident not having a bowel movement in a 72-hour	

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	times a day for constipation. Physician's Orders, dated 6/26/23, indicated Lactulose oral solution 20 grams/30 milliliters (ml), give 30 ml by mouth every 12 hours as needed for complaints of constipation. KUB (A kidney, ureter, and bladder X-ray, may be performed to assess the abdominal area for causes of abdominal pain) X-ray to rule out any gastrointestinal obstruction or impaction. Physician's Orders, dated 7/26/23, indicated prune juice twice a day for constipation. Fleets rectal enema, insert 1 application rectally every 24 hours as needed for constipation and Fleets rectal enema, insert 1 application rectally one time a day every Wednesday for constipation. The Medication Administration Record (MAR) for 6/2023 and 7/2023 indicated the Lactulose was not administered. The Polyethylene Glycol 3350 Powder was ordered every other day, however, it was signed out as being given two times a day. Nurses' Notes, dated 6/23/23 at 11:23 a.m., indicated the resident had complaints of abdominal discomfort. An assessment of the resident indicated bowel sounds were present times 4, firmness and pain to the left lower quadrant. He has had no bowel movement in multiple days. The Physician was notified and gave an order for a rectal enema one time. The 6/2023 MAR indicated the enema was administered on 6/24/23 at 1:32 p.m. There was no follow up assessment or documentation regarding the results of the enema. Nurses' Notes, dated 6/26/23 at 3:59 p.m., indicated the portable X-ray company was called		period receive a pharmacologic or non-pharmacologic intervention for constipation. Nurses are to also monitor that a bowel movement occurred and if it did not to reach out to the MD for additional orders. Nurses were also educated to check that all x-rays have been completed and results received and relayed to the NP/MD. Nurses were educated on completing change in condition follow up documentation with special focus on post fall documentation. Post fall charting should include: Daily follow up fall assessment documentation per facility policy for ul class="BulletListStyle1 SCXW16309262 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" Neurological checks per facility policy Vital signs per facility policy	

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	and notified of the KUB ordered by the Physician. There was no follow up documentation or information after 6/26/23. There was no documentation the KUB X-ray was completed. Nurses' Notes, dated 7/12/23 at 1:24 p.m., indicated the resident had complaints of constipation for a few days. The Physician was notified and a new order for an enema was obtained. The 7/2023 MAR, indicated the enema was administered on 7/14/23 (2 days later) at 1:15 p.m. There was no documentation of the results of the enema. Nurses' Notes, dated 7/16/23 8:55 p.m., indicated the resident had complained of constipation and abdominal pain, the Physician was notified and ordered a KUB X-ray, however, the resident called EMS himself and was taken to the hospital, where he was diagnosed with a urinary tract infection. Hospital notes, dated 7/16/23, indicated a cat scan of the abdomen and pelvis showed significant constipation/fecal impaction. The resident was admitted to the hospital with constipation and a urinary tract infection. The resident returned to the facility on 7/20/23. A Nurses' Note, dated 7/26/23 at 9:13 a.m., indicated the resident had complaints of constipation and not having a bowel movement in about a week. The Physician gave orders to send him out to the hospital. The resident did not want to go back to the hospital so in lieu of going out, he agreed to have an enema.		Nurses were educated on documentation requirements on residents that are transferred to the hospital for changes in condition. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; DON/designee will audit 5 clinical documentation in point of care 2 times a week, for 4 months, to ensure bowel movements are documented and any residents not having a bowel movement in 3 days have had a pharmacologic/non-pharmacologic intervention performed and the bowel issue has been resolved. Audit will include if radiologic testing has been completed as ordered in relation to constipation. DON/Designee will audit 5 clinical with falls weekly, for 4 months, to ensure follow up assessments for falls are completed. Audit will include if radiologic testing has been completed as ordered in relation to falls.	

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	Nurses' Notes, dated 7/27/23 at 12:19 a.m., indicated the pharmacy was called regarding the enema. The enema was not covered by insurance, so it had not been sent. The 7/2023 MAR indicated the enema was administered on 7/27/23 at 1:15 p.m. The current 9/20/21 "Bowel Elimination Protocol" policy, provided by the Vice President of Operations on 7/27/23 at 1:00 p.m., indicated residents who had no bowel movements for 72 hours will be considered for pharmacological intervention or non-pharmacological intervention, such as prune juice, or encourage increased fluid intake. If the resident continued to have no bowel movement after additional intervention, notify the medical doctor for further instructions. It should be considered that some residents may have a normal bowel pattern greater than 72 hours without constipation. Interview with the Nurse Consultant on 7/27/23 at 1:55 p.m., indicated the KUB X-ray was not completed as ordered in June 2023. The resident's bowel movement record indicated the resident was not having routine bowel movements and nursing staff were not monitoring how long the resident had gone without a bowel movement. The resident had a long history of constipation. 2. On 7/25/23 8:33 a.m., Resident E was observed in bed. At that time, she was observed with tremors to her left arm, hand and head. Her eyes were open, and she was lifting her left leg over her right leg. The resident was not responsive. At 8:50 a.m., the resident remained in bed, still having the tremors to the left arm and leg. Her eyes were		DON/Designee will audit 2 residents that were transferred to the hospital weekly, for 4 months, to ensure that contact information, medication list, discharge summary have been provided and documented. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 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 by which systemic corrections will be completed: 8/22/2023	

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	open but she was staring and not responsive to her name. Interview with the day shift nurse, LPN 5, on 7/25/23 at 8:40 a.m., indicated the Physician was just here and assessed the resident. He indicated the resident was having a stroke and since she was hospice, he wanted us to call her sister to see if she wanted her sent out to the hospital. While standing at the nurses' station, the telephone rang, and it was the resident's sister, who informed the nurse her symptoms could be seizure activity. She indicated the last time she was admitted to the hospital for the same symptoms, it was a seizure and not a stroke. The sister informed the nurse she would reach out to the resident's niece to see what she wanted to do. During an interview on 7/26/23 at 9:37 a.m., the Interim Director of Nursing indicated the resident's niece came to the facility yesterday and decided to send her out to the hospital. The record for Resident E was reviewed on 7/27/23 at 10:00 a.m. The resident was admitted to the facility on 4/7/23. Diagnoses included, but were not limited to, metabolic encephalopathy, type 2 diabetes, diabetic neuropathy, high blood pressure, anxiety disorder, heart failure, and convulsions. The resident was admitted to the hospital on 5/28/23 and returned to the facility on 6/5/23. The resident was again admitted to the hospital on 7/25/23, where she remained. The 6/22/23 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact for daily decision making. The resident needed extensive assist with 1 person			

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	physical assist for bed mobility. She was an extensive assist with 2 person physical assist for transfers. The resident had a history of falls since the last assessment. A Care Plan, revised on 6/23/23, indicated the resident has had a fall. The approaches were for the resident to wear non skid socks when attempting to ambulate and when not wearing shoes. The resident had numerous falls since admission. The following list of falls were documented but lacked assessment and monitoring post fall: - On 5/15 at 4:44 p.m. the resident had a fall. There was a fall follow up on 5/16 and 5/17/23. - On 5/21/23 at 12 p.m. the resident had a fall. There was a fall follow up on 5/22 and a post fall observation assessment on 5/22 at 2:11 p.m. - On 5/22 at 1:40 p.m. the resident had a fall and there was no fall follow up or post fall observation assessments completed. - On 6/16 at 8:24 a.m. the resident had a fall and there was no fall follow up or post fall observation assessments completed. - On 6/28 at 6:24 p.m. the resident had a fall and there was no fall follow up assessment completed. There was a post fall observation in progress, dated 6/30/23. - On 7/3 at 3:48 p.m. the resident had a fall and there was a fall follow up assessment competed on 7/4, and a post fall observation assessment completed on 7/3 at 4:30 p.m. There was no post fall observation or fall follow up assessments completed for 72 hours for the all of the falls above. Nurses' Notes, dated 4/7/23 at 11:55 p.m., indicated the resident was observed sitting on he			

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	floor by the bed. Her face was bloody and the gown was saturated with blood. She has a small laceration on the forehead. 911 was called and the resident was transferred to the hospital. The ER (emergency room) Discharge Notes, dated 4/8/23 at 2:37 a.m., indicated repaired head laceration. There was no documentation of the resident after she returned from the hospital or the time she returned. There was no assessment of the resident after her return or the extent of her injuries. Neuro checks were not initiated. Nurses' Notes, dated 4/9/23 at 11:32 a.m., indicated the resident was observed on the floor, near her bed, face down. The resident's nose was bleeding and upon further assessment, she complained of pain to the left arm. The Physician was notified and the resident was sent to the ER. The resident was admitted to the hospital with a broken nose. ER Notes, dated 4/9/23, indicated the patient had an unwitnessed fall at the nursing home and was found face down with a bloody nose. She was seen here yesterday for another fall where she had a scalp laceration, staples were placed and she was discharged back to the nursing home. There was no assessment or documentation regarding the head laceration and staples after she returned back to the facility. Nurses' Notes, dated 5/28/23 at 7:36 a.m., indicated "Patient was sent out to hospital this am. Morning meds given." An E-Interact transfer form, dated 5/28/23 at 8:30 a.m., indicated the reason the resident was sent to			

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	the hospital was for GI bleeding (gastrointestinal). The vital sign documentation on the form was outdated. There were no recent vital signs documented for the resident prior to hospitalization. A Nurses' Note, dated 5/28/23 at 2:53 p.m., indicated the resident was admitted to the hospital, however, no tests had confirmed the source of the bleeding. There was no documentation in Nursing Progress Notes for the most recent hospital admission on 7/25/23 regarding her change of condition. A blood pressure of 192/97 was recorded in the vital sign section, however, no other vital signs were checked or recorded. A hand written Nurses' Note, dated 7/25/23 at 10:10 a.m., by the Interim DON, indicated the Hospice Nurse was here for the evaluation of the resident and her tonic clonic seizure to the right side. A relative came in to see the resident and she wanted her sent to the hospital. There was no other documentation or an assessment of the resident prior to the hospitalization. Interview with the Nurse Consultant on 7/27/23 at 4:00 p.m., indicated neuro check assessments were initiated for the above mentioned falls, however, were not completed. Nurses were to document on the residents and complete an assessment for 72 hours post fall. Fall follow up documentation and assessments were not completed for the resident. Interview with the Nurse Consultant on 7/28/23 at 8:30 a.m., indicated the computer system was down during the late morning hours on 7/25/23, so			

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	the Nurse's Note was hand written. There were no other notes regarding when the tremors started, an assessment of the resident at the time, or a current set of vital signs. There was no complete assessment after the resident returned with the staples post fall or prior to going out to the hospital for GI bleed. The current 2/12/21 "Fall Reduction Program" policy provided by the Vice President of Operations on 7/27/23 at 1:00 p.m., indicated each nurse, each shift will observe the resident and document for 72 hours in the resident's medical record which included vital signs, neuro checks for unwitnessed falls, behavior changes, and physical changes. 3. The record for Resident 12 was reviewed on 7/26/23 at 11:29 a.m. Diagnoses included, but were not limited to, end stage renal disease, dependence on renal dialysis, and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 6/27/23, indicated the resident was cognitively intact for daily decision making. He required supervision only for activities of daily living. He received insulin injections and dialysis treatments. A Care Plan, dated 11/10/21, indicated the resident was at risk for complications related to diabetes and insulin use. Interventions included, but were not limited to, administered diabetic medications as ordered, educate the resident regarding medications and importance of compliance, and educate as to the correct protocol for glucose monitoring and insulin injections. The July 2023 Physician's Order Summary indicated the resident received insulin detemir			

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	(long-acting insulin) solution per a sliding scale twice daily and insulin lispro (short-acting insulin) solution per a sliding scale before meals. A Nurses' Note, dated 7/18/2023 at 5:09 a.m., indicated a nurse from the hospital called at approximately 3:19 a.m. to report the resident was seen in the emergency department for diabetic hyperglycemia and would be discharged back to the facility. The resident arrived to the facility at 5:12 a.m. via ambulance. Upon arrival he was alert and oriented in his normal demeanor with a blood sugar of 174. The record lacked documentation of a completed assessment of the resident's condition prior to leaving the facility. Interview with the Nurse Consultant on 7/27/23 at 3:50 p.m., indicated she was unable to locate any documentation or assessments completed related to the transfer to the hospital on 7/18/23. 3.1-37(a)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of			

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	155653	A. BUILDING 00 B. WING	07/28/2023

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	vision or hearing assistive devices. Based on record review and interview, the facility failed to ensure residents had access to receive services for impaired vision for 1 of 1 residents reviewed for vision and hearing. (Resident 60) Finding includes: During an interview with Resident 60 on 7/24/23 at 10:02 a.m., he indicated he had complaints of not being able to see very well. His eyes were bad and he had told staff he wanted to see the eye doctor, but had not seen one since admission. The record for Resident 60 was reviewed on 7/26/23 at 9:40 a.m. The resident was admitted on 2/10/23. Diagnoses included, but were not limited to acute spinal cord infarction, chronic ischemic heart disease, high blood pressure, type 2 diabetes, major depressive disorder, anxiety disorder, panic disorder, stroke with no residual, and coronary artery bypass graft. The 5/30/23 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making and no vision impairment or corrective lens. There was no Care Plan for impaired vision. There was no documentation the resident has seen an eye doctor since admission. Interview with the Social Service Director on 7/27/23 at 12:26 p.m., indicated the resident had signed the consent for vision services on 6/6/23. The eye doctor was here last month on 6/28/23, however, the resident was not on the list, therefore was not seen. The eye doctor was scheduled to come on 7/31/23, however, the	F 0685	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for the alleged citation. F685 Treatment/Devices to Maintain Hearing/Vision What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 60- consent was received and resident was seen by the Optometrist on July 31, 2023. Poor vision care plan was added to resident's medical record. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents who have poor vision have the potential to be affected by the same alleged deficient practice. What measures will be put into	08/22/2023

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	resident was not on that list either, but there were 2 residents on the list that had been discharged, so she has added the resident to the list. 3.1-39(a)(1)		place or what systemic changes will be made to ensure that the deficient practice does not recur; Social Services was educated to assess all residents on admission and quarterly for their need for ancillary services. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Social Service Director/designee will audit 5 residents on admission and quarterly weekly, for 4 months, to ensure that they are assessed for ancillary services and referred to appropriately. SSD/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 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 by which systemic corrections will be completed: 8/22/2023	
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			

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	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 observation, record review, and interview, the facility failed to ensure a resident with a Stage 4 pressure ulcer received the necessary care and services to treat and improve the wound related to not providing a wound vac in a timely manner for 1 of 3 residents reviewed for pressure ulcers. (Resident 60) Finding includes: On 7/27/23 at 9:06 a.m. the Wound Nurse was observed changing Resident 60's bandage to his pressure ulcer on the sacrum. After the bandage was removed, the wound bed was pink with some slough (necrotic tissue) and undermining (tunneling). The record for Resident 60 was reviewed on 7/26/23 at 9:40 a.m. The resident was admitted on 2/10/23. Diagnoses included, but were not limited to acute spinal cord infarction, chronic ischemic heart disease, high blood pressure, type 2 diabetes, major depressive disorder, anxiety disorder, panic disorder, stroke with no residual, and coronary artery bypass graft. The 5/30/23 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was	F 0686	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The Facility requests paper compliance for this citation. F686- Treatments/ to Prevent/Heal Pressure Ulcers What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 60 was assessed, and no adverse effects were noted related to not having the wound vac initiated timely.	08/22/2023

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	cognitively intact for daily decision making. The resident was at risk for pressure ulcers, and had 1 stage 3, 1 stage 4, and 1 unstageable (present on admission) pressure ulcer. The Care Plan, revised on 7/26/23, indicated the resident was at risk for impaired skin integrity and the current area of impairment included the sacrum. A Wound Physician Note, dated 7/10/23, indicated the sacrum pressure ulcer measured 6.7 centimeters (cm) by 8.5 cm by 2.0 cm, and was 3.0 cm. at 2 o'clock with 90% granulation and 10% viable tissue. The recommendation and new treatment was to add negative pressure wound therapy (a wound vac) three times a week at 30-125 intermittent suction. A Nurses' Note, dated 7/13/23 at 7:37 a.m., indicated the wound vac was applied to the sacral wound. The wound vac was discontinued on 7/24/23. Interview with the Wound Nurse on 7/27/23 at 9:48 a.m., indicated the wound was healing, but slowly. The wound vac was ordered to be delivered by the previous Administrator on 7/11/23 (a day after it was ordered by the Physician). She received a text from her on 7/11/23 at 4:25 p.m., indicating the wound vac had been ordered. She placed the wound vac on the resident on 7/13/23 for the first time. There was delay in receiving the wound vac and getting it in place. Interview with the Nurse Consultant on 7/27/23 at 1:55 p.m. indicated the wound vac was not placed on the resident in a timely manner.		How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents who have wounds have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Wound care nurse and nursing staff was re-educated on ensuring that all wound treatments, including wound vacs are initiated timely. Nursing staff must also ensure that the facility has an alternate treatment order in case of wound vac malfunction or if the wound vac is unavailable. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; DON/Designee to review all new	

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	3.1-40(a)(2)		wound orders 5 times per week, for 4 months, to ensure all treatments are initiated in a timely manner. DON/Designee must also audit all residents with a wound vac to ensure we have alternate treatment orders in case of wound vac malfunction or in case the wound vac is not available. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 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 by which systemic corrections will be completed: 8/22/23	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates			

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	that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to ensure splints were applied as ordered for 1 of 1 residents reviewed for limited range of motion (ROM). (Resident 46) Finding includes: On 7/24/23 at 10:56 a.m., Resident 46 indicated he was in need of therapy for his left side and did not wear any type of splinting devices. There was no splinting device noted to his left hand/wrist at the time of interview. On 7/27/23 at 11:26 a.m., Resident 46 was observed in bed with no splint noted to his left hand/wrist. On 7/28/23 at 10:38 a.m., Resident 46 was observed in bed with no splint noted to his left hand/wrist. He indicated he never wore one and no one ever offered to help him put one on. Resident 46's record was reviewed on 7/26/23 at 9:43 a.m. Diagnoses included, but were not limited to, left-sided weakness/paralysis following a stroke and lack of coordination.	F 0688	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this citation. F688 Increase/Prevent Decrease in ROM/Mobility What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 46 was assessed for any adverse effects related to not	08/22/2023

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	The Quarterly Minimum Data Set (MDS) assessment, dated 5/30/23, indicated the resident was cognitively intact for daily decision making. He required extensive assistance with two persons physical assist for bed mobility, transfers, dressing, toilet use, and personal hygiene. A Physician's Order, dated 8/12/22, indicated the resident may wear a left wrist/hand orthosis as tolerated during the day, except during bathing and skin care checks, and off at night. A Care Plan, dated 7/14/23, indicated the resident required splint assistance for upper extremity strengthening and due to a decrease with activities of daily living (ADLs). Interventions included, but were not limited to, encourage participation, notify nurse/therapy of any issues identified during the program, and observe skin for areas of impairment during application/removal of the splint. Interview with the Interim Director of Nursing on 7/27/23 at 2:56 p.m., indicated the resident had a history of refusing the splinting device and he was unsure if he still had the splint orders at the time of the interview. Interview with the Nurse Consultant on 7/28/23 at 10:42 a.m., indicated the resident had a history of refusing to wear the splinting device, but it was not documented on the days he was observed. A policy titled, "Splinting and Assistive Devices," created on 9/20/21, indicated "...3. Nursing staff to provide splinting and assistive device to resident. Monitor for any skin integrity breaks and further decline in ADLs, ROM, and mobility. 4. Document for any refusals and pain. Notify MD and refer to		having ordered splint on. No adverse effects noted. continued to refuse splint application, order and care plan discontinued. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents with adaptive equipment have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Nurses were educated on ensuring adaptive equipment/devices are in place as per orders. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; DON/Designee will audit 5 residents with adaptive equipment/devices weekly, for 4	

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	therapy as necessary. Update plan of care accordingly." 3.1-42(a)(2)		months, to ensure adaptive equipment/device is in place as ordered. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 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 by which systemic corrections will be completed: 8/22/2023	
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.			

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	Based on observation, record review, and interview, the facility failed to ensure a resident with a history of falls had fall interventions in place to prevent further injury related to not wearing non-skid socks for 1 of 2 residents reviewed for falls. (Resident E) Finding includes: On 7/24/23 at 10:00 a.m., Resident E was observed in bed with her eyes closed. At that time, she was wearing plain white socks to both of her feet. On 07/25/23 8:33 a.m., and 8:50 a.m., the resident was observed in bed. At that time, she was wearing plain white socks. The record for Resident E was reviewed on 7/27/23 at 10:00 a.m. The resident was admitted to the facility on 4/7/23. Diagnoses included, but were not limited to, metabolic encephalopathy, type 2 diabetes, diabetic neuropathy, high blood pressure, anxiety disorder, heart failure, and convulsions. The 6/22/23 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact for daily decision making. The resident needed extensive assist with 1 person physical assist for bed mobility. She was an extensive assist with 2 person physical assist for transfers. The resident had a history of falls since the last assessment. A Care Plan, revised on 6/23/23, indicated the resident has had a fall. The approaches were for the resident to wear non-skid socks when attempting to ambulate and when not wearing shoes.	F 0689	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this citation. F689 Free of Accident Hazards/Supervision/Devices What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident E was discharged from the facility; no changes were made to medical record/resident at this time. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents at risk for falls have the potential to be affected by the same alleged deficient practice.	08/22/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Nurses' Notes, dated 4/7/23 at 11:55 p.m., indicated the resident was observed sitting on he floor by the bed. Her face was bloody and the gown was saturated with blood. She has a small laceration on the forehead. 911 was called and the resident was transferred to the hospital. The ER (emergency room) Discharge Notes, dated 4/8/23 at 2:37 a.m., indicated repaired head laceration. There was no documentation of the resident after she returned from the hospital or the time she returned. There was no assessment of the resident after her return or the extent of her injuries. Neuro checks were not initiated. Nurses' Notes, dated 4/9/23 at 11:32 a.m., indicated the resident was observed on the floor, near her bed, faced down. The resident's nose was bleeding and upon further assessment, she complained of pain to the left arm. The Physician was notified and the resident was sent to the ER. The resident was admitted to the hospital with a broken nose. ER Notes, dated 4/9/23, indicated the patient had an unwitnessed fall at the nursing home and was found face down with a bloody nose. She was also seen yesterday for another fall where she had a scalp laceration, staples were placed and she was discharged back to the nursing home. The resident had numerous other falls since admission, including the following: On 5/15 at 4:44 p.m. On 5/21/23 at 12 p.m. On 5/22 at 1:40 p.m. On 6/16 at 8:24 a.m. On 6/28 at 6:24 p.m.		What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Nursing staff were educated on ensuring fall interventions are in place per the plan of care. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The DON /designee will audit 5 residents with fall interventions weekly, for 4 months, to ensure fall interventions are in place as ordered. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 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.	

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	On 7/3 at 3:48 p.m. Interview with Nurse Consultant on 7/27/23 at 4:00 p.m., indicated the resident was to have on non-skid socks when she was not wearing any shoes. This Federal tag relates to Complaint IN00408677. 3.1-45(a)		Date of Completion: 8/22/2023	
F 0690 SS=D 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 restore continence to the extent possible.			

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	§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 observation, record review, and interview, the facility failed to ensure residents with complex urinary tract infections were seen by the urologist and residents with suprapubic (inserted through the abdomen) foley (urinary) catheters had them changed on a monthly basis for 2 of 3 residents reviewed for catheters. (Residents 60 and 2) Findings include: 1. During an interview on 7/24/23 at 10:05 a.m., Resident 60 indicated staff did not perform catheter care for him every shift or every day. At that time, he was observed with an indwelling foley catheter. The record for Resident 60 was reviewed on 7/26/23 at 9:40 a.m. The resident was admitted on 2/10/23. Diagnoses included, but were not limited to acute spinal cord infarction, chronic ischemic heart disease, high blood pressure, type 2 diabetes, major depressive disorder, anxiety disorder, panic disorder, stroke with no residual, and coronary artery bypass graft. The resident was admitted to the hospital on 2/13/23 returning on 2/21/23, on 4/22/23 returning on 4/27/23, and on 7/16/23 returning to the facility on 7/20/23. The 5/30/23 Significant Change Minimum Data Set	F 0690	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this citation. F690 Bowel/Bladder Incontinence, Catheter, UTI What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 60 received orders to follow up with urologist to have suprapubic catheter placed. Resident 2 suprapubic catheter change was completed on 8/9/23.	08/22/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING 00 B. WING	07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	(MDS) assessment indicated the resident was cognitively intact for daily decision making. The resident was an extensive assist with a 1 person physical assist for bed mobility, dressing, toilet use, and personal hygiene. He had an indwelling catheter. A Care Plan, revised on 7/24/23, indicated the resident had an urinary tract infection. A Hospital Discharge Note, dated 3/27/23, indicated to follow up with Urology. Hospital Discharge Instructions for an Emergency Room (ER) visit, dated 4/19/23, indicated to schedule an appointment within 3 days to see the Urologist. The hospital ER information, dated 7/16/23, indicated the resident had chronic urinary retention related to paraplegia and an indwelling catheter that had not been exchanged for several weeks, diagnosed with an acute urinary tract infection. A Urology consult, dated 7/18/23, indicated the resident was sent to the ER with abdominal pain and constipation. He had some suprapubic abdominal pain with chills as well. He had a foley catheter in place, however, it had not been exchanged in several weeks and was exchanged in the emergency department. An urinalysis does appear to be concerning for an infection with 4+ bacteria, greater than 900 white blood cells, and positive for leukocytes and nitrites, and a culture was pending. Urology has been consulted for discussion regarding a suprapubic tube placement. The patient had seen my partner for similar issues prior, and it was recommended to undergo suprapubic tube placement when last		How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents with indwelling catheters have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Nursing staff were re-educated on ensuring that all follow up appointments are made related to urology follow up and ensuring that suprapubic catheters are changed as ordered and as needed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; IP Nurse/Designee will audit the medical records for residents with suprapubic catheters weekly, for 4 months, to ensure appointments	

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	seen a few months prior, however, the patient did not follow-up regarding this. Hospital Discharge Instructions, dated 7/20/23, indicated to follow up with a urologist. Physician's Orders, dated 7/21/23, indicated Cefdinir (an antibiotic) Capsule 300 milligrams (mg), 1 capsule by mouth every 12 hours for urinary tract infection. There were no orders to change the foley catheter bag or the foley itself every 4 to 6 weeks. Interview with the Nurse Consultant on 7/27/23 at 1:55 p.m., indicated the resident had no follow up appointments made with the urologist after each hospital admission. The foley catheter was to be changed only if indicated by the Physician. 2. On 7/24/23 at 10:56 a.m., Resident 2 was observed in bed. He indicated he had been asking for a doctor appointment to exchange his suprapubic catheter for 3 months. On 7/25/23 at 4:02 p.m., the resident was observed sitting up in his chair doing a crossword puzzle. The resident indicated he asked again about his catheter being exchanged, with no response. The record for Resident 2 was reviewed on 7/26/23 at 11:28 a.m. Diagnoses included, but were not limited to, heart failure, hypertension (high blood pressure), obstructive uropathy (bladder obstruction), diabetes, and muscle weakness. The Annual Minimum Data Set (MDS) assessment, dated 6/11/23, indicated the resident was cognitively intact. A Physician's Note, dated 6/22/23, indicated the		are made with urologist for follow up, changing of catheters and catheter care are completed as ordered and as needed. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/22/2023	

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	resident's tube (suprapubic catheter) has been intermittently changed with Interventional Radiology. The resident does not routinely get his tube exchanged, so he often had to go to the emergency department. "...I called the Interventional Radiology coordinator to see if we could get him set up to have his tube exchanged every month. Was concerned that if he was exchanged without imaging guidance, we would lose access due to his obesity. It does not appear that he ever followed up with interventional radiology regarding tube exchange..." Interview with the Nurse Consultant on 7/26/23 at 2:52 p.m.,indicated he has not had the suprapubic catheter changed since the last hospital stay on 5/26/23. They were arranging for him to get it changed now. 3.1-41(a)(2)			
F 0692 SS=D 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 indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake			

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	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 observation, record review and interview, the facility failed to ensure residents maintained acceptable parameters of nutritional status related to meal consumption records not completed and dietary supplements not given to the resident for 1 of 4 residents reviewed for nutrition. (Resident 60) Finding includes: During an interview on 7/24/23 at 10:01 a.m., Resident 60 indicated he was supposed to get Glucerna "or something like that," however, he had not received it in a long time. The Registered Dietitian (RD) told him he was supposed to receive it. The record for Resident 60 was reviewed on 7/26/23 at 9:40 a.m. The resident was admitted on 2/10/23. Diagnoses included, but were not limited to acute spinal cord infarction, chronic ischemic heart disease, high blood pressure, type 2 diabetes, major depressive disorder, anxiety disorder, panic disorder, stroke with no residual, and coronary artery bypass graft. The 5/30/23 Significant Change Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. The resident had no oral problems and weighed 207 pounds with no current significant weight loss or gain. The Care Plan, revised on 6/21/23, indicated the resident was at risk for impaired nutritional	F 0692	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this citation. F692 Nutrition/Hydration Status Maintenance What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 60 medical reviewed, for was updated to ensure that and that documentation is available for nursing staff. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action	08/22/2023

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	status due to readmission to facility and therapeutic diet. The approaches were to provide diet and supplements as ordered. The resident's weights were as follows: - 6/8/23 208 pounds - 6/28/23 183 pounds - 7/5/23 181 pounds - 7/20/23 195 pounds. The meal consumption log indicated breakfast was not documented on 6/30, 7/5, 7/6, and 7/11/23. The lunch meal was not documented on 7/5 and 7/6/23, and the dinner meal was not documented on 7/21, 7/22, 7/23, and 7/24/23. Physician's Orders, dated 7/20/23, indicated Ensure 2 times daily for supplement. An RD note, dated 7/26/23, indicated the resident had a 10% weight loss over the last 90 days. The resident had variable food consumption and was receiving Ensure for nutritional support. The resident's MNA (mini nutritional assessment) score of 7 indicated he was malnourished. The 7/2023 MAR (Medication Administration Record) indicated there was no documentation of Ensure supplement being administered. Interview with the Nurse Consultant on 7/27/23 at 1:55 p.m., indicated there was no documentation the resident received his Ensure supplement as it was not on the MAR. Meal consumption totals were to be completed after every meal. 3.1-46(a)(1)		will be taken; All residents have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Dietary staff were re-educated to ensure all dietary supplements are on the meal trays according to the meal ticket. Nursing staff were re-educated to ensure all items on the meal tickets are on the resident's trays and that they document percentages of resident's meal intakes daily. Education also was provided to administer supplements as ordered. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; DON/Designee will audit 5 random trays 2 times weekly at various shifts for 4 months to ensure that	

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			residents are receiving ordered supplements. DON/Designee to audit 5 residents meal intakes 2 times weekly, for 4 months, to ensure compliance with documentation requirements for meal intake. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/22/23	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning,			

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	is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure lung sounds were assessed prior to administering nebulizer treatments and staff remained with the resident during the treatment for 1 of 1 nebulizer treatments observed. (Resident 271) Finding includes: On 7/27/23 at 9:46 a.m., LPN 2 was preparing to administer an Ipratropium-Albuterol nebulizer treatment to Resident 271. The LPN placed the vial of solution in the nebulizer canister and placed the mask over the resident's face. She did not assess his lung sounds prior to administering the treatment. The LPN indicated she would return to the resident's room in about 15 minutes to remove the mask once the nebulizer treatment was completed. The record for Resident 271 was reviewed on 7/27/23 at 3:48 p.m. Diagnoses included, but were not limited to, shortness of breath, chronic obstructive pulmonary disease (COPD), and stroke. The Admission Minimum Data Set (MDS) assessment, dated 7/26/23, indicated the resident was cognitively intact. A Physician's Order, dated 7/19/23, indicated the resident was to receive Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) milligrams (MG)/3 milliliters (ML), 3 ml inhale orally two times a day	F 0695	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this citation. F695 Respiratory/Tracheostomy care and Suctioning What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident was discharged from the facility; no corrective action at this time. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All have nebulizer have the	08/22/2023

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	for asthma. Use 1 ampule per nebulizer twice a day. The resident had no order to self administer his medications. Interview with the Nurse Consultant on 7/27/23 at 12:11 p.m., indicated the LPN should have stayed with the resident during his nebulizer treatment and she should have assessed his lung sounds. The facility policy titled, "Nebulizer-Medication Administration" was provided by the Nurse Consultant on 7/27/23 at 12:00 p.m. The policy indicated baseline pulse, respiratory rate, and lung sounds were to be obtained prior to the treatment. Staff was to remain with the resident for the treatment unless the resident had been assessed and authorized to self-administer their medication. 3.1-47(a)(6)		potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff were re-educated on performing respiratory assessments before and during the nebulizer treatment. Staff were also re-educated on the need staff to stay with the resident during the nebulizer treatment, not unless they have assessment to nebulizer. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place; DON/designee will perform observations with 2 nurses twice weekly for 4 months to ensure that they are performing respiratory assessments before and during the nebulizer treatments and that staff is staying with the resident during the nebulizer treatment. Director of Nursing/designee will	

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			present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8-22-23	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure ongoing communication with the dialysis center was completed with each dialysis session for 1 of 1 residents reviewed for dialysis. (Resident 12) Finding includes: Resident 12's record was reviewed on 7/26/23 at 11:29 a.m. Diagnoses included, but were not limited to, end stage renal disease, dependence on renal dialysis, and type 2 diabetes mellitus.	F 0698	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this citation.	08/22/2023

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	The Quarterly Minimum Data Set (MDS) assessment, dated 6/27/23, indicated the resident was cognitively intact for daily decision making. He received insulin injections and dialysis treatments. A Care Plan, dated 7/24/23, indicated the resident was at risk for adverse effects related to end stage renal disease with dependence on hemodialysis. Interventions included, but were not limited to, check and change dressing daily at access site and encourage resident to go for the scheduled dialysis appointments on Monday, Wednesday, and Friday each week. The Dialysis Communication binder included communication forms that had information for the facility to fill out prior to the resident going to the dialysis center. The information included the time of the last meal, last weight and date, medications given within the last four hours, any problems since the last treatment, and other pertinent information (dentist and other appointments with dates). The Dialysis Communication sheets were blank on 7/5/23, 7/17/23, 7/21/23, and 7/24/23. There were no Dialysis Communication sheets for 7/14/23, 7/19/23, and 7/26/23. Interview with the Interim Director of Nursing on 7/27/23 at 2:49 p.m., indicated the resident was a brittle diabetic and the dialysis facility wanted to be informed of any abnormal blood sugars from the same morning of his dialysis appointments. Facility staff were also to document his most recent set of vital signs in the dialysis binders before he left. The Communication sheets should be filled out entirely before he left for dialysis.		F698 Dialysis What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 12 was and no adverse effects were noted related to not having the dialysis communication binder completed. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents who go to have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All current dialysis residents were reviewed with no unusual findings. Nursing staff educated related to ensuring that the dialysis communication binder is updated	

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	Interview with the Nurse Consultant on 7/28/23 at 10:46 a.m., indicated she had no further information to provide. A policy titled, "Dialysis Communication," dated 9/1/20, indicated "...2. Communication binders for dialysis residents will be available during dialysis transportation. 3. Completion of documentation on pre dialysis will be completed by facility. 4. Upon return from dialysis, nurse to review communication binder, and review documentation from dialysis center." 3.1-37(a)		with an assessment prior to leaving for dialysis and upon return from dialysis. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; DON/Designee will audit all dialysis residents three times per week, for 4 months, to ensure that dialysis communication binder is updated before and after all dialysis sessions. DON/Designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/22/23	

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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 reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure medications were managed appropriately related to missed insulin doses and medication not held as ordered for 1 of 6 residents reviewed for unnecessary medications (Resident 12). Finding includes: The record for Resident 12 was reviewed on 7/26/23 at 11:29 a.m. Diagnoses included, but were not limited to end stage renal disease, dependence on renal dialysis, and type 2 diabetes mellitus.	F 0757	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests compliance for this citation.	08/22/2023

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	155653	A. BUILDING 00 B. WING	07/28/2023

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	The Quarterly Minimum Data Set (MDS) assessment, dated 6/27/23, indicated the resident was cognitively intact for daily decision making. The resident received insulin injections and dialysis treatments. A Care Plan, dated 7/24/23, indicated the resident was at risk for adverse effects related to end stage renal disease with dependence on hemodialysis. Interventions included, but were not limited to, check and change dressing daily at access site and encourage resident to go for the scheduled dialysis appointments on Monday, Wednesday, and Friday each week. A Physician's Order, dated 4/6/22, indicated amlodipine (blood pressure medication) 5 milligram (mg) tablet one time a day, do not give on dialysis days. The July 2023 Medication Administration Record indicated amlodipine was administered on 7/3/23, 7/7/23, 7/10/23, 7/19/23, 7/24/23, and 7/26, which were all on scheduled dialysis days. A Physician's Order, dated 11/7/22, indicated insulin detemir (long-acting insulin) solution 100 units/milliliter inject per sliding scale: if 180 - 450 = 6 Units; 451 - 500 = 6 Units notify Physician , subcutaneously two times a day, hold if blood sugar was under 180. A Physician's Order, dated 12/7/22, indicated insulin lispro (short-acting insulin) 100 units/milliliter solution inject per sliding scale: if 150 - 200 = 1 unit; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 - 400 = 5 units if over 400 call the Physician, subcutaneously before meals. Hold if blood sugar was under 150 and inject 4 unit subcutaneously before meals.		F 757 Unnecessary Medications Plan of Correction How will corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 12 was assessed and did not suffer any adverse effects related to the documentation not being completed for insulin administration and BP medication not being held prior to hemodialysis. Resident 12 frequency order for BP medications was updated to reflect that they are held on dialysis days. How identify other residents having the potential to be affected by the same deficient practice? All residents with insulin, and residents on hemodialysis, have the potential to be affected by the	

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	The June 2023 Medication Administration Record indicated the insulin detemir was not administered as ordered at 8:00 a.m. on 6/1/23, 6/3/23, and 6/12/23. The July 2023 Medication Administration Record indicated the insulin detemir was not administered as ordered at 6:00 a.m. and 5:00 p.m. on 7/21/23. The June 2023 Medication Administration Record indicated the insulin lispro was not administered as ordered on 6/1/23, 6/3/23, 6/4/23, 6/6/23, 6/9/23, and 6/12/23. The July 2023 Medication Administration Record indicated the insulin lispro was not administered as ordered at 7/7/23 at 11:30 a.m., 7/8/23 at 11:30 a.m., 7/12/23 at 11:30 a.m., 7/21/23 at 7:30 a.m. and 11:30 a.m. Interview with the Nurse Consultant on 7/28/23 at 10:42 a.m., indicated the medications should have been administered as ordered. 3.1-48(a)(6)		same alleged deficiency. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Director of Nursing or designee re-educated staff nurses on the facility Medication Administration policy, specifically on administering insulin as ordered and signing the EMAR immediately post administration. This documentation includes the documentation of what the blood sugar was and how many units of insulin were administered. Nursing Staff educated regarding holding BP medications as ordered on dialysis days. How monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? DON/designee will audit twice weekly, for 4 months, 5 residents with insulin orders, to ensure insulin administration and documentation has occurred per	

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			facility policy. DON/Designee will audit, twice weekly, for 4 months, all residents on dialysis to ensure that the medication is being held per MD order. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/22/23	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:			

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	(i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident			

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	for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure residents did not receive unnecessary medications related to PRN (as needed) anti-anxiety medication only administered after non-pharmaceutical interventions were attempted for 1 of 6 residents reviewed for unnecessary medications. (Resident E) Finding includes: The record for Resident E was reviewed on 7/27/23 at 10:00 a.m. The resident was admitted to the facility on 4/7/23. Diagnoses included, but were not limited to, metabolic encephalopathy, type 2 diabetes, diabetic neuropathy, high blood pressure, anxiety disorder, heart failure, and convulsions. The 6/22/23 Significant Change Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. In the last 7 days, the resident had received an antipsychotic medication 7 times and an antidepressant 7 times. Physician's Orders, dated 6/26/23 and discontinued on 7/13/23, indicated Ativan tablet 0.5 milligrams (mg), give 1 tablet by mouth every 4 hours as needed for anxiety. The 7/2023 Medication Administration Record (MAR), indicated the Ativan was signed out as being administered on the following days and times: 7/3 at 12:18 p.m. 7/4 at 7:37 a.m., 1:35 p.m., and 11:14 p.m. 7/5 at 9:49 a.m. 7/6 at 6:40 a.m. 7/9 at 9:36 a.m.	F 0758	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this citation. F758 Free from unnecessary psychotropic meds/PRN use What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident E was discharged from the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All Residents with an order for PRN psychotropic medications have the potential to be affected by the same alleged deficient	08/22/2023

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	7/10 at 1:25 p.m. 7/11 at 9:25 a.m. 7/13 at 12:06 p.m. There was no documentation in the clinical record if non-pharmaceutical interventions were tried prior to the administration of the PRN Ativan Interview with the Nurse Consultant on 7/28/23 at 8:30 a.m., indicated there was no documentation of interventions tried prior to the administration of the PRN Ativan. 3.1-48(a)(4)		practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff were re-educated on ensuring that they attempt and document 3 non-pharmacologic intervention prior to the administration of a prn psychotropic medication. Staff were also educated on documenting behaviors after notifying the physician of the behaviors. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; DON/Designee will randomly audit 5 residents receiving prn psychotropic medications twice weekly, for 4 months, to ensure that they attempt a non-pharmacologic intervention prior to the administration of a prn psychotropic medication.	

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			The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/22/23	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 5 residents observed during medication pass. Three errors were observed during 30 opportunities for errors during medication administration. This resulted in a medication error rate of 10%. (Residents 34 and 5) Findings include: 1. During observation of medication administration on 7/25/23 at 9:26 a.m., LPN 4 was	F 0759	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this citation.	08/22/2023

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	preparing Resident 34's medications. She dispensed one Seroquel (an antipsychotic medication) 25 milligram (mg) tablet in the med cup. She then proceeded to dispense one Zoloft (an antidepressant) 100 mg tablet in the med cup. The resident also received one Norco (a narcotic pain medication) and one Xanax (an anti-anxiety medication). There were a total of 4 pills in the medication cup. The LPN proceeded to the resident's room to administer the medications. The record for Resident 34 was reviewed on 7/25/23 at 10:30 a.m. Diagnoses included, but were not limited to, schizoaffective disorder, major depressive disorder, and anxiety. A Physician's Order, dated 5/12/23, indicated the resident was to receive Seroquel 25 mg twice a day for Schizoaffective Disorder. Give with a 100 mg tablet to equal 125 mg. A Physician's Order, dated 6/9/23, indicated the resident was to receive Zoloft 100 mg daily. Take with a 25 mg tablet to equal 125 mg. Interview with the Nurse Consultant on 7/27/23 at 12:00 p.m., indicated the resident should have received a 100 mg and 25 mg tablet of both medications to equal 125 mg. 2. During observation of medication administration on 7/26/23 at 4:27 p.m., RN 1 was preparing Resident 5's medications. The RN dispensed the following medications into the med cup: one Feosol (an iron supplement) tablet 325 milligrams (mg), one Keppra (a seizure medication) 500 mg tablet, one Xarelto (a blood thinner) 20 mg tablet, and one Zinc Chelate (a vitamin supplement) 50 mg tablet. Four tablets were in the medication cup.		F759 Free of Medication Error Rate of 5% or More What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; and 34 were assessed and noted with no adverse reactions due to medication errors. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents who receive medications have the potential to be affected by the same alleged deficient practice. p paraid="405121084" paraeid="{9eabb407-159c-43e8-aabf-d67fafcc87d8}{49}" >What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; RN's, , and QMA's were educated	

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	The RN removed the Metoprolol (a cardiac medication) 50 mg punch card from the medication cart. He then proceeded to place the card back in the med cart. The RN proceeded into the resident's room. The RN was stopped and was asked to check the medication orders. Interview with RN 1 at that time, indicated he placed the Metoprolol punch card back in the med cart before dispensing the medication. 3.1-48(c)(1)		on medication administration following the 5 rights of medication pass: Right Resident ·Right Medication ·Right Dose ul class="BulletListStyle1 SCXW255147283 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" Right Route Right Time How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Nurse manager/designee will randomly audit/observe 2 Nurse's/QMA's administer medications 2 times per week, for 4 months, to ensure proper medication administration	

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			technique. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 4months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/22/2023	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §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			

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	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, record review, and interview, the facility failed to ensure medications were labeled and stored correctly for 1 of 5 residents observed during medication administration. (Resident 5) Finding includes: Observation of medication pass on 7/26/23 at 4:05 p.m., with RN 1, indicated Resident 5's insulin pen was on top of the medication cart. The RN entered the resident's room to check her blood sugar. He closed the door behind him and the medication cart was out of his view. At 4:27 p.m., the RN administered the resident's oral medications. The insulin pen remained on top of the medication cart. The medication cart remained out of the RN's view while he administered the medications. At 5:28 p.m., the RN was preparing to administer the resident's insulin. The insulin pen had remained on top of the medication cart. The RN indicated the resident was to receive 30 units of Humalog (fast acting) insulin based on the order. The label on the insulin pen indicated the resident was to receive 20 units. The RN proceeded to the	F 0761	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this citation. F761 Label/Storage Drugs & Biologicals What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Insulin was immediately labeled and stored appropriately.	08/22/2023

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	medication room to look for another insulin pen for the resident. The new insulin pen indicated the resident was to receive 20 units of insulin. The RN administered 30 units of insulin. The record for Resident 5 was reviewed on 7/26/23 at 5:35 p.m. Diagnoses included, but were not limited to, stroke and type 2 diabetes mellitus. A Physician's Order, dated 5/17/23, indicated the resident was to receive 30 units of insulin via the Humalog Kwikpen subcutaneously before meals. Interview with the Nurse Consultant on 7/27/23 at 12:00 p.m., indicated the insulin pen should have been stored inside of the med cart and a medication change sticker should have been added to the label. 3.1-25(j) 3.1-25(m)		educated not to leave medications on top of medication out of sight. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents with medications have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff were re-educated to ensure Insulins are labeled/dated upon opening and kept refrigerated when not in use. Staff were re-educated that if a dose change of insulin occurs that a change order sticker with the correct dose should be utilized on the insulin pen. Staff were educated to never leave	

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			medication on top of the medication cart when the medication cart is not in the view of the nurse. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Nurse managers/designee will audit 5 insulins two times per week, for 4 months, to ensure they are labeled with an open date and expiration date and are stored appropriately. The nurse manager will also verify if an insulin dose change occurred and that the change sticker is on the insulin pen. DON/Designee will observe medication carts two times per week, for 4 months, to ensure no medications are left on top while out of the view of the nursing staff. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155653	A. BUILDING 00 B. WING	07/28/2023

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			auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/22/2023	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §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 and interview, the facility failed to store and prepare food under sanitary	F 0812	Please accept the following as the facility's credible allegation of	08/22/2023

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	155653	A. BUILDING 00 B. WING	07/28/2023

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	conditions related to built up grease on the stove top, open food containers, and uncovered food in the freezer for 1 of 1 kitchens observed. This had the potential to affect the 64 residents who received food from the kitchen. (The Main Kitchen) Findings include: During the initial kitchen tour on 7/24/23 at 8:50 a.m., with the Dietary Manager, the following was observed: a. The stove top and fire irons had a build up of grease. b. The dry food storage area had an open container of dry oats on the floor and an open container of grape jelly on the counter. c. The freezer had a block of cheese uncovered sitting on the counter. Interview with the Dietary Food Manager on 7/24/23 at 9:00 a.m., indicated the stove should have been cleaned and the food items in the dry storage and freezer should not have been left open. 3.1-21(i)(3)		compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this citation. F812 Food Procurement, Store/Prepare/Serve-Sanitary What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Stove and fire irons were cleaned. The dry oats were removed off the floor and discarded. The cover was replaced jelly. The block of on the counter was discarded. How will identify other residents	

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			who have the potential to be affected by the same alleged deficient practice? The deficient practice has the potential to affect all facility residents. What corrective measures will the facility take or alter to ensure that the problem will not recur?¿¿ Dietary staff were educated on ensuring that the stove and fire irons are clean. Dietary staff were also educated related to ensuring that there are no food products touching the floor and that all food products are covered at all times. What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent? Dietary manager/designee will conduct observation in the kitchen 3 times a week, for 4 months, to ensure food/beverages are covered and stored appropriately at all	

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			times in different areas in the kitchen. Dietary will also observe the stove and fire irons to ensure their cleanliness. Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. By what date the systemic changes will be completed: 8/22/23	
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. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted			

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	155653	A. BUILDING 00 B. WING	07/28/2023

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	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; 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			

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	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 interview and record review, the facility failed to ensure the resident's medical record was complete and accurate related to dialysis fistula monitoring for 1 of 1 residents reviewed for dialysis. (Resident 12) Finding includes: Resident 12's record was reviewed on 7/26/23 at 11:29 a.m. Diagnoses included, but were not limited to, end stage renal disease, dependence on renal dialysis, and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 6/27/23, indicated the resident was cognitively intact for daily decision making. He received insulin injections and dialysis treatments. A Care Plan, dated 7/24/23, indicated the resident was at risk for adverse effects related to end stage renal disease with dependence on hemodialysis. Interventions included, but were not limited to, check and change dressing daily at access site	F 0842	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this citation. F842 Resident Records – Identifiable Information What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	08/22/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	and encourage resident to go for the scheduled dialysis appointments on Monday, Wednesday, and Friday each week. A Physician's Order, dated 8/25/21, indicated assess dialysis access site for redness, swelling, pain, drainage and notify physician with any symptoms and document in progress note. Assess for bruit and thrill, document + for present, - for absent every shift. The July 2023 Medication/Treatment Administration Record (MAR/TAR) indicated on day shift (-) on 7/1 thru 7/6; (-) on 7/11, (-) on 7/12, (+/-) on 7/13, (-) on 7/14-7/17, (-) on 7/19-7/20 and blank on 7/21. On the evening shift, documentation indicated (-) on 7/1 thru 7/18, (-) on 7/20 thru 7/26, and (+/-) on 7/19/23. On the evening shift it was documented (+/-) on 7/12/23, 7/2, 7/4, 7/5, 7/7, 7/8, 7/9, 7/13, 7/14, 7/15, 7/16, 7/17, 7/18, 7/20, 7/21, 7/22, 7/23, 7/24, 7/25, and 7/26/23. It was documented as (-) on the night shift on 7/3, 7/6, 7/10 thru 7/12, and 7/19/23. Interview with the Interim Director of Nursing on 7/27/23 at 2:51 p.m., indicated the questions in the order itself needed to be changed as it should read as two separate questions with two separate answers in the MAR/TAR. It had read that way for a long time and it should have been changed. Whenever he worked the floor, he always marked positive for bruit/thrill and negative for redness, swelling, pain, and drainage, which was why sometimes it was marked both positive and negative. Interview with the Nurse Consultant on 7/28/23 at 10:46 a.m., indicated she had no further information to provide.		The order for Resident 12 was updated to reflect accurate documentation of dialysis AV fistula. No adverse effects noted due to inaccurate documentation. How will identify other residents who have the potential to be affected by the same alleged deficient practice? All the residents who are on dialysis and have an AV Fistula, have the potential to be affected by this alleged practice. What corrective measures will the facility take or alter to ensure that the problem will not recur?¿¿ Nursing staff re-educated on ensuring the correct orders are entered in PCC for the monitoring of residents with an AV Fistula. What quality assurance plans will be implemented to monitor facility performance to ensure corrections	

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	3.1-50(a)(1) 3.1-50(a)(2)		are achieved and permanent? DON/Designee will complete an audit of all residents with an AV Fistula once weekly for 4 months, to ensure that correct orders and accurate documentation for the monitoring of the AV fistula is noted. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. By what date the systemic changes will be completed: 8/22/23	
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			

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	155653	A. BUILDING 00 B. WING	07/28/2023

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	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 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.			

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	155653	A. BUILDING 00 B. WING	07/28/2023

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	§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, 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			

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	155653	A. BUILDING 00 B. WING	07/28/2023

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	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, 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	F 0867	Please accept the following as the facility's credible allegation of compliance. This plan of	08/22/2023

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	155653	A. BUILDING 00 B. WING	07/28/2023

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	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 for quality of care related to follow up documentation and assessment after a fall. This deficient practice had the potential to affect 64 of 64 residents residing in the facility. Finding includes: Interview with the Administrator in Training (AIT) and the Medical Record/Human Resource Director on 7/28/23 at 12:45 p.m., indicated the Quality Assessment and Assurance (QAA) Committee had a meeting on 7/11/23 and the committee consisted of the Medical Director, the Administrator, the DON, Infection Control Nurse, the Minimum Data Set (MDS) Nurse, the Food Sanitation Supervisor, the Social Service Director, the Activity Director and Maintenance. The Department Heads also 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 improvement or corrective plan and continuous monitoring of interventions. The following deficiency was cited on this survey at an isolated scope with potential for more than minimal harm and had been cited previously:		correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this citation. F867- QAPI/QAA What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Falls QAPI Plan was put into place. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the	

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	155653	A. BUILDING 00 B. WING	07/28/2023

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	- F684 Quality of Care was previously cited on a Complaint survey dated 2/28/23 and on the Annual with Complaints survey on 9/1/22. Cross reference F684. 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 Medical Record/Human Resource Director and the AIT on 7/28/23 at 12:45 p.m., indicated the previous Director of Nursing (DON) was covering and monitoring falls. The problem of falls was brought up during the May 2023 QAPI meeting, and they were doing the audits, however, they did not have access or know where those audits were currently. They were unsure if another plan had been put into place. The previous DON left her position on July 5, and during the QAPI meeting in July, the Administrator was going to take over monitoring the falls and develop a new performance improvement plan. They were both unsure if anyone was currently monitoring fall follow up and assessment as the current Administrator just resigned. 3.1-52(b)(2)		deficient practice does not recur; DON was educated on the need for the QAPI falls plan and the required monitoring. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The facility will implement a fall review program that will include the DON, Administrator and restorative aide, therapy director and social services. This committee will discuss all fall incidents to ensure that fall interventions and complete documentation are in place to prevent further falls. DON/designee will present a summary of the fall audits F684 and F689 to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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			Date by which systemic corrections will be completed: 8/22/23	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the residents' environment, as well as the kitchen area, was clean and in good repair related to dirty floors, marred walls, loose baseboards and lime build up in for 1 of 2 floors and the Main Kitchen. (Second Floor and the Main Kitchen) Findings include: 1. During the Environmental tour with the Environmental Manager on 7/27/23 at 2:54 p.m., the following was observed: Second Floor: a. In Room 217, the walls were marred behind and on the sides of beds one and two. Two residents resided in the room. b. In Room 224, the walls outside of the bathroom door were marred. Two residents resided in the room. c. In Room 228, the walls behind the bed were marred. The headboard was missing on bed one. Two residents resided in the room.	F 0921	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this citation. F921 Safe/Functional/Sanitary/Comfortable Environment What corrective action(s) will be accomplished for thoe residents found to have been affected by the deficient practice; Maintenance repaired marred walls and headboard was replaced	08/22/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155653	A. BUILDING 00 B. WING	07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARBOR HEALTH & REHAB	5025 MCCOOK AVE EAST CHICAGO, IN 46312

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	Interview with the Environmental Manager at that time indicated that he was working on getting all areas together. 2. During the follow up tour in the kitchen on 7/23/23 at 3:18 p.m. with the Environmental Manager, the following was observed: a. The floor had a build up of dirt and debris. b. The walls behind the stove and in the dish room were marred. c. The baseboard in the dish room was peeling away from the wall. 3.1-19(f)		in 228. The kitchen floor was cleaned, the walls behind the stove and dish room were repaired and the baseboard in the dish room was also repaired. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taksen; All residents have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff were re-educated on the procedure of notifying maintenance/environmental services of any necessary repairs/cleaning needed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;	

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			Maintenance supervisor/designee will audit the kitchen and 5 rooms per week, for 4 months, on alternating units for Maintenance issues, dirt, debris. Any identified issues will be corrected. /designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/22/2023	
F 0925 SS=D Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation and interview, the facility failed to maintain an effective pest control program to ensure the facility was free from pests related to live gnats and flies for 2 of 2 residents observed with gnats in their rooms. (Residents G and F)	F 0925	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in	08/22/2023

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	Finding includes: During the survey period, 7/24/23 through 7/28/23, the following was observed: During a random observation on 7/24/23 at 10:44 a.m., Resident G was observed lying in bed. He indicated he had a problem with flies, and he wanted a fly sticker since he can't use his hands due to being a paraplegic. There were flies observed flying around the resident's face. During a random observation on 7/26/23 at 9:39 a.m., Resident F was observed lying in bed with a sheet over her legs. There were several gnats on her bed sheet and a couple were flying around the resident's head. There were 2 residents who resided in the room. During a random observation on 7/26/23 2:46 p.m., Resident F was observed asleep in bed. A sheet covered the resident and there were 3 gnats on the sheet by the residents legs. There were 2 residents in the room. A service receipt from the pest control company, dated 7/20/23, indicated biozyme was used at 8:19 a.m. to spray for blow flies, drain flies, fly larvae, fruit flies, fungus fly, gnats, house flies, humpback flies, and midges. The main kitchen area was sprayed as well. Interview with the Director of Maintenance, on 7/24/23 at 10:51 a.m., indicated he would check for a fly strip and place one in Resident G's room. Interview with the Director of Maintenance, on 7/24/23 at 1:11 p.m., indicated the pest control company was just here last week on 7/20/23 and		response to the regulatory requirement. The facility requests paper compliance for this citation. F925 Maintains Effective Pest Control What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; was assessed for pests and control company was called out to treat the facility. Resident G and F and no adverse effects noted related to the gnats being on the bed sheets. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by the same alleged deficient practice.	

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	sprayed for flies and gnats. The faciility just switched pest control companies last month, so this was a new company. This Federal tag relates to Complaint IN00404782. 3.1-19(f)(4)		What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff were re-educated on the procedure of notifying maintenance/environmental services of any observation of pests. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Environmental services supervisor/Maintenance department/ will observe 10 separate facility areas per week for pests, for 4 months. Any identified pests control issues will be resolved immediately. /designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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F 9999 Bldg. 00	3.1-14 PERSONNEL (p) Initial orientation of all staff must be conducted and documented and shall include the following: (4) A detailed review of the appropriate job description, including a demonstration of equipment and procedures required of the specific position to which the employee will be assigned. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. This rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure each new employee had their Physical Exam signed by a Physician and/or a Nurse Practitioner (NP) and job specific orientation was completed for 5 of 5 new employees who had been hired within the last 120 days. (LPN 1, CNA 1, Housekeeper 1, Dietary Aide 1, and Activity Aide 1) Findings include: The Employee records were reviewed on 7/28/23 at 11:00 a.m.	F 9999	Date by which systemic corrections will be completed: 8-22-23 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this citation. **F9999 Final Observation-Personnel Files** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** LPN 1, CNA 1, Housekeeper 1, Dietary Aide 1, and Activity Aide job specific orientation and the physical exam completed. **How will identify other residents who have the potential to be affected by the**	08/22/2023

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	a. LPN 1 was hired on 4/13/23. There was no job specific orientation and the physical exam was not signed by a Physician. b. CNA 1 was hired on 5/17/23. There was no job specific orientation and the physical exam was not signed by a Physician. c. Housekeeper 1 was hired on 4/7/23. There was no job specific orientation and the physical exam was not signed by a Physician. d. Dietary Aide 1 was hired on 4/7/23. There was no job specific orientation and the physical exam was not signed by a Physician. e. Activity Aide 1 was hired on 5/23/23. There was no job specific orientation and the physical exam was not signed by a Physician. Interview with the Human Resources Director on 7/28/23 at 11:22 a.m., indicated the Medical Director does all of the physical exams and she does not go back to look to see if the job specific orientation was completed.		**same alleged deficient practice?** Audit of employees files hired over the last 120 days was completed to ensure compliance with physical examination and job specific orientation form completion. **What corrective measures will the facility take or alter to ensure that the problem will not recur?¿¿** HR Director was educated on the importance of ensuring all new hires receive a physical examination and job specific orientation form is completed. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** HR Director/Designee will audit 3 personnel files a week, for 4 months, to ensure that Physical are completed and signed by the physician and Job Specific orientation and Checklist is complete. HR Director /designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality	

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			Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **By what date the systemic changes will be completed: 8/22/23**	