STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155251	A. BUILDING 00 B. WING	08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HOBART SKILLED NURSING FACILITY, THE	2901 W 37TH AVE HOBART, IN 46342

(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 the Investigation of Complaints IN00409913, IN00411506, IN00412700, IN00413008, IN00413907, IN00415513, and IN00416438. Complaint IN00409913 - Federal/state deficiencies related to the allegations are cited at F561 and F694. Complaint IN00411506 - Federal/state deficiencies related to the allegations are cited at F684. Complaint IN00412700 - Federal/state deficiencies related to the allegations are cited at F677 and F686. Complaint IN00413008 - Federal/state deficiencies related to the allegations are cited at F677. Complaint IN00413907 - Federal/state deficiencies related to the allegations are cited at F755. Complaint IN00415513 - Federal/state deficiencies related to the allegations are cited at F684 and F694. Complaint IN00416438 - Federal/state deficiencies related to the allegations are cited at F684 and F686. Survey dates: August 29 and 30, 2023. Facility number: 000154 Provider number: 155251 AIM number: 100289680 Census Bed Type: SNF/NF: 46	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute and admission or agreement by this facility of the facts alleged, or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is September 22, 2023. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after September 22, 2023.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Judith Hoese	Administrator	09/20/2023

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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	Total: 46 Census Payor Type: Medicare: 7 Medicaid: 30 Other: 9 Total: 46 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/5/23.			
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.			

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	§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 record review and interview, the facility failed ensure a resident's preference to receive medications at a different time were honored to not interrupt sleep patterns for 1 of 3 residents reviewed for Intravenous (IV) antibiotics. (Resident B) Finding includes: The closed record for Resident B was reviewed on 8/29/23 at 2:45 p.m. The resident was admitted to the facility on 6/1/23 and discharged home on 6/15/23. Diagnoses included, but were not limited to, diverticulitis, atrial fibrillation, heart disease, insomnia, and anxiety. The Admission Minimum Data Set (MDS) assessment, dated 6/8/23, indicated the resident was alert and oriented and received IV medications while a resident. Physician's Orders, dated 6/1/23, indicated change IV tubing every 24 hours. Assess IV site every shift and monitor for signs and symptoms of infiltration and infection every shift. A Physician's Order, dated 6/2/23 and discontinued on 6/9/23, indicated Piperacillin (an antibiotic) 3.375 grams intravenously every 8 hours for diverticulitis for 13 days. The times to be administered were 6:15 a.m., 2:00 p.m., and 10:00 p.m. The 6/2023 Medication Administration Record (MAR), indicated the resident had refused the	F 0561	1. It is the policy of this facility to ensure a resident's preference to receive medications at a different time are honored not to interrupt sleep patterns. Resident B discharged from the facility on 6/15/2023. 2. All residents have the potential to be impacted the the alleged deficient practice. 3. All nursing staff were educated on the policy "Resident Preferences" by the DON and/or designee on or before 9/19/2023. Anyone who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. A facility-wide audit was completed related to resident preferences by the DON/Designee on or before 9/20/2023. Any concerns were immediately addressed, and care plans were updated as appropriate. 4. Audit Tools entitled "Resident Preferences Audit" will be utilized by DON and/or Designee 5 times per week for 4 weeks, weekly for 4 weeks, then monthly for 4 months and as needed thereafter. Any concerns noted will be	09/22/2023

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	medication at 6:15 a.m. on 6/2, 6/4, 6/5, 6/6, 6/7, 6/8 and 6/9/23. Nurses' Notes, dated 6/4/23 at 6:29 a.m., indicated entered the resident's room to hook up the IV antibiotics and the resident requested that she wanted to sleep longer and to not start the infusion. At 6:59 a.m., the resident still refused the IV infusion. Nurses' Notes, dated 6/5/23 at 5:19 a.m., indicated the resident refused the IV antibiotic. The resident stated "I said I didn't want this until I wake up." The resident was aware the medication was scheduled every 8 hours and the dose should be administered as ordered. Nurses' Notes, dated 6/6/23 at 5:36 a.m., indicated the resident refused three times to start the IV antibiotic. She indicated she would like it at 7:00 a.m. A NP Progress Note, dated 6/6/23 at 12:53 p.m., indicated according to nursing staff documentation, the resident has refused the IV antibiotics because she wanted the times of the medication adjusted and does not want to be disturbed when she was asleep. Nurses' Notes, dated 6/7/23 at 6:45 a.m., indicated the resident refused the IV antibiotic and wanted it administered at 7:00 a.m. Nurses' Notes, dated 6/8/23 at 5:59 a.m., indicated the resident refused the IV antibiotic and wanted it administered at 7:00 a.m. Nurses' Notes, dated 6/9/23 at 5:19 a.m., indicted the resident continued to refuse the IV medication. The resident indicated she doesn't		immediately addressed and corrected. All concerns will be addressed as needed in the monthly QAPI meeting. If patterns or concerns are noted, an action plan may be established. If the facility is 95% compliant after 6 months, the monitoring will be discontinued.	

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	want to be woken up and will take the medication after she wakes up. A telephone interview with a family member on 8/29/23 at 6:31 p.m. indicated the resident had refused the early morning dose of the IV antibiotics. The resident wanted it at a different time and not so early in the morning, because the IV interrupted her sleep. Interview with the Director of Nursing on 8/30/23 at 2:00 p.m., indicated she was not employed at the facility when the resident was admitted and discharged. She had no additional information. This Federal tag relates to Complaint IN00409913. 3.1-3(u)(1)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure a dependent resident received help with Activities of Daily Living (ADLs) related to the timeliness of incontinence care for 1 of 3 residents reviewed for ADLs. (Resident H) Finding includes: On 8/29/23 at 9:02 a.m. LPN 1 was observed turning Resident H to view 2 wounds located on the resident's lower back and sacrum. There was dried stool covering the wound bed. The resident had a bowel incontinence episode and requested	F 0677	1. It is the policy of this facility to provide the necessary care and services for, including good nutrition, grooming, and oral hygiene, for those residents who are unable. Resident H was discharged from the facility on 9/8/2023. 2. All residents have the potential to be negatively impacted by this deficient practice. 3. All nursing staff were educated	09/22/2023

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	to be changed. Resident H was observed on 8/29/23 at 3:34 p.m. The room had a strong urine odor. The resident indicated she was just changed a few minutes ago. Interview with Resident H at the time of observation, indicated she was on a diuretic (water pill) and she urinated constantly. She was last changed that morning when LPN 1 showed the surveyor her wounds. The record for Resident H was reviewed on 8/29/23 at 10:01 a.m. The resident was admitted on 8/4/23. Diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), hypertension (high blood pressure), heart failure, arthritis, and osteoporosis. The Annual Minimum Data Set (MDS) assessment, dated 8/11/23, indicated the resident was cognitively intact. Bed mobility required extensive assistance with 2-person physical assist. Transfers and toileting required total dependence with 2-person physical assist. Personal hygiene and dressing required extensive assistance with one-person physical assist. The resident was frequently incontinent of urine and always incontinent of bowel. A Care Plan, dated 8/9/23, indicated the resident required assistance with activities of daily living related to weakness, morbid obesity, right ankle injury, heart failure, and peripheral edema. Approaches included, but were not limited to, assist as needed so the resident was clean and dry. A Care Plan, dated 8/9/23, indicated the resident		on the policy "Perineal/Incontinence Care" as well as the policy "Activities of Daily Living" by the DON and or designee on or before 09/19/2023. Anyone who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. A facility wide audit was completed related to resident care as far as toileting needs/preferences by the DON/Designee on or before 9/20/2023. Any concerns were immediately addressed, and care plans were updated as appropriate. 4. The DON and/or designee will use audit tool entitled "Toileting/Incontinence Care Audit" five days a week for four weeks and three days a week for four weeks, then monthly for four months. Any concerns noted will be immediately addressed and corrected. All concerns will be addressed as needed in the monthly QAPI meeting. If patterns or concerns are noted, an action plan may be established. If the facility is 95% compliant after 6 months, the monitoring will be discontinued.	

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	was incontinent of bladder and bowel. A Physician's Order, dated 8/5/23, indicated to administer Bumetanide (diuretic) 1 milligram (mg) tablet by mouth one time a day for fluid retention. Interview with the Director of Nursing on 8/30/23 at 2:05 p.m., indicated the resident should have been changed in a timely manner. This Federal tag relates to Complaints IN00412700 and IN00413008. 3.1-38(a)(2)(B) 3.1-38(a)(2)(C)			
F 0684 SS=G Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review and interview, the facility failed to assess a resident and promptly notify the Physician in a timely manner after a fall resulting in a three day delay in treatment and hospitalization for a fracture (Resident N) and also failed to complete an assessment of a resident including vital signs after a fall (Resident E) for 2 of 4 residents reviewed for falls. Findings include:	F 0684	1. It is the expectation of this facility to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and residents' choices. Resident N expired 9/15/2023. Resident E was discharged from the facility on 8/5/2023. 2. All residents have the potential	09/22/2023

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	1. 8/30/23 at 9:15 a.m. Resident N was observed in bed with her eyes closed. The bed was low and there was a floor mat on the left side, the right side of the bed was against the wall. At that time, the Nurse Practitioner (NP) was seated on a chair by the bed. Interview with the NP at that time, indicated she was waiting for the resident's daughter to call because they were placing the resident on hospice care today. When asked about the fall with resulting in the fracture, she indicated she really did not know how she fell out of bed, but ever since the fall and fracture, the resident's condition had gone downhill. Her daughter wanted an orthopedic consult, and one was ordered, however, surgery was not an option because the resident was very high risk. On 8/30/23 at 11:00 a.m., 2 LPNs were asked to remove the bandage from the resident's pressure ulcer on the sacrum. The resident's right leg had a large yellow and faded blue bruise and was wrapped with an ace bandage with a soft splint support on the backside. The record for Resident N was reviewed on 8/30/23 at 9:30 a.m. Diagnoses included, but were not limited to, dementia, osteoarthritis, high blood pressure, heart disease, depressive disorders, anxiety, osteoporosis, fracture of shaft of right tibia and of right fibula. The 5/30/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively impaired and had no falls since the last assessment. The resident was totally dependent on staff with a 2 person physical assist for bed mobility and transfers.		to be impacted by the alleged deficient practice. 3. All nursing staff were educated on the policy "Incidents/Accidents/Falls" by the DON and/or designee on or before 9/192023. Anyone who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. A facility-wide audit was completed related to residents fall risk to ensure that each resident's comprehensive person-centered care plan is up to date by the DON/Designee on or before 9/20/2023. Any concerns were immediately addressed, and care plans were updated as appropriate. 4. Audit tool entitled "Falls Compliance Audit" will be utilized by DON and or Designee 5 times a week for 4 weeks, weekly for 4 weeks, then monthly for 4 months and as needed thereafter. Any concerns noted will be immediately addressed and corrected. All concerns will be addressed as needed in the monthly QAPI meeting. If patterns or concerns are noted, an action plan may be established. If the facility is 95% compliant after 6 months, the monitoring will be discontinued.	

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	The 8/2/23 Significant Change MDS assessment, indicated the resident was cognitively impaired and had 1 fall with a major injury since the last assessment. The resident was an extensive assist with a 2 plus person physical assist with bed mobility and totally dependent on staff with a 2 person assist for transfers. The 7/24/23 Quarterly Fall Risk Review Assessment indicated the resident was a high risk for falls The Care Plan, dated 7/25/23, indicated the resident had a fractured right tibia and fibula. The Care Plan, dated 7/25/23, indicated the resident had an actual fall with injury and a fracture. The approaches to make sure the bed was in the lowest position and a floor mat next to the bed. A Nurses' Note, dated 7/25/23 at 9:45 p.m., indicated the resident was observed with a large bruise on the right leg and it was in an anatomically odd position. A full head to toe assessment was completed and there was dark purple bruising noted with a green and yellow border to the right lower leg. The Physician was notified and a new order was obtained to send the resident to the hospital. 911 was called and arrived 20 minutes later and the resident was transported to the emergency room. The Emergency Room Notes, dated 7/25/23, indicated the resident arrived at 11:44 p.m. An assessment of the right lower leg indicated the "extremity compartments are soft, mild tenderness to palpation and not out of proportion to injury, no paralysis, non-circumferential swelling, normal sensation, no pallor, strong pulses, no			

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	paresthesias [sic], not cool to the touch. The right knee has swelling, effusion and ecchymosis present. Decreased range of motion and tenderness present." An X-ray of the right knee indicated there was a long blade plate and screws in place indicating an old distal femoral shaft fracture. The impression was there was an acute comminuted slightly displaced impacted fracture in the proximal right tibia shaft distal to the tibia plateaus and an associated fracture with angulation in the neck of the fibula. An X-ray of the right tibia and fibula indicated acute proximal tibia and fibular fractures, however, better seen on the knee X-ray. The bones were osteoporotic (a bone disease that develops when bone mineral density and bone mass decreases, or when the quality or structure of the bone changes. This can lead to a decrease in bone strength that can increase the risk of fractures.) A long leg post mold splint was applied to the right leg. There was no clear indication for surgery given the patient's condition and the POA's desire. A Nurses' Note, dated 7/26/23 at 4:10 a.m., indicated the resident returned from the hospital. The resident was noted with a long leg splint to the right leg. A IDT (Interdisciplinary Team) Progress Note, dated 7/26/23 at 2:55 p.m., indicated the resident had a recent unwitnessed fall from bed and was sent out for abnormal posture of leg. The resident returned with a fracture to tibia/fibula with a splint in place. The facility protocol was initiated and the IDT team met to discuss the incident and prevent			

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	future falls. The Care Plan was reviewed and updated, and staff were inserviced on fall protocol and reporting. New interventions were to have the bed in lowest position and a floor mat on open side of bed. A Fall Investigation initiated by the Director of Nursing, dated 7/25/23, indicated staff were asked to answer these questions: - Any incidents that occurred over the weekend? - Did you report any incident to the nurse at any time during your shift? - Did You hear from another staff member about any incident? A CNA indicated she was told by another CNA that Resident N was on the floor. The CNA gave the name of the staff member who told her that information. The CNA did not report the incident as she thought the other staff member had already told the nurse. The Follow Up to the Investigation indicated the resident had an unwitnessed fall on 7/22/23 from bed. The staff had noted on 7/25/2023 the resident had an obvious deformity to her right leg and the resident was sent to the emergency room for X-rays and an evaluation. The resident had a right tibia/fibula fracture and returned to the facility with a follow up appointment with a referral to an orthopedic specialist, scheduled for 8/3/23. The staff were educated. Interview with the Director of Nursing (DON) on 8/30/23 at 3:00 p.m., indicated when the bruising and deformity was discovered on 7/25/23 and the resident was sent out to the hospital, a CNA came up to her and indicated the resident had fallen out of bed over the weekend. The DON started an investigation and reviewed the security cameras.			

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	The resident's room was near the nurses' station and the resident's bed could be seen by the camera. On 7/22/23, she saw movement on the floor under the bed and at that moment 2 CNAs entered the room and closed the door. After they left the room, there was no more movement on the floor. She asked every staff member over the weekend to answer questions regarding any unusual events or if any resident had a fall. Only 1 CNA indicated she was told by another CNA, Resident N was on the floor. The 2 CNAs who picked the resident up and put her back to bed, denied any resident fell and they were terminated. The DON indicated a full set of vital signs were checked on 7/22/23, however, there was no physical assessment of the resident for 3 days after the fall on 7/22/23. An undated, but identified as current "Incident/Accident/Falls" policy provided by the Interim Administrator on 8/30/23 at 4:38 p.m., indicated "It was the policy of the facility to ensure that any incident/accident to include fall is reported immediately to the nurse or appropriate person designated to be in charge." 2. The closed record for Resident E was reviewed on 8/30/23 at 2:55 p.m. The resident was admitted to the facility on 8/4/23 and discharged against medical advice on 8/5/23. Diagnoses included, but were not limited to, osteomyelitis of the left foot and ankle, MRSA infection in the left foot, anxiety, arthritis, major depressive disorder, schizoaffective disorder, and high blood pressure. A Nursing Admission Assessment, dated 8/4/23, indicated the resident had a left foot wound and was admitted for Intravenous (IV) antibiotics. The resident was cognitively intact.			

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	155251	A. BUILDING 00 B. WING	08/30/2023

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	A Fall Risk Assessment, dated 8/4/23, indicated the resident was a low risk for falls. An e-Interact Change in Condition Evaluation, dated 8/5/23 at 10:15 a.m., indicated the resident had an unwitnessed fall and no injuries were noted. There were no current vital signs checked after the fall or neurological checks initiated. Interview with the Director of Nursing on 8/30/23 at 4:00 p.m., indicated there were no neuro checks initiated or current vital signs checked after the fall. An undated, but identified as current "Incident/Accident/Falls" policy provided by the Interim Administrator on 8/30/23 at 4:38 p.m., indicated in case of a fall, the resident will have a head to toe assessment completed. Any resident who had an unwitnessed fall must have neuro checks started and continued per policy. Neuro checks will be initiated even if the resident states they did not hit their head in an unwitnessed fall. This Federal tag relates to Complaints IN00411506, IN00415513, and IN00416438. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent			

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	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 history of pressure ulcers received the necessary treatment and services to promote healing related to turning and repositioning, ensuring treatments were in place, completing treatments as ordered, and initiating treatments in a timely manner for 3 of 3 residents reviewed for pressure ulcers. (Residents J, N, and H) Findings include: 1. On 8/29/23 at 9:07 a.m., Resident J was observed in his room in bed. LPN 2 was present in the room and the resident was identified as having a pressure ulcer to his bottom. The resident's brief was unfastened and a skin assessment was completed. The resident did not have a dressing in place to his left or right buttock. The LPN indicated at that time the area looked healed and "maybe that was why he didn't have a dressing on." The record for Resident J was reviewed on 8/29/23 at 11:48 a.m. Diagnoses included, but were not limited to, stroke, hemiplegia (paralysis on one side of the body) affecting the right dominant side, type 2 diabetes, and chronic kidney disease. The 8/4/23 Admission Minimum Data Set (MDS) assessment, indicated the resident was	F 0686	1. It is the policy of this facility to provide care consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individuals clinical condition demonstrates that they were unavoidable and that 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. Resident J's medical record was reviewed and the pressure ulcers to left and right butt were healed as of 9/12/2023. Resident N expired on 9/15/2023. Resident H was discharged from the facility on 9/8/2023. 2. Any resident at risk for pressure wounds has the potential to be impacted by the alleged deficient practice. 3. The DON and/or designee in-serviced staff on or before 9/19/2023 on the "SWAT" policy,	09/22/2023

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	cognitively impaired for daily decision making and he required extensive assistance with bed mobility and transfers. The resident was admitted with two stage 2 (partial thickness loss of the dermis presenting as a shallow open ulcer) pressure ulcers and one unstageable (full thickness tissue loss in which the base of the ulcer was covered with slough) pressure ulcer. A Care Plan, dated 7/31/23, indicated the resident was admitted with a wound that was potentially related to pressure, vascular insufficiency, diabetic neuropathy, and severe burns. Interventions included, but were not limited to, administer treatments as ordered. A Physician's Order, dated 8/7/23, indicated the resident's left and right buttocks were to be cleansed with normal saline, the area was to be patted dry, and a hydrocolloid (a type of wound dressing) was to be applied to the areas every Monday, Wednesday, and Friday until resolved. The August 2023 Treatment Administration Record (TAR), indicated the treatment had not been signed out as being completed on 8/28 and 8/30/23. The Weekly Wound Evaluation, dated 8/28/23, indicated the area to the left buttock was a stage 2 pressure ulcer and measured 0.5 centimeters (cm) x 0.2 cm x 0.1 cm. The area was identified as not being healed. The area to the right buttock was a stage 2 pressure ulcer and measured 1 cm x 1 cm x 0.1 cm. The area was identified as not being healed. Interview with the Director of Nursing on 8/30/23 at 1:33 p.m., indicated the treatments should have been completed as ordered. 2. On 8/30/23 at 11:00		and the "Sterile Dressing Change" policy. Any employee who fails to comply with the points of the in-service will be further educated. A facility-wide audit was completed to ensure that all residents with impaired skin integrity/pressure ulcers have the appropriate treatment ordered and in place by DON/Designee on or before 9/20/2023. 4. Audit tool entitled "Pressure Ulcer Compliance Audit" as well as "Treatment Audit Tool" will be utilized by DON/Designee 5 times a week for 4 weeks, weekly for 4 weeks, then monthly for 4 months and as needed thereafter. Any concerns noted will be immediately addressed and corrected. All concerns will be addressed as needed in the monthly QAPI meeting. If patterns or concerns are noted, and action plan may be established. If the facility is 95% compliant after 6 months, the monitoring will be discontinued.	

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	a.m., 2 LPNs were asked to remove the bandage from Resident N's pressure ulcer. There was a foul odor coming from the wound and the bandage, dated 8/29/23 was saturated with dark, foul smelling drainage. The wound was located on the sacrum and was large with black necrotic tissue covering the top and surrounding area. The record for Resident N was reviewed on 8/30/23 at 9:30 a.m. Diagnoses included, but were not limited to, dementia, osteoarthritis, high blood pressure, heart disease, depressive disorders, anxiety, osteoporosis, fracture of shaft of right tibia and of right fibula. The 5/30/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively impaired and had no falls since the last assessment. The resident was totally dependent on staff with a 2 person physical assist for bed mobility and transfers. The 8/2/23 Significant Change MDS assessment, indicated the resident was cognitively impaired and had 1 fall with a major injury since the last assessment. The resident was an extensive assist with a 2 plus person physical assist with bed mobility and totally dependent on staff with a 2 person assist for transfers. The resident had a Stage 2 pressure ulcer (partial thickness loss of the dermis presenting as a shallow open ulcer). A Care Plan, dated 7/27/23, indicated the resident had a pressure ulcer to the sacrum. A Nurses' Note, dated 7/27/23 at 6:28 a.m., indicated the resident had an open area on the buttocks. There were 3 small open areas all measuring 0.5 centimeters (cm) by 0.5 (cm). A new order for barrier cream twice a day until healed			

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	was obtained. A Skin Wound Progress Note, dated 8/1/23 at 11:46 a.m., indicated wound rounds were completed and the Physician was notified of the status of the pressure ulcer and new orders were received. A Weekly Wound Evaluation, dated 7/28/23, indicated the resident had a stage 2 pressure ulcer to the sacrum measuring 1 cm by 4 cm with a small amount of serous drainage. The wound was pink and new orders for hydrocolloid bandage three times a week was received. A Weekly Wound Evaluation, dated 8/1/23, indicated the sacrum pressure ulcer was still a Stage 2 and measured 0.7 cm by 1 by 0.1 cm and was observed to have 25% epithelial tissue and 75% skin. The wound was pink and the same treatment was in place. The Treatment Administration Record (TAR) and the Medication Administration Record (MAR) for July 2023, indicated there was no order transcribed for the hydrocolloid bandage for the Stage 2 pressure ulcer. There were no treatments signed out as being completed for pressure ulcer. The TAR for 8/2023, indicated no treatment was signed out as being completed until 8/3/23. A Physician's Order, dated 8/3/23, indicated cleanse the sacrum with normal saline, pat dry, and apply a hydrocolloid bandage every Tuesday, Thursday, and Saturday until resolved. The last documented Weekly Wound Evaluation was on 8/28/23, which indicated the pressure ulcer was now an unstageable (full thickness tissue			

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	loss in which the base of the ulcer was covered with slough) pressure ulcer and measured 5 cm by 5 cm by 0.2 cm with undermining (tunneling) at 6 o'clock and 3 cm. The wound was 100% necrotic and a new treatment was in place. Interview with the Director of Nursing on 8/30/23 at 3:00 p.m., indicated the treatment had not been put on the TAR, so it was not signed out as being completed. A new wound nurse has been put in place and has started to do the assessments. 3. On 8/29/23 at 9:02 a.m., LPN 1 was observed turning Resident H to view 2 wounds located on the resident's lower back and sacrum. The sacrum pressure ulcer had no dressing covering the wound. There was dried stool covering the wound bed. The resident had a bowel incontinence episode and requested to be changed. The second wound was on the resident's lower back, which was covered with a foam dressing. The record was reviewed for Resident H at 8/29/23 at 10:01 a.m. The resident was admitted on 8/4/23. Diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), hypertension (high blood pressure), heart failure, hyperlipidemia (high cholesterol), arthritis, asthma, low back pain, and osteoporosis. The Annual Minimum Data Set (MDS) assessment, dated 8/11/23, indicated that the resident was cognitively intact. Bed mobility required extensive assistance with 2-person physical assist. The resident was frequently incontinent of urine and always incontinent of bowel. The resident had a pressure ulcer and was at risk for pressure ulcers and injures. A Care Plan, dated 8/9/23, indicated the resident was at risk for skin breakdown due to decreased			

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	mobility and incontinence. Approaches included, but were not limited to, keep clean and dry. A Weekly Wound Evaluation, dated 8/28/23 at 5:05 p.m., indicated to cleanse the sacrum with normal saline, pat dry, skin prep peri wound, apply Santyl (ointment) to wound bed, and cover with dry dressing daily and as needed. The Treatment Administration Record (TAR) for 8/2023, indicated the treatment for the sacrum wound was not signed out on 8/28/23. A Physician's Note, dated 8/25/23 at 5:16 a.m., indicated the resident had an open area to the intergluteal cleft (sacral wound), that was approximately 3.5 cm (centimeters) by 1.5 cm. The wound bed was grayish green in color and had a moderate amount of sanguineous drainage noted. The Nurse Practitioner (NP) recommended a wound nurse to evaluate. An order was given to apply medihoney daily after cleansing with wound cleaner, and apply a dry dressing. Interview with the Director of Nursing (DON) on 8/30/23 at 2:03 p.m., indicated the resident should have had a dressing covering the pressure ulcer. This Federal tag relates to Complaints IN00412700 and IN00416438. 3.1-40(a)(2)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered			

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	care plan, and the resident's goals and preferences. Based on observation, record review, and interview, the facility failed to ensure Intravenous (IV) catheters were monitored, assessed, and bandages and tubing were changed for 3 of 3 residents reviewed for IV antibiotics. (Residents K, B and E) Findings include: 1. On 8/29/23 at 1:30 p.m., Resident K was observed in bed. A single lumen PICC (peripherally inserted central catheter) line was observed in the right upper arm. There was no date on the bandage covering the PICC line. On 8/30/23 at 9:15 a.m., the resident was being transferred back to bed. There was still no date on the PICC line bandage. The record for Resident K was reviewed on 8/29/23 at 11:35 a.m. The resident was admitted on 7/27/23. Diagnoses included, but were not limited to, heart disease, stroke, anxiety disorder, high blood pressure, and chest pain. The resident was admitted to the hospital on 8/6/23 and returned back to the facility on 8/15/23. The Admission Minimum Data Set (MDS) assessment, dated 8/22/23, was still in progress. A Care Plan, dated 8/15/23, indicated the resident was receiving Intravenous (IV) infusions. The approaches were to have no signs and symptoms of infection at the IV site, follow IV protocol for changing equipment and flushing, and monitor the site for redness, swelling, and drainage.	F 0694	1. It is the policy of this facility to administer parenteral fluids consistent with professional standards of practice and in accordance with physicians' orders, the comprehensive person-centered care plan, and the residents' goals and preferences. Resident K's medical record was reviewed and updated to ensure that appropriate orders are in place to assess the IV site, flush the lumen after the antibiotic was administered and to change the dressing and tubing per policy. Resident B was discharged from the facility on 6/15/2023. Resident E was discharged from the facility on 8/5/2023. 2. Any resident receiving parenteral fluids has the potential to be impacted by the alleged deficient practice. 3. The DON and/or designee in-serviced all licensed nurses on or before 9/19/2023 on the "Flushing a PICC" policy, "Dressing Change, PICC" policy and "Changing a Needleless Access Device, PICC" policy. Any employee who fails to comply with the points of the in-service will be further educated. A facility-wide audit of all residents with a PICC was completed to	09/22/2023

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	Physician's Orders, dated 8/16/23, indicated Daptomycin (an antibiotic) 350 milligrams (mg). Use 630 mg intravenously one time a day for MRSA of the wound for 38 days. There were no Physician's Orders to assess the IV site, flush the lumen after the antibiotic was administered or to change the bandage and tubing. Interview with the Director of Nursing on 8/30/23 at 9:30 a.m., indicated the batch orders for the IV monitoring and assessment were not put into the computer. 2. The closed record for Resident B was reviewed on 8/29/23 at 2:45 p.m. The resident was admitted to the facility on 6/1/23 and discharged home on 6/15/23. Diagnoses included, but were not limited to, diverticulitis, atrial fibrillation, heart disease, insomnia, and anxiety. The Admission Minimum Data Set (MDS) assessment, dated 6/8/23, indicated the resident was alert and oriented and received IV medications while a resident. Physician's Orders, dated 6/1/23, indicated change IV tubing every 24 hours. Assess IV site every shift and monitor for signs and symptoms of infiltration and infection every shift. A Physician's Order, dated 6/2/23 and discontinued on 6/9/23, indicated Piperacillin (an antibiotic) 3.375 grams intravenously every 8 hours for diverticulitis for 13 days. The times to be administered were 6:15 a.m., 2:00 p.m., and 10:00 p.m. The IV Treatment Administration Record for the		ensure that all residents have appropriate orders with impaired skin integrity/pressure ulcers have the appropriate treatment ordered and in place to assess the IV site, flush the lumen after medication is administered and to change the dressing and tubing per policy by DON/Designee on or before 9/20/2023. 4. Audit tool entitled "Intravenous Access Compliance Audit" will be utilized by DON and/or Designee 5 times a week for 4 weeks, weekly for 4 weeks, then monthly for 4 months and as needed thereafter. Any concerns noted will be immediately addressed and corrected. All concerns will be addressed as needed in the monthly QAPI meeting. If patterns or concerns are noted, an action plan may be established. If the facility is 95% compliant after 6 months, the monitoring will be discontinued.	

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month of 6/2023, indicated assess the IV site every shift was blank and not signed out as being completed on nights on 6/1, days on 6/2 6/8, 6/10 and 6/12/23. The tubing change every 24 hours was blank on 6/2, 6/7, 6/8, 6/10, 6/12 and 6/14/23.

Interview with the Director of Nursing on 8/30/23 at 2:00 p.m., indicated she was not employed at the facility when the resident was admitted and discharged. She had no additional information for review.

3. The closed record for Resident E was reviewed on 8/30/23 at 2:55 p.m. The resident was admitted to the facility on 8/4/23 and discharged against medical advice on 8/5/23. Diagnoses included, but were not limited to, osteomyelitis of the left foot and ankle, MRSA infection in the left foot, anxiety, arthritis, major depressive disorder, schizoaffective disorder, and high blood pressure.

A Nursing Admission Assessment, dated 8/4/23, indicated the resident had a left foot wound and was admitted for Intravenous (IV) antibiotics. The resident was cognitively intact.

A Baseline Care Plan, dated 8/4/23, indicated the resident was receiving IV antibiotics.

Physician's Orders, dated 8/4/23 indicated, Ceftriaxone IV 2 grams intravenously one time a day for cellulitis of the left foot wound until 8/31/23.

There were no Physician's Orders to assess the IV site, flush the lumen after the antibiotic was administered or to change the bandage and tubing.

There was no assessment or documentation in

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	nursing progress notes of the IV site. The 8/2023 Medication Administration Record (MAR), indicated the IV antibiotic was administered on 8/5/23 at 6:15 a.m. Interview with the Director of Nursing on 8/30/23 at 4:00 p.m., the resident was only at the facility for 24 hours and left against medical advice. Since the resident was gone within 24 hours, there was no follow up audit on her chart for the IV orders. This Federal tag relates to Complaints IN00409913 and IN00415513. 3.1-47(a)(2)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-			

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(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
	§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, record review, and interview, the facility failed to establish and/or maintain a system that accounted for, periodically reconciled, and ensured the disposition of all controlled drugs, related to incomplete and inaccurate documentation of narcotic medications for 3 of 3 residents reviewed for narcotics. (Residents G, K, and L) This had the potential to affect all residents who received narcotic medication. Findings include: 1. Interview with Resident G on 8/29/23 at 1:45 p.m., indicated she had no issues with pain. She also indicated Tylenol controls her pain and she doesn't need anything stronger. The record for Resident G was reviewed on 8/30/23 at 10:26 a.m. Diagnoses included, but were not limited to, spinal stenosis, intervertebral disc replacement of the lumbar region, and spondylosis (osteoarthritis of the spine). The Quarterly Minimum Data Set (MDS) assessment, dated 7/25/23, indicated the resident was cognitively intact. She required extensive	F 0755	1. It is the policy of the facility to establish and/or maintain a system that accounted for, periodically reconciled, and ensure the disposition of all controlled drugs. Resident G, resident K, and resident L's care plans were reviewed and updated as appropriate to reflect risk for pain and pain regimen reviewed with NP/MD. 2. All residents have the potential to be impacted by the alleged deficient practice. 3. The DON and/or designee in-serviced all licensed nurses on or before 9/19/2023 on the "Medication Administration" as well as "Controlled Substance Medications" policy. Any employee who fails to comply with the points of the in-service will be further educated. A facility-wide audit of all residents receiving controlled substance was	09/22/2023

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	assistance with bed mobility and transfers and she did not have any pain. She had received an opioid medication 2 days during the assessment reference period. The resident did not have a Care Plan related to pain. A Physician's Order, dated 4/19/23, indicated the resident was to receive Norco (a narcotic pain medication) 5-325 milligrams (mg), 1 tablet every 4 hours as needed (PRN) for pain. The order was discontinued on 7/25/23. The June 2023 Medication Administration Record (MAR), indicated the PRN Norco had not been signed out as being given for the entire month. The June 2023 Controlled Drug Receipt/Record/Disposition Form, indicated the resident received the PRN Norco on 6/2 at 8:00 p.m., 6/3 at 12:00 a.m. and 4:00 a.m., 6/4 at 12:00 a.m. and 6:00 a.m., 6/10 at 12:00 p.m., 6/12 at 3:00 p.m. and 9:00 p.m., 6/13 at 12:00 a.m. and 4:00 a.m., and 6/15/23 at 12:00 a.m. The July 2023 MAR, indicated the resident received the PRN Norco on 7/15 at 3:00 a.m., 7/17 at 11:00 p.m., 7/22 at 1:00 a.m., and 7/25/23 at 5:00 a.m. All entries had been signed out by RN 1. The July 2023 Controlled Drug Receipt/Record/Disposition Form, indicated RN 1 had administered the PRN Norco on 7/14 at 11:00 p.m. 7/15 at 10:30 p.m., 7/16 at 6:00 a.m. and 11:00 p.m., 7/22 at 5:00 a.m., and 7/24/23 at 11:00 p.m. and 5:00 a.m. LPN 1 had documented on the form that she had administered the Norco on 7/21 at 5:00 p.m. and		completed to ensure that all residents have Narcotic Count Sheets in place that reflect physicians' orders by DON/Designee. A facility-wide audit was completed to review all PRN narcotic medications that have not been administered in 30+ days and orders were obtained to discontinue by DON/Designee on or before 9/20/2023. 4. Audit tool entitled "Controlled Substance Audit Tool" will be utilized by DON and/or Designee 5 times a week for 4 weeks, weekly for 4 weeks, then monthly for 4 months and as needed thereafter. Any concerns noted will be immediately addressed and corrected. All concerns will be addressed as needed in the monthly QAPI meeting. If patterns or concerns are noted, an action plan may be established. If the facility is 95% compliant after 6 months, the monitoring will be discontinued.	

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	9:00 p.m. and 7/22/23 at 4:00 p.m. The medication administration was not documented on the July 2023 MAR. A Nurse Practitioner (NP) Progress Note, dated 7/25/23 at 9:28 a.m., indicated the resident was being evaluated for chronic care management. The resident was still taking Tylenol for knee pain which had been effective and had reported they had not been taking the Norco anymore. The Norco was going to be discontinued due to non use. Interview with the Director of Nursing (DON) on 8/30/23 at 1:00 p.m., indicated she had the resident's Norco discontinued due to the resident indicating it was not needed anymore, because the Tylenol helped. Interview with the DON at 1:33 p.m., indicated when PRN narcotics were given, they were to be documented on the MAR and on the narcotic sheet. She also indicated she recently inserviced staff on PRN narcotic administration documentation. Interview with LPN 2 on 8/30/23 at 1:37 p.m., indicated the resident used to have complaints of pain to the knees and had received PRN Norco in the past. The LPN also indicated when a PRN narcotic was given, it was to be signed out on the MAR and on the narcotic sheet. She indicated she was guilty of only signing the med out on the narcotic sheet and not the MAR. The LPN indicated she had recently had an inservice about narcotic medication administration. 2. The record for Resident K was reviewed on 8/29/23 at 11:35 a.m. The resident was admitted on 7/27/23. Diagnoses included, but were not limited to, heart disease, stroke, anxiety disorder, high blood			

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	pressure, and chest pain. The resident was admitted to the hospital on 8/6/23 and returned back to the facility on 8/15/23. The Admission Minimum Data Set (MDS) assessment, dated 8/22/23, was still in progress. Physician's Orders, dated 7/27/23, indicated Hydrocodone 5-325 milligrams (mg), give 1 tablet by mouth every 8 hours as needed for pain. The controlled Receipt Record Disposition form indicated 30 tablets of the Hydrocodone were received on 7/27/23. The medication was signed out on the disposition form but not on the Medication Administration Record (MAR) on the following dates: 7/28/23 at 12:00 a.m. 7/29/23 at 2:00 p.m. 7/30/23 at 11:00 a.m. 8/2/23 at 7:00 p.m. 8/3 at 7:00 p.m. 8/4 12:00 p.m. 8/5 11:00 a.m. Interview with LPN 1 on 8/30/23 at 1:37 p.m., indicated she was supposed to sign out the medications on the E-Mar as well as the narcotic disposition record. Interview with the Director of Nursing on 8/30/23 at 2:00 p.m., indicated she had inserviced nursing staff to make sure they sign E-Mar as well as the narcotic sheet. 3. On 8/30/23 at 10:28 a.m., Resident L was observed asleep in her room. Interview with Resident L on 8/30/23 at 2:26 p.m., indicated she received her pain medication, and that she always had pain.			

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The record was reviewed for Resident L at 8/29/23 at 3:51 p.m. The resident was admitted on 6/8/23. Diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), heart failure, hypertension (high blood pressure), end stage renal disease, stroke, arthritis, non-Alzheimer's dementia, anxiety, and depression.

The Significant Change Minimum Data Set (MDS) assessment, dated 6/14/23, indicated the resident was cognitively intact.

A Care Plan, dated 8/1/23, indicated the resident had pain in her right and left shoulder at times. Approaches were to administer medication per order and notify doctor and family of any changes.

A Care Plan, dated 8/1/23, indicated the resident had osteoarthritis and arthritis and had a potential for pain. Approaches were to administer pain medications as ordered and monitor for verbal and non-verbal indicators of pain.

A Physician's Order, dated 7/25/23, indicated to administer Percocet oral tablet 10-325 mg (Oxycodone with/ Acetaminophen), 1 tablet by mouth every 6 hours for severe degenerative joint disease of both knees.

There was no controlled drug receipt record/disposition form for dates 7/25/23-7/29/23.

There was no controlled drug receipt record/disposition form for dates 8/4/23-8/12/23.

The Medication Administration Record (MAR) on 8/13/23, indicated the medication was signed out for 3 doses. Only 1 dose was recorded on the drug

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	receipt record/disposition form for 8/13/23. The Medication Administration Record (MAR) on 8/14/23, indicated the medication was signed out for all 4 doses. There was no documentation on the drug receipt record/disposition form on 8/14/23. The drug receipt record/disposition form on 8/15/23 had a sign out for percocet at 6:00 p.m. There was no documentation on the MAR for this dose. The Medication Administration Record (MAR) on 8/15/23, indicated the medication was signed out for 12:00 a.m., 6:15 a.m., and 12:00 p.m. doses. There was no documentation for those doses on the drug receipt record/disposition form for 8/15/23. There was no documentation in the Medication Administration Record (MAR) on 8/16/23. The drug receipt record/disposition form had signed out 3 doses at 6:00 a.m., 2:00 p.m., and 9:30 p.m. There were three doses signed out on the controlled drug receipt record/disposition form on 8/17/23. The 6:00 a.m., 2:00 p.m., and 8:00 p.m., doses. There was no documentation for those doses signed out on the MAR. The Medication Administration Record (MAR) on 8/18/23, indicated the medication was signed out for all 4 doses. The controlled drug record/disposition form had no documentation for the 12:00 a.m. dose. On 8/20 and 8/24/23 the 12:00 a.m., dose was signed out in the MAR. No documentation was			

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	recorded on controlled drug received record/disposition form. The Medication Administration Record (MAR) on 8/25/23, indicated the medication was signed out for the 12:00 p.m. and 6:00 p.m., doses. The 6:00 a.m. dose was signed out on the controlled drug received record/disposition form. No other doses were documented. The Medication Administration Record (MAR) on 8/27/23, indicated the medication was signed out for the 6:00 a.m., dose. No documentation was recorded on controlled drug received record/disposition form. The Medication Administration Record (MAR) on 8/28/23, indicated the medication was signed out for the 6:00 p.m., dose. No documentation was recorded on controlled drug received record/disposition form. Interview with the Director of Nursing on 8/30/23 at 1:32 p.m., indicated the nurses were expected to document narcotic scheduled and prn doses in PCC (electronic computer system) and on the controlled drug receipt record/ disposition form. Interview with the Director of Nursing at 8/30/23 at 1:36 p.m., indicated she was unable to find the controlled drug receipt record/disposition form for 7/27-7/29/23. She was also unable to provide documentation of the controlled drug receipt record/disposition form for 8/4-8/12/23. Interview with LPN 1 on 8/30/23 at 1:37 p.m., indicated she was required to document narcotic medication administration in PCC (electronic computer system) and on the controlled drug receipt record/ disposition form.			

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	Interview with the Interim Executive Director and Director of Nursing (DON) on 8/30/23 at 2:00 p.m., indicated they were aware of the documentation discrepancies and performed an inservice on documentation. A "Medication Administration" policy provided by the Executive Director on 8/30/23 at 4:38 p.m. The policy indicated,..."Medication Administration Record will be signed after for each medication administered to the resident. Medications that are refused by the resident or are not administered for other reasons will be circled on the particular day of no administration. The reason for not administering the medication will be documented on the back of the Medication Administration Record."... This Federal tag relates to Complaint IN00413907. 3.1-48(b)(2)			