DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155486	A. BUILDING 00 B. WING	09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MIDDLETOWN NURSING AND REHABILITATION CENTER	131 S 10TH ST MIDDLETOWN, IN 47356

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: September 18, 19, 20, 21, and 22, 2023 Facility number: 000343 Provider number: 155486 AIM number: 100289600 Census Bed Type: SNF/NF: 12 Total: 12 Census Payor Type: Medicaid: 6 Other: 6 Total: 12 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 26, 2023	F 0000	F 0000 This plan of correction is submitted to serve as a credible allegation of compliance in association with stated completion dates. Preparation and/or execution of this plan of correction does not constitute an admission or agreement, the provider of conclusion set facts on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by state and federal law.	
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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jerrod Moore	Administrator	10/12/2023

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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	comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §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 interview, and record review, the facility	F 0656	**Tag F 656** **What corrective action(s) will**	10/12/2023

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	failed to develop or update care plans for the use of Prolia, new skin impairments, a bolster mattress and antidepressant for Resident 9. This affected 3 of 11 residents reviewed for care plan development. (Residents 2, 4, and 9) Findings include: 1. Resident 2's record was reviewed on 9/21/23 at 11:33 a.m. The record indicated Resident 2 had diagnoses that included, but were not limited to, osteoporosis (weakened bones). Current physician's orders included, but were not limited to, Prolia, 60 milligrams, given under the skin one time a day, every 180 days for osteoporosis, with a start date of 6/23/2023. No care plan could be found for the medication nor the diagnosis. On 9/22/23 at 11:28 a.m., the Director of Nurses indicated they do not have a care plan for the use of Prolia to treat osteoporosis.2. The clinical record for Resident 4 was reviewed on 9/19/2023 at 11:10 a.m. The medical diagnoses included diabetes and kidney disease. A Quarterly Minimum Data Set Assessment, dated for 6/8/2023, indicated that Resident 4 was cognitively intact and at risk for developing pressure ulcers. An observation on 9/19/2023 at 10:12 a.m. indicated that Resident 4 had on pressure relieving boots and had a foam dressing to his left gluteal. An interview with LPN 3 at this time indicated that Resident 4 had two open areas to his left gluteal that were in the stages of healing, and they were utilizing a foam dressing to treat.		**be accomplished for those residents found to have been affected by the deficient practice?** All residents must have a completed care plan to ensure proper care of the residents. When an item, such as; a medication, dressing, mattress, etc., is not properly care planned, it may cause an adverse effect for the resident. All licensed nursing staff have been re-educated on the proper procedure for new and discontinued orders in order for it to be properly care planned. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** The Social Service Director and Director of Nurses have created an action plan form for the ongoing issues (See attachment #1). All licensed nurses have be re-educated on the importance of documenting new or discontinued orders, as well as the new procedure put into place so it will be properly care planned. All nurses have been educated to print any new or discontinued orders and place in the Director of Nurses' caddy on outside of office door. With this new system in place this will help to better monitor all residents and their needs, and ensure proper care plans. **What measures will be put into**	

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	A physician order, dated for 9/4/2023, indicated to change the foam dressing to Resident 4's dressing as a treatment for " ...open areas on left gluteal". Review of the care plans indicated Resident 4 was at risk for developing skin impairments but did not encapsulate the open areas to his left gluteal. An interview with the Director of Nursing on 9/21/2023 at 1:45 p.m. indicated the facility did not have a care plan to address the current open areas to Resident 4's left gluteal. 3. The clinical record for Resident 9 was reviewed on 9/20/2023 at 1:41 p.m. The medical diagnoses included diabetes and anxiety disorder. A Quarterly Minimum Data Set Assessment, dated for 8/2/2023, indicated that Resident 9 was cognitively impaired, had one fall during the review period, and utilized antianxiety medications. An observations on 9/19/2023 at 1:45 p.m. indicated Resident 9 was sleeping in her recliner and had bolsters to her mattress. An observations on 9/20/2023 at 10:45 a.m. indicated Resident 9 was sitting in her recliner and had bolsters to her mattress. A physician order, dated for 9/8/2023, indicated Resident 9 utilized Zoloft (an antidepressant) for anxiety. Review of the care plans for Resident 9 did not indicate the use of a bolster mattress. A care plan, dated for 6/29/2023, indicated that		**place and what systemic changes will be made to ensure that the deficient practice does not recur?** To ensure the current deficiencies are corrected, the facility will audit each case weekly for 4 weeks, then every 2 weeks for 2 months, and then monthly for the next 4 months (Attachment #1). While this monitoring is going on, the facility will also be using the new system to ensure this does not affect any other residents (Attachment #3). **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Social Service Director will continue to ensure the plans are completed, and Director of Nursing will monitor that the nurses are following the proper procedure. For the current deficiencies, they will be monitored as previously stated. **By what date the systemic changes for each deficiency will be completed?** Systemic changes have been made as of October 10th. We respectfully request paper compliance for Tag F 656.	

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	Resident 9 utilized antianxiety medications (Buspar) but did not encapsulate the use of Zoloft. An interview with the Director of Nursing on 9/21/2023 at 1:50 p.m. indicated that the facility did not have a care plan to utilize a bolster mattress for Resident 9 nor have a care plan for her use of Zoloft. A policy entitled, "Care Planning-Interdisciplinary Team", was provided by the Director of Nursing on 9/22/2023 at 10:45 a.m. The policy indicated, " ...Our facility's Care Planning/Interdisciplinary Team is responsible for the development of individualized comprehensive care plan for each resident ..." 3.1-35(a) 3.1-35(b)(1)			
F 0851 SS=F Bldg. 00	483.70(q)(1)-(5) Payroll Based Journal §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical,			

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	mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing			

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	information on the schedule specified by CMS, but no less frequently than quarterly. Based on interview and record review, the facility failed to report required nursing staffing data to the payroll based journal (PBJ) for April 1-June 30, 2023, for 1 of 1 Quarter reviewed on Certification and Survey Provider Enhanced Reporting (CASPER). Findings include: A PBJ Staffing Data Report, dated 9/12/2023, indicated it encapsulated data from April 1-June 30, 2023, and was triggered for failure to submit data for the quarter. A Staff Activity Report, dated for 9/18/2023, indicated that no staffing hours were reported between April 1-June 30, 2023. An interview with the Business Office Manager on 9/18/2023 at 1:30 p.m., indicated that she reported the PBJ information quarterly by manually entering the data into the system. An interview with the Business Office Manager on 9/18/2023 at 2:30 p.m., indicated that did not have validation report and confirmed that no hours had been reported for April 1-June 2023 per the Staff Activity Report for that timeframe. A policy entitled, "Staffing", was provided by the Business Office Manager on 9/19/2023 at 2:22 p.m. The policy indicated, " ...Our facility furnished information from payroll records setting forth the hours worked by nursing personnel on each day for each quarter and reported to the appropriate state agency ..."	F 0851	**Tag F 851** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** If the facility truly did not have any staff between April 1st and June 30, 2023, all residents would in fact be affected. It is very important we have all proper staff to ensure the all the needs of the residents are being met. To ensure this does not happen again all staff hours will be entered into the QIES system after each pay period. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** If nursing staff was not present during the time, then of course the residents would have been affected. The Administrator is in charge of the nursing schedule and ensuring the proper ratio of nurses and certified nurse's aides are met to care for all resident needs. The facility maintains that there is always 8 hours of continuous RN coverage, even if that means the DON changes hours or works extra hours to meet the criteria, and even maintains at least 2 nurse aides for day shift hours and evening hours even during low census.	10/12/2023

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			What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The Business Office Manager created a Payroll Based Journal Quarter Audit sheet (See attachment #2). All staff hours will be entered into the QIES system after each pay period, and then reviewed by the Administrator within 30 days after each quarter. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The corrective actions will be monitored by the Administrator. The Administrator will continue to ensure all nurse staffing needs are met per IDOH and CMS guidelines. While the Business Office Manager will enter all data after each pay period. **By what date the systemic changes for each deficiency will be completed?** The corrective actions will be implemented by October 12, 2023, but the first QIES data report will not be done until October 27, 2023 following our next pay period. We respectfully request paper compliance for Tag F 851.	