STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155608	A. BUILDING 00 B. WING	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHCARE CENTER AT WITTENBERG VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(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. Survey dates: June 13, 14, 15, 16, and 17, 2022. Facility number: 000515 Provider number: 155608 AIM number: 100290820 Census Bed Type: SNF/NF: 79 SNF: 19 Total: 98 Census Payor Type: Medicare: 17 Medicaid: 57 Other: 24 Total: 98 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/27/22.	F 0000		
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The			

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

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	comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on record review and interview, the facility failed to ensure individualized care plans were developed related to pain, medications and oxygen for 3 of 23 resident care plans reviewed. (Residents 31, 152 and 80) Findings include:	F 0656	Care plans have been completed for residents 31, 152, and 80. A care plan review has been completed to ensure care plans are in place as appropriate for medications, oxygen, and pain. Education related to the initial	07/15/2022

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	1. Resident 31's record was reviewed on 6/15/22 at 10:32 a.m. The resident was admitted on 3/29/22. Diagnoses included, but were not limited to, spondylolithesis (spinal disorder in which a vertebra slips forward onto the bone below it), anxiety and osteoarthritis. The Admission Minimum Data Set (MDS) assessment, dated 3/29/22, indicated the resident was cognitively intact and occasionally had pain that she rated 6 out of 10. Physician Orders, dated 5/23/22, indicated the resident was to receive Voltaren gel, Tylenol and Tramadol (pain medications), as well as clonezepam (anti-anxiety medication) and Eliquis (anticoagulant). The Pain Care Plan, dated 5/23/22, indicated "what the resident currently rated her pain" and "what was an acceptable pain level." Both questions were not answered. The care plan also indicated "what makes pain better" and "what makes pain worse." Both questions were also not answered. The Medication Care Plan, dated 5/23/22, indicated the resident had diseases and conditions that were treated with medications. The interventions were that medications were to be overseen by nursing and the Physician during her stay, remain free of side effects and to observe black box warnings for medications. The care plan lacked specific medications, diagnoses and interventions. 2. On 6/15/22 at 2:10 p.m., Resident 152 was observed seated in her room. She indicated she was having pain and discomfort in her chest and was waiting for the nurse to bring her medicine.		Care plan has been completed with nursing to ensure that care plans related to specific medications, pain and oxygen are completed with the initial assessment. A monthly review of 5 random assessments and initial care plans will be completed by the DON or designee to ensure care plans are in place for pain, medications and oxygen as needed. The results of this review will be brought to the QAPI committee monthly for no less than 4 mos.	

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The resident's record was reviewed on 6/16/22 at 9:48 a.m. The resident was admitted on 5/13/22. Diagnoses included, but were not limited to, osteoarthritis, gastric reflux and angina.

A Physician Order, dated 5/18/22, indicated the resident was to receive Nitroglycerin as needed for chest pain.

A Physician Order, dated 5/29/22, indicated the resident was to receive Mylanta as needed for gastric reflux.

The Pain Care Plan, dated 5/13/22, indicated "what the resident currently rated her pain" and "what was an acceptable pain level." Both questions were not answered. The care plan also indicated "what makes pain better" and "what makes pain worse." Both questions were also not answered.

Interview with the MDS Nurse on 6/15/22 at 11:46 a.m., indicated the care plans should have been updated and she was unable to locate additional care plans.

3. On 6/15/22 at 9:33 a.m., Resident 80 was observed lying in bed. She had oxygen in place via nasal cannula set at 2 liters.

Resident 80's record was reviewed on 6/15/22 at 9:25 a.m. Diagnoses included, but were not limited to, hypertension, major depressive disorder, and atrial fibrillation. The resident was admitted to the facility on 5/10/22.

The Admission MDS (Minimum Data Set) assessment, dated 5/10/22, indicated the resident received anti-anxiety, antidepressant, and opioid (narcotic pain medication) medications. The

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	resident also received oxygen therapy. The Medication Administration Record (MAR), dated 6/2022, indicated the resident received clonazepam (Klonopin, anti-anxiety medication) 0.5 mg (milligrams) twice a day, sertraline (Zoloft, antidepressant medication) 25 mg daily, and mirtazapine (Remeron, antidepressant medication) 15 mg daily. There was lack of documentation of any care plans related to the anti-anxiety medication, antidepressant medications, or oxygen use. The resident's care plan for pain was incomplete. Interview with MDS 1 on 6/15/22 at 11:45 a.m., indicated she was unable to locate any care plans for the medications or oxygen. The care plans should have been completed. 3.1-35(a)			
F 0657 SS=D 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. (E) To the extent practicable, the participation of the resident and the resident's			

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	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 interview and record review, the facility failed to provide documentation of care conferences held with the resident and facility staff for 1 of 1 residents reviewed for care planning decisions. (Resident 16) Finding includes: Interview with Resident 16 on 6/13/22 at 1:41 p.m., indicated he was unaware if the facility held a recent care plan meeting and was not invited to attend. Resident 16's record was reviewed on 6/15/22 at 1:01 p.m. Diagnoses included, but were not limited to, multiple sclerosis (a chronic, typically progressive disease involving damage to the nerve cells in the brain and spinal cord) and paraplegia (paralysis of the legs and lower body). The Annual Minimum Data Set (MDS) assessment, dated 3/15/22, indicated the resident was cognitively intact for daily decision making. The last Care Planning meeting documented was completed on 1/20/22.	F 0657	A care plan meeting was held for Resident 16 on 6/29/22. A review of the MDS assessment calendar was completed through the last quarter. Any missed care plan meetings were rescheduled and held with the resident and or family member as appropriate. Education related to the requirement set forth in F657 was completed for all individuals responsible for scheduling the care plan meetings. The concierge will retain a copy of the letters that are sent out to request care plan meetings. A review of the letters as compared to the MDS calendar will be completed monthly by the Administrator or Designee. The results of this review will be brought to the QAPI committee monthly for no less than 4 months.	07/15/2022

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	The record lacked any documentation of a Care Planning meeting in March 2022, when the most recent MDS assessment was completed. Interview with the Administrator on 6/15/22 at 3:23 p.m., indicated the last Social Service person should have had documentation of an invitation to the care plan meeting, They also should have documented what was discussed with the disciplines that attended the meeting regarding the resident's health as well as answering any questions or concerns that a resident or representative had. 3.1-35(d)(2)(B)			
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, interview, and record review, the facility failed to ensure ADL (activities of daily living) care was provided for a dependent resident related to long, dirty fingernails, for 1 of 4 residents reviewed for ADL care. (Resident 36) Finding includes: On 6/14/22 at 11:07 a.m., Resident 36 was observed in his bed. His eyes were closed and his fingernails were noted to be very long. On 6/16/22 at 11:37 a.m., the resident was observed in his bed, his fingernails were long and had debris underneath them. The resident's record was reviewed on 6/15/22 at	F 0677	Upon surveyor observation, the nurse and C.N.A. assigned cleaned and trimmed resident # 36 nails. Observation rounds of all residents' nails was completed. Any resident that was found to need nail care received care as appropriate. Education related to nail care has been completed with all CNAs and nurses. Nail care has been added to the manager weekly rounding tool. Any concerns related to nail care will be brought to the QAPI committee monthly for no less	07/15/2022

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	1:27 p.m. The resident was admitted on 5/28/10. Diagnosis included, but were not limited to, traumatic brain injury and dementia. The Quarterly Minimum Data Set assessment, dated 3/30/22, indicated the resident had severe cognitive impairment and required extensive two person assistance for bed mobility, toileting and transfers. An ADL Care Plan, updated 1/6/22, indicated the resident required extensive staff assistance for ADLs. Interventions included to assist with ADLs as needed while encouraging the resident's participation. Interview with CNA 4 on 6/16/22 at 12:56 p.m., indicated he had assisted the resident with morning care. He had changed him and washed him, but did not provide nail care. Interview with the Assistant Director of Nursing on 6/16/22 at 1:12 p.m., indicated she observed the resident and the resident's fingernails were in need of care. She then instructed CNA 4 to provide nail care. 3.1-38(a)(3)		than 4 months to ensure continued compliance.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan,			

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	and the residents' choices. Based on observation, interview, and record review, the facility failed to identify and/ or monitor skin discolorations for 3 of 5 residents reviewed for non-pressure skin conditions. (Residents 152, 23, and 72) Findings include: 1. On 6/13/22 at 10:16 a.m., Resident 152 was observed seated in her room. The top of her left hand had dark blue discolorations. On 6/17/22 at 9:14 a.m., the resident was seated in her room speaking with a staff member. Her left hand remained with dark blue discolorations. The resident indicated she thought it occurred when an ambulance driver placed an intravenous line in her hand. The resident's record was reviewed on 6/15/22 at 9:48 a.m. The resident was admitted on 5/13/22. Diagnoses included, but were not limited to, osteoarthritis and angina. A Skin Care Plan, dated 5/13/22, indicated the resident was at risk for pressure ulcers and other skin injuries. Interventions included to observe skin for redness and breakdown, and to follow community skin care protocol. The resident's skin assessments did not indicate the discoloration on her left hand had been identified or was being monitored. Interview with the Unit Manager on 6/17/22 at 10:24 a.m., indicated there were no skin sheets related to the left hand, and discolorations should have been monitored once identified. 2. On 6/13/22 at 10:53 a.m., Resident 23 was observed	F 0684	During the course of the survey, an assessment was done and documented regarding R152's skin discoloration on her left hand; R23's multiple dark discolorations around both eyes, across her forehead, on her hand, and around her wrist; and R72's skin discoloration around her left forearm. R152's, R23's, and R72's observed skin discolorations are being monitored weekly until resolved. The facility did a whole house skin sweep of its residents identifying any skin discolorations and ensuring that each have an assessment documented and are being monitored weekly until resolved. Any new skin discoloration identified after the whole house skin sweep will be reported to the clinical management team to ensure that an assessment was done and monitored weekly until resolved. Clinical staff was in-serviced on ensuring that any observed skin discoloration on residents will be reported to the nurse in charge immediately. Nurse in charge will ensure that an assessment was done, documented and monitored weekly until resolved. Survey compliance tool was	07/15/2022

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	sitting in a wheelchair in her room. She had multiple dark purple discolorations around both eyes and across her forehead. Her forehead also had a bump that was swollen. The resident was wearing a brace on her right wrist and hand. She indicated she had leaned forward from her wheelchair while getting something out of her drawer and fell out of her wheelchair. When she fell out of her wheelchair, she had hit her face and hurt her hand on her night stand. She was taken to the hospital where they had put on a brace to her right hand. She removed her right brace to show that she had multiple dark purple discolorations to her hand and around her wrist. She further indicated she was unaware if the nurses were monitoring all of her discolorations. She was not aware if she was supposed to take her brace off or not, but she would take it off at night to sleep. On 6/16/22 at 9:11 a.m., Resident 23 was observed sitting in her wheelchair in her room watching television. The resident had the brace to her right wrist, multiple dark purple discolorations to her face and a swollen bump to her forehead. Record Review for Resident 23 was completed on 6/14/22 at 2:07 p.m. Diagnoses included, but were not limited to, diabetes mellitus, depression, and Parkinson's disease. The Quarterly Minimum Data Set (MDS) assessment, dated 3/2/22, indicated the resident was cognitively intact. The resident required a limited 1 person assist for bed mobility, transfers, and toilet use. She required supervision of 1 person for locomotion and personal hygiene. A Progress Note, dated 6/7/22, indicated that on 6/5/22, Resident 23 was just administered her		developed to audit identified skin discolorations ensuring that each have an assessment done, documented and monitored weekly until resolved. he Director of Nursing and/or designee will do audits utilizing survey compliance tool weekly x 4 weeks, every 2 weeks x 1 month and monthly x 3 months. Any identified negative trends will be addressed one on one with the responsible staff. Any identified trends will be forwarded to the QAPI Committee for review and follow up until resolved.	

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	morning medications. The nurse left the room and a few minutes later she heard a "boom". The resident was found face down on the ground. The resident was observed to have a "golfball" size contusion to her forehead, bruising to her face, and swelling to her right thumb and was sent out to the Emergency Room. A Progress Note, dated 6/5/22, indicated the facility received a call from the hospital. The resident would return to the facility with no acute injuries. The resident would return with a splint to her right thumb/wrist area. There were no fractures or dislocations. There was no documentation to indicate the facility was monitoring the resident's discolorations to her face, the swelling to her forehead, or to the multiple discolorations underneath her right hand splint. Interview with LPN 2 on 6/16/22 at 10:11 a.m., indicated she had never observed the discolorations underneath the resident's splint. She further indicated they would document fall charting for 72 hours after a fall but was unsure of the policy on how long they had to monitor discolorations. Interview with the Administrator on 6/16/22 at 11:16 a.m., indicated they did not have a policy related to how long they should be monitoring discolorations but the nurses should still be monitoring the discolorations to her face and underneath her splint. 3. On 6/14/22 at 10:31 a.m., Resident 72 was observed lying in bed with her eyes closed. The resident had a large dark purple discoloration			

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	observed to her left forearm. On 6/17/22 at 9:28 a.m., Resident 72 was observed lying in bed with her eyes closed. The resident still had a large dark purple discoloration observed to her left forearm. Record Review for Resident 72 was completed on 6/16/22 at 1:24 p.m. Diagnoses included, but were not limited to, dementia and anxiety. The Quarterly MDS assessment, dated 5/2/22, indicated the resident was cognitively impaired. The resident required an extensive 2+ person assist for bed mobility, transfers, toile use, and personal hygiene. There was no documentation to indicate the facility had assessed or was monitoring the resident's skin discoloration. Interview with CNA 3 on 6/17/22 at 9:31 a.m., indicated the resident was resistant to care at times. She would sometimes hit staff with her arms and then get bruising. Interview with LPN 2 on 6/17/22 at 2:10 p.m., indicated she had completed the resident's skin assessment that day and noticed the discoloration. She was unaware the discoloration was there prior to that day. She further indicated the resident was dependent on staff for daily care and staff should have noticed the resident's discolorations and reported it to the nurse. 3.1-37(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility.			

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	§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 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 a Physician Order with instructions for a splint was in place for 1 of 3 residents reviewed for limited range of motion. (Resident 23) Finding includes: On 6/13/22 at 10:53 a.m., Resident 23 was observed sitting in a wheelchair in her room. She had multiple dark purple discolorations around both eyes and across her forehead. Her forehead also had a bump that was swollen. The resident was wearing a brace on her right wrist and hand. She indicated she had leaned forward from her wheelchair while getting something out of her drawer and fell out of her wheelchair. When she fell out of her wheelchair, she had hit her face and hurt her hand on her night stand. She was taken to the hospital where they had put on a brace to her right hand. She removed her right brace to	F 0688	During the course of the survey, R23's attending physician was consulted regarding the splint and since there were no injuries or fractures, the splint was discontinued. The facility identified other residents with splints or brace, through chart review and observation, have the potential to be affected by the same deficient practice. The identified residents will be ensured that each splint or brace have an order and instructions in their chart. Clinical staff was in-serviced on ensuring that residents with a splint or brace must be	07/15/2022

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	155608	A. BUILDING 00 B. WING	06/17/2022

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	show she had multiple dark purple discolorations to her hand and around her wrist. She further indicated she was unaware if the nurses were monitoring all her discolorations. She was not aware if she was supposed to take her brace off or not but she would take it off at night to sleep. On 6/16/22 at 9:11 a.m., Resident 23 was observed sitting in her wheelchair in her room watching television. The resident had the brace to her right wrist and multiple dark purple discolorations to her face and a swollen bump to her forehead. Record Review for Resident 23 was completed on 6/14/22 at 2:07 p.m. Diagnoses included, but were not limited to, diabetes mellitus, depression, and Parkinson's disease. The Quarterly Minimum Data Set (MDS) assessment, dated 3/2/22, indicated the resident was cognitively intact. The resident required a limited 1 person assist for bed mobility, transfers, and toilet use. She required supervision of 1 person for locomotion and personal hygiene. A Progress Note, dated 6/7/22, indicated that on 6/5/22, Resident 23 was just administered her morning medications. The nurse left the room and a few minutes later she heard a "boom". The resident was face down on the ground. The resident was observed to have a "golfball" size contusion to her forehead, bruising to her face, and swelling to her right thumb. She was sent out to the Emergency Room. A Progress Note, dated 6/5/22, indicated the facility received a call from the hospital. The resident would return to the facility with no acute injuries. The resident would return with a splint to her right thumb/wrist area. There were no		documented and an order and instructions properly placed in the chart. Survey compliance tool was developed to audit residents with a splint or brace ensuring that it is documented and an order and instructions are properly placed in the chart. The Director of Nursing and/or designee will audit utilizing the survey compliance tool weekly x 4 weeks, every 2 weeks x 1 month and monthly x 3 months. Any identified negative trends will be addressed one on one with the responsible staff. Any identified trends will be forwarded to the QAPI Committee for review and follow up until resolved.	

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	fractures or dislocations. There was no documentation to indicate a Physician Order was in place for the splint with instructions for how long the resident was to wear the splint. There was also no further documentation related to the splint following the note she would be returning from the hospital with it. Interview with LPN 2 on 6/16/22 at 10:11 a.m., indicated she could not find any orders for the resident's splint. She was unsure how long the resident should wear the splint. She further indicated the resident was able to take the splint off herself, but the nurse was unsure if it was supposed to be removed at all and for how long. Interview with the Administrator on 6/16/22 at 11:16 a.m., indicated they did not have a policy related to splints or braces. The staff should have received a Physician Order for the splint with instructions for how long the resident was to wear the splint. 3.1-42(a)(2)			
F 0729 SS=B Bldg. 00	483.35(d)(4)-(6) Nurse Aide Registry Verification, Retraining §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or			

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	competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(d)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.			
	Based on record review and interview, the facility failed to ensure a QMA/CNA's certifications were not expired. This had the potential to affect the residents who resided on the 500 hall locked unit. Findings include: Employee licenses and certifications were reviewed on 6/16/22 at 2:32 p.m. The certification for QMA 1 had expired on 6/6/22. The QMA's CNA certification had also expired on 6/6/22. QMA 1 had worked on 6/8/22, 6/9/22, 6/13/22, and 6/14/22 on the 500 hall locked unit. Interview with the Administrator on 6/16/22 at 4:00	F 0729	Upon surveyor notification QMA 1 renewed her license. A review of all Clinical Staff was completed to ensure licenses and certifications were up to date and in good standing. HR will send out a list of expiring licenses and certifications monthly. The DON or designee will be responsible for ensuring the clinical staff maintain their license and or certifications. Any concerns related to licenses and certifications will be brought to the QAPI committee for review	07/08/2022

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	p.m., indicated she had just noticed today that QMA 1's license was expired. She had called the QMA and informed her she needed to renew her certifications. 3.1-14(e)		monthly for no less than 4 months.	
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 insulin was given as ordered and the Physician was notified of blood sugar results out of parameters for 1 of 6 residents reviewed for unnecessary medications. (Resident 30) Finding includes:	F 0757	R30's insulin sliding scale regimen was reviewed and adjusted to properly manage R30's blood sugar. During the course of the survey, the identified Agency nurse, who did not administer the correct	07/15/2022

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	Resident 30's record was reviewed on 6/15/22 at 9:31 a.m. Diagnoses included, but were not limited to, diabetes mellitus, and Parkinson's disease (a disorder of the central nervous system that affects movement). The Quarterly Minimum Data Set assessment, dated 3/23/22, indicated the resident had received insulin injections. The resident had been sent to the emergency room on 6/16/22 at 6:28 a.m., due to noted drooping of the right side of his face and he was unresponsive. The current Physician Order Summary indicated the resident was to have received Novolog Flexpen (insulin) subcutaneous (under the skin) four times a day for per the sliding scale for blood sugar readings: 150 - 200 administer 2 units (U), 201-250 administer 4 U, 251 - 300 administer 6 U, < (less than) 70 or > (greater than) 300 call MD. The June Medication Administration Record, indicated the following: - On 6/8/22 he received the Novolog evening dose of 6U for a blood sugar level of 301. There was no documentation the Physician was notified of a blood sugar level outside the parameters of above 300. - On 6/10/22, he received the Novolog bed time dose of 4U for a blood sugar level of 353. There was no documentation the Physician was notified of a blood sugar level outside the parameters of above 300. - On 6/14/22 , the morning dosage of Novolog		insulin dose, and the nurse, who did not document the amount of insulin administered, were in-serviced on strictly following resident's sliding scale order and accurately administering and documenting the appropriate amount of insulin based on the sliding scale. The facility reviewed and identified other residents who have blood sugar testing and corresponding sliding scale orders have the potential to be affected by the the same deficient practice The identified residents will be ensured that their blood sugar readings and the corresponding sliding scale insulin administered are accurate and documented. Clinical staff was in-serviced on residents who have blood sugar testing and corresponding sliding scale orders ensuring that their blood sugar readings and sliding scale insulin are administered accurately, including physician notification if indicated, and documented properly. Survey compliance tool was developed to audit residents who have blood sugar testing and corresponding sliding scale orders ensuring that their blood sugar readings and sliding scale insulin are administered accurately, including physician notification if indicated, and documented properly. The Director of Nursing and/or	

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	was not documented as to how much insulin was given. His blood sugar was documented as 155, per the sliding scale 2 U of Novolog insulin should have been administered. - On 6/15/22, the morning dosage of Novolog was not documented as to how much insulin was given. His blood sugar was documented as 187, per the sliding scale 2 U of Novolog insulin should have been administered. Interview with the Assistant Director of Nursing on 6/1622 at 2:43 p.m., indicated the Novolog insulin dosage on 6/10/22 was incorrectly given. The Agency Nurse should have at least given the 6U of insulin and called the physician. The Physician was not notified of the blood sugars that were over 300. On 6/15/22, the Nurse documented that the Novolog insulin was given, but had not documented the amount or dosage per the sliding scale. 3.1-48 (a)(3)		designee will audit utilizing the survey compliance tool daily x 2 weeks, weekly x 4 weeks, every 2 weeks x 1 month and monthly x 3 months. Any identified negative trends will be addressed one on one with the responsible staff. Any identified trends will be forwarded to the QAPI Committee for review and follow up until resolved.	
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on observation, record review, and interview, the facility failed to ensure a resident was free from a significant medication error related to an insulin pen not primed prior to insulin administration for 1 of 8 residents observed during medication pass. (Resident 79) Finding includes: On 6/14/22 at 9:45 a.m., medication pass was observed with LPN 3. The LPN prepared Resident	F 0760	R79 did not have any negative effects from the observed deficient practice during the survey. During the course of the survey, LPN3 was inserviced on the proper administration of insulin through an insulin pen, which includes completing an air shot of 2 units to ensure there was no air in the pen or needle. facility identified other residents	07/15/2022

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	79's medication which included Novolog (a fast acting insulin) administered by insulin pen. The LPN indicated the resident was to receive 15 units of Novolog. She turned the dial to 15 units on the pen. She then indicated she did not have any needle caps in her medication cart. She went to another nurses station to obtain some needle caps. She returned and placed the needle on the pen. The LPN entered the resident's room. After confirming his identification, she prepared to administer the insulin. The LPN was stopped and asked to step out. She was asked if she had primed the insulin pen prior to preparing the 15 units of Novolog. The nurse then turned the dial to 2 units and primed the pen. She then set it back on 15 units and proceeded to administer the insulin. The Novolog pen administration video instructions, from the manufacturer website Novologpro.com, indicated, "Step 3. To ensure proper dosing complete an air shot...." The instructions indicated to keep pen in an upright position, dial 2 units and depress the button to administer an air shot to ensure there was no air in the pen or needle. Interview with the Director of Nursing on 6/14/22 at 10:08 a.m., indicated insulin pens should be primed if that was what the manufacturer recommended. 3.1-48(c)(2)		who utilizes an insulin pen have the potential to be affected by the the same deficient practice. The identified residents will be ensured that an air shot of 2 units is done, to ensure there was no air in the pen or needle, prior to administration of insulin. Clinical staff was in-serviced on residents utilizing insulin pen ensuring that an air shot of 2 units is done prior to administration of insulin to ensure there was no air in the pen or needle. Survey compliance tool was developed to audit clinical staff through observation ensuring that they demonstrate an air shot of 2 units prior to administration of insulin. The Director of Nursing and/or designee will audit through observing clinical staff utilizing the survey compliance tool, daily for one week, weekly x 4 weeks, every 2 weeks x 1 month and monthly x 3 months. Any identified negative trends will be addressed one on one with the responsible staff. Any identified trends will be forwarded to the QAPI Committee for review and follow up until resolved.	

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F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on record review and interview, the facility failed to ensure residents were evaluated for meeting criteria of a true infection prior to use of antibiotics for 2 of 4 residents reviewed for antibiotic stewardship. (Residents 11 and 203) Findings include: 1. On 6/17/22 at 10:39 a.m., the Antibiotic Stewardship book was reviewed. The June 2022 Monthly Surveillance Log indicated Resident 11 was treated for a urinary tract infection (UTI) on 6/9/22. The column that indicated if McGreer's criteria (a standardized set of guidelines used to determine true infections) had been met was not completed. The column that indicated what organism was present (infectious pathogen determined by lab cultures) indicated UTI. The resident had been given Bactrim (an antibiotic) for seven days. A Nursing Note, dated 6/4/22, indicated the resident was more confused that evening. The Nurse Practitioner had been notified and ordered a urinalysis and blood work.	F 0881	R11 and R203 have both completed their antibiotic regimen and had no negative effects from the observed deficient practice. The facility identified other residents who are on antibiotics have the potential to be affected by the the same deficient practice. The identified residents will be evaluated for meeting the criteria of true infection utilizing the McGeer's Criteria. Clinical staff was in-serviced on ensuring that prior to acquiring orders of antibiotics from the attending physician, the McGeer's criteria has to be filled out to identify true infections. The Monthly Infection Surveillance Log will be utilized to ensure that prior to antibiotic utilization, the McGeer's criteria is properly filled out to identify true infections.	07/15/2022

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	The document, "McGreer's Definitions for Healthcare Associated Infections for Surveillance for Long Term Care Facilities", indicated the following criteria for a UTI: a resident without a catheter must have at least 3 of the 6 symptoms indicated, including fever, new burning with urination, new flank pain, change in character of urine, worsening of mental status. 2. The June 2022 Monthly Surveillance Log indicated Resident 203 was admitted on 6/9/22 with an intravenous (IV) antibiotic for sepsis. The column that indicated if McGreer's criteria had been met was not completed. The column that indicated what organism was present indicated Sepsis. The resident was on IV Vancomycin (an antibiotic) daily for sepsis. The McGreer's criteria for systemic infection indicated the resident needed two or more blood cultures identifying the same organism and another symptom including fever, new hypothermia, drop in blood pressure or worsening mental status. Interview with the Assistant Director of Nursing (ADON), who was also the Infection Preventionist, on 6/17/22 at 1:40 p.m., indicated they used the McGreer's criteria to identify infections. The criteria had not been completed for the above residents as it should have been.		The Assistant Director of Nursing/Infection Preventionist and/or designee will audit each antibiotic order utilizing the Infection Surveillance Log, daily x 1 week, weekly x 4 weeks, every 2 weeks x 1 month and monthly x 3 months. Any identified negative trends will be addressed one on one with the responsible staff. Any identified trends will be forwarded to the QAPI Committee for review and follow up until resolved.	
F 9999 Bldg. 00	3.1-14 PERSONNEL (k) There shall be an organized ongoing inservice education and training program planned in	F 9999	MDS 1 completed resident rights training. LPN 1 completed resident rights, abuse, and dementia training.	07/15/2022

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	advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (7) Documentation of orientation to the facility and to the specific job skills. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure annual resident rights training, abuse training, and dementia training was completed for 3 of 10 employee records reviewed. (MDS 1, LPN 1, CNA 2) The facility also failed to ensure each employee had record of a completed general and job specific orientation for 3 of 10 employee records reviewed. (RN 1, Activities 1, CNA 1) Finding includes: The employee records were reviewed on 6/16/22 at		C.N.A. 2 completed resident rights and dementia training RN 1 is no longer employed by Wittenberg Village. Activities 1 completed job specific orientation for Activity Assistant. C.N.A. 1 is no longer employed by Wittenberg Village. A review of employee records has been completed. Any employee that was missing general or job specific orientation, dementia, abuse, or resident rights training has been provided with required training and orientation. The Administrator or Designee will be responsible for ensuring required training and orientation is completed prior to any employee being eligible to begin work. The management team has been educated on the annual requirement for dementia, resident rights, and abuse training. Each manager will be responsible to ensure that these trainings are completed as required. Each manager will complete a monthly audit of employee Relias training. The results of these audits will be brought to the QAPI committee monthly for no less than 12 months to ensure continued compliance.	

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	2:32 p.m., and indicated the following: a. MDS 1 was hired 4/20/22 and had no documentation of resident rights training. b. LPN 1 had no documentation of 2021 resident rights, abuse, or dementia training. c. CNA 2 had no documentation of 2021 resident rights or dementia training. d. RN 1 was hired 2/26/22 and had no documentation of general or specific orientation. e. Activities 1 was hired 2/28/22 and had no documentation of specific orientation. f. CNA 1 was hired 4/5/22 and had no documentation of general or specific orientation.			