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
	155764	A. BUILDING 00 B. WING	06/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and the Investigation of Complaint IN00375538. This visit included a State Residential Licensure Survey. Complaint IN00375538 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677 and F880. Survey dates: June 20, 21, 22, 23, 24, and 27, 2022. Facility number: 010739 Provider number: 155764 AIM number: 200856890 Census Bed Type: SNF/NF: 16 SNF: 41 Residential: 45 Total: 102 Census Payor Type: Medicare: 30 Medicaid: 16 Other: 11 Total: 57 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 7/1/22.	F 0000	This plan of correction shall serve as this facilities' credible allegation of compliance Preparation, submission, and implementation of the plan of corrections does not constitute an admission of or agreement with the facts and conclusions set forth in this survey report Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements The facility respectfully request paper compliance Thank you for your consideration, Respectfully, Kevin Mehay Executive Director Spring Mill Health Campus 317-525-3537	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and			

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

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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	communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, record review and interview, the facility failed to ensure a resident's	F 0550	**F550**	07/15/2022

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	dignity was maintained related to not placing a dignity bag over a foley (urinary) catheter drainage bag for 1 of 1 residents reviewed for urinary catheters. (Resident L) Finding includes: On 6/21/22 at 10:03 a.m., Resident L was observed in bed. His foley catheter drainage bag was not covered with a dignity bag and urine was visible. On 6/22/22 at 9:49 a.m., the resident was in his room in bed sleeping. The resident's foley catheter was draining pink tinged urine. The drainage bag was not covered with a dignity bag. At 12:01 p.m., the resident was in his room in bed. The resident had a visitor at that time. The foley catheter drainage bag was not covered with a dignity bag. On 6/23/22 at 9:55 a.m., the resident was in his room in bed. The resident was talking to his roommate, who was seated in a wheelchair next to the resident's bed. The resident's foley catheter drainage bag was not covered with a dignity bag and urine was visible. On 6/27/22 at 8:22 a.m., the resident was in his room in bed. The resident's foley catheter was draining dark yellow urine. The drainage bag was visible from the doorway. The record for Resident L was reviewed on 6/23/22 at 10:09 a.m. Diagnoses included, but were not limited to, urinary retention, neurogenic bladder, and urinary tract infection. The Admission Minimum Data Set (MDS) assessment, dated 6/1/22, indicated the resident was moderately impaired for daily decision making		**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident L foley catheter drainage bag was covered with a dignity bag. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** An audit of other residents with urine collection bags was completed and did not identify any other residents affected.	

and he had an indwelling catheter.

A Physician's Order, dated 5/26/22, indicated the resident was to have a 16 french/30 milliliter (ml) foley catheter.

Interview with the Director of Nursing and the Nurse Consultant on 6/23/22 at 2:00 p.m., indicated the resident's foley catheter drainage bag should have been covered with a dignity bag.

3.1-3(t)

What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?

Staff have been re-educated on the importance of resident's rights to include privacy. The Director of Nursing / Designee will be responsible for validating privacy rounds/inspections and subsequent follow up.

How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

Director of Nursing or Designee will complete observations on 3 residents once a day at various times, 5 times weekly for 4 weeks, and 2x weekly thereafter to ensure urine collection bag is covered to ensure compliance.

The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.

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			By what date the systemic changes will be completed? Date of Completion: 7/15/2022	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, record review and interview, the facility failed to ensure call lights were in reach for 1 of 15 sampled residents. (Resident 19) Finding includes: On 6/21/22 at 10:30 a.m., Resident 19 was observed in his room seated in a wheelchair. The resident's call light was positioned behind him hanging from the bedside cabinet door, out of the resident's reach. At 11:08 a.m., the resident was repeatedly yelling, "Nurse." At 11:10 a.m., activity staff entered the resident's room and turned on his call light. A CNA entered the resident's room at 11:15 a.m. At 2:11 p.m. and 3:39 p.m., the resident was observed in bed. His call light remained out of reach and continued to hang from the bedside cabinet door. The record for Resident 19 was reviewed on 6/22/22 at 10:03 a.m. Diagnoses included, but were not limited to, stroke, pneumonia, bipolar, and intellectual disabilities. The Quarterly Minimum Data Set (MDS) assessment, dated 4/26/22, indicated the resident	F 0558	**F558** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **What corrective actions will be accomplished for those residents found to be affected by the alleged deficient practice:**	07/15/2022

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	was cognitively impaired for daily decision making. He needed extensive assistance with bed mobility and transfers. Interview with the Director of Nursing on 6/27/22 at 10:30 a.m., indicated the resident was able to use his call light and the call light should have been in reach. 3.1-3(v)(1)		Resident 19 call light was placed within reach. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be affected by the alleged deficient practice. **What measures will the facility take or systems the facility will alter to ensure that the problem will be corrected and will not recur.** Staff were re-educated to ensure call lights are within reach for all residents when exit residents' rooms and when doing rounds. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** Director of Nursing or Designee will audit 10 residents once a day at various, 5 times weekly for 4 weeks, and 5 residents 2x weekly thereafter to ensure we compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or	

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			until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **By what date the systemic changes will be completed?** Systemic changes will occur by 7/15/22	
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Based on observation, record review and interview, the facility failed to ensure medications were not borrowed from another resident for medication administration for 1 of 6 residents observed during medication pass. (Resident D) Finding includes: On 6/23/22 at 12:28 p.m., RN 1 was observed administering medications to Resident D. RN 1 removed a Lidocaine (a patch used for pain control) 4% patch from a clear bag labeled Lidocaine 4%, Another resident's name was on the bag, and instructions were to apply to the lower back topically one time a day. The RN	F 0602	**F602 Free from Misappropriation/Exploitation** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set*	07/15/2022

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	opened the single patch and gathered other medications to go into the resident's room. The RN was stopped before entering the room and was asked to review the medication packaging again before entering the room. Resident D's record was reviewed on 6/21/22 at 2:40 p.m. Diagnoses included, but were not limited to, stroke, dysphagia, left leg below the knee amputation, chronic kidney disease, anemia, and heart failure. A Physician's Order, dated 6/18/22, indicated Lidocaine 4% patch apply to lower back topically one time a day. Interview with RN 1 on 6/23/22 at 2:50 p.m., indicated she was aware not to borrow other resident's medications if medications were not available. Interview with the Nurse Consultant on 6/27/22 at 7:05 p.m., indicated nursing staff were not supposed to borrow medications from other residents. 3.1-28(a)		*forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident D Lidocaine Patches were ordered. **2) How the facility identified other residents:** All residents who receive medications have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** RN 1 was educated on misappropriation as it relates to borrowing other residents' medications for another resident. Nursing staff will be re-educated on misappropriation of resident's belongings. **4) How the corrective actions will be monitored:** Director of Nursing or designee will complete 2 medication observations per week for 4 weeks then 1 time a week for 4 weeks to	

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			ensure that the licensed staff is not borrowing medications during the med pass. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 07-15-2022**	
F 0623 SS=A Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.			

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	§483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;			

(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at §

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	483.70(l). Based on record review and interview, the facility failed to ensure a resident and/or their Responsible Party were notified in writing related to a transfer to the hospital for 1 of 1 residents reviewed for hospitalization. (Resident 19) Finding includes: The record for Resident 19 was reviewed on 6/22/22 at 10:03 a.m. Diagnoses included, but were not limited to, stroke, pneumonia, bipolar, and intellectual disabilities. The Quarterly Minimum Data Set (MDS) assessment, dated 4/26/22, indicated the resident was cognitively impaired for daily decision making. He needed extensive assistance with bed mobility and transfers. Nurses' Notes, dated 4/3/22 at 3:58 p.m., indicated the resident's blood sugar was 423, the Physician was contacted and staff were instructed to administer the resident's insulin as ordered. The resident was observed having shortness of breath and his oxygen saturation was 85%. He was started on 2 liters of oxygen as ordered and his value increased to 90%. Orders were received to send the resident to the emergency room for evaluation. The resident was admitted to the hospital and returned to the facility on 4/20/22. Nurses' Notes, dated 4/4/22 at 8:33 a.m., indicated all appropriate paperwork was sent with the resident to the hospital including the facility bed hold policy. There was no documentation indicating the	F 0623	**F623** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident 19 POA was provided with a copy of the transfer notice and facility bed hold policy . **2) How the facility identified other residents:** All residents who transfer or are discharged are affected by this deficient practice. **3) Measures put into place/ System changes:**	07/15/2022

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	resident's Responsible Party had received written notification of the state transfer form. Interview with the Director of Nursing and the Nurse Consultant on 6/23/22 at 2:00 p.m., indicated they would see if the resident's Responsible Party had received a written copy of the transfer notice. No additional documentation was provided. 3.1-12(a)(6)(ii) 3.1-12(a)(6)(iii)		Licensed nurses and Social service will be re-educated on Bed hold policy/transfer notice. An audit will be done weekly on all transfers and bed holds. Social Services Director is responsible for complaince **4) How the corrective actions will be monitored:** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 07/15/2022**	
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 dependent residents received assistance with ADL's (activities of daily living) related to nail care for 3	F 0677	**F 677** **The facility requests paper compliance for this citation.**	07/15/2022

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	of 5 residents reviewed for ADL's. (Residents B, D, and C) Findings include: 1. On 6/21/22 at 11:20 a.m., Resident B was observed in his room in bed. The resident's fingernails on both hands were long. Interview with the resident at that time, indicated he did not like his nails long. He also indicated that he had asked staff to cut his nails and they told him he would have to do it himself. The record for Resident B was reviewed on 6/21/22 at 2:15 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), lack of coordination, and muscle weakness. The Medicare 5 day Minimum Data Set (MDS) assessment, dated 5/27/22, indicated the resident was cognitively intact, required extensive assistance with personal hygiene, and needed total assistance with bathing. The Care Plan, dated 2/22/22 and reviewed on 5/12/22, indicated the resident required assistance with ADL's including bed mobility, transfers, eating, toileting, and bathing related to decreased mobility, weakness from immobility, COPD, and recent COVID-19 infection. Interventions included, but were not limited to, assist with personal hygiene including dressing and grooming as needed. Self participation was to be encouraged. The Bath and Skin report sheet, dated June 2022, indicated the resident refused his bath and/or shower on 6/1, 6/4, 6/8, 6/11, 6/15, 6/18, and 6/22/22.		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **What corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice.** Resident B, D and C nail care was provided How will the facility identify other residents who have the potential to be affected by the same alleged deficient practice? All residents residing in the facility have the potential to be affected by this alleged deficient practice. **What corrective measures will the facility take, or will the facility alter to ensure that the problem will not occur?**	

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	Documentation indicated his nails were not trimmed on 6/15, 6/18, and 6/22/22. Interview with the Director of Nursing on 6/23/22 at 2:00 p.m., indicated the resident had a history of refusing his showers but he should have been asked if he wanted his fingernails trimmed. Interview with the resident on 6/27/22 at 2:35 p.m., indicated his fingernails were trimmed a few days ago by staff. 2. During observations on 6/20/22 at 1:39 p.m., 6/21/22 at 1:50 p.m., 6/22/22 at 9:45 a.m. and 1:55 p.m., and on 6/23/22 at 7:55 a.m., Resident D was observed in bed. At those times, the resident's fingernails were long and dirty. The record for Resident D was reviewed on 6/21/22 at 2:40 p.m. The resident was admitted on 6/17/22 from the hospital. Diagnoses included, but were not limited to, stroke, dysphagia (difficulty swallowing), left leg below the knee amputation, chronic kidney disease, and heart failure. The Admission Minimum Data Set (MDS) assessment was still in progress. A Care Plan, dated 6/17/22, indicated the resident required assistance with ADL's including bed mobility, eating, transfers, toileting and bathing. The approaches were staff would complete ADL's for the resident daily and assist with personal hygiene including dressing and grooming as needed. The resident's showers were scheduled every Tuesday and Friday on the day shift. A complete bed bath was given on 6/21/22. There was no		Staff was re-educated on the importance of providing ADL care to include nail care as needed to residents. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** Director of Nursing or Designee will complete observation on 10 residents once a day, 5 times weekly for 4 weeks, and 5 residents 2x weekly thereafter to ensure ADL care compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **By what date the systemic changes will be completed? Date of Completion: 7/15/2021**	

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documentation indicating the resident had her nails trimmed and/or cleaned.

Interview with RN 1 on 6/23/22 at 9:50 a.m., indicated the resident's nails were dirty and in need of cleaning.

3. During observations on 6/21/22 at 10:22 a.m. and 2:00 p.m., on 6/22/22 at 9:50 a.m., and on 6/23/22 at 7:53 a.m., 9:40 a.m., and 11:40 a.m., Resident C was observed in bed. At those times, his nails were very long and curled as well as dirty.

During an interview with Resident C's spouse and daughter on 6/21/22 at 2:00 p.m., they indicated his nails were very long.

The record for Resident C was reviewed on 6/21/22 at 3:00 p.m. The resident was admitted on 6/14/22 from the hospital. Diagnoses included, but were not limited to, type 2 diabetes, ulcerative colitis, pressure ulcer, end stage renal disease, peripheral vascular disease, heart failure, stroke, dependence on renal dialysis, and hemiplegia.

The Admission Minimum Data Set (MDS) assessment was still in progress and not completed.

A Care Plan, dated 6/14/22, indicated the resident required assistance with ADL's including bed mobility, eating, transfers, toileting and bathing. The approaches were to assist with personal hygiene including dressing and grooming as needed.

The resident was to receive complete bed baths on Tuesday and Friday evenings. A bed bath

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	was given on 6/17/22. There was no documentation nail care had been provided. Interview with RN 1 on 6/23/22 at 9:50 a.m., indicated the resident's nails were very long and dirty. This Federal tag relates to Complaint IN00375538. 3.1-38(a)(3)(E)			
F 0684 SS=E 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 ensure areas of bruising, abrasions, and a foot discoloration were assessed and monitored. The facility also failed to ensure treatments were completed and signed out as ordered for 5 of 5 residents reviewed for skin conditions (non-pressure related). (Residents 19, D, C, 206, and 205) Findings include: 1. On 6/20/22 at 2:30 p.m., Resident 19 was observed in his room in bed. Scratch marks were observed on the resident's left lower leg and an abrasion was noted on his left knee. On 6/22/22 at 1:30 p.m., the resident was observed	F 0684	**F684 Quality of Care** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or*	07/15/2022

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	in his room in bed. The abrasion to his left knee remained and a fading yellow/green bruise was observed to his left lateral knee. The scratch marks also remained. The record for Resident 19 was reviewed on 6/22/22 at 10:03 a.m. Diagnoses included, but were not limited to, stroke, pneumonia, bipolar, and intellectual disabilities. The Quarterly Minimum Data Set (MDS) assessment, dated 4/26/22, indicated the resident was cognitively impaired for daily decision making. He needed extensive assistance with bed mobility and transfers. There was no Care Plan related to the bruising and abrasion. The weekly Skin Observation sheet, dated 6/20/22, indicated the resident had skin concerns that were not new. There was no documentation indicating where the areas were located. Interview with the Director of Nursing on 6/23/22 at 2:00 p.m., indicated the areas should have been identified on the weekly Skin Observation sheet. Nurses' Notes, dated 6/24/22 at 9:23 a.m., indicated the Physician and family were made aware of the fading discoloration and abrasion. No new orders were noted. Nursing would continue to monitor.2. On 6/20/22 at 1:39 p.m., Resident D was observed in bed with her eyes open. At that time, the bandage to her left stump was dated 6/18/22. The record for Resident D was reviewed on 6/21/22 at 2:40 p.m. The resident was admitted on 6/17/22 from the hospital. Diagnoses included, but were not limited to, stroke, dysphagia, left leg		*executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** 1. The physician was made aware that resident 19 had scratch marks on the left leg and an abrasion to the left knee. Treatments were obtained and care plans updated. 2. Treatment to resident D left stump was changed immediately. 3. Resident C's missing ointment was ordered, all ointments were placed in the correct treatment cart and the treatments were applied. 4. The physician was notified of the area to resident 206 hand, treatment obtained, and care plan updated. 5. Treatment to resident 205 right knee was changed immediately. **2) How the facility identified other residents:** All residents who have non pressure areas have the potential to be affected by this deficient practice. **3) Measures put into place/ System changes:**	

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	below the knee amputation, chronic kidney disease, and heart failure. The Admission Minimum Data Set (MDS) assessment was still in progress The Care Plan, dated 6/17/22, indicated the resident was at risk for pressure related skin breakdown. The approaches were to administer treatments as ordered. Physician's Orders, dated 6/17/22, indicated to cleanse the left stump with normal saline, pat dry, apply an island dressing, and wrap with kerlix every evening shift. Interview with RN 1 on 6/20/22 at 1:45 p.m., indicated the resident's bandages to the left stump were to be changed every day. 3. On 6/21/22 at 10:22 a.m., Resident C was observed in bed. His left foot was dark and discolored with dry loose skin noted. Both feet were observed with a large amount of dry scaly skin. During an interview on 6/21/22 at 2:00 p.m., with Resident C's spouse and daughter, indicated they were not sure if the medicated ointment was being applied to the resident's foot. On 6/23/22 at 7:53 a.m., and 9:37 a.m., the resident was observed in bed. His left foot was in the heel boot and the right foot was observed directly on the bed. RN 1 was asked to provide the ointments for the resident on 6/23/22 at 9:42 a.m. The RN was not able to find any of the creams. She went into the		Staff will be re-educated the importance of following physicians' orders, completing weekly skin assessment per policy and notifying the physician as needed for any new areas of concern. **4) How the corrective actions will be monitored:** Director of Nursing or designee will complete 3 wound dressing audits per week to ensure that the dressings have been changed per physicians orders, no ointments have been left at the bedside and that all areas have been addressed. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 07-15-2022**	

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resident's room and found the Triamcinolone Acetonide cream (a topical skin cream) inside a dresser drawer. The other bottle of Lac Hydrin lotion (a lotion for dry scaly skin) was on a different medication cart on a completely different unit. The Bactroban (an antibiotic skin ointment) ointment was not found at all.

On 6/23/22 at 11:40 a.m., the Assistant Director of Nursing (ADON) changed the resident's bandage on his sacral area. At that time, the resident's left foot was observed in the heel boot. The skin was loose as well as dark and discolored.

Interview with ADON at that time, indicated the resident was admitted to the facility with the wound to the left foot. The Wound Doctor was following the wound and observing and assessing it weekly.

The record for Resident C was reviewed on 6/21/22 at 3:00 p.m. The resident was admitted on 6/14/22 from the hospital. Diagnoses included, but were not limited to, type 2 diabetes, ulcerative colitis, pressure ulcer, end stage renal disease, peripheral vascular disease, heart failure, stroke, dependence on renal dialysis, and hemiplegia.

The Admission Minimum Data Set (MDS) assessment was still in progress and not completed.

Physician's Orders, dated 6/14/22, indicated Triamcinolone Acetonide cream 0.1 % apply to affected areas topically at bedtime for dry skin. Bactroban Cream 2 %, apply to left foot topically every shift.

Physician's Orders, dated 6/20/22, indicated Lac-Hydrin Twelve lotion 12 %, apply to bilateral

lower extremities topically two times a day for dry skin. Suspend or offload heels when in bed every shift.

The Admission Clinical Observation assessment, dated 6/14/22, indicated the resident was admitted with a sacral open area that measured 3.7 centimeters (cm) by 2.3 cm and a left foot area. There was no assessment or measurements of the foot.

A Nurses' Note, dated 6/19/22 at 11:38 a.m., indicated the resident's skin was dry and his bilateral lower extremities were noted to be excessively dry. The Physician was notified and a new order for Lac Hydrin lotion was obtained.

The Skin and Wound Measurement assessment, dated 6/21/22, indicated this was the first documented measurement of the left foot. The wound was identified as a diabetic wound to the dorsum of the left foot. The wound was present on admission and measured 86.9 cm by 14.6 cm by 8.6 cm wide.

The 6/2022 Treatment Administration Record (TAR), indicated the Bactroban was not signed out as being administered on 6/20 and 6/21/22 for the day shift, on 6/19/22 for the evening shift and on 6/15 and 6/19/22 for the midnight shift. The Lac Hydrin lotion was not signed out as being applied on 6/20/22 for the evening shift. The Triamcinolone Acetonide cream was not signed out as being applied on 6/19 and 6/20/22 at 8:00 p.m.

A Skin/Wound Note by the Wound Physician, dated 6/21/22 at 4:46 p.m., indicated the resident's left foot was necrotic secondary to diabetes. The resident was one week status post hospital

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discharge for vascular issues as the patient was evaluated by the vascular physician. Will continue to monitor.

Interview with the Director of Nursing on 6/23/22 at 2:00 p.m., indicated the treatments should have been signed out as being completed. 4. During an interview on 6/21/22 at 10:35 a.m., Resident 206 indicated he had a new wound located on his left hand and the staff had not addressed it. The resident was unable to explain how he had injured the hand. The abrasion was approximately the size of a quarter and red in color.

On 6/22/22 at 11:30 a.m., the resident was observed sitting in a wheelchair with no wound treatment to the left hand.

On 6/23/22 at 9:32 a.m., the resident was observed sitting in a wheelchair with no wound treatment to the left hand.

The record for Resident 206 was reviewed on 6/22/22 at 1:38 p.m. Diagnoses included, but were not limited to, toxic encephalopathy, non-Alzheimer's dementia, high blood pressure, and wound infection.

The Admission Minimal Data Set (MDS) assessment, dated 4/7/22, indicated the resident was cognitively intact.

The record lacked orders for wound treatment to the area on the left hand and documentation of any wound assessments completed.

Interview with the Assistant Director of Nursing (ADON) on 6/23/22 at 10:59 a.m., indicated she was aware of the wound to the left hand as she had assessed it on 6/21/22. She had received new

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	orders from the wound doctor, but the record lacked the appropriate documentation. 5. On 6/20/22 at 2:41 p.m., Resident 205 was observed lying in bed with a wound dressing noted to the right knee dated 6/15/22. Resident 205's record was reviewed on 6/22/22 at 2:33 p.m. Diagnoses included, but were not limited to, fracture of right tibial tuberosity, orthostatic hypotension, spinal stenosis, and hypertensive heart disease with heart failure. A Care Plan, revised on 6/21/22, indicated the resident had potential/actual impairment to skin integrity of the right knee surgical wound. Interventions included, but were not limited to, follow facility protocols for treatment of injury and treatment as ordered. Physician's Orders, dated 6/15/22 at 3:29 p.m., indicated right knee cleanse with normal saline, pat dry, apply silver alginate and cover with foam dressing 3 times weekly every evening shift every Monday, Wednesday, and Friday for wound care and as needed. Interview with the Assistant Director of Nursing (ADON) on 6/20/22 at 2:50 p.m., indicated the dressing should have been changed per the Physician's Orders on Monday, Wednesday, and Friday each week. The ADON indicated the dressing would be changed later that day. 3.1-37(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration.			

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	(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.			
	Based on observation, record review, and interview, the facility failed to ensure residents' diets were followed as ordered and recommended by speech therapy as well as ensuring the Registered Dietitian's (RD) recommendations were acted upon timely for 3 of 3 residents reviewed for nutrition. (Residents 20, C, and 159) Findings include: 1. On 6/21/22 at 9:40 a.m., Resident 20 was observed sitting at the dining room table waiting for her breakfast. CNA 3 brought the resident a plate of food. She received scrambled eggs, ground meat with some gravy and a bowl of oatmeal. The CNA did not bring a beverage with the meal. The resident started to cut up the scrambled eggs and then she mixed the ground meat and gravy with the eggs. She started to eat	F 0692	F692 **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of*	07/15/2022

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	the scrambled eggs and sausage mixture and still had nothing to drink. The CNA came back over to the table and gave her a plastic cup with coffee. She took some more bites of the scrambled egg mixture and then she drank some of the coffee and continued to eat. At 9:56 a.m., the Social Service Director (SSD) brought the resident a glass of apple juice, and took her bowl of oatmeal and heated it up. She brought the oatmeal back and the resident put some cream and brown sugar on it and let it sit for a minute while it cooled off. The resident did not alternate bites of food with sips of any of the drinks. Interview with the resident at that time, indicated she needed extra gravy for her foods and she did not always get it. She picked up her meal ticket and pointed to the part where it stated "extra gravy." The resident indicated it helped her swallow the food much easier. Another complaint the resident had was she did not always get something to drink right away, often times she had to wait a long time for a beverage. The beverages also helped her get the food to go down. The record for Resident 20 was reviewed on 6/22/22 at 2:20 p.m. Diagnoses included, but were not limited to, hypertensive kidney disease, dysphagia, high blood pressure, and peg tube. The Quarterly Minimum Data Set (MDS) assessment, dated 4/25/22, indicated the resident was cognitively intact and had no oral problems. The resident's weight was 153 pounds with no weight loss. A mechanically altered diet was ordered and the resident only needed supervision for eating. A Care Plan, updated 6/20/22, indicated the		*federal and state law.* **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** RD and Speech Therapy recommendations reviewed and followed for residents 20 and 159. Speech evaluation was completed for Resident 20. Resident C no longer residents in the facility. **How will facility identify other residents who have the potential to be affected by the same alleged deficient practice?** The deficient practice has the potential to affect all facility residents with speech and RD recommendations. An audit of all residents receiving speech and RD recommendation was completed to ensure orders were entered and followed. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** Licensed nursing staff were re-educated on ensuring that all RD and Speech	

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	resident was at risk for impaired nutritional status. A Speech Therapist Note and recommendations, dated 12/23/21, indicated ground meat with extra gravy and sauces. No bread products, alternate bites with sips, and eat small bites. The resident had no current weight loss. An RD Note, dated 5/10/22 at 11:21 a.m., indicated the resident received a mechanical soft texture, regular diet. She followed aspiration/reflux precautions- extra gravy and sauces when possible and no bread products. Interview with the Nurse Consultant on 6/23/22 at 2:00 p.m., indicated if there was a speech therapy recommendation then it should have been followed. Speech therapy would be contacted to evaluate the resident since that recommendation was 6 months ago and beverages should be served with the meal. 2. The record for Resident C was reviewed on 6/21/22 at 3:00 p.m. The resident was admitted on 6/14/22 from the hospital. Diagnoses included, but were not limited to, type 2 diabetes, ulcerative colitis, pressure ulcer, end stage renal disease, peripheral vascular disease, heart failure, stroke, dependence on renal dialysis, and hemiplegia. The Admission Minimum Data Set (MDS) assessment was still in progress and not completed. A Care Plan, dated 6/14/22, indicated the resident was at risk for impaired nutritional status due to new admission to the facility. The first and only weight obtained was on 6/21/22		Therapy recommendations are followed. Dietary staff was re-educated on the importance of providing meals according to diet orders. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** DON/ designee will review 5 residents with Speech Therapy or RD recommendations weekly to ensure resident diets are followed as ordered 5 times weekly for 4 weeks then 2 times weekly thereafter to ensure compliance. Dietary Manager or designee will observe tray line once a day at various mealtimes, 5 times weekly for 4 weeks then 2 times weekly thereafter to ensure meals are served per diet order. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **By what date the systemic**	

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	155764	A. BUILDING 00 B. WING	06/27/2022

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	which indicated the resident weighed 124 pounds. There was no weight upon admission. A RD Note, dated 6/17/22, indicated the resident needed assistance with meals. She addressed lab values from the hospital and the resident's diet was pureed texture. The resident was at risk for malnutrition related to acute illness and low body weight. The RD recommended Prostat 30 milliliters (ml) twice a day and a renal type MVI (multivitamin) with minerals daily to aid in wound healing. Recommend Nepro supplement 1 carton three times a day to support intakes and weight stability/weight gain. Recommend add Renal diet to current diet order related to end stage renal disease. Physician's Orders, dated 6/22/22, indicated 1 carton of Nepro three times a day, Renal diet, Pureed texture. Interview with the Director of Nursing and the Nurse Consultant on 6/23/22 at 1:50 p.m., indicated the RD recommendations were not followed through timely. She would expect to have them completed within 24 or 48 hours. 3. During an interview on 6/20/22 at 10:31 a.m. with Resident 159, indicated he needed a gluten free diet, however, they kept sending him food with gluten in it. He had asked for grits every morning for breakfast, but they constantly sent him oatmeal and he couldn't eat it. On 6/23/22 at 9:17 a.m., the resident received his breakfast. He was served scrambled eggs, 2 pieces of sausage, and a blueberry muffin. He did not receive any hot cereal. The record for Resident 159 was reviewed on		**changes will be completed?** **Date of Completion:** **7/15/2021**	

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6/22/22 at 11:45 a.m. The resident was admitted on 6/2/22. Diagnoses included, but were not limited to, adult failure to thrive, high blood pressure, anxiety, and paranoid personality.

The Admission Minimum Data Set (MDS) assessment, dated 6/8/22, indicated the resident was cognitively intact, and was not receiving any special diet.

A Care Plan, dated 6/2/22, indicated the resident was at risk for impaired nutritional status due to new admission to the facility and a gluten free diet. The approaches were to provide diet as ordered.

Physician's Orders, dated 6/7/22, indicated the resident was to receive a regular diet. Gluten Free double portions and grits with breakfast.

A RD Note, dated 6/7/22, indicated the resident had allergies to lactose and gluten. The current diet order was for a gluten free renal diet and regular texture. Recommend a regular gluten free diet as no diagnosis listed warranted a renal diet.

The resident weighed 174 pounds on 6/15/22 and 168 pounds on 6/21/22.

The last documented Nutrition At Risk (NAR) note was on 6/16/22 at 3:08 p.m., which indicated the resident's weight was 174 pounds. All recommendations were followed and carried out. The resident was noted with a gluten allergy. Will continue to follow in NAR.

Interview with the Director of Nursing on 6/23/22 at 2:00 p.m., indicated she was aware the resident had a gluten allergy, however, she was not aware he was receiving oatmeal and not grits as

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	recommended. 3.1-46(a)(1)			
F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.			
	Based on observation, record review, and interview, the facility failed to ensure oxygen was being administered at the correct flow rate and time for 5 of 5 residents reviewed for oxygen use. (Residents 19, 34, D, C, and 28) Findings include: 1. On 6/20/22 at 2:30 p.m., Resident 19 was observed in his room in bed. His oxygen concentrator was turned off and his nasal cannula was not in use. On 6/21/22 at 2:11 p.m. and 3:39 p.m., the resident was observed in bed. His oxygen concentrator was turned off and his nasal cannula was not in use. The record for Resident 19 was reviewed on 6/22/22 at 10:03 a.m. Diagnoses included, but were not limited to, stroke, pneumonia, bipolar, and intellectual disabilities.	F 0695	**F695** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **What corrective actions will be accomplished for those**	07/15/2022

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	The Quarterly Minimum Data Set (MDS) assessment, dated 4/26/22, indicated the resident was cognitively impaired for daily decision making. He needed extensive assistance with bed mobility and transfers. He also received oxygen while a resident. A Physician's Order, dated 4/20/22, indicated the resident was to receive 2 liters of oxygen continuously by the way of a nasal cannula related to chronic obstructive pulmonary disease (COPD). The Care Plan, dated 4/21/22, indicated the resident was at risk for complications including shortness of breath which was experienced while lying flat and upon exertion secondary to emphysema and COPD. Interventions included, but were not limited to, oxygen per nasal cannula as ordered. Interview with the Director of Nursing and the Nurse Consultant on 6/23/22 at 2:00 p.m., indicated the resident's oxygen concentrator should have been turned on and in use when he was in bed. 2. On 6/21/22 at 2:14 p.m. and 3:32 p.m., Resident 34 was observed in his room in bed. The resident had 3 liters of oxygen in use by the way of a nasal cannula. On 6/22/22 at 9:57 a.m. and 1:30 p.m., the resident's oxygen concentrator was set at 3 liters. The resident's nasal cannula was in use. The record for Resident 34 was reviewed on 6/22/22 at 11:34 a.m. Diagnoses included, but were not limited to, acute and chronic respiratory failure and heart failure.		**residents found to be affected by the alleged deficient practice:** Resident's 19 and 28 physician orders were reviewed, and Oxygen settings were placed at the correct setting. Resident C and D no longer resides in the facility. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents with respiratory needs have the potential to be affected by this alleged deficient practice. **What measures will the facility take or systems the facility will alter to ensure that the problem will be corrected and will not recur.** Staff have been re-educated on the importance of following the doctor orders to ensure the resident has the correct oxygen settings. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** Director of Nursing or Designee will observe five oxygen dependent residents once a day at various	

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	The Admission Minimum Data Set (MDS) assessment, dated 5/22/22, indicated the resident was cognitively impaired for daily decision making and required extensive assistance with bed mobility and transfers. The resident was receiving oxygen while a resident. The Care Plan, dated 5/16/22, indicated the resident required oxygen therapy related to congestive heart failure, respiratory failure, and morbid obesity with hypoventilation. Interventions included, but were not limited to, oxygen as ordered. A Physician's Order, dated 5/16/22, indicated the resident was to receive 4 liters of oxygen continuously every shift. Interview with the Director of Nursing and the Nurse Consultant on 6/23/22 at 2:00 p.m., indicated the oxygen concentrator should have been set at 4 liters. 3. On 6/20/22 at 1:39 p.m., Resident D was observed in bed. At that time, she was wearing oxygen via nasal cannula. The rate was at 0.5 liters per minute. On 6/21/22 at 1:50 p.m. and on 6/22/22 at 9:45 a.m., and 1:55 p.m., the resident was observed in bed. At those times, she was wearing oxygen via nasal cannula. The rate was at 0.5 liters per minute. The record for Resident D was reviewed on 6/21/22 at 2:40 p.m. The resident was admitted on 6/17/22 from the hospital. Diagnoses included, but were not limited to, stroke, dysphagia, left leg below the knee amputation, chronic kidney disease, and heart failure. The Admission Minimum Data Set (MDS)		times, 5 times weekly for 4 weeks, and 2x weekly thereafter to ensure oxygen is use and on the correct flow rate per MD order. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **By what date the systemic changes will be completed?** Systemic changes will occur by 7/15/22	

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assessment was still in progress.

A Care Plan, dated 6/17/22, indicated the resident was at risk for complications secondary to the diagnosis of coronary artery disease. The approaches were to administer oxygen as ordered.

Physician's Orders, dated 6/17/22, indicated oxygen via nasal cannula at 1 liter continuously every shift.

Interview with RN 1 on 6/23/22 at 9:50 a.m., indicated the resident's oxygen was to be set at 1 liter per minute.

4. On 6/21/22 at 10:22 a.m. and on 6/22/22 at 9:50 a.m. and 2:00 p.m., Resident C was observed in bed. At that time, he was wearing oxygen via nasal cannula at 2 liters per minute.

Interview with the resident's daughter and spouse on 6/21/22 at 2:00 p.m., indicated the oxygen was only supposed to be as needed. Both of them took care of him at home and checked his pulse oximetry daily and only placed the oxygen on him if it was low. Both family members indicated they had told the nurses, however, nothing had been done about the oxygen.

The record for Resident C was reviewed on 6/21/22 at 3:00 p.m. The resident was admitted on 6/14/22 from the hospital. Diagnoses included, but were not limited to, type 2 diabetes, ulcerative colitis, pressure ulcer, end stage renal disease, peripheral vascular disease, heart failure, stroke, dependence on renal dialysis, and hemiplegia.

The Admission Minimum Data Set (MDS) assessment was still in progress and not

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completed.

A Care Plan, dated 6/14/22, indicated the resident was at risk for complications secondary to potentially experiencing altered respiratory status/difficulty breathing related to hypoxia from recent pneumonia.

Physician's Orders, dated 6/14/22, indicated may apply nasal cannula oxygen at 3 liters per minute prn (as needed) for shortness of breath if oxygen saturation was less than 92%.

Another Physician's Order, dated 6/14/22, indicated oxygen via nasal cannula at 3 liters per minute continuously.

A Nurses' Note, dated 6/15/22 at 7:49 p.m., indicated family requesting resident to be on 1 liter of oxygen. The Physician was notified and the oxygen was titrated to 1 liter. The resident was saturating at 94-95% on 1 liter per nasal cannula. The family was in the room and aware.

Interview with RN 1 on 6/23/22 at 9:50 a.m., indicated the resident did not get out of bed due to the family did not want him up. She was unaware the family did not want him to be on oxygen and indicated his oxygen saturations were fine while he was lying in bed. 5. On 6/20/22 at 3:06 p.m. and 6/21/22 at 3:33 p.m., Resident 28 was observed lying in bed with her oxygen on. The oxygen concentrator was set on 4 liters per minute (lpm). The humidification water bottle and oxygen tubing was dated 6/20/22.

Resident 28's record was reviewed on 6/21/22 at 1:38 p.m. Diagnoses included, but were not limited to, high blood pressure, diabetes mellitus, chronic lung disease, and depression.

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	A Physician's Order, dated 5/7/22, indicated to administer oxygen via a nasal cannula at 2 lpm continuously. Interview with the Director of Nursing on 6/22/22 at 1:59 p.m., indicated the oxygen concentrator should have been set to 2 lpm per the Physician's Order. 3.1-47(a)(6)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, record review, and interview, the facility failed to ensure each resident was free from pain related to a resident exhibiting signs and symptoms of pain with no relief for 1 of 1 residents reviewed for pain. (Resident C). Finding includes: During an interview on 6/21/22 at 2:00 p.m., with Resident C's spouse and daughter, they indicated the daughter had come in early on 6/19/22 (Sunday) morning and her father was crying out in pain. The room door was closed, his bed was in a low position, and the air was blowing on him. He thought he was sick and wanted to go to the emergency room. She went out to find the nurse and asked if the resident had anything for pain. The nurse indicated the last time he received pain	F 0697	F 697 **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of*	07/15/2022

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	medication was on Saturday at 3:30 p.m. when she had asked the facility to give him something for pain. The daughter expressed that her father couldn't ask for the Tylenol, as he was confused and she had already asked the nurse to regularly schedule the medication. On 6/22/22 at 9:50 a.m., the resident was observed in his room lying in bed. He was positioned all the way to the left side of the bed and was crying. He indicated his wife was so worried about him and he could not reach her. On 6/23/22 at 11:40 a.m., the Assistant Director of Nursing (ADON) and CNA 1 were observed in the resident's room. At that time, the ADON was going to change the resident's bandages on his sacral area. The resident was repositioned on to the left side. After the resident was on his left side, he started to moan out loud. CNA 1 asked the resident if he was ok, however, he did not respond. The ADON removed the bandage and started to clean the wound, again the resident moaned out loud. The CNA comforted the resident and told him they were almost done. During the treatment, the resident was observed to moan out loud in pain several times. Interview with the ADON at that time, indicated it would be no problem to pre-medicate the resident with Tylenol prior to the treatment. The record for Resident C was reviewed on 6/21/22 at 3:00 p.m. The resident was admitted on 6/14/22 from the hospital. Diagnoses included, but were not limited to, type 2 diabetes, ulcerative colitis, pressure ulcer, end stage renal disease, peripheral vascular disease, heart failure, stroke, dependence on renal dialysis, and hemiplegia.		*federal and state law.* **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident C no longer resides in the facility. **How will facility identify other residents who have the potential to be affected by the same alleged deficient practice?** All residents receiving pain management medications have the potential to be affected by this alleged deficient practice. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** Licensed nursing staff were re-educated on ensuring pain is assessed and that pain medications are administered as ordered by the physician to include prior to wound treatments. **What quality assurance plans will be implemented to monitor**	

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	The Admission Minimum Data Set (MDS) assessment was still in progress and not completed. A Care plan, dated 6/14/22, indicated the resident was at risk for pain related to a wound. The approaches were to administer analgesics as per orders and evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability, and impact on cognition. Monitor/document for probable cause of each pain episode. Notify the physician if interventions were unsuccessful. A Pain Assessment, dated 6/14/22, indicated the resident was not able to answer the questions. The staff provided an assessment of the pain. The resident had vocal complaints and the frequency of the pain was 3 to 4 days a week. Tylenol was ordered prn (an needed). Physician's Orders, dated 6/14/22, indicated Tylenol Tablet 325 milligrams (mg) (Acetaminophen). Give 650 mg by mouth every 4 hours as needed for pain. The Medication Administration Record (MAR) for 6/2022, indicated the Tylenol had only been administered on 6/18 at 3:31 p.m. and 6/19 at 3:54 p.m. There was no Tylenol signed out prior to the treatment on 6/25/22. Interview with the Director of Nursing on 6/23/22 at 2:00 p.m., indicated they could take a look at ordering the Tylenol on a scheduled basis and prior to the wound treatments.		**facility performance to ensure corrections are achieved and permanent?** DON/ designee will review 5 residents with orders for pain medications weekly to ensure pain is assessed and pain medications are administered as ordered by the physician 5 times weekly for 4 weeks then 2 times weekly thereafter. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **By what date the systemic changes will be completed? Date of Completion: 7/15/2021**	

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	3.1-37(a)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure a post dialysis assessment was completed at the time of return from hemodialysis for 1 of 1 residents reviewed for dialysis. (Resident C) Finding includes: The record for Resident C was reviewed on 6/21/22 at 3:00 p.m. The resident was admitted on 6/14/22 from the hospital. Diagnoses included, but were not limited to, type 2 diabetes, ulcerative colitis, pressure ulcer, end stage renal disease, peripheral vascular disease, heart failure, stroke, dependence on renal dialysis, and hemiplegia. The Admission Minimum Data Set (MDS) assessment was still in progress and not completed. A Care Plan, dated 6/14/22, indicated the resident was at risk for complications secondary to requiring dialysis. The approaches were to obtain vitals as ordered or needed. Physician's Orders, dated 6/14/22, indicated dialysis every Monday, Wednesday, and Friday. The chair time was 11:45 a.m., and transportation	F 0698	**F 698 Dialysis** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **What corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice.** Resident C no longer resides in	07/15/2022

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(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
	would pick up at 11:00 a.m. Pre dialysis vital signs and assessment one time a day every Monday, Wednesday and Friday. Physician's Orders, dated 6/20/22, indicated post dialysis vital signs and assessment one time a day every Monday, Wednesday and Friday. The Medication Administration Record (MAR) for 6/2022, indicated a post dialysis assessment was not completed on 6/15, 6/17, and 6/20/22. Interview with the Director of Nursing on 6/23/22 at 2:50 p.m., indicated she had asked the RN on duty if the resident had a dialysis book and she said no he did not, they send information to the center, however, nothing ever comes back. The resident was to have a pre and post dialysis assessment completed on dialysis days. 3.1-37(a)		the facility. How will the facility identify other residents who have the potential to be affected by the same alleged deficient practice? All facility residents who utilize dialysis services have the potential to be affected by the same alleged deficient practice. An audit was completed on all residents who receive dialysis to ensure post forms were completed. **What corrective measures will the facility take, or will the facility alter to ensure that the problem will not occur?** Nursing staff were re-educated on ensuring Pre and Post assessment are completed on all resident receiving dialysis services. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** Director of Nursing or Designee will audit all dialysis dependent residents' documentation weekly for 4 weeks, and 2x weekly thereafter to ensure pre and post documentation is present in the	

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			clinical record. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **By what date the systemic changes will be completed? Date of Completion: 7/15/2021**	
F 0740 SS=G Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on observation, interview and record review, the facility failed to ensure to follow up with the nurse practitioner's (NP) orders for obtaining outside behavioral health services which resulted in a resident displaying continued tearfulness and emotional distress. (Resident 28) Finding includes:	F 0740	**F 740** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of*	07/15/2022

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	On 6/20/22 at 2:15 p.m., Resident 28 indicated she was in need of outside resources for mental health and depression. She indicated she had ongoing, worsening depression symptoms. During the interview, it was noted she had increased tearfulness and crying. On 6/21/22 at 3:33 p.m., the resident had noted tearfulness and she asked again if the facility had made any appointments with an outside psychological service. The resident stressed again how her depression was worsening and she felt she needed to see a professional regarding her mental health. She indicated that she was dependent on staff for ADL's (activities of daily living) as she could no longer walk, she stayed in her room and did not have the desire to participate in activities. The resident was not observed out of her room at all during the survey. Resident 28's record was reviewed on 6/21/22 at 1:38 p.m. Diagnoses included, but were not limited to, anemia, high blood pressure, renal failure, diabetes mellitus, hyperlipidemia, anxiety disorder, depression, chronic lung disease, respiratory failure, and cellulitis of the right lower limb. The Admission Minimum Data Set (MDS) assessment, dated 5/12/22, indicated the resident had been feeling down, depressed, or hopeless for 7-11 days out of the last 14 days. She had trouble falling or staying asleep, or sleeping too much for 7-11 days out of the last 14 days. She had been feeling tired or having little energy for 2-6 days out of the last 14 days. A Referral Form, dated 4/12/22, from a NP assessing the resident indicated to arrange for		*this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **What corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice.** Referral was sent for resident 28 for behavioral health services. How will the facility identify other residents who have the potential to be affected by the same alleged deficient practice? All facility residents who have the need for behavioral health services have the potential to be affected by the alleged deficient practice. **What corrective measures will the facility take, or will the facility alter to ensure that the problem will not occur?** Nursing staff, IDT and Social Services were in serviced on ensuring all referrals for behavioral	

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	ambulatory psychiatry to assess the resident. A Physician's Order, dated 5/7/22, indicated the resident may have psychological services as needed. A Physician's Progress Note, dated 4/11/22 at 12:31 p.m., indicated the resident was reporting severe anxiety and depression. A Physician's Progress Note, dated 4/15/22 at 8:01 p.m., indicated the resident was seen and she reported she was depressed. The Physician increased the Lexapro (a medication to treat anxiety and depression) to 10 milligrams (mg) daily. A Physician's Progress Note, dated 6/11/22 at 10:51 p.m., indicated the resident was feeling hopeless and depressed. The Physician increased her dose of Lexapro to 20 mg daily. Interview with the Director of Nursing (DON) on 6/23/22 at 10:30 a.m., indicated there was no follow up for the ambulatory psychological services after they received the referral. The DON indicated after speaking with the referring NP, the NP indicated she sent the referral for outside psychological services due to the resident having increased emotional distress, tearfulness, and crying while she was assessing her. 3.1-43(a)(1)		health services are completed. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** Social Services or Designee will audit behavior and mood documentation 5 times weekly for 4 weeks, and 2x weekly thereafter to ensure any referrals are completed for behavioral health services as ordered by the MD were completed to ensure compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **By what date the systemic changes will be completed?** **Date of Completion: 7/15/2021**	
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			

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	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 the resident's blood pressure and pulse were monitored prior to the administration of antihypertensive medications and orders were received to hold blood pressure medication, as well as indications for the use of Tylenol for 3 of 5 residents reviewed for unnecessary medications. (Residents 51, 28, and 206) Findings include: 1. The record for Resident 51 was reviewed on 6/22/22 at 1:50 p.m. The resident was admitted on 5/31/22 from the hospital. Diagnoses included, but were not limited to, kidney disease, dependence on renal dialysis, insomnia, depressive disorders, and high blood pressure. The Admission Minimum Data Set (MDS)	F 0757	**F757 Drug Regimen is free from unnecessary Drugs** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is*	07/15/2022

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	assessment, dated 6/6/22, indicated the resident was cognitively intact and in the last 7 days she had received insulin for 7 days, an antidepressant for 5 days, and a hypnotic for 0 days. A Care Plan, dated 6/1/22, indicated the resident was at risk for complications secondary to the diagnosis of hypertension. The approaches were to give antihypertensive medications as ordered and monitor for side effects such as orthostatic hypotension and increased heart rate. Physician's Orders, dated 5/31/22, indicated Coreg (a medication to lower blood pressure and heart rate) tablet 12.5 milligrams (mg). Give 1 tablet by mouth one time a day every Monday, Wednesday, and Friday. Hold if systolic blood pressure (top number) was less than 120 and/or heart rate was less than 60 beats per minute. The dose was scheduled to be administered at 7:00 p.m. Physician's Orders, dated 5/31/22, indicated Catapres (a medication to lower blood pressure) tablet 0.1 mg. Give 1 tablet by mouth at bedtime every Monday, Wednesday, Friday, and Saturday. Hold if systolic blood pressure was less than 130. The medication was scheduled at 8:00 p.m. The 6/2022 Medication Administration Record (MAR), indicated there was no documentation of a pulse or blood pressure prior to the administration of the Coreg or Catapres medication. Interview with RN 1 on 6/23/22 at 1:00 p.m., indicated she was aware of the resident's blood pressure medication on dialysis days and non dialysis days and how the orders were different.		*required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** 1. The physician was notified of resident 51 B/P medications were held without physician notification several days. Resident 51 has not had a negative outcome. 2. The physician was notified that resident 28 B/P medications were not given per physician's orders. 3. Medication reconciliation was completed for resident 206 to address pain. **2) How the facility identified other residents:** All residents who receive medications have the potential to be affected by this deficient practice. **3) Measures put into place/ System changes:** Licensed nurses will be educated on the importance of following physicians orders. **4) How the corrective actions will be monitored:**	

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	The resident's blood pressure was to be taken and documented at the time the medication was administered. Interview with the Director of Nursing on 6/23/22 at 2:00 p.m., indicated the resident's blood pressure should be taken right before the medication was administered. 2. Resident 28's record was reviewed on 6/21/22 at 1:38 p.m. Diagnoses included, but were not limited to, anemia, high blood pressure, renal failure, diabetes mellitus, hyperlipidemia, anxiety disorder, depression, chronic lung disease, respiratory failure, and cellulitis of the right lower limb. The Admission Minimum Data Set (MDS) assessment, dated 5/12/22, indicated the resident was cognitively intact. A Physician's Order, dated 5/6/22 at 11:06 p.m., indicated Diltiazem (a medication to lower blood pressure) 30 milligram (mg) tablet every 8 hours. A Care Plan, initiated on 3/29/22, indicated the resident was at risk for complications secondary to the diagnosis of hypertension. Interventions included, but were not limited to, give antihypertensive medications as ordered and monitor for side effects. The June 2022 Medication Administration Record (MAR), indicated the medication was not given as ordered on the following dates and times: - 6/8/22 at 4:00 p.m. - 6/11/22 at 12:00 a.m. - 6/12/22 at 12:00 a.m. - 6/13/22 at 12:00 a.m. - 6/15/22 at 12:00 a.m. - 6/17/22 at 12:00 a.m.		The Director of Nursing or designee will complete a medication review audit 5 days a week to ensure that physician orders have been followed. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 07/15/2022**	

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- 6/18/22 at 12:00 a.m.
- 6/19/22 at 12:00 a.m.
- 6/21/22 at 12:00 a.m.

The record lacked documentation of a current set of vital signs checked at the time of medication administration.

Interview with the Director of Nursing (DON) on 6/23/22 at 10:27 a.m., indicated there were no set parameters in the Physician's Orders for holding the medication. It would be up to the nurse to call the Physician to determine whether or not to hold the medication. The DON indicated the record did lack documentation of the current vital signs being assessed at the time of the medication administration.

3. Resident 206's record was reviewed on 6/22/22 at 1:38 p.m. Diagnoses included, but were not limited to, toxic encephalopathy, non-Alzheimer's dementia, high blood pressure, and wound infection.

The Admission Minimum Data Set (MDS) assessment, dated 4/7/22, indicated the resident was cognitively intact.

A Physician's Order, dated 4/11/22 at 6:00 p.m., indicated Acetaminophen tablet 325 milligram (mg) every 4 hours as needed for fever.

The June 2022 Medication Administration Record (MAR), indicated the Acetaminophen tablet was administered on 6/1/22 at 7:41 a.m. and 6/19/22 at 5:43 p.m. The resident had vital signs checked at the time of administration and had a temperature of 97.8 degrees Fahrenheit on 6/1/22 and 96.5 degrees Fahrenheit on 6/19/22.

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	Interview with the Director of Nursing (DON) on 6/23/22 at 10:30 a.m., indicated she would be clarifying the orders as the Acetaminophen should have been ordered for pain or fever. The medication should not have been administered with a temperature of 97.8 or 96.5 degrees Fahrenheit. 3.1-48(a)(3) 3.1-48(a)(4)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;			

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	§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.			
	Based on record review and interview, the facility failed to ensure a psychotropic medication was not ordered prn (as needed) longer than 14 days related to a prn hypnotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 51) Finding includes: The record for Resident 51 was reviewed on 6/22/22 at 1:50 p.m. The resident was admitted on 5/31/22 from the hospital. Diagnoses included, but were not limited to, kidney disease, dependence on renal dialysis, insomnia, depressive disorders, and high blood pressure. The Admission Minimum Data Set (MDS) assessment, dated 6/6/22, indicated the resident was cognitively intact and in the last 7 days she	F 0758	**F758 Free from Unnec Psychotropic Meds** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is*	07/15/2022

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	had received insulin for 7 days, an antidepressant for 5 days, and a hypnotic for 0 days. A Care Plan, dated 6/1/22, indicated the resident was at risk for complications secondary to receiving sedative/hypnotic therapy related to insomnia. Physician's Orders, dated 5/31/22, indicated Ambien (a hypnotic medication) tablet 10 milligrams (mg). Give 1 tablet by mouth every 24 hours prn for insomnia. The 6/2022 Medication Administration Record (MAR), indicated the Ambien was signed out as being given on 6/9, 6/12, 6/13, 6/15, and 6/18/22. Interview with the Director of Nursing on 6/23/22 at 2:00 p.m., indicated she was not aware the resident was receiving a prn hypnotic medication longer than 14 days. 3.1-48(b)(1)		*required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Medication reconciliation was completed for resident 51 to address the need for PRN hypnotic. **2) How the facility identified other residents:** All residents who receive antipsychotic medications have the potential to be affected by this deficient practice. **3) Measures put into place/ System changes:** Licensed nurses will be educated on the importance of following physicians orders and that PRN antipsychotics have a 14-day expiration date. **4) How the corrective actions will be monitored:** The Director of Nursing or designee will complete a medication review audit 5 days a week to ensure that physician orders have been followed and that all PRN medications have the appropriate stop date. **The results of these audits will**	

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			be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 07/15/2022**	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse,			

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	except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review, and interview, the facility failed to ensure medications were stored properly and with appropriate labeling for 1 of 1 medication rooms and for 1 of 2 medication carts observed. (Health Care 1 Medication Room and Health Care 2 Medication Cart) Findings include: 1. On 6/24/22 at 12:09 p.m., the overhead cabinet in the Health Care 1 Medication Room contained two unlabeled bottles of Acetaminophen 325 milligram (mg) tablets and an opened unlabeled bottle of antacid 750 mg tablets. Interview with QMA 1, indicated he was unaware to whom the bottles belonged and could not provide any further information. 2. On 6/24/22 at 12:00 p.m., 9 unidentified pills were observed in the bottom drawer of the Health Care 2 Medication Cart. Interview with LPN 1 at that time, indicated the midnight shift staff were supposed to clean out the medication cart drawers. On 6/27/22 at 2:46 p.m., the Medication Storage policy was received from the Nurse Consultant as current. The policy indicated the facility should ensure that medications and biologicals were stored in an orderly manner in cabinets, drawers, carts, refrigerators/freezer of sufficient size to prevent crowding. The facility should destroy and reorder medications and biologicals with soiled,	F 0761	**F 761** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **What corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice.** Heath Care 1 Medication room and Health Care 2 medication cart were audited. Medication was stored properly, and unlabeled medications were removed and destroyed. How will the facility identify other	07/15/2022

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	illegible, worn, makeshift, incomplete, damaged, or missing labels. Interview with the Nurse Consultant on 6/27/22 at 1:53 p.m., indicated the medications should have been properly labeled and stored in the Medication Room and Medication Cart. 3.1-25(j) 3.1-25(o)		residents who have the potential to be affected by the same alleged deficient practice? All residents residing in the facility have the potential to be affected by this alleged deficient practice. An audit of all medication carts and medication storage rooms was completed to ensure medication were properly stored and labeled. **What corrective measures will the facility take, or will the facility alter to ensure that the problem will not occur?** License staff was re-educated on the importance proper storage and labeling of medications. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** Director of Nursing or Designee will audit one medication storage room and one medication cart twice per week for 4 weeks, and weekly thereafter to ensure compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or	

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			until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **By what date the systemic changes will be completed?** **Date of Completion: 7/15/2021**	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §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)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies,			

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	and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.			

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	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on random observations, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to glove use, N95 masks not removed after leaving a transmission based precaution (TBP) isolation rooms, improper storage of bed pans and wash basins, the lack of COVID-19 monitoring for 2 of 3 residents reviewed, lancets not disposed of correctly, and the glucometer not sanitized correctly for 2 of 2 glucometers observed. (Residents E, J, F, G, H, K, D, C, L, and M) Findings include: 1. On 6/21/22 at 11:06 a.m., two pink wash basins were stacked together and observed on the shower bench in the bathroom of Room 2206. Two residents resided in this room and shared the bathroom. 2. On 6/21/22 at 11:20 a.m., a pink wash basin was on the floor of the shower and another wash basin was observed on the shower bench in the bathroom of Room 2210. Both of the wash basins were uncontained. Two residents resided in this room and share the bathroom. 3. On 6/21/22 at 10:31 a.m., a fracture bed pan was observed on top of the toilet riser in the bathroom of Room 2212. The bed pan was uncontained. Two residents resided in this room and shared the bathroom. 4. On 6/21/22 at 10:40 a.m., a pink wash basin was	F 0880	**F880 Infection Prevention Control** **The facility requests paper compliance for this citation** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents/staff identified:** 1. The wash basins were discarded from the bathroom of room 2206. 2. The wash basins were discarded from the bathroom/shower of room 2210. 3. The bed pan was discarded from the bathroom of room 2212	07/15/2022

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	observed on the back of the toilet in the bathroom of Room 2213. Two residents resided in this room and shared the bathroom. Interview with the Director of Nursing on 6/24/22 at 10:30 a.m., indicated the bed pans and/or wash basins should have been contained. The facility policy titled, "Cleaning-Sanitizing Bedside Equipment" was provided by the Nurse Consultant on 6/27/22 at 11:45 a.m. The policy was identified as current. The policy indicated bedside equipment such as bedpans, wash basins, and urinals may be stored in separate plastic bags in shared resident bathrooms if the items were appropriately labeled to indicate which resident they belonged to, otherwise, those items should be placed in plastic bags and stored in the bedside cabinet or closet. 5. On 6/21/22 at 3:00 p.m., CNA 4 was observed exiting Resident E's room. The CNA was wearing a pair of blue disposable gloves. She proceeded to walk down the hallway and continued to wear the gloves. At 3:15 p.m., the CNA exited Resident E's room again. She was carrying a trash bag and was wearing blue disposable gloves. The CNA touched her mask with her gloved right hand and proceeded to throw the bag of garbage away. After throwing the garbage away, the CNA removed her gloves and used hand sanitizer. Interview with the Director of Nursing on 6/23/22 at 2:00 p.m., indicated gloves were not to be worn in the hallway. 6. During a random observation on 6/20/22 at 10:01 a.m., CNA 1 was observed wearing gloves to both hands standing in the hallway. She was picking up dirty breakfast dishes. She donned an isolation gown with the same dirty gloves and walked into Resident J's		4. The wash basin was discarded from the bathroom of 2213. 5. CNA 4 was educated on glove use in the hallway. 6. CNA 1 was educated on PPE usage. 7. CNA 2 was educated on PPE usage. 8. Resident C and D was assessed with no negative findings. 9. QMA 1 was educated on proper disposal of lancets and glucometer cleaning. **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficiency. **3) Measures put into place/ System changes** Staff will be re-educated regarding infection control guidelines, PPE utilization Glucometer cleaning and proper storage of wash basins and bed pans.	

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	room, which had a sign on the door that indicated he was in droplet isolation and to enter you must wear an isolation gown, N95 face mask, eye protection and gloves. CNA 1 was wearing an N95 face mask and a face shield as she entered the room. She picked up the resident's dirty plate and cup and placed it in the bin on the cart. She had removed her gown and gloves inside the room, however, she did not remove/replace the N95 face mask and continued to pick up other residents' dirty breakfast dishes. During a random observation on 6/20/22 at 1:43 p.m., CNA 1 was again wearing gloves in the hallway. She walked into Resident F's room and picked up the dirty lunch dishes with the same dirty gloves. She came out of the room, removed her gloves and performed hand hygiene. The CNA donned a clean isolation gown and pulled a pair of blue disposable gloves from her pocket and donned them to both hands and walked into Resident G's room. She was already wearing an N95 face mask and a face shield. The resident was in isolation and under droplet precautions. She left the room and doffed her isolation gown inside the room, but left her gloves on and placed the dirty lunch plates in the bin. She removed her gloves and performed hand hygiene and then sanitized her face shield. She did not remove her N95 face mask and put a new one on over her nose and mouth after leaving the Transmission Based Precaution (TBP) room. She walked over to Resident H's room who was also in isolation and under TBP. She donned a clean isolation gown outside of the room and pulled another pair of blue gloves out of her shirt pocket and donned them to both hands. The CNA entered the room and picked up the dirty dishes, still wearing the same N95 face mask.		**4) How the corrective actions will be monitored:** The Director of Nursing or designee will complete daily care rounds on at least 5 staff members 5 times per week at varied times/shifts to ensure proper infection control techniques are followed and that wash basins/bed pans are stored properly. Also, an audit of residents who are in transmission-based precautions will be completed daily to ensure that the appropriate charting is completed. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 07-15-2022**	

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7. On 6/22/22 at 9:45 a.m., CNA 2 was observed wearing a N95 face mask and a face shield. She was observed walking out of Resident K's room who was in isolation and under TBP. She had removed her isolation gown and gloves inside the room. She did not remove her N95 face mask. She performed hand hygiene and walked over to the food cart to get another breakfast tray. She walked over to Resident C's room and donned an isolation gown and gloves to both hands. She was already wearing a face shield and the same N95 face mask. She entered the resident's room to feed him.

Interview with the Director of Nursing on 6/22/22 at 2:00 p.m., indicated all staff were to change their N95 face mask and don a new mask before entering another TBP room. N95 face masks were to be discarded after each use.

The current and updated 2/8/22 "COVID-19 Infection Control Guidance in Long-term Care Facilities" indicated, "The supply and availability of NIOSH-approved respirators have increased significantly over the last several months. Healthcare facilities should not be using crisis capacity strategies at this time and should promptly resume conventional practices. All individuals must fully don all appropriate PPE (gloves, gown, N95 respirator mask and eye protection) before entering the room, doff and perform hand hygiene before exiting the room.

8. The record for Resident D was reviewed on 6/21/22 at 2:40 p.m. The resident was admitted on 6/17/22 from the hospital. Diagnoses included, but were not limited to, stroke, dysphagia, left leg below the knee amputation, chronic kidney disease, and heart failure.

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The resident was unvaccinated for COVID-19.

Physician's Orders, dated 6/20/22, indicated Contact and Droplet isolation related to new admission/re-admission.

The COVID-19 Screener assessment was completed 1 time a day from 6/17-6/24/22, and on 6/27/22. There was no COVID-19 Screener assessment completed on 6/25 and 6/26/22. The assessment had documented vital signs, a lung sounds assessment, and an oxygen saturation assessment.

Nurses' Notes from 6/17-6/27/22 indicated lung sounds were not assessed at least 3 times a day while the resident was in isolation and on TBP.

9. The record for Resident C was reviewed on 6/21/22 at 3:00 p.m. The resident was admitted on 6/14/22 from the hospital. Diagnoses included, but were not limited to, type 2 diabetes, ulcerative colitis, pressure ulcer, end stage renal disease, peripheral vascular disease, heart failure, stroke, dependence on renal dialysis, and hemiplegia.

Physician's Orders, dated 6/14/22, indicated Contact and Droplet isolation related to new admission/re-admission.

A COVID-19 Screener assessment was completed with a full set of vital signs and included an assessment of the resident's lung sounds on 6/14-6/18, 6/20-6/23, 6/25 and 6/27/22. This assessment was only completed 1 time a day.

Nurses' Notes from 6/14-6/27/22 indicated lung sounds were not assessed at least 3 times a day while the resident was in isolation and on TBP.

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Interview with the Nurse Consultant on 6/27/22 at 12:00 p.m., indicated she was aware residents in TBP needed to be assessed at least every shift with a lung sounds assessment.

The current and updated 2/8/22, "Long-term Care COVID-19 Clinical Guidance" policy indicated "Screen all residents daily for fever and for COVID-19 symptoms. Ideally, include an assessment of oxygen saturation via pulse oximetry. Increase monitoring of residents with suspected or confirmed COVID-19, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least three times daily to identify and quickly manage serious infection."

10. On 6/22/22 at 11:45 a.m., QMA 1 entered Resident L's room to check his blood sugar. QMA 1 sanitized his hands and donned gloves. He wiped the resident's finger with an alcohol wipe, used the lancet to perform a finger stick, wiped the first drop of blood with a clean napkin, and collected the next drop of blood on the test strip. Once the blood sugar was collected, he threw away the lancet and his gloves into the resident's garbage can in the room, sanitized his hands and exited the room. At the medication cart, he sanitized the glucometer with a Super Sani-Cloth Germicidal Disposable wipe for 10 seconds and let it air dry.

Instructions for use on the Super Sani-Cloth wipe label indicated to disinfect nonfood contact surfaces only, unfold a clean wipe and thoroughly wet surface. Allow treated surface to remain wet for a full two minutes and let air dry.

11. On 6/22/22 at 12:00 p.m., QMA 1 entered Resident M's room to check her blood sugar. After the procedure was completed, QMA 1 threw

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	away the lancet into the resident's garbage can. Interview with QMA 1 on 6/22/22 at 1:39 p.m., indicated he should have placed the used lancets into the sharps container. He reviewed the Super Sani-Cloth wipe label and indicated it takes two full minutes to sanitize the glucometers. Interview with the Director of Nursing on 6/22/22 at 2:21 p.m., indicated QMA 1 should have placed the lancets in the sharps container and wiped the glucometer with the Super Sani-Cloth for two minutes per the instructions for use on the container. This Federal tag relates to Complaint IN00375538. 3.1-18(b)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaint IN00375538. Complaint IN00375538 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677 and F880. Survey dates: June 20, 21, 22, 23, 24, and 27, 2022. Facility number: 010739 Residential Census: 45 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	This plan of correction shall serve as this facilities' credible allegation of compliance Preparation, submission, and implementation of the plan of corrections does not constitute an admission of or agreement with the facts and conclusions set forth in this survey report Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements The facility respectfully request paper compliance Thank you for your consideration,	

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	Quality review completed on 7/1/22.		Respectfully, Kevin Mehay Executive Director Spring Mill Health Campus 317-525-3537	
R 0026 Bldg. 00	410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands.			
	Based on record review and interview, the facility failed to ensure each resident received a copy of their Resident Rights upon admission for 3 of 7 sampled residents. (Residents 2, 6, and 5) Findings include:	R 0026	**R026** **The facility requests paper compliance for this citation.** *This Plan of Correction is the*	07/15/2022

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	1. The record for Resident 2 was reviewed on 6/24/22 at 2:36 p.m. Diagnoses included, but were not limited to, type 2 diabetes, depressive disorder, and bipolar. The resident was admitted to the facility 9/21/21. There was no documentation indicating the resident had received a copy of her Resident Rights upon admission. Interview with the Nurse Consultant on 6/27/22 at 4:09 p.m., indicated there was no documentation of the resident or resident representative receiving a copy of the Residents' Rights. 2. The record for Resident 6 was reviewed on 6/27/22 at 10:45 a.m. He was admitted to the facility on 6/7/22. No diagnoses were listed. There was no documentation indicating the resident had received a copy of his Resident Rights upon admission. Interview with the Nurse Consultant on 6/27/22 at 4:09 p.m., indicated there was no documentation of the resident or resident representative receiving a copy of the Residents' Rights. 3. Resident 5's record was reviewed on 6/27/22 at 10:06 a.m. The resident was admitted to the facility on 5/21/21. Diagnoses included, but were not limited to, anxiety disorder, dementia, and major depressive disorder. The record lacked documentation of the resident or resident representative receiving a copy of the Residents' Rights. Interview with the Nurse Consultant on 6/27/22 at 4:09 p.m., indicated there was no documentation		*center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Residents 2, 5 and 6 were given a copy of their resident rights. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** A copy of resident's rights was given to all residents residing on the Assisted Living. **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?**	

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	155764	A. BUILDING 00 B. WING	06/27/2022

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	of the resident or resident representative receiving a copy of the Residents' Rights.		Staff have been re-educated on the importance of resident's rights given to all residents residing on the Assisted Living **How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Director of Admissions / Designee will be responsible for giving a copy of resident's rights to all new admissions/responsible parties. This will be audited for all new admissions and yearly thereafter. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **By what date the systemic changes will be completed? Date of Completion: 7/15/2022**	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all			

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	residents. Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to marred walls, peeling paint, dirty shower curtains, call lights lacking pull cords, and urine odors on 2 of 2 units. (The Legacy Unit and Assisted Living) Findings include: 1. During the Environmental Tour with the Maintenance Supervisor on 6/27/22 at 3:39 p.m., the following was observed: The Legacy Unit a. The wall next to bed B in Room 120 was scratched and marred. There was an area of peeling paint underneath the bathroom sink and the caulk around the bathroom sink was cracked. The sink was pulling away from the wall. Two residents resided in this room and shared the bathroom. b. There were areas of cracked and chipped paint around the air conditioning unit in Room 125 next to bed B. One resident resided in this room. The Assisted Living Unit a. A strong urine odor was noted in Room 206. One resident resided in this room. b. The emergency call light in the bathroom of Room 209 was lacking a pull cord. The outside of the shower curtain had light brown stains in areas. One resident resided in this room. Interview with the Maintenance Supervisor at the time, indicated the above areas were in need of	R 0144	**R144** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Room 120 bed B repairs made to the walls and sink. Room 125 repairs made to the walls. Room 206 was deep cleaned and carpets treated. Room 209 call light was added and the shower curtain was cleaned. **How will the facility identify other residents having the potential to be affected by the**	07/15/2022

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	cleaning and/or repair.		**same deficient practice?** All of the residents residing on the Assisted Living have the potential to be affected by the alleged practice. An audit was completed of all resident rooms with no findings. **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** Maintenance and Housekeeping Staff have been re-educated on the importance to ensure the residents' environment is clean and in good repair. **How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Director of Environmental Services / Designee will inspect five residents' rooms once a day at various times, 5 times weekly for 4 weeks, and 2x weekly thereafter to ensure compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved	

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			x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **By what date the systemic changes will be completed? Date of Completion: 7/15/2022**	
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment.			
	Based on observation, record review, and interview, the facility failed to ensure 1 of 5 residents observed during medication administration received the correct dose of a medication. (Resident 4) Finding includes: On 6/27/22 at 8:45 a.m., QMA 2 was observed administering the following medications to Resident 4: - Acetaminophen 325 milligram (mg) 2 tablets as needed for pain every 4 hours - Calcitriol (a treatment for low calcium) 0.25 microgram (mcg) 1 capsule by mouth daily - Feosol (an iron supplement) 325 mg 1 tablet by mouth daily - Protonix (a treatment for acid reflux) 40 mg 1 tablet by mouth daily	R 0243	**R243 Health Services** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of*	07/15/2022

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	- Lantus (insulin) 100 unit/milliliter 5 unit subcutaneous injection twice daily Physician's Orders, dated 6/20/22 at 9:30 p.m., indicated Acetaminophen 325 mg, two tablets by mouth every four hours as needed for pain. Physician's Orders, dated 6/22/22 at 5:20 p.m., indicated Acetaminophen 500 mg tablet three times daily for pain. Interview with QMA 2 on 6/27/22 at 11:00 a.m., indicated the resident had two different orders for Acetaminophen and two different packages of Acetaminophen were in the cart. She indicated she pulled the wrong package of Acetaminophen and gave the incorrect dose to the resident. QMA 2 immediately marked the package with a highlighter to draw attention to the different instructions for use. Interview with the Assisted Living Director on 6/27/22 at 12:05 p.m., indicated she spoke with the Nurse Practitioner and was told that it was okay to give the Acetaminophen 325 mg tablet at that time.		*federal and state law.* **1) Immediate actions taken for those residents identified:** NP was called who indicated it was ok to give the Acetaminophen 325mg tablet at that time. **2) How the facility identified other residents:** All residents on Assisted Living who receive medications have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** QMA 1 was educated on administering the correct dose of a medication per the order. Nursing staff will be re-educated on administering the correct dose of a medication per the order. **4) How the corrective actions will be monitored:** Director of Nursing or designee will complete 2 medication observations per week for 4 weeks then 1 time a week for 4 weeks to ensure that the licensed staff is administering the correct dose of a medication per the order **The results of these audits will**	

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			be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 07-15-2022**	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter.			
	Based on record review and interview, the facility failed to ensure an annual health statement was obtained for 3 of 7 records reviewed. (Residents 2, 6, and 5) Findings include: 1. The record for Resident 2 was reviewed on 6/24/22 at 2:36 p.m. Diagnoses included, but were not limited to, type 2 diabetes, depressive disorder, and bipolar. The resident was admitted to the facility on 9/21/21. The record lacked documentation of the Annual Health Statement indicating the resident was free of communicable disease.	R 0409	**R409** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of*	07/15/2022

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	Interview with the Nurse Consultant on 6/27/22 at 4:09 p.m., indicated there was no documentation regarding the Annual Health Statement in the chart. 2. The record for Resident 6 was reviewed on 6/27/22 at 10:45 a.m. He was admitted to the facility on 6/7/22. No diagnoses were listed. The record lacked documentation of the Annual Health Statement indicating the resident was free of communicable disease. Interview with the Nurse Consultant on 6/27/22 at 4:09 p.m., indicated there was no documentation regarding the Annual Health Statement in the chart. 3. Resident 5's record was reviewed on 6/27/22 at 10:06 a.m. The resident was admitted to the facility on 5/21/21. Diagnoses included, but were not limited to, anxiety disorder, dementia, and major depressive disorder. The record lacked documentation of the Annual Health Statement indicating the resident was free of communicable disease. Interview with the Nurse Consultant on 6/27/22 at 4:09 p.m., indicated there was no documentation regarding the Annual Health Statement in the chart.		*correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** A health assessment was completed for Residents 2, 5 and 6 was completed indicating the residents are free of communicable diseases. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** All residents admitting on the Assisted Living have the potential to be affected by this alleged deficient practice. **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** DON, ADON have been re-educated on the importance of completing this assessment prior to admission and annually thereafter to all residents residing on the Assisted Living	

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			How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Director of Nursing / Designee will be responsible for completing the health assessments for all residents residing on Assisted Living. This will be audited for all new admissions and yearly thereafter. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **By what date the systemic changes will be completed? Date of Completion: 7/15/2022**	