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	04/19/2021

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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and the Investigation of Complaints IN00349272 and IN00351157. This visit included a State Residential Licensure Survey. Complaint IN00349272 - Substantiated. Federal/State deficiencies related to the allegations are cited at F686 and F692. Complaint IN00351157 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580, F684, F686 and F689. Survey dates: April 12, 13, 14, 15, 16, and 19, 2021. Facility number: 155764 Provider number: 010739 AIM number: 200856890 Census Bed Type: SNF/NF: 8 SNF: 37 Residential: 43 Total: 88 Census Payor Type: Medicare: 32 Medicaid: 6 Other: 7 Total: 45 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/21/21.	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	

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

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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 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			

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	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 each resident's dignity was maintained related to wearing hospital gowns in bed during the day for 2 of 3 residents reviewed for dignity. (Residents G and 38) Findings include: 1. On 4/12/21 at 9:45 a.m. and 3:20 p.m., Resident G was observed in her room in bed. The resident was wearing a hospital gown. On 4/13/21 at 9:40 a.m., 12:58 p.m., and 2:23 p.m., the resident was observed in her room in bed. The resident was wearing a hospital gown. On 4/14/21 at 9:19 a.m., 11:33 a.m., 2:15 p.m., and 3:20 p.m., the resident was observed in her room in bed. The resident was wearing a hospital gown. The record for Resident G was reviewed on 4/13/21 at 1:03 p.m. Diagnoses included, but were not limited to, Parkinson's disease, quadriplegia, and stroke. The Admission Minimum Data Set (MDS) assessment, dated 2/23/21, indicated the resident had short and long term memory problems, was severely impaired for daily decision making, and needed limited assistance with dressing. It was also very important to the resident to choose what clothes to wear. The Care Plan was reviewed. There was no Care Plan related to the resident wearing a gown in bed during the day.	F 0550	**F550** **Dignity** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident G is no longer at facility. No corrective actions can be made. Resident 38 was interviewed regarding her preferences. Preferences have been added to the plan of care. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** All residents have the potential to be affected by 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?** Residents were interviewed regarding preferences including. Interviews included choice of	05/03/2021

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	Interview with the Director of Nursing on 4/16/20 at 10:00 a.m., indicated the resident did not have a Care Plan related to gown use during the day and one was initiated on 4/14/21. 2. On 4/12/21 at 10:36 a.m. and 2:20 p.m. and on 4/13/21 at 10:30 a.m. and 1:14 p.m., Resident 38 was observed in bed dressed in a hospital gown. The record for Resident 38 was reviewed on 4/13/21 at 1:20 p.m. Diagnoses included, but were not limited to, diabetes, stroke, malnutrition, and pressure ulcers. The Admission Minimum Data Set (MDS) assessment, dated 3/29/21, indicated the resident was severely cognitively impaired and required extensive 1 person physical assistance with dressing and personal hygiene. There was no documentation to indicate the resident and/or her representative preferred for her to remain in bed during the day and in a hospital gown. Interview with the Director of Nursing on 4/14/21 at 11:50 a.m., indicated there was no documentation to indicate the resident and/or her representative preferred her to remain in bed in a hospital gown. 3.1-3(t)		clothing. These preferences have been updated in the resident's care plan. Nursing staff in serviced on ensuring resident preferences are adhered to. 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? DON/designee to randomly observe 5 cognitively impaired residents weekly to ensure that their preferences are adhered to and the plan of care is being followed. DON/designee will present a summary of the audits to the Quality Assurance Committee monthly for 6 months. Thereafter, if determined necessary by the QA Committee, auditing and monitoring will be done quarterly and presented quarterly at QA meeting. Monitoring will be ongoing. **Date of Completion: 5/3/2021**	

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F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.			

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	(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to promptly notify the Physician and/or family member of a significant change in condition related to a diet change and a weight loss for 1 of 2 residents reviewed for notification of change and 1 of 5 residents reviewed for nutrition. (Residents B and F). Findings include: 1. The closed record for Resident B was reviewed on 4/14/21 at 9:07 a.m. The resident was admitted to the facility on 10/2/2020 and discharged to the hospital on 11/9/20. The resident did not return to the facility. Diagnoses included but were not limited to, stage 5 chronic kidney disease or end stage renal disease, arrhythmia, repeated falls, anemia, syncope, dysphagia, chronic obstructive pulmonary disease, dependence on renal dialysis, and cognitive communication deficit. The Admission Minimum Data Set (MDS) assessment, dated 10/8/20, indicated the resident was not cognitively intact. The resident needed limited assist with 1 person physical assist with	F 0580	**F 580** **Notify of Changes** **What corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice;** Resident B is no longer at the facility. No corrective actions can be made. Resident F POA and MD notified of fluctuations in weight. . **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents who have changes in condition have the potential to be affected by the same deficient practice.	05/03/2021

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	transfers, dressing, toileting and eating. The resident had 1 fall with no injury since the last assessment. The resident had no pressure sores and received dialysis while a resident. Nurses' Notes, dated 11/5/20 at 12:59 p.m., indicated new orders for mechanical soft diet with nectar thick liquids, no straw, 1:1 feed, and aspiration precautions. There was no documentation family or a responsible party was notified of the diet change. Nurses' Notes, dated 11/6/20 at 12:51 p.m., indicated the resident returned from dialysis at 10:30 a.m. and was very lethargic yet easily aroused. He was a 2 assist to put to bed at that time. Nurses' Notes, dated 11/6/20 at 7:43 p.m., indicated the resident was alert to care, lethargic but easily aroused. Nurses' Notes, dated 11/7/20 at 1:17 p.m., indicated the resident was alert and oriented to care. The resident remained in bed this shift, and staff assisted resident with meals. There were no Nurses' Notes for 11/8/20. Nurses' Notes, dated 11/9/20 at 5:35 a.m., indicated the resident left the facility for dialysis transported by his daughter in her personal vehicle. The resident was alert times 1 and lethargic. His blood pressure was running low. The resident responded to verbal and tactile stimuli and was very tired. The resident needed assist times 2 to get in the front seat of the vehicle.		**What corrective measures will the facility take or will the facility alter to ensure that the problem will not occur?** Licensed nurses were in serviced on: ·The policy titled "Notification of Resident Change in Condition". ·Documentation of notifications of any changes in condition. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** The DON/designee will review 5 resident charts, including review of events and progress notes weekly for 6 months to ensure that the physician and or family member are notified of any changes in condition. The DON will review the significant weight change report each month to ensure the family and physician are notified of any significant change in weight. The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done	

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	Nurses' Notes, dated 11/9/20 at 9:44 a.m., indicated "received a call from resident's daughter at 6:35 a.m., stating that she is taking resident to the hospital ER for eval [evaluation] and treatment per dialysis center due to resident 'not appearing like his usual self'." Nurses' Notes, dated 11/9/20 at 11:09 a.m., indicated the hospital was called to inquire the status of the resident. The resident was admitted with the diagnosis of respiratory distress. Interview with the resident's daughter on 4/16/21 at 2:15 p.m., indicated she was not informed of the resident's new diet and that it had been changed to a mechanical soft with thickened liquids. When she arrived to pick him up on Monday 11/9/20, the resident had oxygen on and was very lethargic. She had asked the staff why he had oxygen on, and they did not know why. She was not informed of the oxygen. The daughter stated, "You would have thought they would have called an ambulance and sent him out to the hospital if he was that sick." Interview with the Director of Nursing on 4/16/21 at 1:30 p.m., indicated there was no documentation the Physician was called or notified for the increased lethargy for the resident and the condition he was in prior to going out to dialysis on 11/9/20. The resident's family was not notified of the change in diet.2. On 4/12/21 at 10:01 a.m., Resident F was observed in bed, her tube feeding was infusing at 45 milliliters (ml)/hour (hr). The record for Resident F was reviewed on 4/13/21 at 1:30 p.m. Diagnoses included, but were not limited to, respiratory failure, heart disease, heart arrhythmia, hypertension, and contracted right elbow and hand.		quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date of Completion: 5/3/2021**	

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	The Quarterly Minimum Data Set (MDS) assessment, dated 3/26/21, indicated the resident was rarely/never understood, had an unprescribed weight gain, and required an extensive 2 person physical assist with transfers. Physician's orders, dated 3/31/21, indicated enteral feeding by pump via g-tube (feeding tube directly into the stomach): Jevity 1.5 at 45 ml/hr for 18 hours. On at 3:00 a.m., off at 9:00 p.m. The resident's weights were as follows: 4/9 - 120 pounds 4/1 - 143.2 pounds 3/18 - 137.8 pounds 3/11 - 141.8 pounds 3/9 - 141.8 pounds 2/24 - 120 pounds 2/17 - 120.2 pounds 1/27 - 120 pounds A Care Plan, dated 4/9/21, indicated the resident experienced an unplanned weight loss related to deteriorating mental or physical status. The interventions included, but were not limited to, notify Physician and family, observe for intolerance to tube feeding, and refer to Registered Dietician (RD) for nutritional needs as needed. There was no documentation the Physician, RD, and/or the family were notified of the resident's fluctuations in weight. The Nurse Practitioner saw the resident on 4/13/20, however, the fluctuations in weight were not addressed. The resident was not seen by the RD until 4/15/21.			

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	Interview with the Director of Nursing on 4/15/21 at 1:50 p.m., indicated the resident had been weighed via the hoyer lift which may be the cause for the weight variants and there should have been Physician, RD, and family notification related to the weight fluctuations. This Federal tag relates to Complaint IN00351157. 3.1-5(a)(2) 3.1-5(a)(3)			
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to antipsychotic medication use for 2 of 16 MDS assessments reviewed. (Residents E and 33) Findings include: 1. The record for Resident E was reviewed on 4/14/21 at 10:19 a.m. Diagnoses included, but were not limited to, delusional disorders and unspecified dementia with behavioral disturbance. The Admission Minimum Data Set (MDS) assessment, dated 3/10/21, indicated the resident had short and long term memory issues and was moderately impaired for daily decision making. Section N - Medications, indicated the resident had not received an antidepressant within the last 7 days.	F 0641	F 641 Accuracy of Assessments **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** R 33 MDS was modified. R E MDS was modified. **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.	05/03/2021

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	A Physician's Order, dated 3/4/21, indicated the resident was to receive Lexapro (an antidepressant) 10 milligrams (mg) daily. The March 2021 Medication Administration Record (MAR), indicated the resident received the Lexapro daily 3/5 through 3/16/21. Interview with the Director of Nursing on 4/16/21 at 10:00 a.m., indicated the MDS was coded inaccurately related to the Lexapro. 2. The record for Resident 33 was reviewed on 4/13/21 at 2:04 p.m. Diagnoses included, but were not limited to bipolar disorder, depression, chromic obstructive pulmonary disease, and shortness of breath. The Admission Minimum Data (MDS) assessment, dated 3/26/2021, indicated the resident was cognitively intact and had minimal depression. There was no documentation related to the resident receiving antidepressant medication within the past 7 days. A Physician's Order, dated 3/21/21, indicated Venlafaxine 75 mg (milligrams) 1 tablet daily related to depression. Interview with the MDS Coordinator on 4/14/21 at 2:45 p.m., indicated the antidepressant medication use should have been included on the Admission MDS assessment. 3.1-31(i)		MDS staff completed an audit of MDS's submitted in the past 30 days to ensure accuracy of coding. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** MDS staff educated on accuracy of coding the MDS as it pertains to each resident. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** MDS staff/designee will audit 5 MDS's weekly x 3 months to ensure accuracy of the MDS for all areas. Any non-compliance will be corrected. A summary of the audits will be presented to the Quality Assurance Committee monthly x 3 months or until compliance is met. **By what date the systemic changes will be completed:** 5-3-2021	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans			

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	§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with			

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	the requirements set forth in paragraph (c) of this section. Based on record review and interview, the facility failed to initiate Care Plans related to a fall risk and antipsychotic medication use for 2 of 16 residents whose Care Plans were reviewed. (Residents G and E) Findings include: 1. The record for Resident G was reviewed on 4/13/21 at 1:03 p.m. Diagnoses included, but were not limited to, Parkinson's disease, quadriplegia, and stroke. The Admission Minimum Data Set (MDS) assessment, dated 2/23/21, indicated the resident had short and long term memory problems, was severely impaired for daily decision making, and needed extensive assistance with 2 plus person physical assist with bed mobility. The Fall Risk assessment, dated 2/17/21, indicated the resident scored a "13" which was a high risk for falls. The current Care Plan was reviewed. The resident had no Care Plan related to being a fall risk. Interview with the Director of Nursing on 4/16/21 at 10:00 a.m., indicated the resident should have had a Care Plan related to being a fall risk. 2. The record for Resident E was reviewed on 4/14/21 at 10:19 a.m. Diagnoses included, but were not limited to, delusional disorders and unspecified dementia with behavioral disturbance. The Admission Minimum Data Set (MDS) assessment, dated 3/10/21, indicated the resident	F 0656	F 656 Care Plan **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident G is no longer at facility. No corrective actions can be made. Resident E is no longer at facility. No corrective actions can be made. **How will facility identify other residents who have the potential to be affected by the same alleged deficient practice?** All residents with orders for Anti-psychotic medications or at risk for falls have the potential to be affected by the same deficient practice. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** MDS staff/ and licensed staff were educated on ensuring that a care	05/03/2021

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	had short and long term memory issues and was moderately impaired for daily decision making. A Physician's Order, dated 3/4/21, indicated the resident was to receive Lexapro (an antidepressant) 10 milligrams (mg) daily. The March 2021 Medication Administration Record (MAR), indicated the resident received the Lexapro daily 3/5 through 3/16/21. The April 2021 MAR, indicated the resident received the Lexapro daily 4/2 through 4/14/21. The current Care Plan was reviewed. There was no Care Plan related to the antidepressant medication. Interview with the Director of Nursing on 4/16/21 at 10:00 a.m., indicated the resident should have had a Care Plan related to the use of Lexapro. 3.1-35(a)		plans are in place for residents with orders for anti-psychotic and at risk for falls. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** DON/ designee will audit 5 residents who have order for antipsychotic medication weekly x 3 months to ensure care plans are in place. DON/ designee will audit residents 5 residents that are at risk for falls weekly x 3 months to ensure care plan are in place. The DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 3 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will done quarterly and present quarterly at the QA meeting. Monitoring will be ongoing. **By what date the systemic changes will be completed:05/03/2021**	
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			

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	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 brushing teeth and hair grooming for 1 of 2 residents reviewed for ADL's. (Resident 3) Finding includes: Interview with Resident 3 on 4/13/21 at 9:27 a.m., indicated the staff may or may not wash her face before getting her dressed for therapy. They do not assist her with brushing her teeth or grooming her hair. At the time, her hair was observed to be disheveled and matted. During an ADL care observation on 4/14/21 at 9:54 a.m. with CNA 1, the resident was not assisted with brushing her teeth and/or grooming her hair. Interview with the CNA at the time, she indicated she assisted the resident with her additional ADL needs if she was asked. She then asked the resident if she'd like to be assisted with brushing her teeth. The resident replied, "Yes". The record for Resident 3 was reviewed on 4/14/21 at 11:36 a.m. Diagnoses included, but were not limited to, lupus, hypertension, lack of coordination, and chronic inflammatory demyelinating polyneuritis. The Quarterly Minimum Data Set (MDS) assessment, dated 1/8/21, indicated the resident was alert and oriented, required extensive 1	F 0677	**F 677** **ADL Care Provided for Dependent Residents** **What corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice;** Resident 3 received oral and hair care. How will the facility identify other residents who have the potential to be affected by the same alleged deficient practice? All facility residents who are dependent on staff for ADL care have the potential to be affected by the same deficient practice. **What corrective measures will the facility take or will the facility alter to ensure that the problem will not occur?** Nursing staff were in serviced on: ·Assisting dependent residents with ADL care including oral and hair care.	05/03/2021

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	person physical assistance with bed mobility and personal hygiene, she was total dependant with bathing. During a follow-up observation and interview with the resident and the Director of Nursing on 4/14/21 at 2:23 p.m., the resident's hair remained disheveled and matted, she indicated her hair had not been washed or groomed in two months. Therapy had not advanced her ability to groom her own hair. The DON then indicated she would have the resident's hair washed and groomed immediately. 3.1-38(a)(3)		**What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** The DON/designee will observe 5 dependent residents requiring assistance weekly for 6 months to ensure that oral and hair care were completed. The DON/designee will present a summary of the audits to the QA committee monthly for 6 months. Thereafter, if determined by the QA committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing. **Date of Completion: 5/3/2021**	
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review, and	F 0679	F 679 Activities	05/03/2021

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	interview, the facility failed to ensure an ongoing activity program was implemented related to 1:1 visits as well as activity for cognitively impaired and dependent residents for 2 of 2 residents reviewed for activities. (Residents G and 13) Findings include: 1. On 4/12/21 at 9:45 a.m., Resident G was observed in her room in bed. The resident's eyes were closed and her television was turned on. On 4/13/21 at 9:45 a.m., 12:58 p.m. and 2:23 p.m., the resident was in her room in bed with her eyes closed. The television was turned on. On 4/14/21 at 9:19 a.m., 11:33 a.m., 2:15 p.m., and 3:20 p.m., the resident was in her room in bed with her eyes closed. The television was turned on. On 4/15/21 at 9:25 a.m., the resident was in her room in bed with her eyes closed. The television was turned on. The record for Resident G was reviewed on 4/13/21 at 1:03 p.m. Diagnoses included, but were not limited to, Parkinson's disease, quadriplegia, and stroke. The Admission Minimum Data Set (MDS) assessment, dated 2/23/21, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. Listening to music and participating in religious activities were very important to the resident. The Care Plan, dated 1/26/21, indicated the resident scored low on the 1:1 assessment and required 1:1 visits three times a week to engage in meaningful activity. Interventions included, but		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** R G no longer resides in the facility. No corrective actions could be made. R 13 Activity preferences reviewed with resident and plan of care updated. **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. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** Activity staff educated completion of 1:1 visits and activities for cognitively impaired and dependent residents based on the plan of care.	

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	were not limited to, staff will praise the resident for participation in 1:1 visits, will continue to invite and encourage resident to attend daily structured programming while providing weekly 1:1 visits. The One to One Programming log, dated April 2021, indicated the resident was to receive 1:1 visits three times a week and the resident's interests were music, pets, cooking, movies and television. The programming log indicated the resident received small talk and a family visit on 4/7, small talk and daily bread on 4/12, and small talk and a hand rub on 4/14/21. Interview with the Activity Director on 4/16/21 at 2:30 p.m., indicated the resident should have received 1:1 visits three times a week as recommended. 2. On 4/12/21 at 10:15 a.m., Resident 13 was observed sitting up in a broda chair in her room. She was seated next to her bed and in front of the television set. There was no television turned on or any music playing. Her roommate's television was turned on, however, the set was observed on the side wall. On 4/13/21 at 8:50 a.m., and 9:45 a.m., the resident was observed sitting in a broda chair. There was no television turned on, nor was there any music playing. On 4/13/21 at 12:52 p.m., the resident was observed sitting in a broda chair. The privacy curtain was pulled between her and the roommate. The roommate's television was turned on, however, Resident 13's television was off. On 4/13/21 at 3:00 p.m., the resident was observed in bed. There was no television or radio on in her		**What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** Administrator/designee will review 5 1:1 activity visits weekly 6 months to ensure compliance. A summary of the audits will be presented to the Quality Assurance committee monthly for 6 months or until compliance is met. **By what date the systemic changes will be completed: May 3, 2021.**	

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	room. On 4/15/21 at 8:05 a.m. and 9:23 a.m., the resident was observed sitting in a broda chair. At those times, there was no television or music turned on. The record for Resident 13 was reviewed on 4/12/21 at 12:56 p.m. The resident was admitted to the facility on 2/2/21. Diagnoses included, but were not limited to, dementia with behavioral disturbances, cognitive communication deficit, weakness, percutaneous endoscopic gastrostomy (peg) tube, seizures, stroke, adult failure to thrive, and dehydration. The Admission Minimum Data Set (MDS) assessment, dated 2/21/21, indicated the resident had short and long term memory problems and was severely impaired for decision making. The resident needed extensive assist with 2 person assist for bed mobility. The resident received enteral feedings and a mechanically altered diet. The Care Plan, dated 3/2/21, indicated the resident has been admitted for skilled care rehabilitation and had dementia with moderate impairment. The resident required invitation, cues, supervision and transportation with all activity programming. The approaches were for the resident to participate in structured daily activities. Staff will provide invitations, transportation and supervision for the resident to attend structured activities of interest such as tv/movies, basketball, reading, pets, cooking, and music. An initial recreational assessment, dated 2/26/21, indicated the resident's most common use of time was television and church. The resident's preferences and interests were watching television, music, reading and writing. Current			

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	interests included, radio, animals, cooking, television and movies. The individual interventions and 1 to 1 programming log for the month of 4/2021 indicated the resident's interests were Chicago Bulls, wrestling, music, tv/movies, pets, cooking, and being read to (spiritual). The resident had 1 to 1 visits on the following days: 4/2 daily bread 4/5 daily bread 4/7 played music 4/9 daily bread 4/12 read daily bible 4/14 read to her There were no other 1 to 1 activity logs for the months of 2/2021 and 3/2021. Interview on 4/12/21 at 2:50 p.m. with the resident's son, indicated he was not sure if they were providing activities for his mom. Interview with the Activity Director on 4/15/21 at 1:15 p.m., indicated group activities were suspended due to the recent outbreak, however they were doing 1 to 1 visits for the residents. She was aware ongoing activities should be continued for those residents who were cognitively impaired and dependent on staff. 3.1-33(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the			

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	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 record review and interview, the facility failed to complete ongoing assessments and ensure prompt treatment was obtained related to a laceration to the eye after a fall for 1 of 3 residents reviewed for falls. (Resident B) Finding includes: The closed record for Resident B was reviewed on 4/14/21 at 9:07 a.m. The resident was admitted to the facility on 10/2/2020 and discharged to the hospital on 11/9/20. The resident did not return to the facility. Diagnoses included but were not limited to, stage 5 chronic kidney disease or end stage renal disease, arrhythmia, repeated falls, anemia, syncope, dysphagia, chronic obstructive pulmonary disease, dependence on renal dialysis, and cognitive communication deficit. The Admission Minimum Data Set (MDS) assessment, dated 10/8/20, indicated the resident was not cognitively intact. The resident needed limited assist with 1 person physical assist with transfers, dressing, toileting and eating. The resident had 1 fall with no injury since the last assessment. The resident had no pressure sores and received dialysis while resident A Care Plan, dated 10/3/20, indicated the resident was at risk for falling related to muscle weakness, COPD, high blood pressure and a history of falls. The goal was for the resident to remain free from injury throughout the next review.	F 0684	F 684 Quality of Care **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** R B is no longer at the facility. No corrective actions can be made. **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. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** Licensed nursing staff were educated on ensuring completion of ongoing assessments/monitoring post	05/03/2021

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	A fall risk assessment, dated 10/2/20, indicated the a score of 14, which was a high risk for falls. Nurses' Notes, dated 10/5/20 at 3:06 p.m., indicated the resident was seen lying on his right side on the floor in his room in front of the wheelchair. A physical assessment was done, and the resident was noted with a small laceration to the right eyebrow with raised area. There was a small scant amount of drainage of blood. First aid was given. The resident did not know what had happened. The Physician and family were notified. A Fall Event, dated 10/5/20, indicated the resident had an unwitnessed fall while sitting in a wheelchair. The resident was observed lying on the right side and obtained a laceration to the right side of the eyebrow. The resident was confused at the time of fall and had unclear words. Redness with a raised area with a laceration 0.5 centimeters (cm) by 0.5 cm with swelling was noted. First aid was administered. There were no neurological checks available for review or completed after the fall and laceration to the eyebrow. There was no further assessment or monitoring of the laceration to the eyebrow in Nurses' Notes dated 10/6/20 to 11/9/20. Interview with the Director of Nursing on 4/16/21 at 1:30 p.m., indicated there was no follow up assessment or documentation of the laceration to the eyebrow and there were no neuro checks completed after the fall. This Federal tag relates to Complaint IN00351157. 3.1-37(a)		injury including: ·Completion of neuro-checks with any head injury ·Monitoring of an injury for resolution or worsening condition. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** DON/ designee will review 5 resident's post injury to ensure follow-up care is provided and documented in the clinical record including the monitoring/assessing of any injury and the completion of neurological checks for 6 months. DON/designee will present a summary of the audits to the QA committee monthly for 6 months. Thereafter, if determined by the QA committee, auditing and monitoring will be done quarterly and presented quarterly at the Q.A. meeting. Monitoring will be ongoing. **By what date the systemic changes will be completed: 5/3/2021**	

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F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			
	Based on record review and interview, the facility failed to ensure a resident who was admitted with an open area received the necessary treatment and services to promote healing related to the lack of treatment, assessment and monitoring which resulted in an unstageable pressure ulcer 4 days later. (Resident C) The facility also failed to assess and obtain treatments for pressure ulcers in a timely manner for 3 of 5 residents reviewed for pressure ulcers. (Residents C, B and D) Findings include: 1. The closed record for Resident C was reviewed on 4/14/21 at 2:21 p.m. The resident was admitted to the facility on 1/28/21 and discharged to the hospital on 2/10/21. The resident did not return to the facility. Diagnoses included, but were not limited to, chronic kidney disease, adult failure to thrive, chronic obstructive pulmonary disease, weakness, dysphagia, vascular dementia without behavioral disturbance, and anemia.	F 0686	**F686 Treatment/services to prevent/heal pressure ulcers** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident B – resident no longer resides in the facility. No correction action can be made. Resident C- resident no longer resides in the facility. No correction action can be made. Resident D – resident no longer resides in the facility. No correction action can be made. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**	05/03/2021

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	The Admission Minimum Data Set (MDS) assessment, dated 2/3/21, indicated the resident was not cognitively intact and was severely impaired for decision making. The resident was an extensive assist with one-person physical assist for bed mobility and limited assist with 1-person physical assist for dressing, eating and toileting. The resident weighed 137 pounds and had no history of weight loss. The resident received a mechanically altered diet and had 1 unstageable pressure ulcer (Full thickness tissue loss in which the base of the ulcer was covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) noted upon admission. A Care Plan, dated 2/8/21, indicated the resident had alteration in skin integrity as evidenced by pressure ulcers. In the History and Physical from the hospital, dated 1/28/21, a note by the Registered Dietitian (RD), indicated the resident had a pressure ulcer to the right hip. A Full Clinical Body Observation completed at the time of admission to the facility, dated 1/29/21 at 12:58 a.m., indicated "area to right hip isn't open, instead is pink and mostly healed, coccyx area wound 7 cm (centimeters) in diameter." Nurses' Notes, dated 1/29/21 at 1:00 a.m., indicated the resident arrived at the facility around 5:00 p.m., accompanied by EMT (Emergency Medical Technician). The resident was alert with confusion. "Area to right hip appears pink in color, and appeared to be mostly healed, attempted to assess area better multiple times and resident began covering area with arm with		All residents with pressure ulcers have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** An audit was completed of new admission and readmission for the last seven days to ensure residents with open areas are assessed, monitored, have orders for treatments. Nurses have been inserviced on the following: ·Assessing and monitoring pressure ulcers. ·Obtain treatment orders and initiating the treatments timely. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will randomly audit weekly 5 residents with pressure ulcers x 6 months to ensure assessing and monitoring are completed and treatment orders are obtained and initiated timely. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing	

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	155764	A. BUILDING 00 B. WING	04/19/2021

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	resistance." There was no other documentation, or an assessment of the coccyx wound. There were no Physician's Orders obtained for the treatment of the coccyx or right hip wounds. Nurses' Notes, dated 2/2/21 at 12:36 p.m., indicated "Physical Therapy and CNA notified this writer of open area to coccyx and right hip area. Event opened, wound referral filled out. Order for wound doctor and wound nurse to eval and treat." A Wound Assessment form, dated 2/2/21, indicated "7.5 cm by 7.0 cm by .2 cm depth wound to coccyx, not previous documented. Dressing from hospital on dated 1/28/21." Wound Measurements, dated 2/2/21, indicated the coccyx was a new unstageable pressure ulcer with 100% necrotic eschar tissue covering the wound. The surrounding skin was with a 4 cm wound edge of dark purple or rusty discoloration. Physician's Orders, dated 2/2/21, indicated clean coccyx with normal saline and apply dry dressing daily. Clean areas (2) to right rip with normal saline and apply hydrocolloid dressing every 72 hours. Nurses' Notes, dated 2/4/21 at 4:01 p.m., indicated the resident was seen by the wound physician who removed the dead tissue by debriding the coccyx pressure sore. The Wound Physician's Notes, dated 2/4/21, indicated an unstageable (necrosis) pressure ulcer was present to the sacrum, measuring 5 cm by 5.8 cm. There was 100% of thick adherent necrotic		and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 5/3/2021**	

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	tissue covering the wound bed. The physician performed a surgical excisional debridement to the sacral wound. The physician removed 29.00 cm of devitalized tissue and necrotic subcutaneous fat and surrounding connective tissue. The Wound Physician's Notes, dated 2/4/21, indicated the right hip measured 1.1 cm by 1.3 cm by 0.2 cm and was identified as a stage 2 pressure ulcer. Physician's Orders, dated 2/5/21, indicated clean area to sacrum with normal saline and apply emulsion and hydrogel gauze and dry dressing daily and air mattress for pressure relief. Interview with the Director of Nursing (DON) on 4/15/21 at 11:00 a.m., indicated there was no policy to indicate who can assess wounds and if the floor nurses were certified in wound care, then they could stage the wound. The floor nurse was to put a referral Wound Assessment form in the wound book to notify the wound nurse there was a resident with a new open area. The wound nurse currently worked Monday, Wednesday and Thursdays, and was part time. Interview with the DON on 4/16/21 at 1:30 p.m., indicated there was no assessment or documentation of the coccyx open area at the time of admission including color, drainage, or stage. There was no treatment obtained for the coccyx pressure ulcer until 2/2/21 (4 days after admission). 2. The closed record for Resident B was reviewed on 4/14/21 at 9:07 a.m. The resident was admitted to the facility on 10/2/2020 and discharged to the hospital on 11/9/20. The resident did not return to the facility. Diagnoses included but were not			

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	limited to, stage 5 chronic kidney disease or end stage renal disease, arrhythmia, repeated falls, anemia, syncope, dysphagia, chronic obstructive pulmonary disease, dependence on renal dialysis, and cognitive communication deficit. The Admission Minimum Data Set (MDS) assessment, dated 10/8/20, indicated the resident was not cognitively intact. The resident needed limited assist with 1 person physical assist with transfers, dressing, toileting and eating. The resident had 1 fall with no injury since the last assessment. The resident had no pressure sores and received dialysis while resident. Nurses' Notes, dated 11/3/20 at 2:22 p.m., indicated there were 2 open areas (shearing) noted to the left and right buttock. The physician was notified and orders were received. Wound referral placed in wound book. An Event form, dated 11/3/20, indicated right buttock (0.5 centimeters (cm) x 0.3 cm) and left buttock (2 cm x 1 cm). Areas were pink. No other assessment was completed for the open areas. Physician's Orders, dated 11/3/20, indicated cleanse left and right buttocks with normal saline or wound wash, pat dry and apply hydrocolloid twice a week on Monday and Thursday. The Treatment Administration Record (TAR) for the month of 11/2020, indicated the hydrocolloid dressing was signed out only 1 time on 11/5/20 for both the left and right buttocks. There was no wound assessment or documentation of the newly acquired pressure ulcers performed by the wound nurse.			

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	There was no Care Plan for pressure sores. Interview with the Director of Nursing (DON) on 4/15/21 at 11:00 a.m., indicated there was no policy to indicate who can assess wounds and if the floor nurses were certified in wound care, then they could stage the wound. The floor nurse was to put a referral Wound Assessment form in the wound book to notify the wound nurse there was a resident with a new open area. The wound nurse currently worked Monday, Wednesday and Thursdays, and was part time. Interview with the Director of Nursing on 4/16/21 at 1:30 p.m., indicated there was no documentation of any further wound measurements or any other wound assessments completed before the resident was sent out to the hospital.3. The closed record for Resident D was reviewed on 4/15/21 at 10:15 a.m. Diagnoses included, but were not limited to, stroke, chronic kidney disease and type 2 diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 2/4/21, indicated the resident was moderately impaired for daily decision making and was an extensive assist with bed mobility and transfers. The resident was identified as having one Stage 2 pressure ulcer, one Unstageable pressure ulcer and three Deep Tissue Injuries that were all present on admission. The Care Plan, dated 2/8/21, indicated the resident had an alteration in skin integrity as evidenced by pressure ulcer(s) related to decreased mobility and decreased cognition. Interventions included, but were not limited to, complete skin check and observe for complications such as pain, odor, changes in characteristics, increase in necrotic tissue, infection, cellulitis, and osteomyelitis			

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	(bone infection). Notify the Physician immediately if observed. The Braden Scale assessment, dated 2/5/21, indicated the resident scored a "17", a low risk for developing pressure ulcers. A Physician's Order, dated 2/5/21, indicated the resident was to receive betadine (a topical antiseptic) to his left heel daily. The area was to be left open to air. The treatment was discontinued on 2/17/21 when the resident was sent to the hospital. Weekly Wound Measurements completed by the Wound Physician on 2/11/21, indicated the area to the resident's left heel was an unstageable pressure area that measured 2.5 centimeters (cm) x 6 cm x undetermined. Nurses' Notes, dated 2/17/21 at 7:25 a.m., indicated the resident was transferred to the hospital due to a change in mental status. Nurses' Notes, dated 2/20/21 at 6:17 p.m., indicated the resident was readmitted to the facility. Per the hospital report, the resident had Methacillin-resistant Staphylococcus aureus (MRSA) to his left heel wound. The wound was observed and covered with a foam dressing. The resident's physician ordered for the Wound Nurse to see the wounds. The order was entered under general orders. No treatment orders for the left heel were obtained upon the resident's readmission on 2/20/21. An entry in the nursing progress notes, dated 2/21/21 at 9:22 p.m., indicated the wound to the left heel was cleaned and covered.			

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	A Physician's Order, dated 2/22/21, indicated the Wound Nurse was to see the resident. Nurses' Notes, dated 2/23/21 at 2:02 p.m., indicated the resident was in contact isolation related to MRSA to the left heel. The resident's dressing was changed and heel boots were to be on while he was in bed. The Braden Scale assessment, dated 2/23/21, indicated the resident scored an "11" a high risk for developing pressure ulcers. A Physician's Order, dated 2/24/21, indicated the left lateral heel was to be painted with betadine daily and left open to air. The left heel was to be painted with betadine, let air dry, and protect with dry dressing daily. The resident was seen by the Wound Physician on 2/25/21. The wound to the left heel was identified as being unstageable and measuring 3 cm x 6 cm x undetermined. Treatment rendered to toes and left heel with betadine per orders. The February 2021 Treatment Administration Record (TAR), indicated treatment orders for the left heel were obtained on 2/24/21. No treatments were signed out as being completed between 2/20 and 2/23/21. Interview with the Director of Nursing on 4/16/21 at 10:00 a.m., indicated the resident should have been seen by the Wound Nurse and treatment orders should have been obtained in a more timely manner. This Federal tag relates to Complaints IN00349272 and IN00351157.			

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	3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure adequate supervision was provided to prevent falls for a resident who was identified as being a fall risk for 1 of 3 residents reviewed for accidents. (Resident G) Finding includes: On 4/13/21 at 9:40 a.m., Resident G was observed in her room in bed. The resident's bed was not in a low position and she utilized a low air loss mattress. The record for Resident G was reviewed on 4/13/21 at 1:03 p.m. Diagnoses included, but were not limited to, Parkinson's disease, quadriplegia, and stroke. The Admission Minimum Data Set (MDS) assessment, dated 2/23/21, indicated the resident had short and long term memory problems, was severely impaired for daily decision making, and needed extensive assistance with a 2 plus person physical assist with bed mobility.	F 0689	**F 689** **Free of Accident Hazards/Supervision/Devices** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident G is no longer at the facility. No corrective actions can be made. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents that are high risk for falls have the potential to be affected by the same deficient practice. **What measures will be put into place or what systemic**	05/03/2021

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	The Fall Risk assessment, dated 2/17/21, indicated the resident scored a "13" which was a high risk for falls. The current Care Plan did not identify the resident as being a fall risk. Event charting, dated 4/13/21 at 9:27 a.m., indicated the resident fell in her room. She was in bed prior to the fall and the fall was not witnessed. CNA 3 was performing a bed bath, she turned the resident to her right side and left the resident to gather other belongings and the resident rolled from the bed. A full body assessment was completed and no bruising or injuries were noted at that time. The fall investigation, dated 4/13/21, was reviewed on 4/16/21 at 2:30 p.m. CNA 3 was interviewed and she indicated she was performing morning care and she turned the resident on her side and turned away to gather other supplies. At that time, the resident slid from the bed to the floor and landed on her right side. The CNA proceeded to call out for help and the Director of Nursing (DON) assessed the resident for injury. The resident did not voice any complaints of pain and neurological checks were initiated. The resident's Physician and Responsible Party were notified and orders were received for x-rays of the right side. The CNA was counseled and received a one-on-one inservice on 4/13/21. Interview with the DON on 4/19/21 at 8:40 a.m., indicated the resident should not have been left unattended and the CNA was counseled.		**changes will be made to ensure that the deficient practice does not recur;** A list of residents who are high risk for falls was complied. Staff were in-serviced on providing supervision during ADL care/bed mobility with residents who are high risk for falls. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** The DON /designee will observe staff perform ADL care/ bed mobility on 5 residents who are high risk for falls weekly for 6 months. Any noncompliance will be corrected immediately. The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date of Completion: 5/3/2021**	

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	This Federal tag relates to Complaint IN00351157. 3.1-45(a)(2)			
F 0692 SS=G Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake 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 record review and interview, the facility failed to ensure residents maintained acceptable parameters of nutritional status related to weekly weights not obtained, meal consumption records not completed, and the Registered Dietitian's (RD) recommendations not followed for residents who were nutritionally at risk, which resulted in a significant weight loss (Resident C) and potential for weight loss (Resident E) for 2 of 5 residents reviewed for nutrition. Findings include:	F 0692	**F 692 Nutrition/Hydration Status Maintenance** **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. No corrective action can be made. Resident E no longer resides in the facility No	05/03/2021

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	1. The closed record for Resident C was reviewed on 4/14/21 at 2:21 p.m. The resident was admitted to the facility on 1/28/21 and discharged to the hospital on 2/10/21. The resident did not return to the facility. Diagnoses included, but were not limited to, chronic kidney disease, adult failure to thrive, chronic obstructive pulmonary disease, weakness, dysphagia, vascular dementia without behavioral disturbance, and anemia. The Admission Minimum Data Set (MDS) assessment, dated 2/3/21, indicated the resident was not cognitively intact and was severely impaired for decision making. The resident was an extensive assist with one person physical assist for bed mobility and limited assist with 1 person physical assist for dressing, eating and toileting. The resident weighed 137 pounds and had no history of weight loss. The resident received a mechanically altered diet and had 1 unstageable pressure ulcer (Full thickness tissue loss in which the base of the ulcer was covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) noted upon admission. A Care Plan, dated 2/8/21, indicated the resident required a puree diet with nectar thick liquids. The resident weighed 137 pounds on 1/29/21 at the time of admission. The next and last weight was recorded on 2/10/21 and was 124 pounds (a 13 pound weight loss in 12 days). Physician's Orders, dated 1/28/21, indicated monitor and record weight weekly times 4 then monthly. There was no weight obtained on 2/4/21.		corrective action can be made. **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. An audit of weekly weights performed and completed. A review of most recently RD recommendations completed. A review of food consumption orders completed. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** Nursing staff educated on: · Following through on RD recommendations ·Documentation of food consumption ·Obtaining and documentation of weights **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and**	

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	An RD Admission Progress Note, dated 2/2/21 at 12:13 p.m. indicated "hospital records state resident was treated for dehydration, acute kidney injury, hypernatremia, and bilateral lower lobe pneumonia. Had been on TPN (total parental nutrition) with a stop date of 1/26/21. Hemodialysis was initiated on 1/15/2021, and last one was on 1/20/21. Current diet was pureed with nectar thick liquids. Per Speech therapist, the resident needed to be fed and was holding oral food. The resident was a 1 to 1 feed and to alternate puree food with nectar thick liquids. The resident's current weight was 137 pounds with a body mass index of 22.17 [within normal range]. Hospital labs: 1/25/21 Glucose 109, BUN [tests kidney function] 45 H [high], Cr [Creatinine, tests kidney function] 1.5 H, Albumin [protein levels] 2.4 L [low], Ca [calcium] 8.3 L, 1/26/21 Hgb [hemoglobin] 7.4 L, and 1/27/21 BUN 51 H, Cr 1.6 H, CO2 2 L, and Ca 8.0 L. Recommend clarify diet order as general pureed diet with nectar thick liquids. Variable by mouth intakes noted. Recommend add super cereal at breakfast and frozen nutritional treat with lunch and dinner daily to support oral intakes and weight stability. On weekly weights x 4 weeks, then monthly, for admission protocol. Refer to RD as needed." An RD Progress Note, dated 2/9/21 at 1:58 p.m., indicated the resident now has a pressure ulcer to the sacrum. "Please refer to RD note dated 2/2/21 for full assessment. Maintain recommendations to clarify diet order as general pureed diet with nectar thick liquids and to add super cereal at breakfast and frozen nutritional treat with lunch and dinner daily to support oral intakes and weight stability." Physician's Orders, dated 1/28/21, indicated		**permanent?** DON/designee will audit 10 new admission/re-admits weekly X 6 weeks X 6 months to ensure weekly weighs are obtained. DON/ designee will audit 10 residents' meal consumption records weekly x 6 months to ensure documentation is in place. DON/ designee will audit 5 residents' RD recommendations weekly x 6 months to ensure recommendations are being followed through. The DON/designee will present a summary of the audits will be presented to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date of Completion: 5/3/2021**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	pureed diet with nectar thick liquids and monitor and record breakfast, lunch and dinner intake. There were no Physician's Orders for the frozen nutritional supplement or to add super cereal at breakfast. The meal consumption record for 1/2021 and 2/2021 indicated the following: Breakfast intake was not completed on 1/31, 2/5 and 2/9/21. Lunch intake was not completed on 1/31, 2/1, 2/5, and 2/9/21. Interview with the Director of Nursing on 4/16/21 at 1:45 p.m., indicated weekly weights were not completed as ordered by the Physician and the RD's recommendations were not followed through for the nutritional frozen treat and the super cereal. The resident did have a significant weight loss since admission. 2. The record for Resident E was reviewed on 4/14/21 at 10:19 a.m. Diagnoses included, but were not limited to, delusional disorders, unspecified dementia with behavioral disturbance, adult failure to thrive and type 2 diabetes mellitus. The resident was sent to the hospital on 3/16/21 and readmitted to the facility on 4/1/21. The Admission Minimum Data Set (MDS) assessment, dated 3/10/21, indicated the resident had short and long term memory issues and was moderately impaired for daily decision making. The resident required extensive assistance with eating and required a mechanically altered diet. On 3/10/21, the resident weighed 189 pounds.			

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	155764	A. BUILDING 00 B. WING	04/19/2021

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	On 4/1/21, the resident's readmission weight was 170 pounds, indicating a significant weight loss of 10% A Physician's Order, dated 4/1/21, indicated to monitor and record the resident's weight weekly for 4 weeks then monthly. The resident's weight for 4/8/21 was not documented. On 4/13/21, the resident weighed 177 pounds. The April 2021 Physician's Order Summary (POS), indicated the resident was to receive a pureed no concentrated sweet diet with thin liquids and his breakfast, lunch and dinner intake was to be documented. The April 2021 food consumption log, indicated no lunch intake was documented on 4/2 and no breakfast or lunch intake was documented on 4/5, 4/7, and 4/10/21. Interview with CNA 3 on 4/13/21 at 1:10 p.m., indicated the resident needed assistance with his meals and his intake varies. Interview with the Director of Nursing on 4/16/21 at 10:00 a.m., indicated a weekly weight should have been obtained on 4/8/21 and his food intake should have been documented for all 3 meals. This Federal tag relates to Complaint IN00349272. 3.1-46(a)(1)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition			

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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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review and interview, the facility failed to ensure tube feedings were infusing at the correct time as well as following Registered Dietitian (RD) recommendations related to tube feeding flushes for 1 of 1 residents reviewed for tube feeding. (Resident G) Finding includes: On 4/14/21 at 11:33 a.m., Resident G was observed in her room in bed. The resident's tube feeding pump was turned off. At 2:15 p.m. and 3:20 p.m., the tube feeding pump remained off. The record for Resident G was reviewed on 4/13/21 at 1:03 p.m. Diagnoses included, but were not limited to, Parkinson's disease, stroke,	F 0693	**F 693** **Tube Feeding Management/Restore Eating Skills** **What corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice;** Resident G is no longer at facility. No corrective actions can be made. How will the facility identify other residents who have the potential to be affected by the same alleged	05/03/2021

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	dysphagia (difficulty swallowing), moderate protein-calorie malnutrition, adult failure to thrive and gastrostomy (a tube inserted directly into the stomach to provide nutrition) status. The Admission Minimum Data Set (MDS) assessment, dated 1/18/21, indicated the resident had short and long term memory problems, was severely impaired for daily decision making and required extensive assistance with eating. The resident had suffered a 5% weight loss and had a feeding tube. A Physician's Order, dated 1/21/21, indicated the resident was to receive Jevity 1.2 tube feeding 80 cubic centimeters (cc) per hour, turn on at 11:00 a.m. and off at 7:00 a.m. A Physician's Order, dated 1/30/21, indicated tube feed water flush 100 milliliters (ml) every 2 hours. The Registered Dietitian (RD) Progress Note, dated 2/2/21 at 2:53 p.m., indicated "Writer reviewed progress notes and noted that resident had PEG tube placed on 1/18/21. Writer received no referral post return. Current tube feed order: Jevity 1.2 @ 80 ml/hour x 16 hours (on at 3:00 p.m., off at 7:00 a.m.) with 100 ml water flush every 2 hours. Continue with present management, monitor for fluid overload, tube feed tolerance, and weight trends. Refer to RD as needed." The resident was discharged from the facility on 2/3/21 and returned on 2/17/21. The Admission Minimum Data Set (MDS) assessment, dated 2/23/21, indicated the resident had short and long term memory problems, was severely impaired for daily decision making, and was totally dependent on staff for eating. The		deficient practice? All facility residents with orders for enteral tube feedings have the potential to be affected by the same deficient practice. **What corrective measures will the facility take or will the facility alter to ensure that the problem will not occur?** A list of residents with orders for enteral tube feedings complied Licensed nurses and QMA's were in serviced on: ·Following Physician orders related to enteral tube feeding. Licensed nurses were in serviced on: · Following through with RD recommendations **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** The DON/designee will observe 3 residents with orders for enteral tube feeding weekly to ensure that the physician orders for eternal tube feeding are followed for 6 months.	

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	resident received a tube feeding while in the facility. The Care Plan, dated 2/18/21, indicated the resident was dependent on staff for tube feeding for total nutrition and hydration support due to diagnosis of dysphagia related to Parkinson's disease. Interventions included, but were not limited to, administer tube feeding and flushes as ordered by the Physician and dietitian to evaluate adequacy and appropriateness of current feeding in relation to resident's condition and nutrient needs. An RD readmission Progress Note, dated 2/26/21 at 7:10 p.m., indicated the resident was now NPO (receiving nothing by mouth) with gastrostomy (g) tube feedings for nutrition and hydration. The resident received Jevity 1.2 at 80 cc's an hour with 100 ml water flushes every 2 hours. Per readmission nursing notes, the resident was noted with 4+ pitting edema to the bilateral lower extremities (BLE). "With the resident having 4+ pitting edema to BLE, recommend follow-up with the Physician if g-tube flushes should be decreased. Would suggest flushing g-tube with 220 ml water every 6 hours. Refer to RD as needed." A monthly RD Progress Note, dated 3/18/21 at 4:01 p.m., indicated the tube feeding recommendations hand-written on the "dietary recommendations for Physician approval" page, dated 2/26/21, were for tube feed flushes of 160 ml of water every 6 hours. Current flush orders needed to be updated. Recommended flush of 160 ml every 6 hours. Tolerating tube feed well without complications noted. Refer to RD as needed.		F693 B DON/ designee will audit 3 residents orders eternal tube feeding weekly to ensure RD recommendations are followed through for x 6 months. The DON/designee will present a summary of the audits to the QA committee monthly for 6 months. Thereafter, if determined by the QA committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be ongoing. **Date of Completion: 5/3/2021**	

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	A Nutrition at Risk (NAR) Progress Note, dated 3/25/21 at 2:29 p.m., indicated the water flush order still read 100 ml every 2 hours. The April 2021 Physician's Order Summary (POS) indicated the resident was to receive Jevity 1.2 tube feeding 80 cubic centimeters (cc) per hour, turn on at 11:00 a.m. and off at 7:00 a.m. Interview with the Director of Nursing on 4/19/20 at 9:00 a.m., indicated the resident's tube feeding wasn't infusing as ordered on 4/14/21 and the RD recommendations related to the resident's tube feed flush had not been acted upon. 3.1-44(a)			
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 record review and interview, the facility failed to ensure scheduled pain medications were available and pain levels were assessed for 1 of 1 residents reviewed for pain. (Resident 33) Finding includes: Interview with Resident 33 on 4/12/21 at 9:36 a.m., indicated her current pain level was 8 out of 10. She received her last pain pill at 6:00 a.m. and she had run out of pills in the past. The record for Resident 33 was reviewed on 4/12/21 at 2:19 p.m. Diagnoses included, but were	F 0697	F 697 Pain **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** A prescription was obtained for R-33 pain and was sent to the pharmacy.	05/03/2021

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	not limited to, fractured left tibia and fibula, pain, and shortness of breath. The Admission Minimum Data (MDS) assessment, dated 3/26/2021, indicated the resident was cognitively intact and had received opioids 4 of the last 7 days during the look back period. The April 2021 Physician's Order Summary (POS), indicated Hydrocodone-Acetaminophen 5-325 mg (milligrams) 1 tablet every 6 hours: 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m. A Care Plan, dated 3/31/2021, indicated the resident was at risk for potential complications related to fractures of the left tibia and fibula. The interventions included, but were not limited to, assess for pain and administer pain medications as ordered and document pain level and relief achieved. The April 2021 Medication Administration Record (MAR) indicated the medication was not available on the following dates: - on 4/7/21 at 12:00 p.m. - on 4/8/21 at 12:00 p.m. - on 4/9/21 at 6:00 a.m. - on 4/10/21 at 12:00 a.m. There was no documentation to indicate the resident's pain levels were assessed. Interview with the Assistant Director of Nursing on 4/9/21 at 12:16 p.m., indicated the pharmacy needed a script to refill the resident's medication. The Physician was notified. 3.1-37(a)		**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 orders for narcotic pain medications requiring prescriptions. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** Licensed nursing staff were educated on ensuring pain is assessed and that pain medications are administered as ordered by the physician. This includes obtaining required prescriptions from the physician for narcotic pain medications. **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 orders for pain medications weekly to ensure pain is assessed and pain medications are administered as ordered by the physician x 6 months.	

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			DON/designee will present a summary of the audits to the QA committee monthly for 6 months. Thereafter, if determined by the QA committee, auditing and monitoring will be done quarterly and presented quarterly at the Q.A. meeting. Monitoring will be ongoing. **By what date the systemic changes will be completed: 05/03/2021**	
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 provide the necessary care and services for a resident who received Hemodialysis related to not assessing bruit and thrill and not obtaining Physician's Orders for dialysis for 2 of 2 residents reviewed for dialysis. (Residents B and 39) Findings include: 1. Interview with Resident B's daughter on 4/16/21 at 2:15 p.m., indicated she picked the resident up every Monday, Wednesday and Friday and drove him to dialysis.	F 0698	**F 698 Dialysis** **What corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice;** Resident 39 order were updated. Resident B no longer a resident in the facility. No corrective action can be made. How will the facility identify other	05/03/2021

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	The closed record for Resident B was reviewed on 4/14/21 at 9:07 a.m. The resident was admitted to the facility on 10/2/2020 and discharged to the hospital on 11/9/20. The resident did not return to the facility. Diagnoses included but were not limited to, stage 5 chronic kidney disease or end stage renal disease, arrhythmia, repeated falls, anemia, syncope, dysphagia, chronic obstructive pulmonary disease, dependence on renal dialysis, and cognitive communication deficit. The Admission Minimum Data Set (MDS) assessment, dated 10/8/20, indicated the resident was not cognitively intact. The resident needed limited assist with 1 person physical assist with transfers, dressing, toileting and eating. The resident had 1 fall with no injury since the last assessment. The resident had no pressure sores and received dialysis while resident. The Care Plan, dated 10/15/20, indicated the resident required dialysis. A History and Physical from a previous hospital stay indicated the resident had a right arm arterial/venous (AV) shunt access with a positive bruit. Nurses' Notes, dated 10/6/20 at 5:14 a.m., indicated the resident had a shunt to the right upper arm with bruit/thrill noted. There were no Physician's Orders for Hemodialysis three times a week. There were no Physician's Orders to monitor and assess the AV access site for a positive bruit/thrill. The Medication and Treatment Administration Records (MAR/TAR) for 10/2020 and 11/2020 indicated there was no documentation the shunt		residents who have the potential to be affected by the same alleged deficient practice? All facility residents who have an AV Fistula have the potential to be affected by the same deficient practice. An audit was completed on all residents who receive dialysis to ensure dialysis orders are in place for dialysis and that the bruit/thrill is monitored. **What corrective measures will the facility take or will the facility alter to ensure that the problem will not occur?** Nursing staff were in serviced on: ·Ensuring dialysis orders are in place. ·Documentation on MAR that monitoring of the bruit and thrill was completed. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** The DON/designee will review 3 residents for 6 months to ensure that the dialysis orders are in place and that the bruit/thrill was monitored and documented on the MAR.	

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	was monitored for a bruit/thrill at least daily, consistent with professional standards of practice. Interview with the Director of Nursing on 4/16/21 at 1:30 p.m., indicated there were no Physician's Orders for Hemodialysis or to check the resident's shunt for a positive bruit and thrill.2. The record for Resident 39 was reviewed on 4/13/21 at 12:47 p.m. Diagnoses included, but were not limited to, renal failure with hemodialysis. The Admission Minimum Data Set (MDS) assessment, dated 3/31/21, indicated the resident was alert and oriented and required hemodialysis. The April 2021 Physician Order Summary (POS) indicated, Dialysis: AV Fistula Site: Left forearm. Check access site for bruit and thrill. There was no frequency noted. There was no documentation to indicate the left forearm access site was being assessed. Interview with Director of Nursing on 4/14/21 at 8:35 a.m., indicated the resident's access site was not being assessed as ordered. 3.1-37(a)		The DON/designee will present a summary of the audits to the QA committee monthly for 6 months. Thereafter, if determined by the QA committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be ongoing. **Date of Completion: 5/3/2021**	
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;			

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

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	Based on record review and interview, the facility failed to ensure there was an indication for the use of psychotropic medications as well as monitoring for side effects by completing Abnormal Involuntary Movement Scale (AIMS) assessments for 2 of 5 residents reviewed for unnecessary medications. (Residents E and 33) Findings include: 1. The record for Resident E was reviewed on 4/14/21 at 10:19 a.m. Diagnoses included, but were not limited to, delusional disorders and unspecified dementia with behavioral disturbance. The Admission Minimum Data Set (MDS) assessment, dated 3/10/21, indicated the resident had short and long term memory issues and was moderately impaired for daily decision making. A Physician's Order, dated 3/4/21, indicated the resident was to receive Lexapro (an antidepressant) 10 milligrams (mg) daily. The March 2021 Medication Administration Record (MAR), indicated the resident received the Lexapro daily 3/5 through 3/16/21. The April 2021 MAR, indicated the resident received the Lexapro daily 4/2 through 4/14/21. The resident did not have a diagnosis of depression. Interview with the Director of Nursing on 4/16/21 at 10:00 a.m., indicated the resident should have had a diagnosis of depression related to the use of Lexapro. 2. The record for Resident 33 was reviewed on 4/13/21 at 2:04 p.m. Diagnoses included, but were not limited to bipolar disorder,	F 0758	**F758 Unnecessary Meds** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 33 AIMS was completed. Resident E is no longer at the facility. No corrective actions can be made. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents with orders for psychotropic medications have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nurses and social services staff were in serviced on ensuring AIMS observations are completed and diagnosis supporting antipsychotic medication usage are obtained for residents with orders for psychotropic medications. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will audit 5 residents with orders for	05/03/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	depression, chronic obstructive pulmonary disease, and shortness of breath. The Admission Minimum Data (MDS) assessment, dated 3/26/2021, indicated the resident was cognitively intact and had minimal depression. The resident received antipsychotic medication within the past 7 days during the look back period. A Physician's Order, dated 3/20/21, indicated Seroquel 300 mg (milligrams) 2 tablets every night related to bipolar disorder. A Care Plan, dated 4/12/21, indicated the resident was at risk for adverse consequences related to receiving antipsychotic medications. The interventions included, but were not limited to, review for continued need at least quarterly. There was no documentation to indicate the resident was assessed for side effects related psychotropic medication use and no AIMS assessment completed. Interview with the Director of Nursing on 4/14/21 at 2:42 p.m., indicated there should have been an AIMS (Abnormal Involuntary Movement Scale) assessment upon admission and every 6 months thereafter. 3.1-48(a)(3) 3.1-48(a)(4)		psychotropics weekly to ensure AIMS observations are completed. DON/designee will randomly audit 5 residents with orders for psychotropics weekly to ensure diagnosis are obtained. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 5/3/2021**	
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on observation, record review, and	F 0760	F 760 Significant Medication Error	05/03/2021

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	155764	A. BUILDING 00 B. WING	04/19/2021

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	interview, the facility failed to ensure a resident was free from significant medication errors related to the administration of Dilantin (an anticonvulsant medication) while enteral feedings were infusing for 1 of 5 residents reviewed for nutrition. (Resident 13) Finding includes: On 4/12/21 at 10:15 a.m., Resident 13 was observed sitting up in a broda chair in her room. At that time, there was a tube feeding pump at the bedside. There was no enteral feeding infusing at that time. The record for Resident 13 was reviewed on 4/12/21 at 12:56 p.m. The resident was admitted to the facility on 2/2/21. Diagnoses included, but were not limited to, dementia with behavioral disturbances, cognitive communication deficit, weakness, percutaneous endoscopic gastrostomy (peg) tube, seizures, stroke, adult failure to thrive, and dehydration. The Admission Minimum Data Set (MDS) assessment, dated 2/21/21, indicated the resident had short and long term memory problems and was severely impaired for decision making. The resident needed extensive assist with 2 person assist for bed mobility. The resident received enteral feedings and a mechanically altered diet. The Care Plan, dated 2/3/21, indicated the resident was dependent on tube feeding and oral diet for adequate nutrition and hydration due to dysphagia. Physician's Orders, dated 2/2/21, indicated Dilantin 125 mg/5 ml (milliliters) four times a day.		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** R 13 orders updated. **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. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** Licensed nursing staff/ QMA's were educated on: The Policy Title ·Enteral Tube Medication Administration including: ·Administration of Dilantin via g-tube and obtaining a physician's order to hold the g-tube feeding 30 minutes before and after Dilantin is administered.	

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	Physician's Orders, dated 2/16/21, indicated Dilantin 125 mg/5 ml four times a day at 6 a.m., 12 p.m., 6 p.m., and 12 a.m. Physician's Orders, dated 3/15/21, indicated Glucerna 1.2 (enteral feeding) at 70 cc (cubic centimeters) on at 6 p.m., and off at 6 a.m. The Medication Administration Record (MAR) for the months of 3/2020 and 4/2020 indicated the Dilantin was administered as ordered during the enteral feeding infusion. Interview with LPN 1 on 4/15/21 at 2:30 p.m., indicated she administered the enteral feeding to the resident at 6:00 p.m. The Dilantin was scheduled at 6 p.m. as well and currently there were no orders to hold the enteral feeding when the Dilantin was administered. Interview with the Director of Nursing on 4/16/21 at 1:30 p.m., indicated the enteral feeding should have been held prior to the administration of the Dilantin medication consistent with professional standards of practice. The current 10/25/14 "Enteral Tube Medication Administration" policy, provided by the Nurse Consultant on 4/16/21 at 2:45 p.m., indicated for medications incompatible with tube feeding (Dilantin (phenytoin) Suspension), turn off the pump to stop continuous feeding 30 minutes prior to medication administration. 3.1-48(c)(2)		**What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** DON/ designee will review all residents who have orders for Dilantin and enteral tube feeding weekly x 6 months to ensure orders follow medication administration recommendations. DON/designee will present a summary of the audits to the Quality Assurance Committee monthly for 6 months. Thereafter, if determined necessary by the QA Committee, auditing and monitoring will be done quarterly and presented quarterly at QA meeting. Monitoring will be on going. **By what date the systemic changes will be completed: 5/3/2021**	
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			

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	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, 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			

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	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. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those specific to properly prevent and/or contain COVID-19, related to personal protective equipment (PPE) not worn properly with resident interaction, improper glove use, and improper handling of soiled linens for random observations for infection control on 3 of 3 Units. (The TCU unit, Healthcare 1, Healthcare 2, Residents E and 14)	F 0880	Spring Mill Health Campus Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F880 Infection Prevention and**	05/03/2021

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	Findings include: 1. During a random observation, on 4/14/21 at 9:32 a.m., Housekeeper 1 was observed walking down the hallway of the TCU unit wearing a pair of disposable gloves. The Housekeeper proceeded to lift the cover on the clean linen cart and obtain multiple pieces of clean linen with his gloved hand. He then proceeded back down the hallway and entered the room he had been cleaning. Interview with the Regional Administrative Consultant on 4/19/21 at 5:10 p.m., indicated she was aware of the situation and the Housekeeper should not have been wearing his gloves in the hallway. 2. On 4/15/21 at 9:25 a.m., staff were observed going in and out of Resident E's room. The resident was in transmission based precautions (TBP) due to being a readmission to the facility. Interview with the Housekeeping Supervisor at that time, indicated the resident had become unresponsive while being fed breakfast. Interview with the Director of Nursing (DON) at 9:30 a.m., indicated the resident was alert but he was going to be sent to the hospital for evaluation. At 9:37 a.m., two male EMS staff members arrived on the unit. Transport Staff 2 was wearing a neck gaiter to cover his nose and mouth. Transport Staff 3 was wearing a surgical mask. Neither transport staff member was wearing a face shield. Transport Staff 2 asked CNA 3 why the resident was in isolation. She indicated the resident was in isolation due to being a new admission quarantine. At that time, both transport staff		**Control** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident E is no longer at the facility. No corrective actions can be made. Resident 14 is no longer at the facility. No corrective actions can be made. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were educated on proper PPE use in Transmission Based Precaution rooms. The infection control in-service was reviewed by an IC Preventionist and used CDC / CMS guidance. Housekeeper 1 was educated on donning PPE prior to entering a room and doffing PPE prior to leaving a resident's room, completing hand hygiene before donning gloves and after removing gloves and prior to leaving the residents room. Housekeeper 1	

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	members entered the resident's room. They did not donn an N95 mask, isolation gown or face shield. Interview with both transport staff members at 9:52 a.m., as they were walking out of the door, indicated they were not notified of the resident being in transmission based precautions. They both indicated they were told the resident was unconscious and not told he was in transmission based precautions. Interview with the Nurse Consultant and DON on 4/15/21 at 11:00 a.m., indicated the nurse who called 911 did not tell the dispatcher the resident was in transmission based precautions. Interview with the Administrator on 4/15/21 at 2:30 p.m., indicated the transport company manager indicated all of it's EMS employees, when dispatched 911, should have a jet pack full of personal protective equipment and ready to use when picking up the resident. The current and updated 3/31/21, "COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure", indicated "Unknown COVID-19 status (Yellow): All residents in this category warrant transmission based precautions (droplet and contact.) HCP will wear single gown per resident, glove, N95 mask and eye protection (face shield/or goggles). Gowns and gloves should be changed after every resident encounter with hand hygiene performed." 3. On 4/12/21 at 11:53 a.m., two Emergency Medical Transporters (EMT) came into the facility. At that time, Transporter 1 was observed with a cloth face mask over her mouth and nose. The facility employee at the front desk did not tell the EMT to change into a different face mask. She		was also educated on the bagging of any soiled linen to carry through the hallway and hand hygiene after bagging linen and prior to leaving the residents room Managers who cover receptionist educated on the notification to transport staff for any resident with isolation precautions and discussing specific requirements with the nurses. Nursing were in-serviced on giving transport staff directions for residents on transmission-based precautions and ensuring proper PPE is worn. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Infection Control Preventions/ DON / Administrator/designee will randomly audit facility staff daily for compliance with PPE, Infection Control and transmission based precautions, daily for 6 weeks until compliance is maintained. The Administrator/ICP / DON / designee will continue to randomly review staffing thereafter and present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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	entered Resident 14's room and was within 6 feet of him as she and the other transporter helped get the resident onto the gurney to transfer out of the facility. Interview with Receptionist on 4/12/21 at 12:45 p.m., indicated she worked Monday through Friday during the day. When she takes her breaks another person covers for her. She was not the screener when Transporter 1 entered the facility. Interview with the Director of Nursing on 4/16/21 at 1:30 p.m., indicated all vendors and EMT personnel must wear N95 or KN95 face masks, which was the facility's policy.4. On 4/12/21 at 10:14 a.m., during a random observation, Housekeeper 1 was observed walking down the hallway with dirty and/or soiled linen in his gloved hand. Once he reached the soiled utility room he placed the uncontained linen on the floor, entered the key code with his still gloved hand, and proceeded into the soiled utility room to discard the linen. Upon exiting the room his glove remained on his hand Interview with the Housekeeping Supervisor on 4/19/21 at 2:01 p.m., indicated the soiled and/or dirty linen should have been contained in a bag and the housekeeper should have discarded his glove prior to leaving the room. 3.1-18(b)		**Date by which systemic corrections will be completed: 5/3/21**	
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 Complaints IN00349272 and	R 0000	This plan of correction shall serve as this facilities' credible allegation of compliance Preparation, submission, and implementation	

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	IN00351157. Complaint IN00349272 - Substantiated. Federal/State deficiencies related to the allegations are cited at F686 and F692. Complaint IN00351157 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580, F684, F686 and F689. Survey dates: April 12, 13, 14, 15, 16, and 19, 2021. Facility number: 010739 Residential Census: 43 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/23/21.		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	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented	R 0407	Spring Mill Health Campus Please accept the following as the	05/03/2021

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	to properly prevent and/or contain COVID-19 related to personal protective equipment (PPE) not worn properly with resident interaction for random observations for infection control on 1 of 2 units. (The Assisted Living Unit and Resident 4) Finding includes: During a random observation, on 4/19/21 at 11:54 a.m., an isolation set up was observed outside of Resident 4's room and a sign was on the door indicating the resident was in transmission based precautions. CNA 2 was observed in the resident's room at the time. The CNA was talking to the resident and she was not wearing an isolation gown. Interview with CNA 2 on 4/19/21 at 1:10 p.m., indicated she should have worn an isolation gown while in the resident's room. Interview with the Resident Care Coordinator on 4/19/21 at 2:00 p.m., indicated the CNA should have worn a gown while in the resident's room. The current and updated 3/31/21, "COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure", indicated "Unknown COVID-19 status (Yellow): All residents in this category warrant transmission based precautions (droplet and contact.) HCP will wear single gown per resident, glove, N95 mask and eye protection (face shield/or goggles). Gowns and gloves should be changed after every resident encounter with hand hygiene performed."		facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **R407 Infection Prevention and Control** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** CNA was re-educated on proper PPE use in Transmission Based Precaution rooms. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were educated on proper PPE use in Transmission Based Precaution rooms. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;**	

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			Administrator/designee will randomly audit facility staff for compliance with PPE, 5 times per week including week-end shifts, and on alternating shifts to ensure compliance. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 5/3/21**	