STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00374167 and IN00375539. This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00374167 - Substantiated. Federal/State deficiencies related to the allegations are cited at F678, F686, and F692. Complaint IN00375539 - Substantiated. Federal/State deficiencies related to the allegations are cited at F557, F624, and F686. Survey dates: March 23, 24, 25, and 29, 2022 Facility number: 000120 Provider number: 155214 AIM number: 100274780 Census Bed Type: SNF/NF: 135 SNF: 15 NCC: 1 Total: 151 Census Payor Type: Medicare: 32 Medicaid: 86 Other: 33 Total: 151 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/4/22.	F 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0557 SS=A Bldg. 00	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Based on record review and interview, the facility failed to ensure a resident who was transferred to another room in the facility had personal belongings brought to the room for 1 of 1 residents reviewed for room to room transfers. (Resident C) Finding includes: Resident C's record was reviewed on 3/23/22 at 4:05 p.m. The diagnoses included, but were not limited to, diabetes mellitus and dementia. The census in the record indicated the resident was moved from her room on the Memory Care Unit to a room on the 2C unit due to a bug infestation on 10/15/21. The resident was moved back to her room on the Memory Care Unit on 12/28/21. On 3/24/22 at 3:01 p.m., the Memory Care Facilitator indicated the resident had been moved due to bugs in the room and the room needed to be exterminated. The family was notified of the room transfer. Personal items were unable to be moved with the resident due to the bug infestation. All of her items were bagged up and her clothing was washed. The clothing was	F 0557	F557 1:1 Resident C no longer resides in the Facility. 1:2 Social Service/designee observed residents who had a room change in the past 30 days to ensure their new rooms had personal belongings brought with them to the new room. No deficiencies were noted. 1:3 The Executive Director re-in-serviced the Social Service Department on treating residents with respect & dignity as evidenced by: the resident's right to retain & use personal possessions, including furnishings, & clothing, as space permits, unless to do so would infringe upon the rights or health & safety of other residents. The Director of Social Service/designee will observe all residents who transfer to another room within the Facility to ensure their personal belongings are	04/12/2022

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	moved into the new room. The facility placed a TV and DVD's in the resident's room. The family was not notified to bring in personal items for the resident's new room. The resident was transferred back to her room on the Memory Care Unit on 12/28/21. This Federal tag relates to Complaint IN00375539. 3.1-9(a)		brought with them to the new room weekly for six (6) months. 1:4 The DON/designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 4-12-22	
F 0624 SS=D Bldg. 00	483.15(c)(7) Preparation for Safe/Orderly Transfer/Dschrg §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. Based on record review and interview, the facility failed to provide and document sufficient information about residents who were being transferred to the hospital Emergency Room related to Transfer Forms/assessments not completed or completed correctly 2 of 3 residents reviewed for transfers to the Emergency Room. (Residents C & E) Findings include: 1) Resident C's record was reviewed on 3/23/22 at	F 0624	1:1 Resident C no longer resides in the Facility. Resident D returned to the Facility on 3/25/22 from the hospital. 2:1 The Unit Managers/designee completed a whole house audit of resident Transfer Forms/evaluations to ensure accurate completion in the past 14 days. Any deficiencies were corrected at that time. 3:1 Director of Nursing /designee	04/12/2022

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	4:05 p.m. The diagnoses included, but were not limited to, diabetes mellitus and dementia. A Focused Charting form, dated 1/27/22 at 1:48 p.m., indicated a temperature of 101.3, blood pressure of 114/83, and pulse at 103. The resident was refusing to eat and to take medications. The Physician visited the resident and orders were received to transfer the resident to the Emergency Room. The Transfer form, dated 1/27/22 at 1:26 p.m., indicated the transfer/discharge details date was 4/28/20 at 2 p.m. and the reason for the transfer was diarrhea. The blood pressure and pulse were dated 1/17/22, the respirations and temperature was dated 1/24/22, the oxygen saturation was dated 1/26/22, and the most recent weight was dated 12/7/21. A Nurse's Progress Note, dated 2/3/22 at 9:39 a.m., indicated there was a left heel pressure ulcer upon re-admission to the facility from the hospital, which was a DTI (deep tissue injury - injury to the underlying tissue from prolonged pressure) which measured 5 cm (centimeters) by 4 cm. A Nurse's Progress Note, dated 2/18/22 at 9:18 a.m., indicated the resident was extremely lethargic and not waking up. The Nurse Practitioner was notified and an order was received to transfer the resident to the Emergency Room. There was no Transfer Form completed and sent with the resident that indicated the status of the resident and the skin condition of the resident. On 3/24/22 at 12:02 p.m., Unit Manager 1 indicated the transfer information on 1/27/22 was not correct or filled out completely. There was no Transfer		re-in-serviced the licensed staff on accurately completing a Resident Transfer Form/evaluation prior to transferring a resident out of the Facility. The Unit Manager/designee will ensure accurate completion of all resident Transfer Forms/evaluations when a resident is transferred out of the Facility weekly for six (6) months. 1:4 The DON/designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 4-12-22	

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	form for the transfer on 2/18/22. 2) Resident E's record was reviewed on 3/29/22 at 9:16 a.m. The diagnoses included, but were not limited to, dementia and stroke. A Wound Specialist Progress Note, dated 3/17/22, indicated a stage 3 (full thickness skin loss) pressure ulcer on the sacrum and a unstageable DTI on the left heel. A Nurse's Progress Note, dated 3/23/22 at 9:44 a.m., indicated the resident was not responding verbally and was lethargic. An order was obtained for a transfer to the Emergency Room. The Transfer Form, dated 3/23/22, was left blank in the area to describe any pressure areas. This Federal tag relates to Complaint IN00375539. 3.1-12(a)(21)			
F 0678 SS=J Bldg. 00	483.24(a)(3) Cardio-Pulmonary Resuscitation (CPR) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. Based on record review and interview, the facility failed to notify Emergency Medical Services (EMS) when CPR (cardiopulmonary resuscitation) was initiated on a resident who was found unresponsive, without vital signs, and had an Advance Directive indicating the desire for CPR (full code status). The staff ceased CPR without an order from the Resident's Physician, resulting in the death of a resident for 1 of 8 residents	F 0678	p paraid="1886179722" paraeid="{d7c443d9-8eca-41e8-b237-980779dec022}{146}" > Deficiency The facility allegedly failed to	04/12/2022

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	reviewed for Advanced Directives. (Resident B) The Immediate Jeopardy began on 2/8/22 when an Agency LPN chose not to notify EMS and initiated CPR with a CNA, then ceased the CPR without a Physician's Order and the resident expired. The Administrator was notified of the Immediate Jeopardy on 3/24/22 at 8:03 a.m. The Immediate Jeopardy was removed on 3/25/22, but noncompliance remained at the lower scope and severity level of isolated, no actual harm, with potential for more than minimal harm that is not Immediate Jeopardy. Finding includes: Resident B's record was reviewed on 3/23/22 at 12:34 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease. Out of hospital DNR (do not resuscitate) declaration (Advance Directive), dated 11/22/21, indicated the resident was a full code and desired CPR. A Physician's Order, dated 11/22/21, indicated full CPR, was to be a full code status. A Physician's Order, dated 2/6/22, indicated Hospice was to evaluate and treat. A Physician's Order, dated 2/8/22, indicated the resident had been admitted into Hospice care. A Nurse's Note, dated 2/8/22 at 3:37 p.m., indicated an admission into Hospice care and the resident remained a full code. The Guardian wanted to review the DNR paperwork and would let the Hospice staff know her wishes for the resident's code status.		continue emergency basic life support once initiated on a Hospice resident who was a full code & observed to be unresponsive while in bed. p role="heading" aria-level="3" paraid="1520180808" paraeid="{d7c443d9-8eca-41e8-b237-980779dec022}{191}" >Goals 1. All staff members will be provided appropriate education, competency, and equipment in order to perform all basic and emergent basic life intervention and protocols. All residents that have an active “Full Code” status will be reviewed for emergent and basic life safety intervention needs. Including but not limited to code status, staff education, and campus equipment needed to	

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	A Nurse's Note, dated 2/8/22 at 7:56 p.m., indicated the resident was found unresponsive and no vital signs were present. CPR was initiated by Agency LPN 1 and Agency CNA 1. CPR was unsuccessful and was stopped. The Burial Permit, dated 2/8/22, indicated the time of death was at 7 p.m. During an interview on 3/23/22 at 2:34 p.m., the Administrator indicated the Guardian had taken the DNR information home to look over before making a decision on the code status. A decision had not been made at the time and the resident remained a full code. Agency LPN 1 had stopped CPR because the resident was Hospice. On 3/23/22 at 3:30 p.m., Agency LPN 1 indicated she was under the impression that residents on Hospice were not to be transferred to the hospital. She had found the resident unresponsive and initiated CPR. She and Agency CNA 1 had alternated performing CPR on the resident for 45 minutes. The CPR was unsuccessful and it was stopped. EMS had not been notified because they would have transferred the resident to the hospital and they would have performed life saving measures. On 3/24/22 at 4:08 p.m., Agency CNA 1 indicated he had entered the resident's room to check on her. She was unresponsive and had just been admitted into hospice care. Agency LPN 1 was notified and CPR was initiated. Agency LPN 1 had stated, "we are not getting her back", and she stopped the CPR. He was unsure how long CPR had been administered and unsure if EMS had been notified.		conduct CPR.	

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	On 3/24/22 at 11:49 a.m., the Administrator indicated that Hospice services were to begin on 2/9/22. The Hospice Agency had not left a binder for the facility. On 3/24/22 at 12:35 p.m., the Hospice Agency Coordinator indicated binders were provided to the facility at the time of admission into Hospice, which included the plan of care and all notes. The binder was left at the facility. The Hospice Agency always discussed the care and treatment of the resident with the staff and this was documented in the binder with each visit. The Hospice Notes, dated 2/8/22 and received from the Hospice Agency on 3/24/22, indicated the full code status was discussed with the Guardian via telephone due to the Guardian unable to meet with Hospice until the next day. Post Form (do not resuscitate declaration and order) was discussed and decisions were to be made. The resident would remain a full code until the form was completed. The Guardian voiced understanding. Hospice spoke with the Wound Nurse and Agency LPN 1 at the change of shift and informed of the code status at the time of admission. Both nurses voiced understanding. The form was signed by Agency LPN 1 on 2/8/22. A facility Cardiopulmonary Resuscitation (CPR) Policy, dated 7/2020 and received from the Administrator as current, indicated facility staff must provide basic life support, which included CPR, prior to the EMS arrival and in accordance with the advance directives. The Licensed Nurse was to designate a staff member to call 911 and the Crash Cart was to be obtained. A facility policy, titled, "Death of a Resident, Documenting", dated 7/2017 and received from			

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	the Administrator as current, indicated a resident may be declared dead by a Licensed Physician or Registered Nurse (RN) with Physician authorization. The Immediate Jeopardy that began on 2/8/22 was removed on 3/25/22 when the facility reviewed the Advance Directives for all residents in the facility, ensured the code status was available in the electronic record and inserviced staff including how to identify the code status of the resident by the name plate outside the resident's door. The facility educated 68 employees and Agency employees on Advance Directives, Physician's Orders, and CPR policy and procedures, which included if CPR has been initiated, it can never be stopped until EMS has taken over CPR or a Physician determines the CPR is unsuccessful. 37 staff members were interviewed and were knowledgeable of the CPR policy and procedures. The Director of Nursing (DON)/ Designee will continue to educate remaining staff and all Agency staff of the CPR policy and procedures and education will continue monthly. The facility also initiated protocols for the DON/ Designee to audit all residents who have expired to ensure the facility policies and procedures have been followed for Advance Directives. The noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy, because not all staff had been inserviced and monitoring of the implemented systems was ongoing. This Federal tag relates to Complaint IN00374167.		p role="heading" aria-level="3" paraid="1338056841" paraeid="{eea1cec2-06e9-43d7-9875-22de21ee2e8d}{177}" >Actions to be taken Resident Specific: The resident was admitted on 11/22/2021 with a diagnosis of Chronic Respiratory Failure with hypoxia, COPD, HTN, Epilepsy, neoplasm of uncertain behavior of craniopharyngeal duct, & GERD.	

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			General Actions: A whole house audit was completed to ensure all residents have a code the code status is in PCC, & the name plate on the resident doorframe reflects the code status. Facility staff members & Agency staff were educated on Code status, Physician order, Code event and CPR policy/ procedures on 2/9/22-2/11/22. Education will continue monthly starting 3/24/22 x 6 months All licensed staff CPR certifications to be audited for expiration/compliance date. Code event training was conducted on 2/9/2022-2/11/22 and will start monthly on 3/24/22 x 6 months. DNS/designee will audit all residents who have expired to ensure the code event was executed per the Physician's orders x 6 months. The DON/designee will report audit findings to the QAPI committee monthly for (6) six months.¿ The QAPI committee will monitor the data presented for any trends & determine if further	

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			monitoring/action is necessary for continued compliance.¿¿¿ . p role="heading" aria-level="3" paraid="890575" paraeid="{1d8af687-8e44-4b5a-a104-1dd996cd4233}{165}"	

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			>Responsible Staff Medical Records/Designee DNS/Designee DNS/Designee	

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			DNS/Designee DNS/Designee p paraid="9455821" paraeid="{7bc47225-1cb3-4835-9540-b0f426e4321d}{55}" >Completion Date	

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			3/24/2022	
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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 observation, record review, and interview, the facility failed to ensure pressure ulcers and skin conditions were assessed, assessed timely, and assessed correctly. They failed to ensure treatments for the pressure areas were obtained timely and treatments were completed as ordered by the Physician for 3 of 4 residents reviewed for pressure ulcers. (Residents C, E, and D) Residents C and E had a worsening in stage of their pressure ulcer areas related to	F 0686	1:1 Resident C no longer resides at the Facility. Resident D no longer resides in the Facility. Resident E was assessed by the Wound Nurse. All pressure areas were identified, measured & evaluations/assessments were completed. Physician's orders for Pressure Ulcer treatments were reviewed & verified with the	04/12/2022

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	155214	A. BUILDING 00 B. WING	03/29/2022

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	delays in treatment and assessments. Findings include: 1) Resident C's record was reviewed on 3/23/22 at 4:05 p.m. The diagnoses included, but were not limited to, diabetes mellitus and dementia. A Significant Change Minimum Data Set (MDS) assessment, dated 2/10/22, indicated a severely impaired cognitive status, extensive assistance of two for bed mobility, dependent on two for transfers, extensive assistance of one for hygiene and dependent on one for bathing. The resident was incontinent of bowel and bladder and had one unstageable deep tissue injury (DTI) upon re-entry to the facility. A Care Plan, dated 2/9/22, indicated a left heel pressure ulcer. The interventions included, the skin condition would be assessed and documented, assistance was to be provided for bed mobility and toileting, bowel and bladder incontinence was to be monitored, and the treatment was to be completed as ordered. A Nurse's Progress Note, dated 2/3/22 at 9:59 a.m., indicated a left heel DTI, which measured 5 cm (centimeters) by 4 cm was present upon re-admission from the Hospital on 2/3/22 and skin prep (protective film) was applied. A Nurse's Progress Note, dated 2/3/22 at 9:29 p.m., indicated a large DTI on the left heel and the Wound Nurse was to assess the area. Transfer orders from the Hospital, dated 2/3/22, indicated a wound to the left heel. Treatment of the wound was to apply venlex (protective cover for pressure ulcers), cover with dry gauze, and		Physician if needed. Treatments in place to all areas. 1:2: The Wound Nurse/designee completed an audit to ensure physician's orders were present for all residents who have pressure areas. Any deficiencies were corrected at that time. 1:3: Director of Nursing /designee re-in-serviced the licensed staff on following physician's orders, ensuring timely treatment orders are present for all pressure ulcers, proper treatment completion of pressure ulcers is documented, & possible adverse reactions related to not following physician's orders. The DON will attend wound rounds weekly to ensure the wound team is following the skin management policy. The Unit Manager/designee will audit (3) three resident records per unit per week to ensure there is a timely physician's order for the pressure ulcer treatment, the order is being followed, & proper documentation of treatments are occurring for (6) six months. For new/readmissions the Unit Manager/designee will follow up with a skin assessment the next business day after admission. 1:4 The DON/designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will	

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	wrap with kerlix daily. The Physician's Transfer Order had not been transcribed to the MAR/TARs (Medication Administration Record/Treatment Administration Records), dated 2/2022. A Physician's Order, dated 2/11/22, indicated the left heel was to be cleansed with wound cleanser, patted dried and skin prep was to be applied. This was the first treatment to the left heel completed by the facility per the MAR/TARs, dated 2/2022. The weekly left heel wound measurements were as follows: On 2/3/22 at 9:59 a.m., 5 cm x 4 cm, DTI. On 2/10/22 at 10:02 a.m., 5 cm x 4 cm, DTI, unchanged. 100% necrotic. A handwritten paper, dated 2/17/22 and no time written, was presented by the Wound Nurse with the measurements of 5.5 cm x 7 cm and no description of the wound. A Nurse's Progress Note, dated 2/18/22 at 9:18 a.m., indicated the resident was extremely lethargic and not waking up. The Nurse Practitioner was notified and an order was received to transfer the resident to the Emergency Room. There was no Transfer Form completed and sent with the resident that indicated the status of the resident and the skin condition of the resident. The Emergency Room Provider Notes indicated the resident was seen on 2/18/22 at 10:19 a.m. An Emergency Room Nurse's Progress Note,		monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 4-12-22	

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	dated 2/18/22 at 12:29 p.m., indicated a skin assessment was completed. Wounds were located on the left heel and sacrum. The Emergency Room Nurse had taken pictures of the left heel and sacrococcygeal area on 2/18/22. No measurements were documented. The measuring tool held up to the areas indicated the sacrococcygeal area was approximately 12 cm long with an area on the inner right buttock and the left heel was approximately 6 cm x 7 cm. The Hospital Wound Nurse Notes, dated 2/18/22 at 5:42 p.m., assessed the sacrococcygeal area as red/tan, non-blanching erythema, the wound was 2 cm x 3 cm with 0.2 cm depth, there was full thickness loss and it was staged at three. A picture of the wound was taken on 2/21/22. The left heel was first assessed on 2/18/22 at 5:40 p.m. and was described as red, necrotic, eschar, purple, measured 7 cm x 8.8 cm and was unable to be staged. there was 90% eschar on the heel. There was a picture of the heel which indicated it was taken on 2/21/22. The right heel, was first assessed on 2/18/22 at 5:40 p.m. and was red/purple and intact. It measured 5 cm x 4 cm and was classified as a DTI. On 3/24/22 at 11:53 a.m., the Wound Nurse indicated she was unsure why the treatment orders for the left heel from the hospital were not transcribed and why treatment to the left heel was not started until 2/11/22. She indicated the left heel was necrotic not a DTI, and it was not assessed correctly on 2/10/22 when it was marked with DTI. On 3/29/22 at 3:15 p.m., the Corporate RN indicated the area on the right heel was not			

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	present in the Emergency Room. The tags on the wound pictures were dated 2/21/22 not 2/18/22 and the amount of time she was in the Emergency Room could have caused those areas and the other areas to decline. 2) Resident E was observed sitting in a reclining chair in her room on 3/29/22 at 9:03 a.m. She wore bilateral heel protectors and had a dressing on her left heel. Resident E's record was reviewed on 3/29/22 at 9:16 a.m. The diagnoses included, but were not limited to dementia and stroke. A Quarterly MDS assessment, dated 1/30/22, indicated a long and short term memory problem, dependent on two for bed mobility and transfers, and dependent on one for bathing. The resident had a urinary catheter and was always incontinent of bowel. There were no pressure or venous/arterial wounds. A Care Plan, dated 3/17/22, indicated a pressure ulcer on the coccyx. The interventions included, assess and document areas, assist with bed mobility, provide incontinence care, notify Physician of worsening or no improvement in the he wound, and wound treatment as ordered. A Care Plan, dated 3/24/22, indicated a left heel pressure area. The interventions included to assist with bed mobility and wound treatments as ordered. A Nurse's Progress Note, dated 2/8/22 at 6:21 a.m., late entry for 1 a.m., indicated a 4 cm in diameter raised, hard area was found to the right of the coccyx. There was no break in the skin. The Physician would be notified of the area.			

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	There were no further Nurses' Progress Notes or assessments of the area to the right of the coccyx. On 3/11/22 at 6:41 a.m., a Nurse's Progress Note, indicated an area on the right buttock, was a stage 1 (non-bleachable red area, not opened), 0.5 cm x 0.5 cm with a depth of 0.2 cm, with a small amount of bloody drainage and sure prep was applied. A Physician's Order was written and discontinued 3/11/22 for sureprep to the right buttock every shift and cover with a bandage until area is resolved. There was no treatment order for the right buttock/sacrum area until 3/17/22. The Physician ordered a hydrocolloid dressing to be applied to the area after cleansing on Tuesday, Thursday, Saturday, and as needed. A Physician's Order, dated 3/15/22, indicated sureprep was to be used every shift on the left heel. There was no assessment of the left heel on 3/15/22. On 3/17/22 at 11:10 a.m., the Wound Nurse's Progress Note indicated an acquired sacrum pressure area. The area was measured at 2.7 cm x 3 cm with 0.3 cm depth, and was now a stage 3 with a small amount of serous drainage. A hydrocolloid dressing (dressing for superficial wounds) was applied. On 3/17/22 at 11:13 a.m., the Wound Nurse's Progress Note indicated an acquired DTI present on the left heel. The area was measured at 5 cm x 7 cm. and skin prep was applied.			

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The resident was transferred and admitted into the hospital on 3/23/22 due to lethargy and decreased responses. She returned to the facility on 3/25/22.

A Nurse's Progress Note, dated 3/25/22 at 5:17 p.m., indicated a return admission to the facility. A red open area was observed on the sacrum.

There was no assessment of the resident's left heel or a complete assessment of the area on the sacrum.

There were no transfer orders from the hospital for treatments to the left heel or sacrum area.

A Physician's Order, dated 3/27/22 and discontinued on 3/28/22, indicated to clean the left heel and apply maxorb alginate (antimicrobial protectant dressing) and cover with a foam dressing every evening shift.

A Physician's Order, dated 3/28/22, indicated to clean the left heel, pat dry, apply maxorb alginate and cover with a border foam dressing every evening shift.

A Physician's Order, dated 3/28/22, indicated exoderm satin hydrocolloid (full thickness pressure bandage) dressing to be applied to the sacrum and to change the dressing every Tuesday, Thursday, Saturday, and as needed.

The heel had not been treated from 3/25/22 to 3/27/22 and the sacrum had not been treated from 3/25/22 to 3/28/22.

On 3/29/22 at 1:29 p.m., the Wound Nurse and the Corporate RN were interviewed. The Wound Nurse indicated she was unable to find follow up

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	charting on the area of the right buttock from 2/8/22 and the next charting on the right buttock was 3/11/22. She indicated if the wound had a depth of 0.2 cm, it would not be a stage 1. The right buttock and the sacrum pressure ulcer was the same area. She would have looked at the area on 3/14/22 and was unable to remember the measurements. She was also unable to "recall" if she knew there had not been a treatment ordered for the area. She indicated she had not assessed the open areas since the resident returned from the hospital on 3/25/22 and would complete the assessments on 3/31/22. The Corporate Nurse indicated they would be completed on 3/29/22. The Corporate RN indicated, from 3/11/21 until 3/17/21, there had been no treatment order for the sacrum area. The nurse had documented on 3/25/22 there was a red open area on the coccyx. There was nothing documented about the left heel. There were no measurements. He indicated the nurses were not to measure or stage the areas and only the Wound Nurse was to measure and stage the areas. The Wound Nurse was to do this on the next business day. The nurses were to follow hospital transfer orders, and if treatments were not ordered, they were to notify the physician for orders. He indicated the pressure ulcers would be assessed "today" by the Wound Nurse and acknowledged no treatment had been ordered for the areas until 3/27/22 and 3/28/22. On 3/29/22 at 3:15 p.m., the Corporate RN presented a paper with the left heel measurements of 2 cm by 1.8 cm with no depth and the sacrum measurements of 3 cm x 2.5 cm with 0.2 cm depth. 3) During an observation on 3/23/22 at 9:57 a.m., CNA 3 and Agency CNA 4 were completing incontinent care. The buttock had excoriation with			

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	small open areas. There was a discoloration of the sacrum/coccyx area approximately 10 cm x 10 cm with an open area on the right lower buttock approximately 3 cm x 3 cm superficial. Agency LPN 2 entered the room and applied bacitracin/zinc ointment to the buttock area. She indicated there was no dressing ordered for the buttock area. Resident D's record was reviewed on 3/24/22 at 1:18 p.m. The diagnoses included, but were not limited to, protein calorie malnutrition and dementia. A Quarterly MDS assessment, dated 12/23/21, indicated a long and short term memory problem, extensive assistance of two for bed mobility, dependent on tow for transfers, and extensive assistance for all other activity of daily living. Was always incontinent of bowel and bladder, had no unhealed pressure ulcers, and no moisture associated skin damage (MASD). A Care Plan, dated 3/7/22, indicated impaired skin integrity of the right and left buttock, MASD. The interventions included, wound treatment as ordered. The Physician's Orders, dated 3/17/22, indicated bacitracin zinc ointment 500 units per gram to buttocks topically every shift for wound healing. The TAR dated 3/2022, indicated bacitracin zinc ointment apply to buttocks topically every shift for wound healing. Scheduled for Days, Evenings, and Night Shift. The TAR indicated the treatment had not been completed on Day Shift on March 18, 19, 20, 22, 24, and 25, 2022 and on Evening Shift on 3/26/22.			

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	A skin management policy, dated 10/2019, and received from the Administrator as current, indicated a head to toe assessment would be completed by a licensed nurse upon admission/re-admission and no less than weekly. The licensed nurse was responsible for assessing any and all skin alterations. Alterations were to be reported to the Physician/Nurse Practitioner and the Responsible Party/family. Treatment orders were to be obtained. All alterations in skin integrity were to be documented in the medical record. Residents were where admitted or readmitted with alterations in skin integrity were to have areas documented on the admission evaluation. The wound Nurse was to be notified and would complete a further evaluation of the wounds on the next business day. This Federal tag relates to Complaints IN00374167 and IN00375539. 3.1-40(1) 3.1-40(2) 3.1-40(3)			
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			

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	that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and interview, the facility failed to ensure residents maintained acceptable parameters of nutritional status related to meal consumption records not completed, weights not obtained as ordered, supplements not provided as ordered, and interventions not put in to place timely with significant weight loss for 3 of 4 residents reviewed for nutrition and weight loss. (Residents B, E and D) The Registered Dietician/Dietary Manager did not assess residents timely to assist in preventing weight loss, which resulted in significant weight losses for residents B and E. Finding includes: 1) Resident B's record was reviewed on 3/23/22 at 12:34 p.m. The diagnoses included, but were not limited to, diabetes mellitus. The admission date was 11/22/21. A Modification of Admission/Medicare 5 day Minimum Data Set (MDS) assessment, dated 11/29/21, indicated long and short term memory problems, no behaviors, required extensive assistance of one for bed mobility and transfers, supervision for eating, held food in her mouth, no significant weight loss or gain, and was on a mechanically altered diet.	F 0692	1:1 Residents B & D no longer reside in the Facility. Resident E was assessed by the Dietician on 3/26/22. Supplements given per order as resident allows. 1:2 Nurse Managers/designee obtained weights of all the current residents if the resident allowed. Registered Dietician/designee completed a whole house review of current resident weights to determine if weight loss occurred & supplements/fortified foods are necessary. Physician & family notified of any change of condition/new orders. Nurse Managers/designee completed a whole house audit on residents who require supplements/fortified foods to ensure completion of documentation. 1:3 The Director of Nursing/designee re-in-serviced the nursing staff on the weight policy, following physician's orders related to weights, supplements/fortified foods, proper	04/12/2022

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	A Care Plan, dated 11/29/21, indicated she was a nutrition risk. The interventions included, document food intake, honor preferences, serve diet as ordered, obtain weights, and mechanical soft diet. The Physician's Orders included: On 11/22/21, Remeron (antidepressant) 15 milligrams for appetite On 12/1/21 to 2/4/22, mechanical soft diet, with thin consistency fluids On 1/20/22 to 2/3/22, Ensure Plus (supplement) 1 can three times a day On 2/4/22, regular puree diet with nectar thick fluids and Ensure Clear (supplement) three time a day The monthly weights were as follows: On 11/22/21, 129.6 pounds On 12/8/21, 120 pounds (7.4% loss) On 1/17/22, 117.1 pounds (9.6% loss) On 2/2/22, 107.3 pounds (17.2% loss) A Nurse's Progress Note, dated 11/24/21 at 9:08 a.m., indicated a new order was received from the dietician to upgrade the diet to a mechanical soft diet and to discontinue the puree diet. A Nurse's Progress Note, dated 1/21/22 2:45 p.m., indicated a poor appetite. A Nurse Practitioner's Progress Note, dated 1/28/22 at 1:05 p.m., indicated the resident was very weak and the staff reported she is not eating or drinking very much. Discussed goals of care and resident's decline with the Power of Attorney (POA). The Daily Skilled Nurses' Notes indicated: On 12/3/21 at 9:56 p.m., refused meals, stated she		documentation of supplements/fortified food consumption, & notification of the Registered Dietician when a resident has a change in condition. Nutrition at risk meetings will be held weekly with the IDT to review resident weight loss, change in condition, pressure ulcers, & supplement/fortified food intake as well as new interventions if needed. 1:4 The DON/designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 4-12-22	

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	doesn't like the food. On 12/24/21 at 1:24 p.m., refused breakfast today. On 1/4/22 at 8:40 p.m., very weak, appetite poor. On 1/20/22 at 11:19 a.m., poor appetite. On 1/21/22 at 2:45 p.m., no appetite this shift. The November 2021 Meal Intake Forms indicated: On 11/23/21, 0-25% for breakfast, lunch and supper. On 11/24/21, 0-25% for breakfast and lunch, and 26-50% for supper. On 11/2521, refused breakfast and lunch and 0-25% for supper. On 11/26/21, 0-25% for breakfast, refused lunch, and 26-50% supper. On 11/2721, 26-50% breakfast, refused lunch, and supper not documented. On 11/28/21, no intake was documented for breakfast, lunch, and supper. On 11/29/21, 26-50% breakfast, refused lunch, and no intake was documented for supper. On 11/3021, 0-25% breakfast, no intake documented for lunch and supper. The December 2021 Meal Intake Forms indicated On 12/1/21, 0-25% for breakfast, lunch, and supper. On 12/2/21, 26-50% breakfast, 0-25% lunch and supper. On 12/3/21, 26-50% breakfast, no intake was documented for lunch and supper. On 12/4/21, refused breakfast and lunch and 0-25% for supper. On 12/5/21, 0-25% for breakfast lunch, and supper. On 12/6/21, 0-25% for breakfast, lunch, and supper. On 12/7/21, refused breakfast, 0-25% lunch and supper. On 12/8/21, 26-50% breakfast, lunch, and supper. On 12/9/21, 0-25% breakfast, refused lunch, 0-25%			

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	supper. On 12/10/21, 0-25% breakfast, refused lunch, supper not documented. On 12/11/21, 26-50% for breakfast and lunch and 0-25% for supper. On 12/12 21, 51-75% for breakfast, lunch and supper not documented. On 12/13/21, 26-50% for breakfast, lunch and supper not documented. On 12/14/21, 0-25% breakfast, refused lunch, 0-25% supper. On 12/15/21, 0-25% breakfast, lunch, and supper. On 12/16/21, 0-25% breakfast and lunch, and 26-50% supper. On 12/17/21, 26-50% breakfast, 76-100% lunch, 51-75% supper. On 12/18/21, 26-50% breakfast, refused lunch, and supper not documented. On 12/19/21, refused breakfast and lunch, and 26-50% supper. On 12/20/21, refused breakfast and lunch, and 0-25% supper. On 12/21/21, 0-25% breakfast, refused lunch, and 0-25% supper. On 12/22/21, 0-25% breakfast, lunch, and supper. On 12/23/21, refused breakfast and lunch, and 26-50% supper. On 12/24/21, 0-25% breakfast, refused lunch, and 0-25% supper. On 12/25/21, 0-25% breakfast, lunch, and supper. On 12/26/21, 26-50% breakfast, no documentation for lunch and supper. On 12/27/21, 0-25% breakfast and lunch, no documentation for supper. On 12/28/21, refused breakfast, 0-25% lunch, and refused supper. On 12/29/21, 0-25% breakfast, lunch, and supper. On 12/30/21, 0-25% breakfast and lunch and 51-75% supper. On 12/31/21, 0-25% breakfast and lunch, and			

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	26-50% supper. The January 2022 Meal Intake Forms indicated: 1/1/22, 0-25% breakfast and lunch, 51-75% supper. 1/2/22, 0-25% breakfast, lunch and supper. 1/3/22, 26-50% breakfast and lunch, 51-75% supper. 1/4/22, breakfast and lunch not documented, 51-75% supper. 1/5/22, refused breakfast, 0-25% lunch, and 26-50% supper. 1/6/22, no documentation of intake for breakfast, lunch, and supper. 1/7/22, 51-75% breakfast, lunch, and supper. 1/8/22, 0-25% breakfast, lunch, and supper. 1/9/22, 0-25% breakfast, refused lunch, no documentation for supper. 1/10/22, breakfast and lunch not documented, 0-25% supper. 1/11/22, nothing documented for breakfast, lunch, and supper. 1/12/22, 0-25% breakfast and lunch, no documentation for supper. 1/13/22, 0-25% breakfast, no documentation for lunch, 0-25% supper. 1/14/22, refused breakfast and lunch, and 0-25% supper. 1/15/22, 0-25% breakfast, lunch, and supper. 1/16/22, 0-25% breakfast, lunch not documented, 51-75% supper. 1/17/22, refused breakfast, 51-75% lunch and supper. 1/18/22, nothing documented for breakfast, lunch, and supper. 1/19/22, nothing documented for breakfast and lunch, refused supper. 1/20/22, nothing documented for breakfast and lunch, 26-50% supper. 1/21/22, 0-25% breakfast, no documentation for lunch, and 26-50% supper.			

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There was no Dietary assessment from the Registered Dietician or Dietary Manager located in the record.

No new interventions were initiated due to the poor appetite and continued significant weight loss until 1/20/22.

The Guardian had not been notified of the significant weight loss until 1/28/22.

On 3/23/22 at 4:15 p.m., the Administrator indicated there were no Registered Dietician or Dietary Manager assessments completed. She indicated the Nurse Practitioner had spoken to the Guardian about the resident's appetite and condition on 1/28/22, 1/31/22, and 2/3/22 and Ensure Plus was initiated on 1/20/22.

2) Resident E's record was reviewed on 3/29/22 at 9:16 a.m. The diagnoses included, but were not limited to, dementia and stroke. The resident was hospitalized from 1/30/22 to 2/3/22 and 3/23/22 to 3/25/22.

A Quarterly MDS assessment, dated 1/30/22, indicated long and short term memory problems, extensive assistance with bed mobility, dependent on staff for transfer, extensive assistance needed with eating, had no significant weight loss or gain, and was on a therapeutic diet.

A Care Plan, dated 9/30/21 and revised on 3/26/22, indicated a she was a nutrition risk. The interventions included, document food and fluid intakes, honor food preferences, provide diet and supplements as ordered (added 3/26/22), puree diet and the Registered Dietician was to evaluate and make diet change recommendations as

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	needed (added 3/26/22), and the Physician would be notified of significant weight changes. The Physician's Orders included: On 2/8/22, weekly weights for four weeks On 3/9/22, complete a three day calorie count. On 3/25/22, reduced carbohydrate puree diet On 3/28/22, fortified pudding with lunch and dinner, fortified cereal with breakfast, 2 cal supplement 120 milliliters was to be given twice a day, The weights were as follows: On 1/28/22, 128 pounds On 2/3/22, 132.1 pounds On 2/13/22, 130.1 pounds On 3/11/22, 108 pounds On 3/26/22, 112.6 pounds On 3/27/22, 112.6 pounds The weekly weights for four weeks were not completed as ordered on 2/8/22. There was a 16.9% weight loss from 2/13/22 to 3/11/22. A Dietary Progress Note, dated 2/10/22, indicated it was a Quarterly Assessment. The resident received a carbohydrate controlled mechanical soft diet. She consumed 51-75% of breakfast, 51-75% lunch, and 51-75% supper. She received no supplements or fortified food. No edema was noted and she had 7% weight gain in 180 days, which was not significant in the time frame. The Dietary Intake Forms indicated: On 2/4/22, breakfast and lunch - 76-100%, supper - 51-75%. On 2/5/22, no intake documented for breakfast and lunch, supper 51-75%. On 2/6/22, no documentation of intakes for breakfast, lunch, and supper.			

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	On 2/7/22, no documentation of intakes for breakfast, lunch, and supper. On 2/8/22, breakfast - 26-50%, 0-25% for lunch and supper. On 2/9/22,no breakfast and lunch, and supper 51-75%. On 2/10/22, breakfast and lunch - 26-50%, and supper 51-75%. On 2/11/22, no breakfast and lunch, and supper 51-75%. On 2/12/22, no intakes documented. On 2/13/22, no intakes documented. On 2/14/22, breakfast and lunch 51-75%, and no supper. On 2/15/22, no intake. On 2/16/22, no intake. On 2/17/22, no intake breakfast and lunch, and supper 76-100%. On 2/18/22, 75-100% breakfast and lunch, and no supper. On 2/19/22, no intake. On 2/20/22, no intake. On 2/2122, 75-100% breakfast and lunch, and supper 26-50%. On 2/22/22, 26-50% breakfast, lunch and supper. On 2/23/22, 26-50% breakfast, 0-25% lunch, no supper. On 2/24/22, no intake. On 2/25/22, 51-75% breakfast, 0-25% lunch, and no supper. On 2/26/22, no intakes documented. On 2/27/22, no intakes documented. On 2/28/22, breakfast and lunch 76-100%, and no supper. On 3/1/22, 0-25% breakfast and lunch, and 51-75% supper. On 3/2/22, breakfast and lunch 76-100%, no supper. On 3/3/22, no intake. On 3/4/22, breakfast and lunch 75-100%, and			

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	supper 51-75%. On 3/5/22, breakfast 76-100%, no lunch and supper. On 3/6/22, refused breakfast, 50-75% lunch, and 26-50% supper. On 3/7/22, 26-50% breakfast and lunch, and no supper. On 3/8/22, 0-25% breakfast and lunch, and no supper. On 3/9/22, 0-25% breakfast, refused lunch, and no supper. On 3/10/22, refused breakfast, 0-25% lunch, and refused supper. On 3/11/22 - no intake. A Nurse's Progress Note, dated 3/11/22 at 10 a.m., indicated she continued to have very poor appetite. She was now fed by the staff. Weight was obtained twice with a mechanical lift and showed a weight loss. The Power of Attorney was notified and a three day calorie count had been started on 3/8/22. A Physician's Progress note, dated 3/11/22 at 11:44 a.m. , indicated a significant weight loss. She refused to eat or drink most of the time as reflected on the three day calorie count. Impression & Plan: Torsemide (diuretic) discontinued and unintentional weight loss, consider appetite stimulant. Also consider reducing or eliminating Metformin/Tradjenta (diabetic medication) due to poor intake. The three day calorie count indicated the following intakes: 3-day cal count March 9-11, 2022 On 3/9/22 - 100% pancake, 25% cereal and 50% supplement 25% potato/noodle, 100 milk and juice 25% dessert			

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	50% sandwich, 25 % vegetable, 100% juice On 3/10/22 - 5 bites of pancake 5% meat, 100% juice, 75% desert 100 % juice, 50% juice, 100% supplement On 3/11/22 - 25 % toast, 100 juice , 100 ensure 25% soup, 25% vegetable, 25% bread, 100% juice, 100% dessert 50% soup, 25% vegetable There were no dietary notes, assessment, and/or recommendations until 3/26/22. A Registered Dietician's Progress Note, dated 3/26/22, indicated a significant change in weight. The weight was 113 and usual body weight was 123. The Body Mass Index was 18.7. A weight change of 17% in 1 month, 11% in 90 days, and 8% in 180 days. Calorie needs were 1398-1677 with 67 grams of protein and fluids of 1677 cc. (cubic centimeters). Intakes were less than 51% and fluid intake was less than 1000 cc's. Recommendations of fortified cereal and fortified pudding with lunch and dinner, and 2 cal supplement 120 cc's twice a day. On 3/29/22 at 1:38 p.m., the Dietary Manager indicated the total calories taken by the resident on the three day calorie count had not been completed. The Registered Dietician placed the resident on fortified foods and supplements, which were not started until 3/28/22. On 3/29/22 at 1:56 p.m., the Dietary Manager indicated she had never completed the three day calorie count form before. She had given a list of weight losses to the Registered Dietician a few weeks ago. There was nothing initiated when the significant loss occurred.			

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	3) During an observation of the noon meal on 3/24/22 at 12:39 p.m., Resident D was sitting in a high back reclining chair in the dining room. CNA 3 attempted to assist the resident with her noon meal several times and the resident would not take a bite or drink. She kept her eyes closed and would not open her mouth. CNA 3 indicated the resident was too sleepy and "she had her good days and bad days." Resident D's record was reviewed on 3/24/22 at 1:18 p.m. The diagnoses included, but were not limited to, protein calorie malnutrition and dementia. A Quarterly MDS assessment, dated 12/23/21, indicated long and short term memory problems, extensive assistance with eating, and no significant weight loss or gain. A Care Plan, dated 7/5/21, indicated a concern with nutritional intakes. The interventions included, provide and serve diet as ordered, serve supplements as ordered, and the Registered Dietician would evaluate as needed. The monthly weights are as follows: 7/5/21 - 124 pounds 9/3/21 - 122 pounds 11/8/21 - 123 pounds 12/6/21 - 119 pounds 2/2022 - 112.4 pounds, provided by the Administrator by a handwritten and undated CNA sheet 3/8/22 - 118 pounds. A Physician's Order, dated 5/19/21, indicated Ensure 1 can twice a day. A Physician's Order, dated 2/20/22, indicated a			

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	mighty shake (supplement), four ounces daily. The Medication/Treatment Administration Records, dated 3/2022, indicated the Ensure had not been given on 3/10/22 at 7 a.m., 3/11/22 at 4 p.m., 3/12/22 at 7 a.m., 3/15/22 at 4 p.m., 3/16/22 at 7 a.m., 3/18/22 at 7 a.m., 3/20/22 at 7 a.m., and 3/22/22 at 7 a.m. The four ounces of the mighty shake had not been given on March 10, 12, 16, 18, 19, 20, and 22, 2022. A facility policy for weight monitoring, dated 10/2018 and received from the Administrator as current, indicated the resident's physician and family/guardian would be notified of any verified significant weight change. Residents with verified significant weight change would be followed by the Interdisciplinary Team. Weekly weights would be taken on a designated day each week. Residents were to be reweighed if a change of plus or minus three pounds in a week was noted. This Federal tag relates to IN00374167. 3.1-46(a)(1)			