STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING 00 B. WING	12/20/2021

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and the Investigation of Complaint IN00368732. This visit resulted in an Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00368732 - Unsubstantiated due to lack of evidence. Survey dates: December 13, 14, 15, 16, 17, 18, and 20, 2021. Facility number: 000478 Provider number: 155494 AIM number: 100290430 Census Bed Type: SNF/NF: 71 Total: 71 Census Payor Type: Medicare: 6 Medicaid: 44 Other: 21 Total: 71 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 2, 2022.	F 0000		
F 0580 SS=E 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			

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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	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. (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			

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	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 observation, record review, and interview, the facility failed provide timely notification to the physician of blood glucose levels for 1 of 19 reviewed for Notification of Change. (Resident 46) Findings include: During an observation, on 12/15/21 at 10:53 a.m., Resident 46 was observed walking into the memory care unit dining room. There was a large pool of liquid on the dining room floor. CNA 8 indicated the resident had just had an accident and she had gotten him cleaned up. This had happened for the third time recently and he was urinating quite frequently. During a continuous observation, on 12/16/21 from 10:15 a.m. to 11:15 a.m., Resident 46 was confused as normal, walking about the memory care unit dining room. He would sit for short periods in the dining room, and then get up and walk around the room. At 10:42 a.m. he sat down in another resident's geriatric wheelchair in the hallway and closed his eyes. CNA 9 assisted the resident to his bed. The clinical record for Resident 46 was reviewed on 12/16/21 at 8:30 a.m. Diagnoses included, but were not limited to, cerebral infarction, alcohol dependence with alcohol induced persisting dementia, atrial fibrillation, altered mental status,	F 0580	F580 Change in Condition p="" paraid="1184384737" paraeid="{760a8ac4-6304-42eb-90 d5-b3c6e50b0337}{56}"> On 12/16/21 Resident #46's primary physician was contacted by the Director of Nursing and notified that the endocrinologist visit had not been scheduled. The primary physician recommended no changes in treatment at that time and scheduled a facility visit on Saturday 12/18/21.Referral documentation was scanned to Dr. Endocrinologist in Sellersburg, IN on 12/16/21 and the office was contacted for an appointment. On 12/17/21 the office scheduled an appointment for resident #46 on January 10,2022 at 11AM. Residents family (daughter) contacted and agreed to appointment. On January 10,2022 resident #46 was seen by the endocrinologist and medication adjustment was completed. On 12/16/21 The Director of Nursing completed an RN assessment on resident #46. The assessment included but is not	01/20/2022

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	mild cognitive impairment, cognitive communication deficit, Type 2 diabetes mellitus without complications, polyneuropathy, hypertension, and heart disease. The Quarterly MDS (Minimum Data Set) assessment, dated 11/5/21, indicated the resident was severely cognitively impaired, had diabetes mellitus, and required injections of insulin daily The hospital discharge summary, dated 4/9/21, indicated the resident would need to continue accuchecks (blood glucose monitoring) after meals and at bedtime after discharged and would need to be continued on high dose sliding scale insulin with the nursing home medical doctor to adjust insulin as needed. Orders at the time of discharge to the facility included, but were not limited to, insulin glargine 26 units every morning, insulin aspart 10 units three times daily every 6 hours and sliding scale as ordered, after giving SSI (sliding scale insulin) do not recheck finger or give more SSI until next scheduled check. Give sliding scale dose based on blood glucose 70 to 150 administer no insulin (none), 151 to 200 give 3 unites, 201 to 250 give 6 units, 251 to 300 give 9 units, 301 to 350 give 12 units, for blood sugars over 350 call the provider. The care plan, initiated on 6/14/21, indicated the resident had type 2 diabetes with risk for hypoglycemia and hyperglycemia. Interventions included, but were not limited to, check blood sugar per order and as needed, and notify MD of blood sugar results outside specified parameters. The physician's order, dated 10/22/21, indicated the resident's parameters were changed to notify the physician of any blood sugar levels below 60 or above 400.		limited to the following items: physical assessment, vital signs, glucose monitoring review (last seven days), current medication orders to treat diabetes and specialty referrals/recommendations. On 12/17/21 A telehealth review was completed with Reliant Health Care. During the telehealth review licensed nursing staff reviewed the RN assessment, the residents blood sugars (for the past seven days) and current treatment plan for diabetes. New orders were received, and family notified. (New orders received for Resident #46 include the following changes: Discontinue Metformin 500mg TID Start metformin 1000mg BID and sliding scale insulin). On 12/17/21 the intradisciplinary team completed an intradisciplinary care plan meeting to review resident #46 related to diabetes management. (For future reference the intradisciplinary team included the following participants: Director of Nursing, Assistant Director of Nursing, Dietary Manager, Director of Activities, Social Services, Therapy, certified Nursing Assistant). The comprehensive review included but was not limited to the following items: RN assessment Nurse Practitioner/Physician recommendations Blood glucose levels Specialist/Referrals Current interventions for managing	

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	The Blood Sugar Summary indicated the resident had multiple blood sugar levels above 400 on the following dates: - October 31 at 11:50 a.m., BS level was 459 mg/dL, with no physician notification documented. - November 5 at 1:14 p.m., BS level was 566 mg/dL, with no physician notification documented. - November 7 at 7:47 p.m., BS level was 484 mg/dL, with no physician notification documented. The physician's order, dated 11/8/21, indicated the resident's parameters were changed to notify the physician of any blood sugar levels below 60 or above 500. The Blood Sugar Summary indicated the resident's blood sugar levels were at/or above 500 on the following dates: - November 13 at 8:25 p.m., BS level 500 mg/dL, with no physician notification documented. - November 14 at 8:08 p.m., BS level 500 mg/dL, with no physician notification documented. - November 15 at 10:05 p.m., BS level 560 mg/dL, with no physician notification documented. - November 16 at 7:39 a.m., BS level 500 mg/dL, with no physician notification documented. - November 17 at 10:09 p.m., BS level 516 mg/dL, with no physician notification documented. - November 20 at 9:20 p.m., BS level 500 mg/dL, with no physician notification documented.		diabetes including medication Resident/Family preferences including appointment/referral and current treatment of diabetes Care Plan interventions were reviewed and updated by licensed nursing staff as indicated during this review to include diabetic management, specialty referrals. p="" paraid="2111795364" paraeid="{760a8ac4-6304-42eb-90 d5-b3c6e50b0337} {156}"> Resident #46 will continue to be monitored weekly by the intradisciplinary team (including the residents' physician) for a minimum of four weeks to validate that the current interventions are effective for management of diabetes. During the four weeks review the intradisciplinary team will complete a diabetic Monitoring Compliance audit that includes the following items- Oral/injectable meds given as ordered Blood sugars are monitored as ordered and MD is notified of blood glucose levels below 60 or above 400 ul="" role="list" Interventions are initiated as indicated to maintain blood sugars between 60 -400 to include medication management by the physician/nurse practitioner Any concerns identified will be communicated to the physician at the time of the review. On 12/16/21 The Director of Nursing	

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	- November 21 at 8:23 p.m., BS level 500 mg/dL, with no physician notification documented. - November 27 at 8:52 p.m., BS level 600 mg/dL, with no physician notification documented. - December 4 at 8:34 p.m., BS level 500 mg/dL, with no physician notification documented. During an interview, on 12/17/21 at 2:40 p.m., Resident 46's physician indicated the resident was on a sliding scale insulin, and he was to be notified any time the resident's blood sugar level was above 400. If the resident was above 400, he would want him to receive fast acting insulin. There was a change in nurses, who did not know the patients, so he chose to use longer acting insulin because there was less room for error. Agency staff did not know patients. He would rather not give the fast-acting insulin and would rather the patients have a high blood sugar level. The most current, undated Chane in Resident's condition or Status policy, provided on 12/20/21 at 2:15 p.m. by the DON (Director of Nursing) included, but was not limited to, "... It is the policy of the facility to ensure that the resident's attending physician and representative are notified of changes in the resident's condition or status... 1. The nurse will notify the resident's attending physician when... There is a change in the residents physical... status... There is a need to alter the resident's treatment plan significantly... Any result of a specifically ordered diagnostic test/evaluations that is outside normal parameters..." 3.1-5(a)(2) 3.1-5(a)(3)		identified fifteen Residents requiring glucose monitoring and diabetes management. On 12/16/21-12/17/21, The Director of Nursing completed an RN assessment on fifteen of fifteen residents. The assessment included but is not limited to the following items: physical assessment, vital signs, glucose monitoring review (last seven days), current medication orders to treat diabetes and specialty referrals/ recommendations. On 12/16/21-12/17/21, a telehealth review was completed with Reliant Health Care for fifteen of fifteen residents. During the telehealth review licensed nursing staff reviewed each resident's RN assessment, blood sugars (for the past seven days) and current treatment plan for diabetes. Results-or recommendations All blood sugars (for the last seven days), most recent A1C lab results, and current diabetic treatment plan reviewed by ADNS for fifteen of fifteen residents with telehealth clinician. All new orders received by clinician were entered into the residents' clinical record and reviewed by DNS. During the telehealth reviews, three of fifteen residents received medication adjustments and seven of fifteen residents received orders for Hgb A1C. Licensed nursing staff will be required to monitor glucose	

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			results as ordered each shift and report to the physician/nurse practitioner if blood glucose levels are below 60 or above 400 (unless otherwise specified by the physician). p="" paraid="1270696326" paraeid="{760a8ac4-6304-42eb-90 d5-b3c6e50b0337}{233}"> All Families notified of any new orders pertaining to clinician review and documented in the clinical record. For fifteen of fifteen residents, no referral request made at this time per telehealth clinician, following telehealth review. On 12/17/21 the intradisciplinary team completed an intradisciplinary care plan meeting for fifteen of fifteen residents. The comprehensive review included but was not limited to the following items: RN assessment ul="" role="list" Nurse Practitioner/Physician recommendations Blood glucose levels Specialist/Referrals Current interventions for managing diabetes including medication Resident/Family preferences including appointment/referral and current treatment of diabetes Care Plan interventions were reviewed and updated by licensed nursing staff as indicated during this review to include diabetic Management and specialty	

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			referrals. Each resident will continue to be monitored weekly by the intradisciplinary team (including the residents' physician) for a minimum of four weeks to validate that the current interventions are effective for management of diabetes and ensure follow up referrals are completed as indicated. During the four weeks review the intradisciplinary team will complete a diabetic Monitoring Compliance audit that includes the following items: oral/injectable meds given as ordered, blood sugars are monitored as ordered and MD is notified of blood glucose levels below 60 or above 400 unless otherwise specified by the physician, interventions are initiated as indicated to p="" paraid="400917200" paraeid="{78b274b6-6f3b-4581-bc3a-ca85ff012e11}{96}"> maintain blood sugars between 60 -400 to include medication management by the physician/nurse practitioner. Any concerns identified will be communicated to the physician at the time of the review. On 12/20/21 The Director of Nursing and Administrator reviewed the change of condition policy and recommended no changes to the policy. On 12/17/21, education was	

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			initiated by executive director (note the executive director, who is also a licensed nurse, regarding management of diabetes including writing orders for specialty referrals and the revised process for scheduling appointments This education was mandated for licensed nursing staff and all administrative managers. (For future reference administrative managers include the following: Activities Director, Rehab Manager, Dietary Manager, Business Office Manager, Assistant Director of Nursing, Director of Nursing, Certified Nursing Assistant, Director of Nursing, Administrator, Dietary Manager, Social Services, staff Development, and Housekeeping and Maintenance Director). As of 12/17/21, 11 of 11 Administrative staff, and 8 of 13 licensed nursing staff have received education regarding diabetic management and communication of physician referrals. Each participant was required to complete a post-test to validate competency. Knowledge was measured by a POST TEST that required 100% accuracy of the answers. (Facility and Agency, Licensed nursing staff will not be allowed to work after 12/17/21 unless they have successfully completed all assigned education). p="" paraid="111814867" paraeid="{78b274b6-6f3b-4581-bc3	

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			a-ca85ff012e11}{159}">All blood sugars will be reviewed daily in the morning clinical meeting (CQI) Monday through Friday for a minimum of four weeks to ensure licensed staff are completing physician notifications for any resident with a blood sugar less than 60 or greater than 400-unless otherwise specified by the physician/physician extender. On 1/17/22 a Change of Condition Quality Review Audit was reviewed and accepted by the Quality Assurance Performance Improvement Committee. The Director of Nursing/Designated Nurse will complete the Change of Condition Quality Review, to validate that any resident who has a change in condition has documentation to show the resident was informed, physician/designee consulted, and resident's representative notified consistent with his or her authority. Notifications will include the following: incident/accident, significant change in the residents physical/mental or psychosocial status (that is a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications), Need to alter a 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 a	

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			decision to transfer of discharge a resident from the facility. Furthermore, this review will include validation that the resident and the resident's representative, if any, are notified of the following: change in room or roommate assignment, change in residents' rights under federal or state law or regulations and validate periodic review of mailing addresses, email addresses and phone numbers of resident representative(s). Any concerns identified during the change of condition quality reviews will be addressed at the time of the review and additional education will be completed at that time. The Change of Condition Quality Review Audit will be completed on five residents a week for twelve weeks. The results of the Audits will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews. Following the initial twelve-week review, A minimum of 10 residents will be reviewed monthly until 100% compliance has been determined by the QAPI committee. (A minimum of seven months must be completed). On 12/17/21, an A Referral Quality Review Audit was reviewed and accepted by the	

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			Quality Assurance Performance Improvement Committee. The Director of Nursing/Designated Nursing will complete the Referral Quality Review Audit Tool, to validate that any resident who has a referral receives care and services necessary to schedule and complete appointments and validate that the Appointment Tracking Log is complete and reviewed daily during the morning meeting. Furthermore, this review will include validation that progress notes are being reviewed during the morning clinical meeting (CQI) to ensure no orders are there that need to be processed for implementation including specialty referrals. Any concerns identified during the referral quality reviews will be addressed at the time of the review and additional education will be completed at that time. The Referral Quality Review Audit will be completed five times a week for twelve weeks (Including a 100% review of all appointments/referrals). The results of the Audits will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews. Following the initial twelve-week 100% review, A minimum of 10	

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			residents will be reviewed monthly until 100% compliance has been determined by the QAPI committee. (A minimum of seven months must be completed). On 12/17/21, a Glucose Monitoring Quality Review Audit was reviewed and accepted by the Quality Assurance Performance Improvement Committee. The Director of Nursing/Designated Nurse will complete the Glucose Monitoring Quality Review Audit Tool, to validate that any resident who has abnormal glucose levels (above 400 or abnormally low below 60-unless otherwise specified by the physician) have appropriate communication with the resident's physician/designee, nursing assessment and review for specialty referrals. Any concerns identified during the Glucose Monitoring Quality reviews will be addressed at the time of the review and additional education will be completed at that time. The Glucose Monitoring Quality Review Audit will be completed five times a week for twelve weeks (Including a 100% review of all residents with glucose monitoring). The results of the Audits will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported	

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			from the Quality Reviews. Following the initial twelve-week 100% review, A minimum of 10 residents will be reviewed monthly until 100% compliance has been determined by the QAPI committee. (A minimum of seven months must be completed). Any patterns will be identified. If needed, an Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator until resolved. A member of the Regional Team will attend the monthly QAPI meetings on site or remotely x 3 months Date of Compliance 1/20/22	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's			

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	representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to revise and update a care plan related restorative therapy for 1 of 21 residents review for care plans. (Resident 51) Finding includes: The clinical record for Resident 51 was reviewed, on 12/18/21 at 1:31 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebrovascular accident, affecting left non - dominant side, weakness, contracture of muscle left ankle and foot, contracture left hand, dementia and traumatic brain injury. The Quarterly MDS (Minimum Data Set) assessment, dated 11/10/21, indicated the resident's cognition was moderately impaired. He required extensive assistance of two staff members with ADL's (Activities of Daily Living). The resident's restorative program was performed in the last 7 calendar days. He received PROM (Passive Range of Motion) for 5 days, AROM (Active Range of Motion) for 5 days and splint or brace assistance for 3 days.	F 0657	**F657 Care Plan timing/Revision** 1. On 12/17/21, resident #51's care plan was reviewed and revised by the MDS Coordinator to reflect the status of the splint. 2. On 1/18/22, the Director of Nursing, MDS Coordinator and therapy will review identified residents in the facility with orders for splints. Each resident will be reviewed to determine if the splint is appropriate and currently in use. Care plans will be reviewed and revised if indicated during this review. *3. On 12/20/21 The Director of Nursing and Administrator reviewed the Care Plan Assessment/Comprehensive Care Plans policy; no changes were required to the policy.* On 1/17/22, the MDS Coordinator	01/20/2022

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	The physician's order, with a start dated of 8/21, indicated the resident was to have an Occupational Therapy evaluation and treat as indicated. The care plan, dated 8/9/14 and revised on 3/26/21, indicated the resident had a contracture to the left shoulder, elbow, and left hand related to hemiplegia. The resident will have no further contractures. Interventions include, but were not limited to, inform the physician of any changes to contracture, and have restorative for PROM and therapy as needed. The review of the resident's Occupational notes, dated 10/26/21, indicated therapy discussed with the resident's nurse he had an area on the left hand in the crease. The nurse assessed and trimmed the resident's fingernails and applied cream on the area in his hand. His splint was put on hold for a week while treatment was completed to the area. The area was not caused from the splint, but from the resident's long fingernails digging into the skin due to contractures. The review of the resident's care plan lacked documentation the resident's splint was placed on hold. During an interview on 12/17/21 at 9:34 a.m., the Occupational Therapist indicated the resident was picked up for OT again on 8/21 for modification of a new splint and self-feeding. At that time the staff had not been trained to apply the new splint, and the old splint had been put on hold. During an interview on 12/18/21 at 4:10 p.m., LPN 17 (Licensed Practical Nurse) indicated the care plan would be updated or revised when there was a change in condition, a change in medication,		was re-educated on the Care Plan Assessment/Comprehensive Care plan policy. This education was completed by the Director of Nursing. The intradisciplinary team is responsible for validating new orders (including hold orders for splints) are reviewed daily in the morning clinical meeting (CQI) Monday through Friday and that care plans are revised as indicated. 4. On 1/17/21, a **Splint Care Plan Quality Review Audit** was reviewed and accepted by the Quality Assurance Performance Improvement Committee. The Director of Nursing/Designated Nursing will complete the **Splint Care Plan Quality Review Audit Tool**, to validate that any resident who has a splint or brace has a care plan that reflects the current treatment. Any concerns identified during the **Splint Care Plan Quality reviews** will be addressed at the time of the review and additional education will be completed at that time. The **Splint Care Plan** will be completed five times a week for twelve weeks (Including a 100% review of all residents with Splints/Braces. The results of the **Audits** will be submitted to the	

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	any new orders, and any therapy changes. During an interview on 12/20/21 at 8:39 a.m., MDS Coordinator indicated if a care plan was put on hold, she would remove the care area from the care plan. The care plan would be reinstated when therapy restarted the splint. On 12/20/21 at 8:30 a.m., the DON (Director of Nursing) presented a copy of the facility's current policy titled Care Plan Assessment/Comprehensive Care Plans" dated 3/23/21. Review of this policy included, but was not limited to, "...The Comprehensive Care Plan will further expand on the resident's risks, goals and interventions using the "Person-Centered" Plan of Care approach for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, physical functioning mental and psychosocial needs. These needs will be defined from observations, interviews, clinical medical record review and through assessment and CAAs. The Physician Orders, Change of Condition Forms, MAR's and Tar's are extensions of the Plan of Care."... 3.1-35(a) 3.1-35(e)		Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews. Following the initial twelve-week 100% review, A minimum of 10 residents will be reviewed monthly until 100% compliance has been determined by the QAPI committee. *(A minimum of seven months must be completed).* Any patterns will be identified. If needed, an Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator until resolved. A member of the Regional Team will attend the monthly QAPI meetings on site or remotely x 3 months Date of Compliance 1/20/22	
F 0658 SS=F Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-			

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	(i) Meet professional standards of quality. Based on observation, record review, and interview, the facility failed to ensure nursing services met professional standards of care for infection control practices, perineal care, quality of care, nursing assessments and monitoring, notification of change, and nursing knowledge of interventions. This deficient practice had the potential to affect all 71 residents residing in the facility. Findings include: 1. During the survey, multiple concerns were identified related to infection control practices of improper use of personal protective equipment in transmission based precautions rooms and perineal care. Cross Reference F880 2. Resident 46 experienced unstable blood glucose levels. Nursing staff had not notified the resident's physician each time his blood glucose levels were outside ordered parameters and failed to ensure an endocrinology appointment was set up as ordered by the physician. The physician did not address continual unstable blood glucose levels, and the resident experienced several instances of high blood glucose levels with no treatment or modification to insulin orders. The resident ultimately was hospitalized with hyperglycemic hyperosmolar nonketotic coma and diabetic ketoacidosis. Upon return to the facility the resident continued to experience unstable blood glucose levels, which the physician had not addressed with any sliding scale insulin coverage. Cross Reference F684 Cross Reference F580	F 0658	**F658 Professional Standards** 1. **Infection Control-**LPN # 13 was verbally educated by the DON on 12/16/21 regarding proper PPE in isolation rooms. LPN # 14 was verbally educated by the DON on 12/16/21 regarding proper PPE in isolation rooms. Nurse Aide #15 was verbally re-educated on completion of peri care and appropriate infection control practices on 12/17/21 by administrative nursing staff. **Glucose Monitoring**- On 12/16/21 The Director of Nursing completed an RN assessment on resident #46. The assessment included but is not limited to the following items: physical assessment, vital signs, glucose monitoring (last seven days), current medications to treat diabetes, and specialty referrals. On 12/17/21, a telehealth review was completed with Reliant Health Care. During the telehealth review licensed nursing staff reviewed the RN assessment, the residents blood sugars (for the past seven days) and current treatment plan for diabetes. New orders were received, and family notified. Resident #46 was seen by an endocrinologist on 1/10/22 and medication orders were adjusted. **Change of Condition-**	01/20/2022

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	3. Resident 54 developed a skin tear. Nursing staff had not adhered to professional standards of notifying the physician of a change in resident condition and obtaining treatment orders or complete any follow-up monitoring or assessment related to the new area of skin impairment. Cross Reference F684 4. Resident 54 had a fall on 12/15/21 resulting in a contusion to the head and complaints of right hip pain. The resident was sent to the hospital for evaluation. Upon return to the facility, the nursing staff had not initiated any neurological checks. The resident was observed complaining of pain and staff were observed to not assess or address the resident's complaints. Cross Reference F689 5. Nursing staff had not transcribed the physician's orders into the clinical record for a resident with excoriation to his contracted left hand. His nails were observed to be digging down into the skin of his palm, and moisture was creating excoriation. The physician ordered to apply a topical treatment and a pillowcase to the hand. When the orders were not transcribed and carried out, the resident developed a fungal infection to his hand. Cross Reference F684 During an interview, on 12/15/21 at 08:24 a.m., LPN (Licensed Practical Nurse) 6 indicated she would access the care plan to locate nonpharmacological interventions for behaviors, however, was unable to locate the care plan in the clinical record, she only referred back to the signs and symptoms of psychotropic medication.		**Resident #54** Resident #54 was assessed by licensed nursing staff on 12/20/21, a change of condition was completed, and treatment orders were clarified regarding skin tear on the rt. arm. Nail care was completed by licensed nursing staff. The physician and responsible party were notified as indicated and residents plan of care was revised. **Resident #51** On 12/20/21 the Clotrimazole order was clarified and rolled pillowcase to be inserted following the application of medication/cream was added to the treatment order. Resident and responsible party was notified and resident #51's care plan was revised as indicated. **Incident/Accidents-** On 12/20/21, resident #54 was reviewed by the intradisciplinary team. Resident #54's CT scan completed 12/15/21 was reviewed and determined to be within normal limits. A pain assessment was completed by licensed nursing staff on 12/20/21 the resident reported no pain at the time of the assessment. **Transcription of orders**- On 12/20/21 the Clotrimazole order was clarified and rolled pillowcase to be inserted following the	

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	The Facility Assessment Tool, dated 12/7/21, provided on 12/14/21 at 10:00 a.m. by the ED, included but was not limited to, "... Consider the following competencies... Activities of daily living... nail and hair care... perineal care... range of motion (upper or lower extremity)... Infection control... isolation, standard universal precautions including use of personal protective equipment... Resident assessment and examinations - admission assessment, skin assessment, pressure injury assessment, neurological check... observations of response to treatment, pain assessment... Caring for persons with Alzheimer's or other dementia... Specialized care... diabetic blood glucose testing, oxygen administration..." 3.1-35(g)(1) 3.1-35(g)(2)		application of medication/cream was added to the treatment order. Resident and responsible party was notified and resident #51's care plan was revised as indicated. 2. On 1/17/21 the Director of Nursing identified residents residing in the facility as having a potential to be affected by the facility provision of care that meets professional standards. *3. On 1/17/22 the administrator and Director of Nursing were provided education by the Regional Nurse consultant via teleconference regarding the components of F658. During the teleconference a team discussion took place to review all items identified in the 2567 and corrective actions necessary to meet professional standards of care. An Adhoc QAPI meeting was conducted on 1/17/22 to review and adopt recommended education/competencies and auditing tools for F580, F657, F658, F684, F686, F688, F689, F695, F697, F756, F838, F880 and F886 to ensure that the facility actions were compliant with implementing services that meet appropriate standards of care.*	

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			(Facility and Agency, Licensed nursing staff will not be allowed to work after 1/20/21 unless they have successfully completed all assigned education). *4. An Adhoc QAPI meeting was conducted on 1/17/22 to review and adopt recommended education and auditing tools for F580, F657, F658, F684, F686, F688, F689, F695, F697, F756, F838, F880 and F886 to ensure that the facility actions were compliant with implementing services that meet appropriate standards of care.* Any patterns will be identified. If needed, an Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator until resolved. A member of the Regional Team will attend the monthly QAPI meetings on site or remotely x 3 months Date of Compliance 1/20/22	
F 0684 SS=J 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			

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	facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. A. Based on observation, record review, and interview, the facility failed to address and manage unstable blood glucose levels for a resident with Diabetes Mellitus and to follow the physician recommendations for care for 1 of 21 residents reviewed for Quality of Care. (Resident 46) B. Based on observation, record review, and interview, the facility failed to ensure the physician was notified and treatment orders were obtained for a new skin impairment for Resident 54. The facility also failed to ensure physician orders were transcribed into the clinical record and implemented for Resident 51. This deficient practice affected 2 of 21 residents reviewed for Quality of Care. The Immediate Jeopardy began on 11/10/21 when the facility failed to follow physician recommendations to refer the resident to an endocrinologist related to unstable blood glucose levels. The resident's blood glucose levels became progressively unstable. On 12/5/21 the resident was hospitalized due to a change in condition and was hospitalized with the diagnoses of Diabetic Ketoacidosis and Hyperglycemic Hyperosmolar Nonketotic Coma. The resident returned to the facility and has continued to have unstable blood glucose levels with no changes made in his insulin treatment. The Executive Director, Assistant DON (Director of Nursing) and Nurse Consultant were notified of the Immediate	F 0684	**F684 Quality of Care** **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice—** **Resident #46** On 12/16/21 Resident #46's primary physician was contacted by the Director of Nursing and notified that the endocrinologist visit had not been scheduled. The primary physician recommended no changes in treatment at that time and scheduled a facility visit on Saturday 12/18/21. Referral documentation was scanned to Dr. Endocrinologist in Sellersburg, IN on 12/16/21 and the office was contacted for an appointment. On 12/17/21 the office scheduled an appointment for resident #46 on January 10,2022 at 11AM. Residents family (daughter) contacted and	01/20/2022

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	Jeopardy on 12/16/21 at 6:45 p.m. The immediate jeopardy was removed on 12/18/21, but noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: A. During an observation on 12/15/21 at 10:53 a.m., Resident 46 was observed walking into the memory care unit dining room. There was a large pool of liquid on the dining room floor. CNA (Certified Nursing Aide) 8 indicated the resident had just had an accident and she had gotten him cleaned up. This had happened for the third time recently and he was urinating quite frequently (common sign of diabetes mellitus). During a continuous observation, on 12/16/21 from 10:15 a.m. to 11:15 a.m., Resident 46 was confused as normal, walking about the memory care unit dining room. He would sit for short periods in the dining room, and then get up and walk around the room. At 10:42 a.m. he sat down in another resident's geriatric wheelchair in the hallway and closed his eyes. CNA 9 assisted the resident to his bed. The clinical record for Resident 46 was reviewed on 12/16/21 at 8:30 a.m. Diagnoses included, but were not limited to, cerebral infarction, alcohol dependence with alcohol induced persisting dementia, atrial fibrillation, altered mental status, mild cognitive impairment, cognitive communication deficit, Type 2 diabetes mellitus without complications, polyneuropathy, hypertension, and heart disease. The Quarterly MDS (Minimum Data Set) assessment, dated 11/5/21, indicated the resident		agreed to appointment. On 1/10/22 resident #46 was seen by the endocrinologist and medication adjustment was completed. On 12/16/21 The Director of Nursing completed an RN assessment on resident #46. The assessment included but is not limited to the following items. A) Physical assessment B) Vital Signs C) Glucose monitoring review (last seven days) D) Current medication orders to treat diabetes E) Specialty referrals or recommendations On 12/17/21 A telehealth review was completed with Reliant Health Care. During the telehealth review licensed nursing staff reviewed the RN assessment, the residents blood sugars (for the past seven days) and current treatment plan for diabetes. New orders were received, and family notified. New orders received for Resident #46 include the following changes- Ø Discontinue Metformin 500mg TID Ø Administer Metformin 1000mg BID and sliding scale insulin Ø Licensed nursing staff are responsible for on-going monitoring of blood glucose level and will report blood sugars above	

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	was severely cognitively impaired, had diabetes mellitus, and required injections of insulin daily The hospital discharge summary, dated 4/9/21, indicated the resident would need to continue accuchecks (blood glucose monitoring) after meals and at bedtime after discharged and would need to be continued on high dose sliding scale insulin with the nursing home medical doctor to adjust insulin as needed. Orders at the time of discharge to the facility included, but were not limited to, insulin glargine 26 units every morning, insulin aspart 10 units three times daily every 6 hours and sliding scale as ordered, after giving SSI (sliding scale insulin) do not recheck finger or give more SSI until next scheduled check. Give sliding scale dose based on blood glucose 70 to 150 administer no insulin (none), 151 to 200 give 3 unites, 201 to 250 give 6 units, 251 to 300 give 9 units, 301 to 350 give 12 units, for blood sugars over 350 call the provider. The care plan, initiated on 6/14/21, indicated the resident had type 2 diabetes with risk for hypoglycemia and hyperglycemia. Interventions included, but were not limited to, administer medications and insulins per order, check blood sugar per order and as needed, monitor labs as ordered, notify MD (physician) of blood sugar results outside specified parameters, and offer snacks as needed. The Blood Sugar Summary indicated the resident had multiple blood sugar levels above 350 on the following dates: - April 23 at 7:23 a.m., the resident's blood sugar (BS) level was 389 mg/dL (milliliters per deciliter). - April 24 at 4:39 p.m. and 4:40 p.m., BS level was		400 or below 60 to the physician/ nurse practitioner. On 12/17/21 the intradisciplinary team completed an intradisciplinary care plan meeting to review resident #46 related to diabetes management. (*For future reference the intradisciplinary team included the following participants: Director of Nursing, Assistant Director of Nursing, Dietary Manager, Director of Activities, Social Services, Therapy, certified Nursing Assistant).* The comprehensive review included but was not limited to the following items: A) RN assessment B) Nurse Practitioner/Physician recommendations C) Blood glucose levels D) Specialist/Referrals E) Current interventions for managing diabetes including medication F) Resident/Family preferences including appointment/referral and current treatment of diabetes Care Plan interventions were reviewed and updated by licensed nursing staff as indicated during this review to include diabetic management and specialty referrals.	

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	567 mg/dL; at 7:51 p.m., BS level was 384 mg/dL. - May 14 at 9:10 a.m., BS level was 397 mg/dL; at 1:24 and 1:25 p.m., BS level was 395 mg/dL; and at 7:44 p.m., BS level was 399 mg/dL. - May 26 at 9:01 p.m., BS level was 558 mg/dL. - June 7 at 10:08 a.m., BS level was 406 mg/dL. - June 8 at 9:30 a.m., BS level was 520 mg/dL; at 10:30 a.m., BS level was 445 mg/dL; at 1:39 p.m., BS level was 353 mg/dL; and at 3:54 p.m., BS level was 463 mg/dL. - June 9 at 7:06 p.m., BS level was 482 mg/dL. - June 10 at 8:19 p.m., BS level was 435 mg/dL. - June 11 at 4:40 p.m., BS level was 449 mg/dL. - June 12 at 4:56 a.m., BS level was 589 mg/d; and at 7:20 p.m., BS level was 545 mg/dL. - June 15 at 12:05 p.m., BS level was 365 mg/dL. - June 17 at 5:02 p.m., BS level was 353 mg/dL. - July 1 at 11:35 a.m., BS level was 513 mg/dL. - July 2 at 9:44 a.m., BS level was 530 mg/dL; at 8:40 p.m., BS level was 452 mg/dL. - July 3 at 8:21 p.m., BS level was 364 mg/dL. - July 10 at 7:47 p.m., BS level was 430 mg/dL. - July 11 at 8:14 p.m., BS level was 450 mg/dL. - July 26 at 11:55 a.m., BS level was 421 mg/dL.		Resident #46 will continue to be monitored weekly by the intradisciplinary team (*including the residents' physician)* for a minimum of four weeks to validate that the current interventions are effective for management of diabetes. During the four weeks review the intradisciplinary team will complete a diabetic Monitoring Compliance audit that includes the following items- Ø Oral/injectable meds given as ordered Ø Blood sugars are monitored as ordered and MD is notified of blood glucose levels below 60 or above 400 Ø Interventions are initiated as indicated to maintain blood sugars between 60 -400 to include medication management by the physician/nurse practitioner Any concerns identified will be communicated to the physician at the time of the review. **Resident #54** Resident #54 was assessed by licensed nursing staff on 12/20/21, a change of condition was completed, and treatment orders were clarified regarding rt. arm dressing change. Nail care was completed by licensed nursing staff. The physician and responsible party were notified as indicated and residents plan of	

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	- July 29 at 5:24 p.m., BS level was 401 mg/dL. - August 11 at 11:24 a.m., BS level was 391 mg/dL. - August 16 at 5:31 p.m., BS level was 442 mg/dL. - September 3 at 10:49 a.m., BS level was 600 mg/dL. - September 4 at 1:07 p.m., BS level was 371 mg/dL; and at 4:55 p.m., BS level was 347 mg/dL. - September 15 at 8:13 p.m., BS level was 382 mg/dL. - September 18 at 8:26 p.m., BS level was 434 mg/dL. - September 20 at 8:57 p.m., BS level was 369 mg/dL. - September 21 at 10:18 a.m., BS level was 569 mg/dL. - October 2 at 7:47 p.m., BS level was 378 mg/dL. - October 3 at 7:15 p.m., BS level was 500 mg/dL. - October 7 at 10:51 a.m., BS level was 357 mg/dL. - October 10 at 7:56 p.m., BS level was 386 mg/dL. - October 11 at 10:13 a.m., BS level was 416 mg/dL. - October 15 at 12:00 p.m., BS level was 457 mg/dL; and at 4:59 p.m., BS level was 490 mg/dL. - October 16 at 8:45 p.m. and 8:46 p.m., BS level was 380 mg/dL; at 3:38 p.m., BS level was 353		care was revised. **Resident #51** On 12/20/21 the Clotrimazole order was clarified and rolled pillowcase to be inserted following the application of medication/cream was added to the treatment order. Resident and responsible party was notified and resident #51's care plan was revised as indicated. **Infection Control** LPN # 13 was verbally educated by the DON on 12/16/21 regarding proper PPE in isolation rooms. LPN # 14 was verbally educated by the DON on 12/16/21 regarding proper PPE in isolation rooms. Nurse Aide #15 was verbally re-educated on completion of peri care and appropriate infection control practices on2/17/21 by administrative nursing staff. **2. How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action(s) will be taken—** On 12/16/21 The Director of Nursing identified fifteen Residents requiring glucose monitoring and diabetes management.	

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	mg/dL; and at 7:45 p.m., BS was 574 mg/dL. - October 17 at 8:00 p.m., BS level was 570 mg/dL. The physician's order, dated 10/19/21 at 12:26 p.m., indicated to discontinue the resident's sliding scale insulin. The physician's order, dated 10/22/21, indicated the resident's parameters were changed to notify the physician of any blood sugar levels below 60 or above 400. The resident's Lantus was increased to 25 units twice daily. There were no other medication changes related to the resident's insulin. The Blood Sugar Summary indicated the resident had multiple blood sugar levels above 400 on the following dates: - October 25 at 7:59 a.m., BS level was 554 mg/dL; and at 12:17 p.m., BS level was 471 mg/dL. The physician's note, dated 10/25/21 at 8:28 a.m., indicated the resident's Lantus was increased from 25 units twice a day to 30 units in the a.m. and 35 units at h.s. (bedtime). The physician's note, dated 10/26/21 at 12:15 a.m., indicated the physician ordered a onetime dose of Novolog (fast acting insulin) 10 units. - October 27 at 9:17 p.m., BS level was 568 mg/dL. The physician's note, dated 10/27/21 at 11:20 a.m., indicated the resident was discharged to the emergency room and returned at 5:52 p.m. with no new orders at that time. On 10/27/21 at 10:22 p.m., the physician changed		On 12/16/21-12/17/21, The Director of Nursing completed an RN assessment on fifteen of fifteen residents. The assessment included but is not limited to the following items. F) Physical assessment G) Vital Signs H) Glucose monitoring review (last seven days) I) Current medication orders to treat diabetes J) Specialty referrals or recommendations On 12/16/21-12/17/21, a telehealth review was completed with Reliant Health Care for fifteen of fifteen residents. During the telehealth review licensed nursing staff reviewed each resident's RN assessment, blood sugars (for the past seven days) and current treatment plan for diabetes. Results-or recommendations All blood sugars (for the last seven days), most recent A1C lab results, and current diabetic treatment plan reviewed by ADNS for fifteen of fifteen residents with telehealth. n clinician. All new orders received by clinician were entered into the residents' clinical record and reviewed by DNS.	

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	the resident's p.m. Lantus dose to 30 units. The resident received 30 units of Lantus in the a.m. and at h.s. - October 30 at 4:28 p.m., BS level was 589 mg/dL. The physician was notified with no new orders received. - October 31 at 11:50 a.m., BS level was 459 mg/dL. No physician notification documented. - November 1 at 8:14 p.m., BS level was 514 mg/dL. The physician was notified with no new orders received. - November 2 at 4:42 p.m., BS level was 483 mg/dL. The physician was notified with no new orders received. - November 5 at 1:14 p.m., BS level was 566 mg/dL. No physician notification documented. - November 6 at 6:05 p.m. and at 7:57 p.m., BS level was 500 mg/dL. The physician was notified with no new orders twice in the same day. - November 7 at 7:47 p.m., BS level was 484 mg/dL No physician notification documented. - November 8 at 9:12 p.m., BS level was 560 mg/dL. The physician's order, dated 11/8/21, indicated the resident's parameters were changed to notify the physician of any blood sugar levels below 60 or above 500. The Blood Sugar Summary indicated the resident's blood sugar levels were at/or above 500 on the following dates:		During the telehealth reviews, three of fifteen residents received medication adjustments and seven of fifteen residents received orders for Hgb A1C. Ø (Resident 1 of 3)-New order for Metformin 500 mg QD Ø (Resident 2 of 3) New order for Metformin 500 mg BID Ø (Resident 3 of 3) New order for Metformin 500mg BID Ø (7 of 15 residents) Hgb A1c lab Ø Licensed nursing staff will be required to monitor glucose results as ordered each shift and report to the physician/nurse practitioner if blood glucose levels are below 60 or above 400 (unless otherwise specified by the physician. All Families notified of any new orders pertaining to clinician review and documented in the clinical record. For fifteen of fifteen residents, no referral request made at this time per telehealth clinician, following telehealth review. On 12/17/21 the intradisciplinary team completed an intradisciplinary care plan meeting for fifteen of fifteen residents. The comprehensive review included but was not limited to the following items:	

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	- November 10 at 8:38 p.m., BS level 500 mg/dL. The physician was notified, advised the facility to set up an appointment with endocrinologist, and to give a onetime dose of 6 units of Novolog. - November 11 at 10:04 p.m., BS level 600 mg/dL. The physician was notified and ordered 8 units of Novolog. - November 13 at 8:25 p.m., BS level 500 mg/dL. No physician notification documented. - November 14 at 8:08 p.m., BS level 500 mg/dL. No physician notification documented. - November 15 at 10:05 p.m., BS level 560 mg/dL. No physician notification documented. - November 16 at 7:39 a.m., BS level 500 mg/dL. No physician notification documented. - November 17 at 10:09 p.m., BS level 516 mg/dL. No physician notification documented. - November 20 at 9:20 p.m., BS level 500 mg/dL. No physician notification documented. - November 21 at 8:23 p.m., BS level 500 mg/dL. No physician notification documented. - November 27 at 8:52 p.m., BS level 600 mg/dL. No physician notification documented. - December 4 at 8:34 p.m., BS level 500 mg/dL. No physician notification documented. The review of the nursing notes, indicated the resident experienced low blood sugars below 60, requiring physician notification on the following dates:		G) RN assessment H) Nurse Practitioner/Physician recommendations I) Blood glucose levels J) Specialist/Referrals K) Current interventions for managing diabetes including medication L) Resident/Family preferences including appointment/referral and current treatment of diabetes Care Plan interventions were reviewed and updated by licensed nursing staff as indicated during this review to include diabetic management, specialty referrals. Each resident will continue to be monitored weekly by the intradisciplinary team (*including the residents' physician)* for a minimum of four weeks to validate that the current interventions are effective for management of diabetes and ensure follow up referrals are completed as indicated. During the four weeks review the intradisciplinary team will complete a diabetic Monitoring Compliance audit that includes the following items- Ø Oral/injectable meds given as ordered Ø Blood sugars are monitored as ordered and MD is notified of blood glucose levels below 60 or above 400 unless otherwise specified by	

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	- June 24 at 12:45 a.m., BS level was 47 mg/dL, and he required a glucagon injection. - August 26 at 8:12 a.m., BS level was 47 mg/dL, and he required two glucagon injections. - September 23 at 8:07 a.m., BS level was 57 mg/dL, and he required a glucagon injection. - September 29 at 7:32 a.m., BS level was 57 mg/dl, and he required a glucagon injection. The nursing note, dated 11/6/21 at 11:29 p.m., indicated the resident required frequent checks by staff due to unpredictable increases and drops in blood sugar levels. The resident had gotten up two times during the shift and urinated on the floor, his bowel sounds were hyperactive, his blood sugar had been reading "HI" since 4:00 p.m. that same day. The resident's physician had been notified twice and had given no new orders. The nursing note, dated 11/10/21 at 8:44 a.m., indicated the resident had altered mental status and was not responding and could not swallow and was sent to hospital. The hospital later called report at 12:19 p.m. to report the resident would be returning to the facility, and that when he had arrived at the hospital his blood sugar had been 26. The nursing note, dated 11/10/21 at 8:25 p.m., indicated the physician was contacted regarding a blood glucose level of "HI". The physician advised to set up an appointment with an endocrinologist, and a onetime dose of NovoLog 6 units. The clinical record lacked documentation of any		the physician. Ø Interventions are initiated as indicated to maintain blood sugars between 60 -400 to include medication management by the physician/nurse practitioner Any concerns identified will be communicated to the physician at the time of the review. On 12/20/21 the Director of Nursing reviewed skin assessments for residents residing in the facility, no other residents were identified as having dressings or skin treatments without a physician's order. On 12/20/21 a facility nail care audit was completed by licensed nursing staff and resident nails were checked and trimmed (if indicated) by licensed/certified staff. Residents residing in the facility on 12/20/21 were identified by Director of Nursing Services as having the potential to be affected by facility adherence to appropriate infection control practices. (See F880 for additional interventions). 3. What measures will be put into place and what systemic changes will be made to ensure that the	

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	communication or appointments with an endocrinologist following the physician's request on 11/10/21. The nursing note, dated 11/10/21 at 11:35 p.m., indicated the resident's blood sugar was 600 mg/dL and the physician was notified at 8:03 p.m., with orders to administer 8 units of fast acting insulin. The resident's sugar was rechecked at 9:35 p.m. and the resident's blood sugar level was 504 md/dL. The nursing note, dated 11/28/21 at 5:42 a.m., indicated the resident's blood glucose level reading was "HI". The physician was made aware, however, the clinical record lacked documentation of any new orders. The nursing note, dated 12/2/21 at 2:30 a.m., indicated the resident's blood glucose level reading was "HI". The physician was made aware, however, the clinical record lacked documentation of any new orders. The nursing note, dated 12/5/21 at 1:36 a.m., indicated the resident was wandering in and out of his room with an unsteady gait and confusion, his blood sugar level registered as "HI", fluids were given, and vitals were obtained. The resident had a tremor in his hand, and he would not answer questions. The physician was notified with new orders to send to the hospital. The nursing note, dated 12/5/21 at 9:25 a.m., indicated the resident was admitted to the hospital for acute renal failure. The hospital discharge summary, dated 12/7/21, indicated the resident's current problems were acute renal failure, dementia, elevated troponin		deficient practice does not recur On 12/17/21, the procedure for scheduling referrals was reviewed and revised by the QAPI Committee. (*Participants involved in the QAPI Committee on 12/17/21 include the following participants Executive Director, Activities Director, Rehab Manager, Dietary Manager, Business Office Manager, Assistant Director of Nursing, Director of Nursing, Certified Nursing Assistant, staff development coordinator and Maintenance Director). Follow up via phone will be conducted with the medical director.* The revised process for scheduling referrals includes the following- A) Licensed nursing staff will be required to document referrals as a physician order B) Physician orders will be reviewed daily Monday through Friday in the morning clinical meeting C) A new **Facility Appointment Log**- this log will be completed by the transportation/scheduler daily to record all appointments and referrals with tracking to include scheduled appointments- residents will remain on the	

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	(acute), hyperglycemic hyperosmolar nonketotic coma, hyperkalemia, and lactic acid acidosis. He was treated with IV fluids and insulin administration. The resident's insulin order for Lantus was decreased to 25 units twice daily with instruction to continue to monitor and adjust insulin as needed. The resident returned to the facility on 12/7/21 in stable condition. The Blood Sugar Summary indicated the resident had continual elevated blood glucose levels above 400 mg/dL upon return to the facility as follows: - December 8 at 11:09 a.m., BS level was 405 mg/dL; and at 4:28 p.m., BS level was 430 mg/dL. - December 9 at 8:31 p.m., BS level was 429 mg/dL. - December 11 at 4:32 p.m., BS level was 428 mg/dL; and at 8:35 p.m., BS level was 483 mg/dL. - December 12 at 4:19 p.m., BS level was 550 mg/dL; and at 8:57 p.m., BS level was 418 mg/dL. - December 13 at 6:02 p.m., BS level was 465 mg/dL; and at 9:33 p.m., BS level was 409 mg/dL. - December 15 at 11:38 a.m., BS level was 501 and 444 mg/dL (both were documented at the same time); at 4:31 p.m., BS level was 500 mg/dL; and at 7:43 p.m., BS level was 600 mg/dL. The clinical record lacked documentation of any orders or administration for sliding scale insulin from the time of readmission, on 12/7/21 until 12/16/21, or any adjustments to the resident's insulin regimen between 12/7/21 and 12/16/21. During an interview on 12/16/21 3:03 p.m., the		appointment log until the scheduled appointment has been completed D) The appointment tracking log will be reviewed daily Monday through Friday by the administrator in the daily morning meeting with the department managers E) The DON/ADON will monitor all progress notes since the previous morning clinical meeting (CQI) to ensure no orders are there that need processed for implementation F) Licensed nursing staff are responsible for on-going monitoring of blood glucose level and will report blood sugars above 400 or below 60 to the physician/ nurse practitioner. G) Administrative nursing staff will communicate any delays in scheduling appointments with the residents' primary care provider as indicated, On 12/17/21, education was initiated by executive director who is also a licensed nurse), regarding management of diabetes including writing orders for specialty referrals and the revised process for scheduling appointments This education was mandated for licensed and all administrative managers. *(For future reference administrative managers include the following:*	

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	DON indicated she believed someone had told her the SSD (Social Services Director) had spoken with the family regarding a referral to an endocrinologist for the resident and they didn't want him to see one. During an interview on 12/16/21 at 3:10 p.m., the SSD indicated she had not spoken to the resident's family until this date (12/16/21) and the daughter had indicated she did want him to see an endocrinologist. If it's clinical, it wouldn't be her responsibility. She did not schedule the outside appointments, the bus driver did that. During an interview on 12/16/21 at 3:18 p.m., the DON and ED both indicated the MDS coordinator was currently responsible for scheduling appointments, but prior to two weeks ago the bus driver had been responsible for it. Neither the ED nor the DON personally had any conversations with the resident's family regarding his blood sugar levels. If family were notified of things, it would need to be documented. The DON had spoken with the resident's physician on this date (12/16/21), and he had no changes and planned to see the resident on his next visit to the facility. The ED indicated the resident had not had any endocrinologist appointments made for the resident at this time. During an interview on 12/17/21 at 1:58 p.m., Resident 46's physician indicated he had been caring for the resident for approximately four months. He had brittle diabetes and bounced back and forth from high to low without any medicine. He decided last month to send the resident to an endocrinologist. Whenever someone had brittle diabetes, an endocrinologist should be considered. He gave an order last month for the resident to see an endocrinologist. He was at the		*Activities Director, Rehab Manager, Dietary Manager, Business Office Manager, Assistant Director of Nursing, Director of Nursing, Certified Nursing Assistant, Director of Nursing, Administrator, Dietary Manager, Social Services, staff Development, and Housekeeping and Maintenance Director).* As of 12/17/21, 11 of 11 Administrative staff, and 8 of 13 licensed nursing staff have received education regarding diabetic management and communication of physician referrals. Each participant was required to complete a post-test to validate competency. Knowledge was measured by a POST TEST that required 100% accuracy of the answers. *(Facility and Agency, Licensed nursing staff will not be allowed to work after 12/17/21 unless they have successfully completed all assigned education).* All blood sugars will be reviewed daily in the morning clinical meeting (CQI) Monday through Friday for a minimum of four weeks to ensure licensed staff are completing physician notifications for any resident with a blood sugar less than 60 or greater than 400-unless otherwise specified by the physician/physician extender.	

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	point where he thought it might be better to let the resident have high blood sugars than to let him bottom out with low blood sugar. He expected the facility to call the endocrinologist and follow up on it, but indicated what they did, was call him and discussed potential realities. As a temporary situation the resident's sugars were a " ... a little bit higher ..." He was the one holding back, but he still felt the resident needed to see an endocrinologist. He was not sure if he documented that conversation. He did not adjust the resident's insulin because he felt they needed to make sure he didn't go into diabetic ketoacidosis (DKA). The resident needed an endocrinologist. He was going to decide on 12/18/21 how to proceed with his care. He indicated he could control the resident's condition. During an interview, on 12/17/21 at 2:40 p.m., Resident 46's physician indicated when the resident was hospitalized on 12/5/21, it was most important that it was not DKA. Even though his sugars were high, it was not a DKA. The bad one that could kill patients was DKA. He gave an order, and nursing staff had more information than him and told him he needed to adjust his orders. Communication between a doctor and a nurse was mostly verbal. He wasn't sure what he wanted to do and wasn't sure of the right direction. He indicated the resident was on sliding scale insulin, and he was to be notified any time the resident was above 400. If the resident was above 400, he would want him to receive fast acting insulin. There was a change in nurses, who did not know the patients, so he chose to use longer acting insulin because there was less room for error. Agency staff did not know patients. He would rather not give the fast-acting insulin and would rather the patients have high blood sugar. He		On 1/17/22 Licensed nursing staff were provided education regarding completion of change of condition for skin changes, transcription of treatment orders and monitoring nail care. The process for monitoring nail care was revised to include routine monitoring with showers. **Infection Control** On 1/17/22, the Director of Nursing /Infection Control Preventionist initiated education with facility licensed and certified nursing staff regarding the proper infection control procedures, isolation precautions (including N95 masks) and PPE. This education included a PPE skills observation and check-off to validate competency with use of PPE, handwashing competency observation, and peri-care instruction. On 12/17/21, the Director of Nursing reviewed the policy and procedures for proper use of PPE (*Personal Protective Equipment)* and Peri Care. No revisions were required. On 1/17/22 the annual facility infection control assessment was reviewed and revised by the Director of Nursing/Infection control preventionist and the Executive Director to include	

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	stated, "This delay in making a determination is mine completely, by tomorrow when I come there, you will see a clarity of direction. It won't be I have solved the problem; it will be I will have decided how I hope to solve the problem." Guidance for Hyperosmolar Hyperglycemic Nonketotic Coma (Updated 5/12/21), was obtained on 12/17/21 from the National Institutes of Health website. The guidance included, but was not limited to, "Hyperosmolar hyperglycemic syndrome (HHS) is a clinical condition that arises from a complication of diabetes mellitus. . . HHS is a serious and potentially fatal complication of type 2 diabetes. The mortality rate in HHS can be as high as 20% which is about 10 times higher than the mortality seen in diabetic ketoacidosis. . . this condition was formerly called . . . hyperosmolar hyperglycemic non-ketotic syndrome. . . HHS is a serious and potentially fatal complication of type 2 diabetes. . . If diabetes is well controlled, the chance of developing HHS is minimal. . . the glucose level in HHS is usually above 600 mg/dl. . . Dehydration is usually more severe in HHS as compared to DKA, and there is more risk for cardiovascular collapse. . . particular attention should be focused on the insulin regimen, missed doses of oral hypoglycemic agents, overconsumption of carbohydrate-rich diet, or simultaneous use of medications that can trigger hyperglycemia or cause dehydration. . . Treatment of HHS requires a multidisciplinary approach. Consultations with an endocrinologist and an intensive care specialist are recommended. . . to improve patient outcome, an interprofessional approach with good care communication and coordination between the Intensivist, nurse, dietician, and the endocrinologist are necessary. . . "		infection control education for facility and agency licensed and certified nursing staff including PPE and handwashing competencies. On 1/17/22 the facility QAPI Committee adopted a weekly infection control rounding tool that will be conducted weekly by the infection control preventionist/designee. This audit will be completed weekly to determine compliance with infection control and identify opportunities for education. **4. What quality assurance program will be put in place and by what date the systemic changes for each deficiency will be completed.** On 12/17/21, an **A Referral Quality Review Audit** was reviewed and accepted by the Quality Assurance Performance Improvement Committee. The Director of Nursing/Designated Nursing will complete the **Referral Quality Review Audit Tool**, to validate that any resident who has a referral receives care and services necessary to schedule and complete appointments and validate that the Appointment Tracking Log is complete and	

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	Guidance for NIH Hyperglycemic crises: Diabetic Ketoacidosis and Hyperglycemic Hyperosmolar State (Updated 5/9/21), was obtained on 12/17/21 from the National Institutes of Health website. The guidance included, but was not limited to, " ... Diabetic ketoacidosis (DKA) and hyperglycemic hyperosmolar state (HHS) are acute metabolic complications of diabetes mellitus that can occur in patients with both type 1 and 2 diabetes mellitus. Timely diagnosis, comprehensive clinical and biochemical evaluation, and effective management is key to the successful resolution of DKA and HHS. Critical components of the hyperglycemic crises' management include coordinating fluid resuscitation, insulin therapy, and electrolyte replacement along with the continuous patient monitoring using available laboratory tools to predict the resolution of the hyperglycemic crisis ... The mortality rate of HHS is higher, reaching 10-20% depending on associated comorbidities and severity of the initial presentation compared with DKA ... and is highest in those with DKA+ [and] HHS ... The two most common precipitating factors in the development of DKA or HHS are inadequate insulin therapy (whether omitted or insufficient insulin regimen) or the presence of infection ... Over 30% of patients have features of both DKA and HHS with most recent evidence confirming that about 1 out of 4 patients will have both conditions at the time of presentation with hyperglycemic crisis ... The cornerstone of DKA and HHS therapy is insulin in physiologic doses ... Once DKA has resolved, patients who are able to eat can be started on a multiple dose insulin regimen with long-acting insulin and short/rapid acting insulin given before meals as needed to control plasma glucose ... Several studies suggested that the omission of insulin is one of the most common precipitating factors of DKA ...		reviewed daily during the morning meeting. Furthermore, this review will include validation that progress notes are being reviewed during the morning clinical meeting (CQI) to ensure no orders are there that need to be processed for implementation including specialty referrals. Any concerns identified during the **referral quality reviews** will be addressed at the time of the review and additional education will be completed at that time. The **Referral Quality Review Audit** will be completed five times a week for twelve weeks (Including a 100% review of all appointments/referrals). The results of the **Audits** will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews. Following the initial twelve-week 100% review, A minimum of 10 residents will be reviewed monthly until 100% compliance has been determined by the QAPI committee*. (A minimum of seven months must be completed).* On 12/17/21, a **Glucose Monitoring Quality Review**	

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	Considering DKA and HHS as potentially fatal and economically burdensome complications of diabetes, every effort for diminishing the possible risk factors is worthwhile ..." The immediate jeopardy, that began on 11/10/21, was removed on 12/18/21 when the DON completed a review of the resident's vitals, glucose monitoring review for the last 7 days, and current medication orders to treat diabetes, the physician adjusted the medication regimen for Resident 54, and the appointment for the resident to see an endocrinologist was scheduled, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy, because the facility would need to conduct ongoing monitoring of Resident 46, diabetic monitoring compliance audits would need to be conducted, diabetic residents would need continued monitoring, and further staff education would need to be provided. B.1. During an observation, on 12/14/21 at 9:46 a.m., Resident 54 was sitting in his recliner in his room. His right arm was observed to have a large, bordered gauze dressing which had a moderate amount of dried, flaking reddish-brown staining. Below the dressing was a approximately 2 inch by 2 inch piece of duct tape. His pants and shirt were also observed to have dried reddish brown staining on them. The resident indicated he had hit his arm and staff had not done anything about it. The dressing was worn and stained, with the gauze fabric pilling and fraying. During an observation, on 12/14/21 at 1:47 p.m., the resident was out to the dining room. He approached the nurse on the unit and asked her if she was going to help fix his arm. The nurse did		**Audit** was reviewed and accepted by the Quality Assurance Performance Improvement Committee. The Director of Nursing/Designated Nursing will complete the **Glucose Monitoring Quality Review Audit Tool**, to validate that any resident who has abnormally high (above 400 or abnormally low below 60-unless otherwise specified by the physician) blood sugars have appropriate communication with the resident's physician/designee, nursing assessment and review for specialty referrals. Any concerns identified during the **Glucose Monitoring Quality reviews** will be addressed at the time of the review and additional education will be completed at that time. The **Glucose Monitoring Quality Review Audit** will be completed five times a week for twelve weeks (Including a 100% review of all residents with glucose monitoring. The results of the **Audits** will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews. Following the initial twelve-week 100% review, A minimum of 10 residents will be reviewed monthly	

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	not answer the resident's question or assess his arm. She assisted him to sit down at a table. During an observation on 12/15/21 at 9:13 a.m., the resident was sitting in his recliner in his room. The duct tape was no longer in place on the resident's arm, however the bordered gauze dressing remained in place, with dried, flaking reddish brown staining to the gauze. The resident stated, "They ain't fixed it! I asked them to fix it and they wouldn't do it!" During an observation, on 12/15/21 at 1:00 p.m., the resident was sitting in his recliner in his room. The dressing to the resident's right arm remained unchanged. During an observation, on 12/17/21 at 8:15 a.m., the resident was sitting in his recliner in his room. The dressing to the right forearm was no longer in place. A small, scabbed area to the arm was observed where the dressing had been. The clinical record for Resident 54 was reviewed on 12/15/21 at 10:40 a.m. Diagnoses included, but were not limited to, muscle weakness, heart failure, hypertension, chronic obstructive pulmonary disease, dependance on supplemental oxygen, chronic pain, presence of cardiac defibrillator, dementia, fracture of right wrist, unspecified intellectual disability, osteoarthritis, lack of coordination, and other abnormalities of gait and mobility. The Quarterly MDS assessment, dated 10/9/21, indicated the resident's cognition was moderately impaired and he had no skin impairments. The care plan, dated 8/29/19, indicated the resident was at risk for self-abusive acts, and had		until 100% compliance has been determined by the QAPI committee. *(A minimum of seven months must be completed).* Any patterns will be identified. If needed, an Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator until resolved. A member of the Regional Team will attend the monthly QAPI meetings on site or remotely x 3 months On 1/17/21 a **Change of Condition Quality Review Audit** was reviewed and accepted by the Quality Assurance Performance Improvement Committee. The Director of Nursing/Designated Nursing will complete the **Change of Condition Quality Review**, to validate that any resident who has a change in condition has documentation to show the resident was informed, physician/designee consulted, and resident's representative notified consistent with his or her authority. Notifications will include the following: incident/accident, significant change in the residents physical/mental or psychosocial status (that is a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications), Need to alter a	

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	a history of scratching and picking at his skin. Interventions included, but were not limited to, notify physician and family as needed of any treatment or medications as ordered for any injury. The care plan, dated 4/12/21, indicated the resident was at risk for bleeding related to the use of antiplatelet medication. Interventions included, but were not limited to, document abnormal findings and notify the physician. The physician's orders, dated 12/4/21, indicated the resident received aspirin 81 mg daily and Plavix 75 mg daily. The nursing note, dated 12/12/21 a 2:30 p.m., indicated the resident appeared to have a small 0.1 cm (centimeter) by 0.5 cm skin tear on his right elbow. Initially he would not allow staff to treat, but when the resident was calm, the area was cleansed with wound cleaner and a border gauze was applied. The resident could not recollect how he obtained the skin tear. The clinical record lacked documentation of any notification to the family, physician, or of any treatment orders for the skin tear. During an interview on 12/20/21 at 12:10 p.m., the DON (Director of Nursing) indicated she had seen the note about the resident's skin tear. When a resident had a new skin impairment, they should open a change in condition note, notify the family and doctor, and ensure treatment orders are in place. 2. During an observation, on 12/13/21 at 10:36 a.m., Resident 51 was observed with long jagged fingernails to his left hand. His left palm and his hand appeared red in color.		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 a decision to transfer of discharge a resident from the facility. Furthermore, this review will include validation that the resident and the resident's representative, if any, are notified of the following: change in room or roommate assignment, change in residents' rights under federal or state law or regulations and validate periodic review of mailing addresses, email addresses and phone numbers of resident representative(s). Any concerns identified during the **change of condition quality reviews** will be addressed at the time of the review and additional education will be completed at that time. The **Change of Condition Quality Review Audit** will be completed five times a week for twelve weeks (this audit will include monitoring for change of condition with abnormal glucose levels and skin treatment changes). The results of the **Audits** will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews.	

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	The clinical record for Resident 51 was reviewed, on 12/18/21 at 1:31 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebrovascular accident, affecting left non-dominant side, weakness, contracture of muscle left ankle and foot, and contracture left hand The Quarterly MDS assessment, dated 11/10/21, indicated the resident's cognition was moderately impaired. He required extensive assistance of two staff members with ADL's (Activities of Daily Living). The physician's verbal orders, dated of 10/26/21, indicated to apply a prescription barrier cream to the resident's buttocks and groin topically every shift for redness. Apply to palm left hand topically every shift for excoriation and a rolled pillowcase to be placed in palm after cream applied. The nurse's note, dated 10/26/21 at 12:31p.m., indicated during care the resident had excoriated area to the palm of his left hand, which was contracted. He was currently working with therapy per order on brace for the contracture. The physician was notified with new orders for prescription barrier cream to area and apply rolled pillowcase to area every shift. The clinical record lacked documentation indicating the order for a rolled pillowcase to be placed in the resident's left palm was transcribed into the resident's clinical record. During an interview on 12/17/21 at 9:30 a.m., LPN 19 (Licensed Practical Nurse) indicated the resident had a roll that he was supposed to wear		Following the initial twelve-week review, A minimum of 10 residents will be reviewed monthly until 100% compliance has been determined by the QAPI committee. *(A minimum of seven months must be completed).* On 1/17/22, an **Infection Control Quality Review Audit Tool** was reviewed and accepted by the Quality Assurance Performance Improvement Committee. The Director of Nursing/Infection Control Preventionist and Administrative staff will complete random PPE observations, using the Infection Control Quality Review Audit Tool, to validate that infection control procedures are followed. This audit will also include monitoring for proper peri care (by licensed observer), following isolation guidelines, handwashing and use of appropriate masks. Any concerns identified during the infection control observations will be addressed at the time of the observation and additional education will be completed at that time. The Infection Control Quality Review Audit will be completed five times a week for twelve weeks. The results of the **Audits** will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education	

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	all the time for his contracture and moisture. His left hand holds moisture. When a doctor gives a verbal order, it should be added to the clinical record at the time he gave the order. On 12/20/21 at 8:30 a.m., the DON presented a copy of the facility's current policy titled Physician Orders (Following Physician Orders)." Review of this policy included, but was not limited to, "...It is the policy of the facility to follow the orders of the physician. At the time of admission, the facility must have physician's orders for the resident's immediate care. The facility will have orders to provide essential care to the resident, consistent with the resident's mental and physical status upon admission. ...2. As assessments are completed, orders will be received from the physician to address significant findings of the assessment." 3.1-37(a) 3.1-37(b)		or competencies are required, based on the compliance reported from the Quality Reviews. Following the initial twelve-week review, A minimum of 10 residents will be reviewed monthly until 100% compliance has been determined by the QAPI committee. *(A minimum of seven months must be completed).* Date of Compliance 1/20/22	
F 0686 SS=D 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			

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	new ulcers from developing. Based on record review and interview, the facility failed to ensure the implementation of interventions were in place to prevent the development of a pressure ulcer for 1 of 5 residents reviewed for pressure ulcers. (Resident 36) Findings include: The clinical record for Resident 36 was reviewed on 12/20/21 at 8:37 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, difficulty walking, muscle weakness, cardiomyopathy, osteoarthritis, encephalopathy, nicotine dependence, schizophrenia, obesity, and viral infections. The Quarterly MDS (Minimum Data Set) assessment, dated 10/15/21, indicated the resident was cognitively intact. The care plan, dated 7/14/21, indicated the resident was unable to lie flat due to becoming shortness of breath. The resident required the head of the bed to be elevated due to shortness of breath when lying flat, related to chronic obstructive pulmonary disease. The intervention was to maintain elevation of the head of the bed to facilitate breathing and prevent shortness of breath. The clinical record lacked documentation of any interventions to prevent the development of pressure ulcers. The nurse's note, dated 8/31/21 at 3:35 p.m., indicated during wound rounds the resident complained of discomfort when the left lower buttock area was touched. The resident reported	F 0686	**F686 Tx/Services to Prevent/Heal pressure Ulcers** 1. On 1/17/21, resident #36's care plan, wound evaluation/assessment and physician orders were reviewed and revised by the Director of Nursing Services and MDS Coordinator to address current care and services necessary for prevention of pressure ulcers. Resident #36 does not have any current pressure ulcers and has been provided a pressure reduction wheelchair cushion. Resident #36's care plan has been reviewed and revised to include potential for skin breakdown. 2. On 1/17/21-1/18/22, residents residing in the facility that are determined to be at risk for pressure ulcers were identified by the Director of Nursing as having the potential to be affected by appropriate treatments to prevent/heal pressure ulcers. On 1/17-1/18/22, the Director of Nursing and MDS Coordinator reviewed the identified residents to validate that current skin conditions have appropriate wound evaluations/assessments, treatments, pressure reducing surfaces/equipment and care plans that reflect current physician	01/20/2022

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	she had an open area and it had been there for a while. The area measured 1.6 cm (centimeters) by 1.6 cm by 0.2 cm. The wound was dry with no drainage, and had a pinkish red wound bed, with a pink peri-wound. The resident indicated she had area in the same place when she was at home, and it opened and closed frequently. The area was cleaned and patted dry. The doctor was notified, and new orders were obtained for Medihoney and foam dressing on the evening shift, started on 8/31/21 and discontinued on 9/7/21. The telehealth visit, dated 9/4/21 at 9:32 a.m., indicated the resident was seen for a pressure wound on the left buttocks. The Stage II wound measured 1 cm long by 4 cm wide by 0.2 cm deep and was identified on 8/31/21. The Treatment Administration Record for September 2021 indicated an order to apply Medihoney, skin prep to the peri-wound, cover with a foam dressing every day shift, started on 9/8/21 and discontinued on 9/21/21. The telehealth visit, dated 9/19/21 at 9:05 a.m., indicated the pressure wound on the left buttocks measured 0.6 cm long by 2.9 cm wide, by 0.2 cm deep. There was no tunneling, undermining or sinus tract. There was scant, thin, and watery serous exudate (fluid made up of cells, proteins, and solid materials) observed. The wound tissue color was black and red and was warm to the touch. The telehealth visit, dated 10/2/21 at 10:41 a.m., indicated an order for silver sulfadiazine cream 1% (percent) applied to the left gluteal fold topically, everyday shift for wound healing. Cleanse the wound with wound cleanser, pat dry, skin prep peri-wound, and cover with dressing. The Stage		orders and wound care needs (including actual and potential for skin breakdown interventions and care plans). Care plans were reviewed and revised to ensure care plans reflect actual and potential risk for skin injuries based on each resident's risk. Any discrepancies were revised if indicated during this review. 3. On 1/17/22, the Director of Nursing /Incensed nurse designee-initiated education with licensed nursing staff regarding treatment and services to prevent and heal pressure ulcers. This education included verification of pressure reduction surfaces and implementation of at risk for skin breakdown care plans for at risk residents. On 12/20/21, Director of Nursing reviewed the procedure for "Baseline Care Plan Assessments/Care Plan "policy and procedure and found the policy to be acceptable. *(Facility and Agency, Licensed nursing staff will not be allowed to work after 1/20/21 unless they have successfully completed all assigned education).*	

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	II pressure wound measured 1.2 cm long by 2.7 cm wide by 0.4 cm deep. There was a small amount of thin and watery sanguineous drainage. The wound was yellow and red in color. The surrounding tissue was warm. The telehealth visit, dated 10/9/21 at 10:44 a.m., indicated an order for Medihoney wound/burn dressing gel. The directions indicated to apply to the left dorsogluteal fold topically every shift for wound healing and cover with a dry dressing. The start date was 10/09/21. The Stage II pressure injury to the left buttocks measured 0.8 cm long by 1.8 cm wide by 0.3 cm deep. There was a small amount of thin/water sanguineous exudate with no odor. There was 0% epithelial tissue, 100% granulation, 0% slough, 0% necrotic tissue. The wound was red in color. The wound margins were undefined, and the surrounding tissue was warm. The current treatment was Medihoney per order. The current preventative interventions were a pressure redistribution mattress and a wheelchair cushion. The telehealth visit, dated 10/30/21 at 11:40 a.m., indicated an order of Medihoney wound/burn dressing gel. The directions indicated to apply to the left dorsogluteal fold, topically every shift for wound healing and cover with a dry dressing, with a start date of 10/09/21. The Stage II pressure injury on the left buttocks, measured 0.2 cm long by 0.7 cm wide by 0.1 cm deep. The nurse's note, dated 11/10/21 at 10:11 a.m., indicated the area to the left buttock was noted as healed. The area had pink intact skin with no drainage noted. Resident denies any pain to area. During an interview on 12/20/21 at 11:10 a.m., LPN (Licensed Practical Nurse)19 indicated the		4. On 1/17/22, an **A Pressure Ulcer Treatment/Prevention Quality Review Audit** was reviewed and accepted by the Quality Assurance Performance Improvement Committee. The Director of Nursing/Designated Nursing will complete random pressure ulcers reviews using the **Pressure Ulcer Treatment/Prevention Quality Review Audit Tool**, to validate that resident(s) receive treatments and Services to prevent/heal pressure ulcers and to validate wound care plans are developed and implemented as indicated to meet the needs of the resident based on wound evaluations/assessments and risk for pressure ulcers. Any concerns identified during the **pressure ulcer/treatment/prevention quality reviews** will be addressed at the time of the review and additional education will be completed at that time. The **Pressure Ulcer Treatment/Prevention Quality Review Audit** will be completed on five residents a week for twelve weeks. The results of the **Audits** will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews.	

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WATERS OF SCOTTSBURG, THE	1350 N TODD DR SCOTTSBURG, IN 47170

(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
	resident needed assistance at times. Every day was different. She could need help one day and then walk on her own another day. The LPN had not seen the prior pressure ulcer. The interventions would be for a new cushion to her chair, but she was not sure if the facility had gotten that for her yet. During an interview on 12/20/21 at 11:14 a.m., the DON (Director of Nursing) indicated the resident could turn a little on her own. She liked for staff to use a draw sheet when they turned her in bed. The DON looked for an at risk for the development of a pressure ulcer care plan but could not locate one. On 12/20/21 at 8:30 a.m., the DON provided the Baseline Care Plan Assessment/Care Plans policy and procedure, revised on 3/23/21. The policy included, but was not limited to, "...The facility Interdisciplinary team in conjunction with the resident, resident's family, surrogate or representative as appropriate along with 'hands on' caregiver, such as a Certified Nursing Assistant will discuss and develop quantifiable objectives along with appropriate interventions in an effort to achieve the highest level of functioning and the greatest degree of comfort/safety and overall well-being attainable for the resident..." 3.1-40(a)(1) 3.1-40(a)(2)		Following the initial twelve-week 100% review, A minimum of 10 residents will be reviewed monthly until 100% compliance has been determined by the QAPI committee. *(A minimum of seven months must be completed).* - Date of Completion—1/20/22----	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience			

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	reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.			
	Based on observation, interview and record review the facility failed to ensure restorative therapy services were provided to prevent a decrease in range of motion for 2 out of 3 residents reviewed for range of motion. (Residents 51 and 28) Findings include: 1. The clinical record for Resident 51 was reviewed, on 12/18/21 at 1:31 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebrovascular accident, affecting left non-dominant side, weakness, contracture of muscle left ankle and foot, and contracture left hand The Quarterly MDS (Minimum Data Set) assessment, dated 11/10/21, indicated the resident's cognition was moderately impaired. He required extensive assistance of two staff members with ADL's (Activities of Daily Living). The physician's order, dated 11/2/21, indicated for	F 0688	**F688 Increase/Prevent Decrease in Range of Motion/Mobility** 1. On 1/18/22, resident #51's therapy recommendations and physician orders will be reviewed and revised by the Director of Nursing Services, therapy and MDS Coordinator to validate appropriate interventions for the left ankle, left foot and left hand including passive range of motion and application of boot/splint. Resident 51's care plan and restorative documentation will be reviewed and revised as indicated during the review. On 1/18/22, resident #28's therapy recommendations and physician orders will be reviewed and revised by the Director of Nursing	01/20/2022

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	an OT (Occupational Therapy) evaluation and to treat as indicated. The care plan, dated 8/9/14 and revised on 3/26/21, indicated the resident had a contracture to his left shoulder, elbow, and hand related to hemiplegia. The intervention was to inform the physician of any changes to his contracture, resident to have restorative for PROM (Passive Range of Motion) and therapy as needed. A review of the resident's clinical record lacked documentation of a restorative therapy program in place and PROM for contractures. During an interview on 12/17/21 at 9:01 a.m., LPN 19 (Licensed Practical Nurse) indicated the resident was not on PT (Physical Therapy) at this time, but he was getting OT. The resident did not have any braces or splints that nursing applied. She did not know if PROM was required by nursing staff. During an interview on 12/17/21 at 9:34 a.m., The Occupational Therapist indicated Resident 51 was picked up for OT again on 8/21. The therapy was for modification of a splint and self-feeding. He had a boot for his left ankle. Staff were trained to apply the boot. The staff have been trained to provide daily PROM with care to prevent worsening of the contractures. During an interview on 12/20/21 at 8:39 a.m., The Restorative Nurse indicated therapy recommends how often the resident would have restorative therapy and what type. Resident 51 should have received active and passive range of motion 7 days per week. During an interview on 12/17/21 at 3:10 p.m., the		Services, therapy and MDS Coordinator to validate appropriate interventions for the left fingers, wrist and shoulder including passive range of motion and application of splint. Resident # 28's care plan and restorative documentation will be revised as indicated during the review 2. On 1/18/22 residents residing in the facility that have contractures, splints or braces will be identified by the Director of Nursing and Therapy. On 1/18/22, each resident identified will be reviewed by the intradisciplinary team (including nursing and therapy) to validate appropriate treatment and services to increase ROM and/or prevent further decline in ROM. Splinting and Range of motion programs will be reviewed during this process to ensure necessary documentation is being recorded, splints are being applied as indicated and range of motion /restorative programs are documented. Any discrepancies will be revised if indicated during this review. 3. On 1/17/22, the Director of Nursing /Incensed nurse designee-initiated education with licensed and certified nursing staff regarding nursing restorative, range of motion, splinting and	

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	DON (Director of Nursing) indicated they could not find any restorative documentation on this resident. 2. The clinical record for Resident 28 was reviewed, on 12/17/21 at 2:00 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, contracture of muscle left upper are, contracture of the left wrist, muscle weakness, muscle wasting and atrophy, and lack of coordination. The Quarterly MDS (Minimum Data Set) assessment, dated 10/4/21, indicated the resident was rarely or never understood. He required extensive assistance of two staff members with ADL's (Activities of Daily Living). The physician's order, dated 12/6/18, indicated the resident was to receive passive ROM (Range of Motion) for left fingers, wrist, and shoulder. The care plan, dated 8/9/14 and revised on 1/10/21, indicated the resident required PROM of the left upper and lower extremities. Staff were to do 8 to 10 repetitions daily, prior to wrist/hand splint application. The resident required a restorative program for splint/brace to prevent further loss of movement and ensure proper limb alignment. A review of the clinical record lacked documentation of a restorative therapy program in place and the resident receiving PROM for contractures. During an interview on 12/17/21 at 9:34 a.m., the Occupational Therapist indicated the resident was not on OT at this time. He had met his goals. He		documentation. On 12/20/21, Director of Nursing reviewed the procedure for "Restorative Nursing "and found the policy to be acceptable. The protocol for monitoring restorative programs was revised to include a weekly restorative review by the MDS Coordinator/or licensed nursing designee. The weekly review will be completed to validate completion of necessary documentation and revisions to restorative programs if indicated. *(Facility and Agency, Licensed nursing staff will not be allowed to work after 1/20/21 unless they have successfully completed all assigned education).* 4. On 1/17/22, a **ROM/Splinting Quality Review Audit** was reviewed and accepted by the Quality Assurance Performance Improvement Committee. The Director of Nursing/Designated Nurse will complete random ROM and Splint reviews using the **ROM/Splinting Quality Review Audit Tool**, to validate that range of motion and splinting are completed and documented as indicated and weekly nursing review is completed. Any concerns identified during the **quality**	

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	required total assistance with all ADL's. During an interview on 12/17/21 at 3:10 p.m., the DON indicated she could not find any restorative documentation on this resident. The current Restorative Nursing Program Policy and Procedure, provided on 12/20/21 at 8:30 a.m. by the DON, included, but was not limited to, "... The facility is responsible for providing maintenance and restorative programs that will not only maintain, but improve, as indicated by the resident's comprehensive assessment to achieve, and maintain the highest practicable outcome. The facility is responsible to ensure that residents receive care and services needed if they are able to perform their own ADL care independently. The facility must also ensure that the resident reaches and maintains his or her highest level of Range of Motion and to prevent avoidable decline in Range of Motion." 3.1-42(a)(2)		**reviews** will be addressed at the time of the review and additional education will be completed at that time. The **ROM/Splinting Quality Review Audit** will be completed on five residents a week for twelve weeks. The results of the **Audits** will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews. Following the initial twelve-week 100% review, A minimum of 10 residents will be reviewed monthly until 100% compliance has been determined by the QAPI committee. *(A minimum of seven months must be completed).* - Date of Completion—1/20/22----	
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.			

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	Based on observation, interview, and record review, the facility failed to ensure residents were free of accidents and had the appropriate follow-up assessments after a fall for 1 of 5 residents reviewed for accidents. (Resident 54) Findings include: During a continuous observation of the Memory Care unit, on 12/16/21 from 10:10 a.m. to 11:12 a.m., LPN (Licensed Practical Nurse) 10 was sitting at the desk in the corner of the dining room. Resident 54 was sitting in the dining room. He indicated "I fell last night. I hurt myself." He would not indicate where he hurt but stated he fell in his room. Activities Aide 11 approached the resident and he told her his head and his knee were hurting, she told the resident, "Yea, they're taking care of you." At 10:13 Activities Aide 11 told LPN 10 she was going to get the resident batteries for his hearing aids but did not discuss the resident's complaints of pain. LPN 10 did not assess the resident during this continuous observation, including any vital signs, assessment of pain or skin, or any neurological assessment. LPN 10 remained at the desk throughout the continuous observation. The clinical record for Resident 54 was reviewed on 12/15/21 at 10:40 a.m. Diagnoses included, but were not limited to, muscle weakness, heart failure, hypertension, chronic obstructive pulmonary disease, dependence on supplemental oxygen, chronic pain, presence of cardiac defibrillator, dementia, fracture of right wrist, unspecified intellectual disability, osteoarthritis, lack of coordination, and other abnormalities of gait and mobility.	F 0689	**F689 Incidents/Accidents** 1. On 12/20/21, resident #54 was reviewed by the intradisciplinary team. Resident #54's CT scan completed 12/15/21 was reviewed and determined to be within normal limits. A pain assessment was completed by licensed nursing staff on 12/20/21 the resident reported no pain at the time of the assessment. 2. On 1/18/22, residents residing in the facility that have fallen in the last 30 days will be identified by the Director of Nursing. On 1/18/22, the identified residents will be reviewed by the intradisciplinary team to validate fall risk assessments, fall care plans, completion of neuro-checks and pain assessments were completed as indicated at the time of the event. Any discrepancies identified will be reviewed by the IDT team and recommendations will be implemented at the time of the review. Care plans will be reviewed and revised as indicated. 3. On 1/17/22, the Director of Nursing /Incensed nurse designee-initiated education with	01/20/2022

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	The Quarterly MDS (minimum data set) assessment, dated 10/9/21, indicated the resident's cognition was moderately impaired, he required supervision with walking, locomotion, and transfers, used a walker, and had a history of falls. The care plan, dated 4/12/19, indicated the resident was at risk for falls, due to a recent fall. The interventions were to have the bed against the wall (dated 7/26/21); to educate the resident to use a walker with ambulation (dated 6/29/20); pathway cleared in room (dated 4/22/19); attempt to keep all areas free of clutter, keep call light in reach, notify and update physician as needed, and therapy screen as indicated, quarterly, and as needed (dated 4/12/19). The physician's orders, dated 12/4/20, indicated the resident took aspirin 81 mg one time daily and Plavix (blood thinner) 75 mg 1 time daily. The nursing note, dated 1/21/21 at 5:25 p.m., indicated the resident was sitting on the floor in his room yelling for help. He indicated he had not hit his head and had no pain. A CNA (certified nurse aide) assisted the resident to his recliner. The resident indicated he was trying to get pants from his closet and his knee gave out. Staff educated the resident to use the call light when needing assistance, and the resident understood. The clinical record lacked documentation of any neurological checks for the unwitnessed fall. The nursing note, dated 7/25/21 at 1:46 p.m., indicated the resident had been found on the floor and stated he had been trying to reach his hat and tripped over his bedside table. The resident had a laceration to the left side of his forehead, measuring about 0.3 to 0.4 cm. The physician was		licensed and certified nursing staff regarding fall prevention, pain assessments, completion of neuro checks for unwitnessed falls and head injuries, and completion of change of condition for accidents/incidents. On 12/20/21, Director of Nursing reviewed the procedure for "Accident/Incident Reporting "and found the policy to be acceptable. Licensed nursing staff are responsible for completing incident/accident documentation including neuro checks for unwitnessed falls and post fall pain evaluations. Falls will be reviewed daily during the morning CQI meeting M-F. The intradisciplinary team will review each event to validate that neuro checks are completed per protocol, documentation of a change of condition is complete, MD and family notifications are complete, preventive measures implemented, 72-hour nursing documentation post event, pain evaluations and care plans will be revised as indicated. Any concerns identified will be addressed at that time and additional education will be initiated as indicated by the Director of Nursing. *(Facility and Agency, Licensed*	

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	notified with orders to send the resident to the hospital. neurological checks were initiated. The nursing note, dated 7/25/21 at 5:09 p.m., indicated the resident would be returning. He had received glue to the laceration. The nursing note, dated 7/25/21 at 5:48 p.m., indicated the resident returned. He complained of a headache and had received Tylenol. He had a medium hematoma to the left side of the head. The clinical record did not include any documentation of neurological checks continuing upon return from the hospital. The nursing note, dated 9/23/21 at 4:15 p.m., indicated the resident was found sitting in his shower. There was bruising from the top to down the back of the resident's head. The resident indicated he lost his balance and fell backwards hitting his head on the shower wall. The nursing note, dated 9/23/21 at 4:40 p.m., indicated the resident had been sent to the hospital for evaluation. The nursing note, dated 9/23/21 at 11:53 p.m., indicated the resident returned to the facility with a diagnoses of minor head injury. Neurological checks were resumed per facility policy. The resident indicated his head did hurt and it was sore. The nursing note, dated 12/15/21 at 9:50 p.m., indicated the resident had an unwitnessed fall in his bathroom and complained of left hip and head pain. He had a contusion to the back of his head. The Change in Condition note, dated 12/15/21 at		*nursing staff will not be allowed to work after 1/20/21 unless they have successfully completed all assigned education).* 4. On 1/17/22, a **Fall Quality Review Audit** was reviewed and accepted by the Quality Assurance Performance Improvement Committee. The Director of Nursing/Designated Nursing will complete random Fall reviews using the **Fall Quality Review Audit Tool**, to validate that documentation is complete including change of condition, MD/RP notification, pain assessments, 72-hour clinical documentation post event and neuro checks if indicated. Any concerns identified during the **quality reviews** will be addressed at the time of the review and additional education will be completed at that time. The **Fall Quality Review Audit** will be completed on five days a week for twelve weeks. The results of the **Audits** will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews. Following the initial twelve-week 100% review, A minimum of 10	

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	9:55 p.m., indicated the resident was being sent to the hospital for evaluation. The clinical record lacked any documentation of further assessment or ongoing neurological checks at this time. During an interview on 12/16/21 at 11:52 a.m., LPN 10 indicated Resident 54 had fallen the night prior. He went to the hospital and came back before she reported to work. She had been observing the resident and had done his vitals twice that morning. She had obtained a full set of vitals at 8:00 a.m. and 10:30 a.m., but she had not yet documented it. She was not doing neurological checks on the resident, he was not on them to her knowledge, and it had not been told to her in report. Neurological checks would be completed if a physician ordered it, if the resident had a head injury, or if the resident had an unwitnessed fall where no one saw anything. If a resident had a fall and hit their head, she would start neurological checks. On 12/16/21 at 12:05 p.m., LPN 10 presented handwritten paper which indicated the resident's name, along with a full set of vitals which she indicated had been completed at 7:00 a.m., and 10:40 p.m. She would be putting these values into the clinical record. During an interview on 12/20/21 at 12:10 p.m., the DON indicated the resident had several falls. If a resident had a fall staff should do a change in condition note, assess pain, skin, notify the physician and family, and put an immediate intervention in place. Neurological checks would be initiated with any unwitnessed fall. She would have expected the staff to initiate and continue neurological checks for the resident's fall on		residents will be reviewed monthly until 100% compliance has been determined by the QAPI committee. *(A minimum of seven months must be completed).* - Date of Completion—1/20/22----	

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	12/15/21. During an interview on 12/20/21 at 3:04 p.m., the ED indicated staff would be educated on neurological checks, they were to be initiated even upon going out to the hospital and would continue upon return. Staff would also be educated on monitoring the resident's pain, and to notify the nurse when the resident complained of pain. The most current, undated, Accident Incident Reporting Policy, provided on 12/17/21 at 4:03 p.m. by the DON, included, but was not limited to, " ... Any accident/incident will be reported immediately to the nurse or appropriate person designated to be in charge ... 10. Documentation of the resident's physical and mental status will be completed each shift following the incident for a minimum of 72 hours or until the condition symptoms improve. Neurochecks will be completed after each unwitnessed fall or head trauma according to policy ..." Policy 3.1-45(a)(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.			

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	Based on observation, record review, and interview, the facility failed to ensure oxygen tubing and humidification were changed weekly and maintained for 1 of 3 resident's reviewed for respiratory care. (Resident 54) Findings include: During an observation, on 12/13/21 at 2:20 p.m., Resident 54 was sitting in his recliner in his room. He had a nasal cannula in place, with oxygen running at 2 liters per minute (lpm). The tubing and pre-filled humidification bottle were dated 12/5/21. The humidification bottle was empty. During observation, on 12/14/21 at 9:17 a.m., the resident was sitting in his recliner in his room. His oxygen tubing remained unchanged, and the humidification bottle was still empty. The date on the tubing and humidification bottle was 12/5/21. During an observation, on 12/14/21 at 9:46 a.m., the resident was sitting in his recliner in his room. His oxygen tubing remained unchanged, and the humidification bottle was still empty. The date on the tubing and humidification bottle was 12/5/21. During an observation on 12/15/21 at 9:13 a.m., the resident was sitting in his recliner in his room. His oxygen tubing remained unchanged, and the humidification bottle remained empty. The date on the tubing and humidification bottle was 12/5/21. During an observation, on 12/15/21 at 1:00 p.m., the resident was sitting in his recliner in his room. The oxygen tubing remained unchanged, and his humidification bottle remained empty. The date on the tubing and humidification bottle was 12/5/21. During an observation, on 12/17/21 at 8:15 a.m.,	F 0695	**F695 Respiratory/Trach** 1. On 12/20/21 resident #54's oxygen tubing and humidifier were changed and dated by licensed nursing staff. 2. On 12/20/21 residents residing in the facility with oxygen, mini-nebs and/or CPAP/BiPAP equipment were identified by the Director of Nursing. A facility tour was completed to ensure that tubing, masks, and humidifiers were appropriately dated, and humidifiers were functioning appropriately. 3. On 1/17/22, the Director of Nursing /Incensed nurse designee-initiated education with licensed staff regarding oxygen and respiratory tubing/equipment. Licensed nursing staff are required to maintain humidifiers and dating/labeling respiratory tubing. On 12/17/21, Director of Nursing reviewed the procedure for "Oxygen Therapy "policy and procedure and found the policy to be acceptable. Licensed nursing staff are responsible for maintaining oxygen and respiratory equipment. Oxygen and respiratory treatment masks/tubing will be changed	01/20/2022

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	the resident's humification bottle was full and the tubing had been changed. The clinical record for Resident 54 was reviewed on 12/15/21 at 10:40 a.m. included, but were not limited to, muscle weakness, heart failure, hypertension, chronic obstructive pulmonary disease, dependence on supplemental oxygen, chronic pain, presence of cardiac defibrillator, dementia, fracture of right wrist, unspecified intellectual disability, osteoarthritis, lack of coordination, and other abnormalities of gait and mobility. The Quarterly MDS assessment, dated 10/9/21, indicated the resident was moderately cognitively impaired, was short of breath when lying flat, used oxygen, and had no skin impairments. The care plan, dated 2/12/21, indicated the resident was at risk for alteration in respiratory status related to COPD and refusing to wear oxygen at times. Interventions included, but were not limited to, oxygen as ordered. The physician's order, dated 12/6/20, indicated the resident used oxygen continuously at 2lpm via nasal cannula, and to change the oxygen tubing and bottle weekly on night shift on Sundays. The review of the MAR indicated the resident's oxygen tubing and bottle were last changed on 12/12/21. The Physician's order, dated 12/12/21 at 4:00 p.m. indicated to administer nasal spray solution in alternating nostrils every 4 hours as needed for nasal dryness. During an interview, on 12/20/21 at 12:10 p.m., the		weekly by nursing staff. *(Facility and Agency, Licensed nursing staff will not be allowed to work after 1/20/21 unless they have successfully completed all assigned education).* 4. On 1/17/22, an**Oxygen/Respiratory Treatment Quality Review Audit** was reviewed and accepted by the Quality Assurance Performance Improvement Committee. The Director of Nursing/Designated Nurse will complete random observations of oxygen equipment including humidifiers, oxygen/respiratory treatment tubing and BIPAP/CPAP equipment using the **Oxygen/Respiratory Quality Review Audit Tool**, to validate that weekly documentation is completed for tubing/masks and humidifiers changes. This audit will also include a visual inspection of oxygen tubing/masks and humidifiers to validate that dating on the equipment matches the documentation. Any concerns identified during the **quality reviews** will be addressed at the time of the review and additional education will be completed at that time. The **Oxygen/respiratory Treatment Quality Review Audit** will be	

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	DON (Director of Nursing) indicated if the prefilled humidification bottles were empty, she would expect it to be changed, on changing oxygen tubing she would refer to the policy. During an interview, on 12/20/21 at 3:04 p.m., the Executive Director (ED) indicated she believed orders to change oxygen tubing and humidification bottle were for Saturday night into Sunday morning. They would need to do an audit to make sure all residents on oxygen had their tubing changed and properly dated. The most current, undated, Oxygen Therapy policy, provided on 12/17/21 at 4:03 p.m., by the DON, included, but was not limited to, "Guidelines for daily care of oxygen equipment: Refill humidifier bottle on the O2 regulator daily with sterile distilled water to the line indicated on the bottle or use prefilled bottles. IMPORTANT: Make a complete exchange of water. Do not add water." 3.1-47(a)(6)		completed on five residents a week for twelve weeks. The results of the **Audits** will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews. Following the initial twelve-week review, A minimum of 10 residents will be reviewed monthly until 100% compliance has been determined by the QAPI committee. *(A minimum of seven months must be completed).* - Date of Completion—1/20/22----	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, record review, and interview, the facility failed to ensure non-pharmalogical interventions were developed and implemented to address residents with pain, for 2 of 6 resident's reviewed for pain management. (Residents 55 and 64)	F 0697	**F697 Pain** 1. 12/20/21, resident #55 was reviewed by the intradisciplinary team and non-pharma logical	01/20/2022

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	Findings include: 1. During an observation, on 12/15/21 at 9:48 a.m., Resident 55 walked out of the bathroom, utilizing her walker with a slow gait, to ambulate towards her bed. During the observation the resident indicated her knee was hurting. During an interview on 12/15/21 at 10:00 a.m., the resident indicated she was having a decent day, but it could be better. Her knee was hurting her and had been hurting for years. It had currently been hurting her for about an hour, but it was too soon for her to take any medication for it. She used to have an order for a topical menthol treatment, and that felt good, it made her pain feel a lot better. She had told the staff, but she did not have any orders for it at this time. She'd asked about it a day or two ago and had told staff she'd like to have it again. Resting also helped her knee pain. The clinical record for Resident 55 was reviewed on 12/14/21 at 2:02 p.m. The resident's diagnoses included, but were not limited to, anxiety disorder, difficulty in walking, and osteoarthritis. The Quarterly MDS (minimum data set) assessment, dated 10/29/21, indicated the resident was cognitively intact, had a scheduled pain management regimen, did not receive as needed pain medication, and did not receive non-medication interventions for pain. The resident reported pain presence frequently and rated it as moderate. The resident received opioid medication daily The care plan, dated 4/26/19, indicated the resident had a potential for pain related to chronic		interventions were added to the resident plans of care. A pain assessment was completed on resident #55 on 12/20/21. The physician was contacted on 1/17/22 to determine if an analgesic gel or cream would be approved per resident's request. On 1/17/21, resident #64 was reviewed by the intradisciplinary team and non-pharma logical interventions were added to the resident plans of care. A pain assessment was completed on 1/15/22 by licensed nursing staff which revealed satisfactory pain management. 2. On 1/17/22 to 1/18/22 residents residing in the facility with routine and prn pain medications were identified by the Director of Nursing. Each resident was reviewed by the intradisciplinary team to validate completion of pain assessments, care plans and effective pain management including non-pharma logical interventions. Interview able residents (BIMS score 8 and above) were interviewed by administrative staff to determine if residents were content with current pain management. 3. On 1/17/22, the Director of	

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	osteoarthritis with chronic bilateral knee pain. Interventions included, but were not limited to; medications as ordered, notify physician of uncontrolled pain, observe for effectiveness of intervention, observe for signs and symptoms of pain, and pain assessment upon admit, quarterly, and as needed (dated 4/26/19). The care plan did not contain any resident specific or non-pharmacological interventions for pain. The discharge summary from the hospital, dated 4/25/19, indicated a muscle rub had been added to the resident's orders and had been helpful for her pain. By the beginning of 2018, the pain was more than she could tolerate, and she began using a wheelchair for long distances. The physician's order, dated 4/25/19, indicated the resident had received menthol-methyl salicylate gel to the knees and elbows three times daily, but it had been discontinued on 7/13/19. The order did not list a discontinuation reason. The nursing note, dated 6/30/21 at 4:10 p.m., indicated the physician was notified of the resident's complaint that ibuprofen was ineffective on her pain. A new order was received for Norco 5/325 mg every 6 hours for moderate pain. The resident's current physician's orders, indicated the resident received the following: norco 5/325 mg, one tablet every 6 hours for moderate pain (dated 6/30/21), Tylenol 325 mg give 2 tablets every 12 hours as needed for pain (dated 7/9/19), and pain monitoring with a verbal numerical scale every shift (dated 2/15/21). The nursing note, dated 7/11/21 at 5:36 p.m.,		Nursing /Incensed nurse designee-initiated education with licensed staff regarding pain management. This education included a education regarding non pharma logical interventions and resident involvement with plan of care. On 12/20/21, Director of Nursing reviewed the procedure for “Pain Management “and found the policy to be acceptable. Licensed nursing staff are responsible for completing pain assessments and implementing non pharma logical and pharma logical interventions for pain management. *(Facility and Agency, Licensed nursing staff will not be allowed to work after 1/20/21 unless they have successfully completed all assigned education).* 4. On 1/17/22, a **Pain Quality Review Audit tool** was reviewed and accepted by the Quality Assurance Performance Improvement Committee. The Director of Nursing/Designated Nurse will complete random pain reviews using the **Pain Quality Review Audit Tool**, to validate the following: documentation regarding pain evaluations, non-pharma logical interventions,	

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	indicated the resident came out of the bathroom screaming she was in pain. The nurse offered pain medication and informed the resident it was a narcotic pain medication. The resident began to scream at her that all she needed was Tylenol, and she did not need a narcotic. The nurse explained to the resident the Tylenol and ibuprofen were not working and the resident was still complaining of a lot of pain. The resident yelled, "No more". The nurse left the room and came back at 6:00 p.m. to offer the narcotic pain medication, which the resident accepted without issue. The clinical record lacked documentation of any implementation of non-pharmacological interventions to address the resident's pain. During an interview on 12/20/21 at 9:06 a.m., LPN 12 indicated the resident complained of chronic back pain, which was treated with routine pain medication. He had provided interventions at times such as distracting with activities, redirection, encouraging her to stretch, but he could not locate any non-pharmacological interventions on the resident's care plan, and could not locate any orders for any type of muscle rub or other non-pharmacological interventions. 2. During an observation, on 12/13/21 at 11:36 AM, Resident 64 asked LPN 12 for pain medication. The LPN assessed the resident's pain using a verbal pain scale, which he rated at a 7 or 9. The LPN then obtained the resident's pain medication and provided it to him. No other interventions for pain were offered at this time. The clinical record for Resident 64 was reviewed on 12/14/21 at 2:40 p.m. Diagnoses included, but were not limited to, idiopathic peripheral autonomic neuropathy, angina pectoris, peripheral		resident/responsible party involvement with the treatment plan and revisions as need with the plan of care as indicated (including non-pharma logical interventions on the care plan). Any concerns identified during the **quality reviews** will be addressed at the time of the review and additional education will be completed at that time. The **Pain Quality Review Audit** will be completed on five residents a week for twelve weeks. The results of the **Audits** will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews. Following the initial twelve-week review, A minimum of 10 residents will be reviewed monthly until 100% compliance has been determined by the QAPI committee. *(A minimum of seven months must be completed).* - Date of Completion—1/20/22----	

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	vascular disease, type 2 diabetes with diabetic neuropathy, osteoarthritis, weakness, and cognitive communication deficit. The Annual MDS assessment, dated 10/28/21, indicated the resident was cognitively intact, was on a scheduled pain medication regimen, received as needed pain medications, and non-medication intervention for pain. The resident reported the presence of pain frequently, rating it at an 8 on a numerical scale of 1 to 10. The care plan, dated 5/14/18, indicated the resident had a potential for pain related to acute general pain, chronic pain, osteoarthritis of bilateral ankles, feet, peripheral vascular disease, and neuropathy. Interventions included, but were not limited to, will be free of pain with intervention as needed, Cymbalta per order for pain and depression, medications as ordered, notify physician of uncontrolled pain, observe for signs and symptoms of pain, pain assessment upon admit, quarterly and as needed. The care plan did not contain any resident specific or non-pharmacological interventions for pain. The resident's current physician's orders, indicated the resident received the following: Norco 5/325 mg every 8 hours as needed, Tylenol 325 mg 2 tablets every 6 hours as needed for pain, gabapentin 400 mg three times daily for pain (dated 10/28/20); Cymbalta 60 mg daily at bedtime for pain (dated 11/4/21); and pain monitoring with a verbal numerical pain scale every shift (dated 2/15/21). The clinical record lacked documentation of any non-pharmacological interventions to address the			

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	resident's pain. During an interview on 12/20/21 at 9:19 a.m., LPN 12 indicated the resident was on opioid pain medication and gabapentin. His care plan did not seem to include any additional interventions, such as distraction, repositioning, activities. He could not locate any non-pharmacological interventions, only pharmacological interventions. During an interview on 12/20/21 at 12:22 p.m., the ADON (Assistant Director of Nursing) indicated nursing staff were to document what interventions were tried prior to medication, but she did not know if they developed resident specific interventions for pain. During an interview on 12/20/21 at 12:27 p.m., the MDS coordinator indicated if there was something specific, they would put it into the care plan, such as specific types of pain, orders for certain things to do, and non-pharmacological interventions. Before pain medication could be given, they were supposed to try non-pharmacological interventions, but some of the patients just wanted medications. There were many nursing measures they could do, and the nurses were supposed to try resident specific interventions if they give a medication. It should be done before starting a new medication. If it was specific to a person, it would be care planned like that, it was really just using the nonpharmacological interventions one could come up with, like turning, repositioning, offering ice water, and toileting. The most current, undated, Management of Pain policy, provided on 12/20/21 at 2:15 p.m., included, but was not limited to, " ... Our mission is to facilitate resident independence, promote resident			

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	comfort and preserve resident dignity. The purpose of this policy is to accomplish that mission through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement. We will achieve these goals through ... Using non-pharmacological and complementary and alternative medicine when appropriate ... 8. Plan of care Initiate an interdisciplinary plan of care based on the initial assessment and development of pain relieving strategies. Include both pharmacological and complimentary interventions in the care plan." 3.1-37(a)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the			

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	attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on record review and interview, the facility failed to ensure the consultant pharmacist recommendations were addressed with the attending physician for 2 of 5 residents' medication regimens reviewed. (Residents 6 and 12) Findings include: 1. The clinical record for Resident 6 was reviewed on 12/14/21 at 1:56 p.m. Diagnosis included, but was not limited to, Type 2 diabetes mellitus with hyperglycemia. On 10/20/21, the Consultant Pharmacist made the following recommendation: "Dear [physician]...This resident's HGB A1c [Test for amount of sugar in the blood] = 8.9 or an average	F 0756	**F756 Drug Regimen Review** 1. On 12/16/21, resident #6 was assessed by the Director of Nursing and diabetic medications and labs were reviewed with telehealth. New order was received for HGB A1c every three months. On 12/30/21, resident #12's pharmacy recommendation for lab work was reviewed and accepted by psych to include CMP and CBC every three months. On 1/17/22 resident #12 was reviewed by the Director of Nursing and psych services to ensure	01/20/2022

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	blood sugar of 209 on 10/4/21. Current Diabetes meds: Lantus 60 units BID (twice daily); Humalog 20 units TID (three times daily). I recommend to increase the Lantus to 66 units BID [twice a day]." Documentation lacked the pharmacist recommendation being addressed by the resident's physician. During an interview with the Assistant Director of Nursing (ADON) on 12/16/21 at 2:30 p.m., she indicated she could not find the signed copy where the physician addressed the recommendation but was sure the nurses called the physician, and he made the changes recommended. During an interview with LPN 20 on 12/17/21 at 8:55 a.m., she indicated when the pharmacy recommendations came in, they would go to the nurse who was taking care of the resident and they would text the doctor and got new orders if they agreed with the recommendation. We would then put the form in the doctor's file for them to review and sign when they came in. 2. The clinical record for Resident 12 was reviewed on 12/16/21 at 10:00 a.m. Diagnoses included, but were not limited to, schizophrenia, unspecified paranoid personality disorder, anxiety disorder, bipolar disorder, major depressive disorder, and panic disorder. On 10/18/21 the Consultant Pharmacist made a recommendation for a specific diagnosis to be given to the resident's medication Fluphenazine (for schizophrenia) which the physician addressed on 11/10/21. The Consultant Pharmacist made the following recommendation: "Justification: Diagnosis alone does not warrant the use of		appropriate psychiatric medications diagnoses and behavior monitoring. 2. On 1/17/22-1/18/22, residents residing in the facility were identified by the Director of Nursing as having a potential to be affected by completion of pharmacy recommendations. The Director of Nursing contacted the pharmacist and reviewed the last 30 days of pharmacy recommendations. Any recommendation identified as not completed was communicated to the physician during the review. 3. On 1/17/22, the Director of Nursing /licensed nurse designee-initiated education with licensed nursing staff regarding medication drug reviews. The protocol for drug regimen reviews was revised to include emailing pharmacy reviews to the director of nursing. The Director of Nursing will be responsible for tracking completion of pharmacy recommendations and maintaining documentation of the completed reviews and physician response(s). On 1/17/22, Director of Nursing reviewed the procedure for “Consultant Pharmacy Services	

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	antipsychotic medications. The clinical condition must also meet at least one of the following criteria. Please check at least one of the following: behavioral symptoms present a danger to the resident and others; expressions or indications of distress cause significant distress to the resident; If not clinically contraindicated, multiple non-pharmacological approaches have been attempted, but did not relieve the symptoms which are presenting a danger or significant distress." Documentation lacked the physician addressed the recommendation. On 12/17/21 at 4:00 p.m., the Director of Nursing (DON) presented a copy of the facility's current policy titled Consultant Pharmacy Services Provider Agreement. Review of this policy included but was not limited to, "...Services:...8. Submitting a written report of findings and recommendations resulting from the review of medications regimen and nursing documentation records to the attending physician and the director of nursing...." 3.1-25(i)		"and found the policy to be acceptable. *(Facility and Agency, Licensed nursing staff will not be allowed to work after 1/20/21 unless they have successfully completed all assigned education).* 4. On 1/17/22, a **Pharmacy Quality Review Audit** was reviewed and accepted by the Quality Assurance Performance Improvement Committee. The Executive Director/Designated Nursing will complete random drug regimen reviews using the **Pharmacy Quality Review Audit Tool**, to validate the following: completion of the pharmacy reviews and proof of supporting documentation including the physicians response to the pharmacy review. Any concerns identified during the **quality reviews** will be addressed at the time of the review and additional education will be completed at that time. The **Pharmacy Quality Review Audit** will be completed on five residents a week for twelve weeks. The results of the **Audits** will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will	

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			determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews. Following the initial twelve-week 100% review, A minimum of 10 residents will be reviewed monthly until 100% compliance has been determined by the QAPI committee. *(A minimum of seven months must be completed).* - Date of Completion—1/20/22----	
F 0838 SS=D Bldg. 00	483.70(e)(1)-(3) Facility Assessment §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities,			

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	overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.			

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	Based on interview and record review the facility failed to update their Facility Assessment Tool when concerns with agency staffing were identified. This deficient practice had the potential to affect all 71 residents residing in the facility. Findings include: The review of the Facility Assessment Tool, on 12/20/21 at 4:30 p.m., lacked documentation the Facility Assessment Tool was updated to address agency staffing concerns at the time they were identified. During an interview on 12/16/21 at 10:33 a.m., the DON indicated the facility used a high number of agency staff. The facility had just rolled out a new training packet since they were aware of an issue with agency staff members and orientation to the facility. She did not know much about agency. She had scanned through the packet when an agency staff started. During an interview, on 12/20/21 at 5:35 p.m., the Executive Director indicated she checked the Facility Assessment on a monthly basis for changes. She indicated the Facility Assessment would be updated annually. During an interview, on 12/20/21 at 5:40 p.m., the RDCO (Regional Director Clinical Operations) indicated in the current facility assessment listed contracted nurses. Updating the facility assessment just to add a specific area to address agency nurses would not change the Facility Assessment Tool. The Facility Assessment Tool lacked a specific plan to ensure the agency staff were oriented to the facility and all packet information was	F 0838	**F838 Facility assessment** 1. On 1/17/22, the facility assessment was reviewed by the administrative team and revised to include agency orientation. 2. All residents residing in the facility have the potential to be affected by the accurate completion of the facility assessment 3. On 12/20/21, the Executive reviewed the procedure for "Facility Assessment "and the process for reviewing the facility assessment was revised to include a monthly team review by administrative staff during the QAPI committee meetings monthly for a minimum of seven months. *(Facility and Agency, Licensed nursing staff will not be allowed to work after 1/20/21 unless they have successfully completed all assigned education).* 4. On 1/17/22, a **Facility Assessment Audit tool** was reviewed and accepted by the Quality Assurance Performance Improvement Committee. The Department Managers will complete random facility assessment reviews using the **Facility Assessment Quality**	01/20/2022

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	completed. The current "Facility Assessment," provided on 12/20/21 at 6:00 p.m. by the E.D., included, but was not limited to, "The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergency. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and updated this assessment whenever there is, or the facility plans for, any changes that would require a substantial modification to any part of this assessment."		**Review Audit Tool**, to determine if the facility assessment addresses the following items: resident population, facility capacity, types of diseases/conditions/physical and cognitive disabilities, over all acuity, other pertinent facts that affect the population, staff competencies, physical environment, equipment, ethnic, cultural or religious factors that may affect the care (Including but not limited to dietary food service and activities). Any concerns identified during the **quality reviews** will be addressed at the time of the review and additional education will be completed at that time. The **Pharmacy Quality Review Audit** will be completed on five times a week for twelve weeks. The results of the **Audits** will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews. Following the initial twelve-week department manager reviews, the facility assessment will be reviewed by the department managers monthly until 100% compliance has been determined by the QAPI committee. *(A minimum of seven months must be completed).*	

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			- Date of Completion—1/20/22----	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, 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			

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	communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based an observation and interview, the facility failed to ensure staff applied the proper PPE (Personal Protective Equipment) in the yellow	F 0880	**F880 Infection Control** 1. LPN # 13 was verbally	01/20/2022

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	zone and during patient care for 3 of 5 observations for infection control. (Residents 68, 70, and 25) Findings include: 1. During an observation on 12/16/21 at 9:22 a.m., LPN (Licensed Practical Nurse) 13 entered the room of Resident 68 without a gown, N-95 mask, or gloves on. She left the room and returned from another hall, opened the door, and started to enter Resident 68's room again. She was entering the room without applying an N-95 mask, gloves, or a gown. The DON (Director of Nursing) stopped the LPN as she entered the room. The resident was in a yellow zone room (transmission based precautions). During an interview at that time, the DON indicated the LPN should have worn the proper PPE of an N-95 mask, gloves, and gown when entering a yellow zone room. 2. During an observation, on 12/16/21 at 9:30 a.m., LPN 14 entered Resident 70's room to deliver ice water without an N-95 mask. She had the door open and was stepping into the room when the DON stopped her and indicated she needed an N-95 mask on. During an interview on 12/16/21 at 9:46 a.m., the SDC (Staff Development Coordinator) indicated the last in-service education on infection control/hand hygiene was conducted on 12/9/21. During an interview on 12/16/21 at 10:33 a.m., the DON indicated staff should have a gown, gloves, N-95 mask and face shield to enter the yellow zone rooms. They should remove the N-95 mask upon leaving the room and put on a surgical mask.		educated by the DON on 12/16/21 regarding proper PPE in isolation rooms. LPN # 14 was verbally educated by the DON on 12/16/21 regarding proper PPE in isolation rooms. Nurse Aide #15 was verbally re-educated on completion of peri care and appropriate infection control practices on 12/17/21 by administrative nursing staff. 2. Residents residing in the facility on 12/20/21 were identified by Director of Nursing Services as having the potential to be affected by facility adherence to appropriate infection control practices. 3. On 1/17/22, the Director of Nursing /Infection Control Preventionist initiated education with facility staff regarding the proper infection control procedures, isolation precautions (including N95 masks) and PPE. This education included PPE skills observation check-off to validate competency with use of PPE, handwashing competencies, and peri-care education. On 12/17/21, the Director of Nursing reviewed the policy and procedures for proper use of PPE (*Personal Protective Equipment)* and Peri Care. No revisions were required. On 1/17/22 the annual facility infection control assessment was reviewed and revised by the Director of Nursing/Infection	

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	Twice weekly in-services for the donning and doffing of PPE were performed. The LPN was new to the building. She came from an agency company with her own training, and they just rolled out a new training packet. She did not know much about agency. She had scanned through the packet when agency staff started. During an interview on 12/16/21 at 10:45 a.m., LPN 13 indicated she had no in-services on PPE donning and doffing from the agency company she was hired through. She had worked at other facilities. The first facility she worked at, did an in service one year ago on donning and doffing of PPE. The second facility she had worked at didn't offer any training. She had not received any packets or on-line training at this facility. She did not get a checklist for PPE use at the facility. She did have a tour of the facility, but they did not show her where to get her PPE. During an interview on 12/16/21 at 11:09 a.m., ADON (Assistant Director of Nursing) indicated the agency company did the background checks and training. During an interview on 12/16/21 at 3:03 p.m., the DON indicated the facility followed the CDC (Centers for Disease Control and Prevention) guidelines but had no facility policy for PPE to be worn in the yellow zone. The signage for the yellow zone isolation indicated the PPE required was a N95 mask or an approved KN95, universal eyewear (face shield or goggles), single gown, and gloves. On 12/16/21 at 3:03 p.m., the DON provided the current Guidelines for Compliance with Infection Control policy and procedure. The policy		control preventionist and the Executive Director. On 1/17/22 the facility adopted a weekly infection control rounding tool that will be conducted by the infection control preventionist/designee to audit compliance with infection control and identify opportunities for education. *(Facility and Agency, Licensed nursing staff will not be allowed to work after 1/20/21 unless they have successfully completed all assigned education).* 4. On 1/17/22, an **Infection Control Quality Review Audit Tool** was reviewed and accepted by the Quality Assurance Performance Improvement Committee. The Director of Nursing/Infection Control Preventionist and Administrative staff will complete random PPE observations, using the Infection Control Quality Review Audit Tool, to validate that infection control procedures are followed. This audit will include monitoring for proper peri care (observation by clinical staff only) , following isolation guidelines, handwashing and use of appropriate masks. Any concerns identified during the infection control observations will be addressed at the time of the observation and additional	

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	included, but was not limited to, "... Precautions will be implemented per CDC guidelines and facility policy..." 3. During an observation on 12/17/21 at 12:28 p.m., CNA (Certified Nursing Aide) 15 performed perineal care on Resident 25. She placed clean washcloths into the shared bathroom sink to get them wet. The neighboring room, which shared the bathroom was Resident 16. The neighboring resident was in isolation for ESBL (extended spectrum betalactamase) of the urine. She then moved the floor mat and began performing perineal care with the same gloves. She cleaned the groin area and folded the washcloth and with 3 swipes cleaned the labia. She folded the washcloth and with 11 swipes, she again cleaned the entire labial area and creases to each side. She rinsed the soap from the labia with 3 swipes of a fresh wet washcloth, folded and with 2 swipes rinsed again. She applied barrier cream and changed her gloves. She then asked the resident to roll onto her left side. She obtained a wet washcloth and applied body wash. She swiped the anal area with 2 of the washcloth. She folded the washcloth and again cleaned the entire buttock and anal area with the same area of the washcloth. She obtained a wet washcloth and rinsed the buttock and anal area with the same area of the washcloths. The bathroom sink was not cleaned prior to the clean washcloths being placed in the sink. The clinical record for Resident 25 was reviewed on 12/17/21 at 2:32 p.m. The diagnoses included, but were not limited to, epilepsy, hypertension, breast cancer, Alzheimer's disease, osteoarthritis, dementia with behavioral, dehydration, stage 3 pressure ulcer (healed), protein calorie		education will be completed at that time. The Infection Control Quality Review Audit will be completed will be completed five times a week for twelve weeks. The results of the **Audits** will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews. Following the initial twelve-week 100% review, A minimum of 10 residents will be reviewed monthly until 100% compliance has been determined by the QAPI committee. *(A minimum of seven months must be completed).* Date of Completion-1/20/22	

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	malnutrition, palliative care, urinary tract infection, urinary and bowel incontinence, anxiety, adult failure to thrive, obesity, and physical debility. The care plan, dated 11/3/21, indicated the resident was incontinent of bladder and bowels, chronic problem related to diagnosis. The interventions indicated pericare after every incontinent episode. Staff to assist to toileting as needed. The care plan, dated 11/17/21, indicated the resident required assistance with ADL'S (Activities of Daily Living). The interventions included, but were not limited to, assist the resident as needed to keep clean and dry. During an interview on 12/17/21 at 9:39 a.m., CNA 15 indicated she would clean the perineal area top to bottom and front to back. She would wash her hands before and after the care and apply gloves. The gloves would be changed when soiled and in between procedures. She failed to mention she would use different areas of the washcloth to clean the perineal area. During an interview on 12/17/21 at 2:32 p.m., the DON indicated staff should not soak the washcloths in the sink to get them wet, especially in a shared bathroom with a resident on transmission based precautions. The CNA should have folded the washcloth between swipes, during perineal care. The staff should change out gloves after touching items, such as the floor mat, before beginning perineal care. The review on 12/17/21 at 2:44 p.m., the DON provided a copy of the Perineal/Incontinence Care policy, last reviewed 1/1/20. The policy included, but was not limited to, "Procedure Purpose...To			

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	prevent infection..." 3.1-18(b) 3.1-18(l)			
F 0886 SS=D Bldg. 00	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner			

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	that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.			
	Based on record review and interview the facility failed to ensure appropriate infection control practices were followed during the COVID-19 pandemic related to testing of a symptomatic residents for 2 of 3 residents reviewed for infection control. (Residents 51 and 28)	F 0886	**F886 Covid Testing** 1. On 10/7/21, 10/18/21,10/25/21 and 1/10/22 resident #51 was tested for Covid	01/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING 00 B. WING	12/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF SCOTTSBURG, THE	1350 N TODD DR SCOTTSBURG, IN 47170

(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
	Findings include: 1. The clinical record for Resident 51 was reviewed, on 12/18/21 at 1:31 p.m. The diagnoses included, but were not limited to, bacteremia, sepsis, contact with and suspected exposure to other viral communicable disease. The Quarterly MDS (Minimum Data Set) assessment, dated 11/10/21, indicated the resident's cognition was moderately impaired. He required extensive assistance of two staff members with ADL's (Activities of Daily Living). The physician's orders, dated 5/3/21, indicated for non-symptomatic non positive COVID residents record TPR (Temperature, Pulse, and Respiration), blood pressure, oxygen saturation and signs and symptoms. Staff were to report immediately any temperature of 99.1 degrees or higher, cough, shortness of breath, and sore throat. COVID-19 test as needed for COVID-19 screening. The care plan, dated 10/23/20 and revised on 3/26/21, indicated the resident was at risk for developing a transmission based infection (COVID-19) which could result in untoward outcomes such as pneumonia, and/or acute respiratory distress. The resident had the following co-morbidities which can increase the risk for developing a serious illness from COVID-19. Interventions include, but were not limited to, laboratory testing for COVID-19 per physician's order and report abnormal results to the physician. The nurse's note, dated 6/9/2021at 11:53 p.m., indicated the resident's lung sounds were diminished with a low grade-temperature. Tylenol		19. All results were negative. Resident #28's clinical record was reviewed and revealed that resident #28 was tested for COVID 19 on 9/1/21, 9/8/21 9/14/21 and 9/21/21. All results were negative. 2. No other residents were identified. 3. On 1/17/22, the Director of Nursing/infection control preventionist initiated education with licensed nursing staff regarding monitoring residents for signs and symptoms of Covid and testing residents who have symptoms that could be associated with Covid. *(Facility and Agency, Licensed nursing staff will not be allowed to work after 1/20/21 unless they have successfully completed all assigned education).* 4. On 1/17/22, a **Covid Testing Quality Review Audit** was reviewed and accepted by the Quality Assurance Performance Improvement Committee. Administrative Nursing staff will complete random facility Covid symptom screening documentation reviews using the **Covid Testing Quality Review Audit Tool**, to determine if nursing staff completed Covid Testing on residents with active signs or symptoms documented	

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	was given to alleviate headache and temperature. The nurse's note, dated 6/10/2021 at 8:00 a.m., indicated Resident 51 had a temperature of 100.7 and hematuria noted to his catheter bag. As needed Tylenol was administered as per order and the physician was notified with new orders to obtain stat (immediately) CBC (Complete Blood Count), CMP (Comprehensive Metabolic Panel), and UA (Urinalysis) with culture if indicated. The clinical record lacked documentation of COVID-19 testing related to symptoms. During an interview on 12/18/21 at 4:10 p.m., LPN 17 (Lincensed Practical Nurse) indicated if a resident was running a temperature or having symptoms, he would assess the resident and do a rapid COVID test. He would isolate the resident and call the physician for orders. During an interview on 12/20/21 at 8:30 a.m., LPN 19 indicated if a resident was having symptoms of COVID-19 the resident would be moved to an isolation room, COVID tested, and the physician would be informed. 2. The clinical record for Resident 28 was reviewed, on 12/17/21 at 2:00 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, contracture of muscle left upper are, contracture of the left wrist, muscle weakness, muscle wasting and atrophy, and lack of coordination, chronic obstructive pulmonary disease, and contact with and suspected exposure to other viral communicable disease. The Quarterly MDS (Minimum Data Set) assessment, dated 10/4/21, indicated the resident		on the covid screening evaluation or clinical record. Any concerns identified during the **quality reviews** will be addressed at the time of the review and additional education will be completed at that time. The **Covid Testing Review Audit** will be completed on five residents -five times a week for twelve weeks. The results of the **Audits** will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews. Following the initial twelve review, A minimum of 10 residents will be reviewed monthly until 100% compliance has been determined by the QAPI committee. *(A minimum of seven months must be completed).* - Date of Completion—1/20/22----	

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	was rarely or never understood. He required extensive assistance of two staff members with ADL's (Activities of Daily Living). The physician's orders, dated 9/3/20, indicated COVID-19 test as needed for COVID-19 screening. Non-symptomatic non positive COVID residents record TPR, blood pressure oxygen saturation and signs and symptoms. Report immediately any temperature of 99.1 degrees or higher, cough, shortness of breath, and sore throat. Dated 1/21/21, COVID-19 test as needed for COVID-19 screening. The clinical record lacked documentation that the resident was COVID-19 tested when the resident presented with respiratory symptoms. The nurse's note, dated 9/8/21 at 2:21a.m., indicated the resident previously had phlegm and was unable to cough it up. He was wheezing throughout all lung lobes. He vomited coffee ground emesis, diaphoretic, respirations of 38, and oxygen saturation on room air was at 83% (percent). His wheezing worsened. During an interview on 12/13/21 at 1:51 p.m., the DON indicated staff would monitor resident for symptoms and they would be tested. The staff were to report any oxygen saturation below 90% and any temperatures above 99.0. The current "Guidelines for Compliance With Infection Control," provided on 12/16/21 at 3:03 p.m. by the DON, included, but was not limited to, "...3. The facility must have a system to identify infections and communicable diseases for resident, ...Change of condition with potential for infection, Lab results suggesting the potential for possible infection."...			

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	3.1-18(b)			