DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155469	A. BUILDING 00 B. WING	03/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN 46342

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F 0000 Bldg. 00	This visit was for the investigation of Complaints IN00347005, IN00348779, IN00348904, IN00349036, and IN00349316. Complaint IN00347005 - Substantiated. Federal/State deficiencies related to the allegations are cited at F690 and F692. Complaint IN00348779 - Substantiated. Federal/State deficiencies related to the allegations are cited at F550 and F684. Complaint IN00348904 - Substantiated. Federal/State deficiencies related to the allegations are cited at F624. Complaint IN00349036 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00349316 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689 and F692. Survey dates: March 29, 30, & 31, 2021. Facility number: 000366 Provider number: 155469 AIM number: 100288900 Census Bed Type: SNF/NF: 90 Total: 90 Census Payor Type: Medicare: 19 Medicaid: 64 Other: 7	F 0000		

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

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

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	Total: 90 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/5/21.			
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that			

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	the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, record review, and interview, the facility failed to maintain the dignity of cognitively impaired dependent residents related to performing a COVID-19 test on them in front of other residents for 2 of 3 residents reviewed for dignity. (Residents S and T) Findings include: 1. On 3/30/21 at 10:15 a.m., a Phlebotomist from an outside company was observed performing a COVID-19 test on Resident S in the activity room on the special care unit. At that time, there were 6 other residents seated in the room. Resident S was seated in a broda chair and could not propel herself out of the room. The Phlebotomist removed the nasal swab from the wrapper and placed it in the resident's nose. Resident S was identified by staff as being cognitively impaired and would not be able to determine or make a decision about having the swab performed in front of the other residents. The record for Resident S was reviewed on 3/31/21 at 11:00 a.m. Diagnoses included, but were not limited to, Alzheimer's disease and recent right femur fracture. The Annual Minimum Data Set (MDS) assessment, dated 1/13/21, indicated the resident	F 0550	**F550 Resident Rights/Exercise of Rights** **The facility request paper compliance for this citation** **This Plan of Correction is the center's credible allegation of compliance** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **1. 1. Immediate actions taken for those residents/staff identified:** Phlebotomist was re-educated on collecting nasal specimens for COVID-19	04/27/2021

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	was not alert and oriented. 2. On 3/30/21 at 10:20 a.m., a Phlebotomist from an outside company was observed performing a COVID-19 test on Resident T in the activity room on the special care unit. At that time, there were 6 other residents seated in the room. Resident T was seated in a wheelchair at a table with 4 other residents. The Phlebotomist removed the nasal swab from the wrapper and placed it in the resident's nose. Resident T was identified by staff as being cognitively impaired and would not be able to determine or make a decision about having the swab performed directly in front of the other residents. The record for Resident T was reviewed on 3/31/21 at 11:15 a.m. Diagnoses included, but were not limited to, dementia without behaviors. The Quarterly Minimum Data Set (MDS) assessment, dated 3/4/21, indicated the resident was not alert and oriented and needed extensive assist for locomotion on the unit. Interview with the Director of Nursing on 3/30/21 at 3:00 p.m., indicated the facility had an outside lab that performed all of their COVID-19 testing. The Phlebotomist was not an employee of the facility, however, the residents' dignity should have been maintained. This Federal tag relates to Complaint IN00348779. 3.1-3(t)		Competency with return demonstration was given on proper completion of collecting nasal specimens with COVID-19 to include maintaining resident dignity in common areas **2. How the facility identified other residents:** All residents in the facility have the potential to be affected by the alleged deficiency **3. Measures put into place/ system changes:** All life scan swabbers assigned to the facility be re-educated on proper privacy/dignity protocols Re-education of Life Scan staff with supervisor signoff on privacy/dignity education and competency completed by Life Scan Labs per policy Facility staff re-educated on resident rights, and specifically dignity in common areas to encourage staff intervene in activities that violate resident rights **4. How the corrective action(s) will be monitored:** The Director of Nursing or designee will complete	

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			observations on 5 residents each time lab collects specimens for COVID-19 testing to ensure proper resident rights are followed related to dignity. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of compliance: 4/27/2021**	
F 0624 SS=D Bldg. 00	483.15(c)(7) Preparation for Safe/Orderly Transfer/Dschrg §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. Based on record review and interview, the facility failed to provide continuity of care for a safe discharge related to discharge planning services for outside resources for 1 of 3 residents reviewed for discharge planning. (Resident F) Finding includes: The closed record for Resident F was reviewed on 3/30/21 at 3:17 p.m. Diagnoses included, but were not limited to, acute osteomyelitis (bone infection)	F 0624	**F624 Preparation for Safe/Orderly Transfer/Discharge** **The facility request paper compliance for this citation** **This Plan of Correction is the center's credible allegation of compliance**	04/27/2021

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of the right ankle and foot, peripheral vascular disease, type 2 diabetes with diabetic neuropathy and hypertension. The resident was admitted on 12/4/20 and discharged on 2/28/21.

The Admission Minimum Data Set (MDS) assessment, dated 12/10/20, indicated the resident was cognitively intact for daily decision making. The resident required extensive assistance with bed mobility and transfers. The resident was admitted with two stage 2 pressure ulcers, one unstageable pressure ulcer, and nine venous ulcers.

A Physician's Order, dated 1/29/21, indicated the resident's left foot big toe, right foot big toe, right foot 4th toe, right lateral ankle and right lateral foot were to cleansed daily with normal saline, painted with betadine (a topical antiseptic), and left open to air daily.

A Physician's Order, dated 2/1/21, indicated the resident was to receive betadine to the right heel after the area was cleansed with normal saline and patted dry. The area was to be covered with an ABD pad then wrapped with kerlix daily until resolved and as needed.

A Physician's Order, dated 2/3/21, indicated the resident's left heel was to be cleansed with normal saline, patted dry, and iodosorb (an antimicrobial dressing) was to be applied. The area was to be covered with an ABD pad and wrapped with kerlix daily.

Social Service Progress notes, dated 2/23/21 at 2:27 p.m., indicated the resident's son left a voice mail indicating the resident would be discharging to Houston, Texas via medical transport on 2/26/21. He also indicated he would arrange for

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1. Immediate actions taken for those residents/staff identified:

Wound supplies and instructions were shipped overnight to resident’s place of discharge

Home health order completed by MD, faxed and confirmed that it was received by Star Home health

2. How the facility identified other residents:

Any discharging resident have the potential to be affected by the alleged deficiency

3. Measures put into place/ system changes:

Facility staff in-serviced on transfer/discharge policy

Nursing staff educated on new discharge communication tool to

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	home health care and medical equipment. Social Service Progress notes, dated 2/25/21 at 2:12 p.m., indicated the resident's son phoned the facility to inform them he was unsure if the discharge would be on 2/26/21 or the following week. He indicated he was waiting for transportation confirmation. He also indicated he needed prescriptions for a hospital bed, a hoyer lift, a wheelchair, and a home health care order as he was setting up those services. The information was provided to the Nurse Practitioner who was in the building. Social Service Progress notes, dated 2/27/21 at 2:59 p.m., indicated the resident's son phoned the facility to inform them resident transport would be there on 2/28/21 between 1:00 p.m. and 6:00 p.m. Discharge Nurses' notes, dated 2/28/21 at 4:56 p.m., indicated the resident left the facility via medical transport with a traveling nurse and her daughters. Education about medication administration was provided and the resident's family received the medications as well as bed hold forms, code status, face sheet, observation detail list report and continuity of care document. Social Service Progress notes, dated 3/1/21 at 11:45 a.m., indicated the Social Service Designee (SSD) spoke with the resident's son. The resident's son needed additional help with arranging home health care and medical equipment. The SSD contacted the home health agency and they indicated they would get the medical equipment. The resident's son was notified. Nursing Progress notes, dated 3/2/21 at 10:22 a.m., indicated one of the resident's family members		ensure compliance with discharge plan of care IDT to meet as needed to discuss upcoming discharges. Social Services to ensure follow up documentation upon discharge is in place to ensure all arranged services are in place **4. How the corrective action(s) will be monitored:** The Social Services director or designee will complete audits for each discharge to ensure that continuity of care is completed related to discharge planning services for outside resources to ensure safe discharge out of facility The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of compliance: 4/27/2021**	

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was present at the facility and met with the Administrator and Director of Nursing (DON) to address discharge concerns. All questions were answered.

Nurses' notes, dated 3/2/21 at 12:47 p.m., indicated the writer packed a box with 14 rolls of kerlix, a box of tape, a box of betadine wipes, a tube of triad (a wound ointment) paste, a box of normal saline, a package of gauze, a package of ABD pads and treatment orders. The treatment orders were highlighted as to which area the medications were to be applied.

Interdisciplinary Team (IDT) Progress notes, dated 3/2/21 at 3:14 p.m., indicated the Assistant Administrator mailed the wound supplies, discharge instructions, and Physician's Orders to the resident's son. The package was mailed using express shipping and would be delivered the next business day.

Social Service Progress notes, dated 3/3/21 at 5:50 p.m., indicated the resident's son was contacted and the wound supplies had been received. He also indicated the medical equipment had not arrived and the home health agency was still waiting for a signed Physician's Order. The Physician signed the order and it was faxed to the home health agency. All of the son's questions were answered.

Phone interview with the resident's son on 3/31/21 at 9:15 a.m., indicated the resident arrived at his home on 3/1/21. He indicated the resident did not have any wound supplies and home health services were still pending.

Interview with the DON on 3/31/21 at 12:23 p.m., indicated the resident was discharged without

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	wound care supplies. She indicated the wound care supplies were not sent due to thinking all of the home health arrangements had been completed by the resident's son. She indicated once they found out home health services had not been finalized due to the Nurse Practitioner's Orders not being accepted in the state of Texas, the resident's Physician was contacted as well as the home health agency and wound care supplies were sent overnight. This Federal tag relates to Complaint IN00348904. 3.1-12(a)(21)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			
	Based on record review and interview, the facility failed to ensure care and treatment was provided in accordance with professional standards related to transportation to dialysis appointments not provided for 2 of 3 residents with ongoing dialysis appointments. (Residents L and C) Findings include: 1. The record for Resident L was reviewed on 3/30/21 at 9:56 a.m. Diagnoses included, but were not limited to, urinary retention, end stage renal disease and renal dialysis.	F 0684	**F684 Quality of Care** **The facility request paper compliance for this citation** **This Plan of Correction is the center's credible allegation of compliance** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of**	04/27/2021

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	The Quarterly Minimum Data Set assessment, dated 1/18/21, indicated the resident was cognitively intact for daily decision making and needed supervision with bed mobility and transfers. The resident was also receiving dialysis. The March 2021 Physician's Order Summary (POS), indicated the resident was to receive dialysis three times a week on Monday, Wednesday and Friday. Pick up was scheduled for 10:00 a.m. Nurses' notes, dated 1/1/21 at 2:45 p.m., indicated the resident's transport did not come that morning to pick him up for dialysis. The transport company was contacted and they indicated they had no one to take him at his scheduled time. Nursing Progress notes, dated 1/27/21 at 10:53 a.m., indicated the writer spoke with a representative from the transport company and was notified they were not able to secure transportation for the resident's dialysis appointment. The transportation company never called to notify the facility. Nurses' notes, dated 3/5/21 at 1:36 p.m., indicated the resident did not go to dialysis that morning due to transportation issues. Nurses' notes, dated 3/8/21 at 9:38 a.m., indicated the resident did not get picked up by transport for his scheduled dialysis appointment. The resident indicated if no one picked him up by noon, he was not going. Interview with the Director of Nursing on 3/31/21 at 9:00 a.m., indicated they have had many issues		**the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **1. Immediate actions taken for those residents/staff identified:** Calls placed to MD to receive orders to send to hospital for dialysis or reschedule were obtained for residents L and C **2. How the facility identified other residents:** All residents with ongoing dialysis appointments have the potential to be affected from the alleged deficient practice **3. Measures put into place/ system changes:** Formal procedure written regarding transportation and transportation communication form implemented to ensure compliance with plan of care Nursing staff re-educated on the importance of ensuring dialysis services are provided as scheduled and MD is notified if new orders are needed to comply	

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	with the transportation company in the past. 2. The record for Resident C was reviewed on 3/29/21 at 10:35 a.m. Diagnoses included, but were not limited to, end stage renal disease, dependence on renal dialysis, hepatic (liver) failure, anemia in chronic kidney disease, and alcohol cirrhosis (liver disease) with ascites (buildup of fluid in the abdomen). The resident was admitted on 2/11/21 and readmitted from the hospital on 2/26/21 and 3/6/21. The Admission Minimum Data Set (MDS) assessment, dated 3/23/21, was not available and still in process. A Care Plan, dated 2/12/21, indicated the resident required dialysis related to end stage renal disease. Physician's Orders, dated 2/12/21, indicated dialysis on Mondays, Wednesdays, and Fridays. Dialysis: hemodialysis chair time 10:00 a.m., ambulance service to pick up at 9:00 a.m. Nurses' notes, dated 2/16/21 at 1:12 p.m., indicated a paracentesis (a procedure to drain excess fluid off of the abdomen) appointment was set up at the local hospital on 2/18/21, a transportation company was to pick the resident up at 7:00 a.m. Nurses' notes, dated 2/16/21 at 2:11 p.m., indicated the resident's paracentesis was set for 2/18/21 at 9:00 a.m., at the hospital. Future paracentesis appointments were confirmed for every Tuesday at 9:00 a.m. Transportation was arranged for the current week and every week thereafter. Nurses' notes, dated 2/17/21 at 12:38 p.m., indicated dialysis was rescheduled for tomorrow at 11:00 a.m. Transportation was currently		with services Education provided to staff involved in transportation of new implemented transportation procedures **4. How the corrective action(s) will be monitored:** The director of nursing or designee will audit 5 residents who have transportation needs each week to ensure compliance with plan of care The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of compliance: 4/27/2021**	

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pending.

Nurses' notes, dated 2/17/21 at 2:05 p.m., indicated the transportation pickup was set for 2/18/21 at 10:15 a.m. to take the resident to dialysis. The dialysis appointment was at 11:00 a.m., and the resident was on standing orders, so his transportation for Monday, Wednesday and Friday was set. The resident was going by wheelchair.

Nurses' notes, dated 2/18/21 at 7:21 a.m., indicated the resident was out for his paracentesis appointment.

Nurses' notes, dated 2/18/21 at 8:55 a.m., indicated the transportation company was called to confirm the dialysis appointment on 2/18/21 at 10:00 a.m. A driver was currently pending and the transport company would call to notify of any changes.

Nurses' notes, dated 2/18/21 at 1:20 p.m., indicated the resident arrived back to the facility from the paracentesis appointment. There was a bandage to the right lower abdomen.

Nurses' notes, dated 2/19/21 at 10:23 a.m., indicated transportation had not arrived to pick the resident up for dialysis. The company indicated they had no driver and to call dialysis to see how late the resident could come today. Another transportation company was called and could not take the resident to dialysis. The original transport company was notified the resident could go to dialysis as late as 2:30 p.m. The company indicated they would call back if they could get him there today.

Nurses' notes, dated 2/19/21 at 10:59 a.m., indicated the transportation company called back

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and notified the facility they were unable to take the resident to dialysis. The Nurse Practitioner was notified.

Nurses' notes, dated 2/21/21 at 7:10 a.m., indicated the resident wanted to go to the hospital. He indicated his stomach was burning. The resident's abdomen was round, and he did not go to dialysis on Friday because transport canceled and they were unable to get another transport service. The resident stated, "I got to get some of this fluid off."

Nurses' notes, dated 3/16/21 at 9:44 a.m., indicated transportation for this mornings scheduled paracentesis had been canceled. The Physician was made aware.

Nurses' notes, dated 3/16/21 at 11:13 a.m., indicated the paracentesis was unable to be rescheduled today. The Physician was made aware and indicated to continue to administer the resident's medications per orders and monitor for increased confusion.

Interview with the Director of Nursing on 3/31/21 at 9:00 a.m., indicated they have had many issues with the transportation company in the past. The resident did miss several of his dialysis and paracentesis appointments in February and March 2021 due to not having transportation.

This Federal tag relates to Complaint IN00348779

3.1-37(a)

F 0689
SS=D
Bldg. 00

483.25(d)(1)(2)
Free of Accident
Hazards/Supervision/Devices
§483.25(d) Accidents.

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	The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on observation, record review, and interview, the facility failed to ensure adequate supervision was provided to prevent accidents related to unthickened liquids served to a resident with swallowing precautions for 1 of 4 residents reviewed for accidents. (Resident R) Finding includes: On 3/30/21 at 11:30 a.m., CNA 1 was observed passing out beverages to the residents in the dining room on the special care unit. CNA 1 gave Resident R a cup of orange kool aid. The liquid was not thickened. The resident took the cup and drank all of it. At 11:35 a.m., the resident was served her lunch tray. She received a mechanical soft diet with a glass of nectar thick apple juice. The resident's tray card indicated she was to receive nectar thick liquids. The resident drank all of the apple juice. The record for Resident R was reviewed on 3/30/21 at 1:12 p.m. The resident was admitted to the facility on 3/16/21. Diagnoses included, but were not limited to, dementia, Alzheimer's disease, dysphagia (difficulty swallowing), and anxiety. Physician's Orders, dated 3/23/21, indicated the resident was to receive a mechanical soft diet and nectar thick liquids. A Minimum Data Set (MDS) assessment was not	F 0689	**F689: Free of Accident Hazards/Supervision/Devices** **The facility request paper compliance for this citation This Plan of Correction is the center's credible allegation of compliance** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **1. Immediate actions taken for those residents/staff identified:** CNA 1 was re-educated on ensuring adequate supervision was provided to prevent accidents related to unthickened liquids being served to residents with swallowing precautions	04/27/2021

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	available. A Care Plan, dated 3/25/21, indicated the resident required a mechanically altered diet with thickened liquids. A nursing approach was to provide diet per Physician's order. A Physician's Progress note, dated 3/29/21 at 2:38 p.m., indicated the resident had dementia and was a poor historian. Interview with the Director of Nursing on 3/30/21 at 2:50 p.m., indicated the resident should have been served thickened liquids as ordered by the Physician. This Federal tag relates to Complaint IN00349316. 3.1-45(a)(2)		Resident R was assessed and chest x-ray ordered per MD Speech therapy assessed Resident R and determined that no longer has swallowing difficulties and discontinued thickened liquids **2. How the facility identified other residents:** All residents with orders for thickened liquids and other altered consistency of diet have the potential to be affected by this alleged deficiency **3. Measures put into place/ system changes:** Audit of all altered diets was completed. List was created to place on drink cart and dining rooms to ensure facility staff aware of diet orders. Thickened liquids will be delivered on meal trays to identified residents **4. How the corrective action(s) will be monitored:** The director of nursing or designee will observe 5 dining services per week for proper fluids are been served as ordered by MD and assistance is provided timely to	

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			residents that needs assistance according to plan of care The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of compliance: 4/27/2021**	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that			

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	catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on record review and interview, the facility failed to ensure residents received appropriate treatment and services related to urinary catheter care for 1 of 3 residents reviewed for urinary catheters. (Resident M) Finding includes: The record for Resident M was reviewed on 3/30/21 at 1:12 p.m. Diagnoses included, but were not limited to, hospice palliative care, falls, pubis fracture, and dementia with behavior disturbance. The Significant Change Minimum Data Set (MDS) assessment, dated 3/23/21, indicated the resident was rarely/never understood, required extensive one person physical assistance with bed mobility and transfers, and had a urinary catheter. Physician's Orders, dated 3/17/21, indicated the resident was to have a supra pubic catheter, provide care every shift, and clean site daily. There was no documentation to indicate the catheter and site care was provided as ordered. Interview with the Director of Nursing (DON) on	F 0690	**F690: Bowel/Bladder Incontinence, Catheter, UTI** **The facility request paper compliance for this citation** **This Plan of Correction is the center's credible allegation of compliance** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **1. Immediate actions taken for those residents/staff identified:**	04/27/2021

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	3/31/21 at 12:26 p.m., indicated the nursing staff were to document catheter and site care in the Treatment Administration Record (TAR), and those records were not available for review. This Federal tag relates to Complaint IN00347005. 3.1-41(a)(2)		Audit of current residents with indwelling catheters to ensure appropriate treatment and services are provided Audit of current residents with indwelling/ suprapubic catheters to ensure orders are in place provided catheter care every shift site to be cleaned daily **2. How the facility identified other residents:** All residents with orders for indwelling/ suprapubic catheters have the potential to be affected **3. Measures put into place/ system changes:** Nurse re-educated on catheter care and proper documentation to comply with MD order and plan of care **4. How the corrective action(s) will be monitored:** The director of nursing or designee will complete audits on all residents with catheters to ensure orders are in matrix and on the MAR. An audit will be completed weekly to ensure the appropriate services and treatments The results of these audits will be reviewed in Quality Assurance	

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			Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of compliance: 4/27/2021**	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.			
	Based on observation, record review, and interview, the facility failed to ensure food consumption, supplements, and weights were monitored, as well as assistance being provided	F 0692	**F692 Nutrition/Hydration Status Maintenance** **The facility request paper**	04/27/2021

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	with meals for residents with a history of weight loss for 2 of 3 residents reviewed for nutrition. (Residents K and D) Findings include: 1. The record for Resident K was reviewed on 3/30/21 at 11:15 a.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing), Down's syndrome, epilepsy, and dementia without behavior disturbance. The resident was admitted to the facility on 1/28/21. The Admission Minimum Data Set (MDS) assessment, dated 2/4/21, indicated the resident was severely impaired for daily decision making and required extensive assistance with eating. The resident received a mechanically altered diet. The Care Plan, dated 2/3/21, indicated the resident was limited in functional status related to eating and drinking independently. Interventions included, but were not limited to, monitor and record intake of food/fluids. A Physician's Order, dated 1/29/21, indicated the resident was to receive a regular pureed diet with nectar thick liquids and a nutritional treat at each meal. A Physician's Order, dated 2/1/21, indicated weekly weights times 4 weeks then monthly. The resident's admission weight on 1/28/21 was 104 pounds. The next documented weight on 2/10/21 was 92 pounds. A Registered Dietitian (RD) Progress note, dated		**compliance for this citation This Plan of Correction is the center's credible allegation of compliance** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **1. Immediate actions taken for those residents/staff identified:** Resident K food and fluid consumption logs reviewed. Resident D assisted with meal in dining room LPN1, CNA1 and CNA2 educated on importance of timely meal assistance to residents and meal intake documentation An audit of all nutritional supplements was completed to ensure orders were correct and percentage of consumption was documented **2. How the facility identified other residents:**	

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	2/16/21 at 10:39 a.m., indicated the resident was noted with an approximate 11 pound weight loss between 1/28/21 and 2/10/21. The resident's weight had been stable the past week. She indicated the resident had fair to good oral intake with 50-100% of meals consumed. Nutritional supplements were in place. No additional recommendations were made except to weigh weekly next week. The RD would continue to follow as needed. The food consumption log for January 2021 indicated there was no meal intake documented on 1/28, 1/29 and 1/31/21. No breakfast or lunch intake was documented on 1/30/21. The food consumption log for February 2021 indicated there was no food consumption documented on 2/1, 2/3, 2/10, 2/12, 2/14, 2/16, and 2/18/21. Breakfast and lunch intake was not documented on 2/4, 2/5, 2/7, 2/8, 2/9, and 2/15/21. Dinner intake was not documented on 2/2, 2/19, 2/20, 2/21, 2/23, and 2/25/21. Interview with the Director of Nursing on 3/31/21 at 9:00 a.m., indicated documentation of the resident's food consumption should have been completed. 2. On 3/30/21 at 11:20 a.m., LPN 1 pushed Resident D to the dining room on the special care unit. The resident was seated at a table by herself. She was seated in a broda chair and was dependent on staff for feeding, repositioning, and locomotion. At 11:33 a.m., LPN 1 placed a lunch tray in front of her with the lid in place. LPN 1 and CNA 2 were observed passing trays to the other residents seated in the dining room. CNA 1 was observed passing out		All residents who are at risk for weight loss have the potential to be affected by the alleged deficient practice **3. Measures put into place/ system changes:** The nursing staff will be re-educated on importance of monitoring and recording food and fluid consumption, and completing weights as ordered The nursing staff will be re-educated on importance on timely assistance of residents with meals Weights will be monitored at weekly Nutrition At Risk Meetings, led by dietitian. Recommendations to be documented and followed as prescribed **4. How the corrective action(s) will be monitored:** The DON/designee will complete daily audit on at least 5 residents' meal intake records per Point of Care compliance report a minimum of 4 times a week. Will also complete an audit tool to ensure compliance with nutritional supplement consumption, weights are completed as ordered, and weight loss is reviewed at weekly NAR meeting. Dining room observation will be done for 5 meal services per week to monitor for residents receiving assistance	

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	beverages to the residents as well. Activity Aide 1 was seated by another resident and assisting her with lunch. LPN 1 sat down to feed another resident. CNA 1 and CNA 2 left the room with the other trays and the beverage cart to pass the meals to those residents who were in their rooms. Resident D remained reclined in her broda chair, with her food in front of her and no staff was observed assisting or feeding her. All 6 residents in the room were eating or being assisted by staff. At 11:42 a.m., CNA 1 came back into the dining room after passing the beverages and walked over to Resident D's chair. She indicated the resident needed a tissue. CNA 1 left the room and came back at 11:45 a.m., with a box of kleenex and wiped the resident's nose. She then left the room again at 11:46 a.m., and returned at 11:48 a.m., and sat down to feed the resident. The resident was served a pureed meal of spinach, chicken, mashed potatoes, bread, and a dessert. She had a cup of orange kool aid and a ready care health shake. The resident was observed to drink the fluids, however, only took small bites of the food. The record for Resident D was reviewed on 3/30/21 at 9:00 a.m. Diagnoses included, but were not limited to, protein-calorie malnutrition, dementia, late onset of Alzheimer's disease, and stroke. The Quarterly Minimum Data Set (MDS) assessment, dated 1/12/21, indicated the resident was not alert and oriented. The resident weighed 98 pounds with a significant weight loss noted. A Care Plan, dated 1/19/21, indicated the resident received a mechanically altered diet. The nursing approaches were to monitor intake of food and obtain and monitor weights.		with eating. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of compliance: 4/27/2021**	

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A Care Plan, dated 4/15/20, indicated the resident was limited in functional status in regards to eating and drinking independently. The nursing approaches were to provide assistance as needed.

There was no current Care Plan for weight loss.

The resident was currently receiving hospice services.

Physician's Orders, dated 3/9/21, indicated house supplement 90 milliliters twice a day. Another order, dated 3/19/21, indicated pureed diet with a 4 ounce ready care shake at all meals.

The resident's weights were as follows:

11/1/20- 103 pounds
1/4/21- 98 pounds
3/2/21- 84 pounds
3/8/21- 84 pounds
3/15/21- 82 pounds

A Registered Dietitian (RD) note, dated 3/23/21 at 10:22 a.m., indicated the resident was now receiving hospice. Body Mass Index was 15 (underweight status). The resident presented with a 14.7% weight loss over the past 60 days and a 18.8% weight loss over the past 120 days. The resident had variable oral intake of 1-100% of most meals. Anticipate further decline in nutritional status due to disease process.

Nurses' notes, dated 3/19/21 at 2:39 p.m., indicated the family was aware of the diet change but appeared to be upset. The sister stated she felt as if staff did not feed the resident. Family notified the resident was pocketing food and holding food in her mouth. Family continued that staff did not take enough time to feed the resident. The

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resident was prompted to eat meals and consumed 25% or less.

The meal consumption logs for the months of 2/2021 and 3/2021 indicated the following:

There was no documentation of the intake of the dinner meal on: 2/1, 2/3. 2/5-2/8, 2/12-2/15, 2/17, 2/19-2/22, 2/24, 3/1, 3/2, 3/5-3/9, 3/11, 3/12, 3/15-3/19, 3/21, 3/22, and 3/24-3/28/21.

There was no documentation of the intake of the lunch meal on: 2/1-2/3, 2/6-2/12, 2/14, 2/16, 2/18-2/22, 2/25, 2/28, 3/1, 3/6-3/9, 3/11, 3/12, 3/14-3/16, 3/18, and 3/23-3/29/21.

There was no documentation of the intake of the breakfast meal on: 2/1, 2/3, 2/6, 2/7, 2/10-2/12, 2/14, 2/19-2/21, 2/25, 2/28, 3/1, 3/6-3/8, 3/11, 3/12, 3/15, 3/16, 3/18, 3/23-3/26, 3/28, and 3/29/21.

There was no documentation of the ready care health shake intake on the 2/2021 or 3/2021 Medication Administration Records.

Interview with the Director of Nursing on 3/31/21 at 9:00 a.m., indicated the meal consumption logs were incomplete and the ready care health shake consumption was not available. She indicated the resident should have been fed when the others in the dining room received their meal trays.

This Federal tag relates to Complaints IN00347005 and IN00349316.

3.1-46(a)(1)