STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	10/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00362891 and IN00362987. Complaint IN00362891- Unsubstantiated due to lack of evidence. Complaint IN00362987 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684. Survey dates: October 25, 26, 27, 28, and 29, 2021 Facility number: 000368 Provider number: 155845 AIM number: 100275220 Census Bed Type: SNF/NF: 17 Total: 17 Census Payor Type: Medicaid: 15 Other: 2 Total: 17 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 11/8/21.	F 0000	.Preparation and submission of this Plan of Correction does not constitute and admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of the requirements under state and federal laws.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and			

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

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	communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, record review and interview, the facility failed to ensure each	F 0550	.Preparation and submission of this Plan of Correction does not	11/20/2021

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	resident's dignity was maintained related to dining assistance for dependent residents for 1 of 2 residents reviewed for dignity and for 2 of 3 meals observed. (Residents B, 1, and C) Findings include: 1. On 10/27/21 at 9:57 a.m., the first breakfast tray was served from the kitchen. At 10:14 a.m., Residents B and 1 received their trays. At 10:17 a.m., the residents were provided assistance with their meals. The other residents in the dining room had already eaten. Interview with the Director of Nursing on 10/29/21 at 11:00 a.m., indicated the residents should not have had to wait on their food. 2. On 10/28/21 at 9:40 a.m., Resident C was observed in his geri chair recliner in the dining room. His geri chair was reclined and he was positioned along the side of the table. He was seated at the table with Resident B. Resident B was being assisted with his meal by PCA 2. At 9:45 a.m., Resident C received his tray. The geri chair had not been repositioned and he was attempting to reach his food from the side of the table. At 9:49 a.m., Resident C was positioned in front of the table and his geri chair was upright. The record for Resident C was reviewed on 10/28/21 at 11:00 a.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing), type 2 diabetes mellitus, and hemiplegia (muscle weakness) following a stroke. The Annual Minimum Data Set (MDS) assessment, dated 10/7/21, indicated the resident was cognitively impaired for daily decision making and required supervision with eating with setup		constitute and admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of the requirements under state and federal laws. F 550 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? 1. Reviewed with C.N.A. to instruct the kitchen staff on who is seated at each table before serving the meal, this will ensure everyone at the table is served at one time. Residents are seated 6 feet apart at 2 of the 12-foot tables used at mealtime all other tables are individually served with 1 person at a table. All residents cannot be served at the same time. The independent residents are served first and resident's requiring assistance are served next. All residents were served their meal within 20 minutes. The residents are served their beverage, then cereal then the rest of the breakfast. 2. The PCA served the breakfast meal to two residents within 4 minutes the resident was sitting	

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	help. Interview with the Administrator on 10/28/21 at 12:00 p.m., indicated the Resident C should not have had to wait on his food and his geri chair should have been positioned upright and in front of his food. 3. On 10/25/21 at 12:34 p.m., PCA 1 was observed to open the closet door and she pulled out her purse. Inside the purse was a bag of chocolate candy. The PCA passed out the chocolate candy to 6 residents who were seated in the dining room. Resident B was seated at another table and did not receive one. The PCA told Resident B that she would go into the kitchen and smash a piece of candy up for him to eat because he was on a pureed diet. On 10/26/21 at 12:48 p.m., Resident B was observed seated in a geri chair. At that time he was served his lunch which was pureed meat, vegetable, mashed potatoes, and pudding. The resident started to feed himself and was doing well with no issues noted. At 1:00 p.m., PCA 1 was observed to walk over to the table and she took his plate of food and pudding away from him and placed it completely out of reach. She walked over to the beverage cart and filled up juice for the other residents and passed them out. She came back over to the resident at 1:02 p.m., and started to feed him. The resident did not have anything to drink with his meal. At 1:04 p.m., the PCA stood up and placed his food across the table and out of reach. She walked into the kitchen and came back with the thickener and prepared drinks for the resident and another resident. She returned to the table where the resident was seated at 1:08 p.m., and handed him the juice to drink. The PCA started to feed the resident once again. At 1:12 p.m., the PCA stood up again and placed the		upright at the table to eat his food this seems to be within a reasonable timeframe to reposition resident. Administrator was informed but the time frame of 4 minutes was not mentioned. The staff of Simmons Loving Care strives to ensure all our residents are served their meals promptly and their meal is enjoyable. 3. PCA 1 was instructed to complete the meal with the resident once she has started and let other staff members fulfill the other request by the residents. The PCA 1 wanted to ensure that resident did not experience any difficulty in swallowing Resident B (121) his meal. The PCA 1 left the resident for only 2-to-4-minute intervals. 3. All staff in serviced on ensuring that everyone is offered a proper treat according to their diet. Residents on a purred diet also receive treats. The PCA 1 does not work in the kitchen and cannot puree the foods however she does serve the puree snacks to the residents, this was a defensive response, and she meant no harm to the residents. PCA 1 was instructed to complete the meal with the resident once she has started and let other staff members fulfill the other request No resident has complained about the serving sequence. All our	

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	resident's plate, pudding and drink across the table and out of reach from him. She left the table and started to pass the other residents ' meal trays to them. The PCA returned to the resident at 1:15 p.m. and assisted him with eating. The record for the resident was reviewed on 10/25/21 at 4:26 p.m. The resident was admitted on 7/16/21 from the hospital. Diagnoses included, but were not limited to, fractured femur, encephalopathy, sepsis, urinary tract infection, transient ischemic attacks, dysphagia, and Parkinson's disease. The Admission Minimum Data Set (MDS) assessment, dated 8/5/21, indicated the resident was not cognitively intact. The resident needed supervision with set up help for eating. The resident had no oral problems and weighed 140 pounds with no significant loss or gain. He received a mechanically altered and therapeutic diet. Physician's Orders, dated 9/28/21, indicated the resident was to receive a pureed regular diet with honey thickened liquids. Interview with the Director of Nursing on 10/27/21 at 10:45 a.m., indicated the PCA should not have offered candy bars to all of the residents in front of Resident B who was on a pureed diet. She also indicated the PCA should not have removed the resident's plate from him while he was trying to feed himself. 3.1-3(t)		residents are treated with dignity and facility will ensure that every resident is served. Deficient practices were reviewed with all Dietary and Nursing Staff. One on one education provided for on Pureed Snacks and Serving Sequence of Trays at Mealtimes. Deficient practice was discussed, and in-service completed with all nursing staff, charge nurses and C.N.A.'s and P.C.A.'s on dignity of the residents and mealtime. Residents that need assistance will be seated together and mealtimes will be staggered to ensure that residents are assisted with their meal in a timely manner (as soon as their tray is delivered). 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. 1 resident requires to be fed and 5 residents require oversight during mealtime due to short attention span during the meal. They are reminded to complete their meal. No other deficient practice noted. Seating is limited in the dining room due to 6-foot distancing therefore residents requiring assistance with meals will be	

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			served at the second feeding to allow adequate time to provide the meal service to residents leaving the facility for dialysis and appointments. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. A. Charge Nurse and Food Service Supervisor will ensure proper sequence in serving meals to residents at mealtime. B. D.O.N. will monitor 3 mealtimes weekly times 3 week for one month then monthly, ongoing. Results of audits/monitoring will be reviewed by QAA Committee to identify any trending in deficiencies. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. Change in serving sequence is as follows: 1. Residents in rooms will be served first. 2. Residents who eat independently or with set-up help will be served second. 3. Residents that require to be fed will be served last.	

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			Charge Nurse will monitor mealtimes daily. Food Service Supervisor will monitor mealtime bi-weekly. Feeding times will be established by the Dietary Manager and Dietician and reviewed monthly to ensure all residents are feed at the same time at 2 of the tables that seat 2 people. Q.A. Committee will review D.O.N recommendations and concerns regarding resident's dignity during mealtime. Results of audits/monitoring will be reviewed by QAA Committee to identify any trending in deficiencies. Q.A. Committee will review dining room schedule quarterly for 6 months then semi-annually. 5. Completion Date: 11/20/21	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);			

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	(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 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 to ensure the Physician was notified of new areas of skin breakdown and/or skin injury, falls, and	F 0580	F580 notify physician of -change - what corrective action(s) will be accomplished for those residents found to have been	11/12/2021

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	malodorous urine for 2 of 2 residents reviewed for notification of change. (Residents 3 and B) Findings include: 1. The record for Resident 3 was reviewed on 10/27/21 at 10:21 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, major depressive disorder, and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 9/9/21, indicated the resident was cognitively impaired for daily decision making and required extensive assistance for bed mobility and transfers. Nurses' Notes, dated 10/15/21 at 7:31 p.m., indicated the resident had two open areas. The first area was to her right lateral buttock area. The open area measured 5 centimeters (cm) long. The top of the open area was 1 cm wide, the bottom of the open area measured 0.5 cm wide. The second open area was a circle measuring 1.0 cm round. Both areas were clean and dry. No swelling was noted. The resident complained of pain to both areas while they were being measured. The nurse was going to pass on to the AM nurse to contact the Physician for orders due to the lateness of the hour. There was no documentation indicating the Physician had been notified of the new open areas. Interview with the Director of Nursing on 10/29/21 at 11:00 a.m., indicated the Physician should have been notified of the new open areas. 2. The record for Resident B was reviewed on 10/25/21 at 4:26 p.m. The resident was admitted on 7/16/21		affected by the deficient practice. In-service held with RN doing the documentation. She indicated that the areas were scratches from Resident 3 scratching. Due to the advancement of her Dementia, she makes whimpering sounds but is not in pain. RN was instructed to finish everything that is required if there is a problem noted with a resident in her care and not leave it to another shift. She was also told that if she is unsure of an area to consult with the nurse, D.O.N. to ensure proper documentation and treatments are provided. In-service on decubitus staging was done and educational materials given for review. This incident was reviewed with LPN on staff who recorded the events on the day that it happened. It was explained to her that every discipline has their own scope of practice. The nurse and therapist have their own responsibilities in ensuring that the resident is cared for. The definitive role of the nurse's responsibilities was reviewed with her and her deficient practice. This was an issue already reviewed by the D.O.N. and it has been used to teaching too for all licensed nurses. All licensed nurses received charting tools (APIE-Assessment, Problem, Interventions and Evaluation) in doing documentation. Point of clarification: Custodian	

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	from the hospital. Diagnoses included, but were not limited to, fractured femur, encephalopathy, sepsis, urinary tract infection, transient ischemic attacks, dysphagia, and Parkinson's disease. The resident was admitted to the hospital for a fractured femur on 7/19/21 and returned to the facility on 7/27/21. The resident was admitted to the hospital on 9/25/21 for severe dehydration and a urinary tract infection. He returned to the facility on 9/28/21. The Admission Minimum Data Set (MDS) assessment, dated 8/5/21, indicated the resident was not cognitively intact. The resident needed extensive assist with 2 person physical assist for transfers and toilet use. The resident needed supervision with set up help for eating. The resident had no oral problems and weighed 140 pounds with no significant loss or gain. He received a mechanically altered and therapeutic diet. He had no pressure ulcers. Nurses' Notes, dated 7/18/21 at 8:36 a.m., Late Entry: indicated, "Summoned to room [number] by therapist and janitor who stated that resident was found on the floor in room. He had been transferred to wheelchair and was being assessed by therapist. He was found to have a small amount of bleeding from his left elbow from a blister that had ruptured. Wound was cleansed and dry dressing applied. Resident had full ROM [range of motion] to upper and lower extremities and had no complaints of pain or discomfort. Therapist continued her assessment to admit for therapy and he was able to comply. Message left for emergency contact [name]." There was no documentation the Physician had been notified of the fall or the blister that had		did not pick up Resident B (121) but a C.N.A. helped the O.T.R. The C.N.A. is the person who went to summon the L.P.N. In-service included s/s of UTI, Skin Assessment, Physician Notification and Change In Condition. - 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; The staff provides good skin to the residents of the facility and has 1% rate of development of pressure areas. All residents skin assessments were reviewed. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; In-Service held with licensed nurses to review change in condition policy and updating of P.O. according to treatment and proper skin documentation. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Licensed Nurse will notify physicians for all changes in conditions as they occur according to facility policy.	

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	ruptured. Nurses' Notes, dated 9/18/21 at 8:55 a.m., indicated, "was brought to writer's attention that resident had foul smelling urine and that it looked slimy oncoming nurse also aware of situation." There was no documentation the Physician had been notified of the foul smelling urine. Nurses' Notes, dated 9/22/21 at 9:50 p.m., indicated, "Resident received in room in geri chair alert and responsive. Reported that resident fell yesterday and sustained a bruise on his left lower eyelid. There was no documentation the Physician had been notified of the fall with injury on 9/22/21. Nurses' Notes, dated 10/19/21 at 11:26 p.m., indicated the resident was received in the dining room in his geri chair. The resident had attempted a couple of times throughout the shift to slide out of the chair. Staff assisted in him back in chair. The resident had a skin tear on his right arm that was covered with a gauze wrap. There was no documentation the Physician had been notified of the skin tear. Interview with the Director of Nursing on 10/27/21 at 10:45 a.m., indicated the Physician was to be notified of all changes or injuries with the resident. 3.1-5(a)(1) 3.1-5(a)(2)		D.O.N. Designee will review all new orders and documentation of resident change in conditions and provide education as needed to licensed nurses. D.O.N. Designee will be informed of all changes in conditions by nursing staff. D.O.N. will monitor 72 hour report every 3 days for one month, then weekly times three months ongoing due to potential changes in staff. Q.A. Committee will review hospitalizations and new order log at quarterly meeting. Q.A. Committee will determine if any other revisions are needed. - by what date the systemic changes for each deficiency will be completed: 11/12/21	
F 0604 SS=D	483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints			

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Bldg. 00	§483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Based on observation, record review, and interview, the facility failed to ensure residents were free from restraints related to a lap buddy restraint without an assessment or interventions tried first for 1 of 1 residents reviewed for restraints. (Resident B) Finding includes:	F 0604	F 604 - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident (B) 121 has been progressing very well and was able to ambulate over 100 feet.	11/01/2021

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	155845	A. BUILDING 00 B. WING	10/29/2021

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	On 10/25/21 at 10:45 a.m., Resident B was observed in a reclined geri chair in his room. The tray was not in use. On 10/27/21 at 9:00 a.m., the resident was observed sitting in a wheelchair with a lap buddy restraint around him. On 10/27/21 at 10:17 a.m., the resident received his breakfast tray and the PCA sat down to feed him. His lap buddy restraint was not removed. On 10/27/21 at 11:00 a.m. and 12:30 p.m., the resident was observed seated in his wheelchair in the dining room with a lap buddy restraint in place. The lap buddy restraint had not been removed. On 10/27/21 at 1:45 p.m., the resident was seated in his wheelchair in the dining room. A lap buddy restraint was in use. The record for the resident was reviewed on 10/25/21 at 4:26 p.m. The resident was admitted on 7/16/21 from the hospital. Diagnoses included, but were not limited to, fractured femur, encephalopathy, sepsis, urinary tract infection, transient ischemic attacks, dysphagia, and Parkinson's disease. The resident was admitted to the hospital for a fractured femur on 7/19/21 and returned to the facility on 7/27/21. The resident was admitted to the hospital on 9/25/21 for severe dehydration and a urinary tract infection. He returned to the facility on 9/28/21. The Admission Minimum Data Set (MDS) assessment, dated 8/5/21, indicated the resident was not cognitively intact. The resident needed		RPT wanted to see if resident would use his legs more in propelling self in hallway but due to being a fall risk and trunk instability he wanted to try the wheelchair with lap buddy. He did do an assessment on the resident but by him being at the end of the hall his documentation did not register due to the wi-fi signal. He did state this to the surveyor. The RPT is new to the facility and very helpful direction was given to the RPT by surveyor. The facility will not use lap buddy in our scope of practice. Other alternatives such as putting resident in bed will be used. Resident is not a candidate for the use of horn and slanted cushions because he pulls sideways to grab objects. Lap Buddy was immediately discontinued, and resident placed back in geri-chair. RPT re-evaluated the resident and will have to remain in a geri-chair due to repetitive leaning forward motions. The goal was to increase the residents leg mobility which cannot be achieved at this time. - 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; No other resident affected. - what measures will be put	

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	extensive assist with 2 person physical assist for transfers and toilet use. There was no assessment for the lap buddy restraint. There was no Physician's Order for the lap buddy restraint. Physician's Orders, dated 8/2/21, indicated geri chair with tray when up and floor mats when in bed. There was no assessment for the geri chair with tray table to be used. An Occupational Therapy Progress Note, dated 7/18/21 at 12:00 p.m., indicated "Patient received an initial occupational therapy evaluation. Patient at high risk for falls secondary to highly uncoordinated motor patterns grossly in bilateral upper and lower extremities. Patient was extremely impulsive and a safety concern. Informed nurse and aide on duty of patient high fall risk and need for close monitoring as well as a "lap buddy" or a "Geri" chair to ensure patient's safety." Nurses' Notes, dated 7/29/21 at 8:03 a.m., indicated the resident was found sitting on the floor mat next to his bed with no injury noted. Nurses' Notes, dated 8/2/21 at 11:36 p.m., indicated the resident was received up in geri chair with tray, resident was verbal and needed assistance. Spoke with doctor and received a verbal order for tray to stay on when resident was up in geri chair also for floor mats to be on the floor when resident was in bed. Nurses' Notes, dated 10/17/21 at 12:37 p.m.,		into place and what systemic changes will be made to ensure that the deficient practice does not recur; In-Service held RPT and no lap buddy devices will be used in the facility. Resident re-evaluated that day and geri-chair will be the only appropriate seating device for Resident (b) 121. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and No lap buddy devices will be ordered by RPT. RPT will evaluate all residents for proper seating devices upon admission and as needed, ongoing. Licensed Nurse will refer residents with posture problems for evaluations by RPT. D.O.N. /Designee will review all referrals to RPT and the Evaluations performed by RPT. D.O.N. will report to Q.A. Committee quarterly on RPT evaluations and recommendations. Q.A. Committee will determine if any other revisions are needed. - by what date the systemic changes for each deficiency will be completed: 11/1/21	

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	10/19/21 at 11:36 p.m., 10/20/21 at 3:29 p.m., and 10/21/21 at 2:09 p.m., indicated the resident was up in the geri chair with the tray table in place. Interview with the Director of Nursing on 10/27/21 at 10:45 a.m., indicated the resident was becoming more mobile and was getting more stronger physically, so they put him in a wheelchair with a lap buddy restraint so he would not fall. There was no restraint assessment for the lap buddy, and there were no other interventions tried first before applying the restraint. 3.1-26(r) 3.1-26(s)			
F 0623 SS=A Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this			

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

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	intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on record review and interview, the facility failed to ensure a resident and/or their Responsible Parties were notified in writing	F 0623	F623 - what corrective action(s) will be accomplished for those	11/25/2021

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	related to a transfer to the hospital for 2 of 2 residents reviewed for hospitalization. (Residents B and C) Findings include: 1. During an interview with Resident B's friend and emergency contact on 10/28/21 at 9:50 a.m., he indicated he had not received the State transfer form after the resident had been admitted to the hospital. The record for Resident B was reviewed on 10/25/21 at 4:26 p.m. The resident was admitted on 7/16/21 from the hospital. Diagnoses included, but were not limited to, fractured femur, encephalopathy, sepsis, urinary tract infection, transient ischemic attacks, dysphagia, and Parkinson's disease. The resident was admitted to the hospital for a fractured femur on 7/19/21 and returned to the facility on 7/27/21. The resident was admitted to the hospital on 9/25/21 for severe dehydration and a urinary tract infection. He returned to the facility on 9/28/21. The Admission Minimum Data Set (MDS) assessment, dated 8/5/21, indicated the resident was not cognitively intact. Nurses' Notes, dated 7/19/21 at 1:15 a.m., indicted the resident complained of severe pain to the left lower extremity, hip and femur areas. The resident yelled out in pain during the assessment and indicated "it hurt real bad." The physician was notified and advised to send to the emergency room for an X-ray. 911 was called and the resident left the facility at 12:57 a.m. He was admitted with a fractured femur.		residents found to have been affected by the deficient practice. /p> - 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; No other resident affected no other residents required notice of transfer. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; In-Service held Social Worker who will be responsible for Notice of Discharge Transfer documentation and informing the resident's family. D.O.N. will monitor Notice of Discharge Transfers as they occur. Administrator will monitor all Notice of Discharge Transfer and documentation log forms monthly. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Licensed Nurse will complete Notice of Transfer/Discharge as they occur and give to Social	

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	Nurses' Notes, dated 9/25/21 at 7:20 a.m., indicated the resident was in bed, alert, and non verbal. He took bites of dinner but drank all the fluids offered. He became weaker and unresponsive even though his blood pressure was 109/62, temperature 97.7, pulse of 70, respirations of 18, and blood glucose of 126. The Director of Nursing was notified and the resident was sent to the emergency room. A State transfer form completed on 7/19/21, indicated the resident was being transferred to the hospital. A State transfer form completed on 9/25/21, indicated the resident was being transferred to the hospital. There was no evidence the State transfer form was mailed to the resident's emergency contact for either hospitalization. Interview with the Business Office Manager on 10/27/21 at 1:38 p.m., indicated the State transfer forms were not mailed to the resident's emergency contact.2. Resident C's record was reviewed on 10/27/21 at 10:00 a.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing), type 2 diabetes mellitus, and hemiplegia (muscle weakness) following a stroke. The Quarterly Minimum Data Set (MDS) assessment, dated 7/11/21, indicated the resident was severely impaired for daily decision making. Nurses' Notes, dated 10/9/21 at 6:55 p.m., indicated the resident was sleepy and had not eaten well for breakfast or lunch. His blood sugar at 6:00 a.m. was high, (too high to be detectable on the glucometer). At 8:30 a.m., his blood sugar remained elevated at 550 and his blood pressure		Worker. Social Worker will mail documentation to responsible if necessary and log completion of the process of notification. D.O.N. /Designee will review all Notice of Transfer/Discharge as they occur. Administrator will monitor all Notice of Discharge Transfer and documentation log forms monthly. Administrator will report to Q.A. Committee quarterly on Transfer/Discharge of Residents quarterly. Q.A. Committee will determine if any other revisions are needed. by what date the systemic changes for each deficiency will be completed: 11/25/21	

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	was 131/101. At 1:00 p.m., his blood sugar was high per the glucometer. The Physician was notified and an order was received for 8 units of Novolog insulin. The resident's blood sugar was still elevated at 502 and his blood pressure was 152/101. The Physician was notified and an order was received to send the resident to the emergency room. The resident was sent to the hospital with a copy of the transfer/discharge notice. There was no documentation indicating the resident's responsible representative had been given a written copy of the transfer/discharge notice. Interview with the Business Office Manager on 10/27/21 at 1:38 p.m., indicated the paperwork was supposed to be mailed to the Responsible Party if they did not go with the resident to the hospital. The paperwork was to be mailed within 72 hours. 3.1-12(a)(6)(ii) 3.1-12(a)(6)(iii)			
F 0640 SS=B Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments.			

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	(v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by			

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	the State and approved by CMS. Based on record review and interview, the facility failed to successfully export the Minimum Data Set (MDS) assessment within 14 days of completion for 7 of 8 residents whose MDS assessments were reviewed for resident assessment. (Residents 8, 3, 18, 14, 2, 17, and 20) Findings include: 1. The record for Resident 8 was reviewed on 10/28/21 at 2:33 p.m. The 5/19/21 Annual Minimum Data Set (MDS) assessment was completed on 5/30/21. The MDS was not exported until 7/12/21. The 8/19/21 Quarterly MDS assessment was completed on 9/2/21. The MDS was not exported until 10/26/21. 2. The record for Resident 3 was reviewed on 10/28/21 at 2:35 PM. The 6/10/21 Quarterly Minimum Data Set (MDS) assessment was completed on 6/24/21. The MDS was not exported until 7/12/21. The 9/9/21 Quarterly MDS assessment was completed on 9/23/21. The MDS was exported and accepted on 10/26/21. 3. The record for Resident 18 was reviewed on 10/28/21 at 2:49 p.m. The 7/19/21 Quarterly Minimum Data Set (MDS) assessment was completed on 8/2/21. The MDS was exported on 8/18/21. 4. The record for Resident 14 was reviewed on	F 0640	F640 MDS transmission is done solely by the DON. MDS files were immediately transmitted. MDS will be transmitted by DON according to tickler file within 14 days of completion. - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. D.O.N. had to coordinate with the Rehab software and PCC software to determine a way to get the rehab information to the MDS Coordinator for proper rehab services to be provided on the MDS. D.O.N. and MDS Coordinator will communicate information bi-weekly to ensure all information is obtained by MDS Team. - 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; No residents affected. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; D.O.N. and MDS Coordinator will communicate information bi-weekly to ensure all information	11/25/2021

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	10/28/21 at 2:53 p.m. The 6/3/21 Quarterly Minimum Data Set (MDS) assessment was completed on 6/17/21. The MDS was exported on 7/12/21. The 9/3/21 Quarterly MDS assessment was completed on 9/17/21. The MDS was exported on 10/26/21. Interview with the Director of Nursing on 10/29/21 at 11:00 a.m., indicated the MDS assessments should have been transmitted within 14 days of completion. 5. Resident 2's record was reviewed on 10/27/21 at 3:22 p.m. The Quarterly Minimum Data Set (MDS) assessment, dated 9/9/21, indicated it had been completed on 9/23/21 but was not exported or transmitted. 6. Resident 17's record was reviewed on 10/28/21 at 10:53 a.m. The Annual Minimum Data Set (MDS) assessment, dated 9/17/21, indicated it had been completed on 10/1/21 but was not exported or transmitted. 7. Resident 20's record was reviewed on 10/28/21 at 11:53 a.m. The Quarterly Minimum Data Set (MDS) assessment, dated 6/16/21, indicated it had been completed on 6/30/21 but was not exported or transmitted. Interview with the Administrator on 10/26/21 at 2:00 p.m., indicated she was not aware the MDS		is obtained by MDS Team. MDS Coordinator will submit Monthly Calendar to D.O.N. D.O.N. will submit the MDS transmissions to Administrator upon completion weekly. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Licensed Nurse will notify physicians for all changes in conditions as they occur according to facility policy. D.O.N. and MDS Coordinator will communicate information bi-weekly to ensure all information is obtained by MDS Team. MDS Coordinator will submit Monthly Calendar to D.O.N. D.O.N. will submit the MDS transmissions to Administrator upon completion weekly. D.O.N. Designee will review all new orders and documentation of resident change in conditions and provide education as needed to licensed nurses. Q.A. Committee will review transmission logs quarterly. Q.A. Committee will determine if any other revisions are needed. by what date the systemic changes for each deficiency will be completed: 11/25/21	

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	155845	A. BUILDING 00 B. WING	10/29/2021

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	assessments were not exported in a timely manner.			
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the			

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	community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on observation, record review and interview, the facility failed to initiate Care Plans related to wandering, bruising, and restraint use for 2 of 11 residents whose Care Plans were reviewed. (Residents 3 and B) Findings include: 1. On 10/25/21 at 2:52 p.m., Resident 3 was observed wandering in and out of the dining room and up and down the hall in her wheelchair. The record for Resident 3 was reviewed on 10/27/21 at 10:21 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, major depressive disorder, and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 9/9/21, indicated the resident was cognitively impaired for daily decision making and wandering occurred 1 to 3 days during the assessment reference period. The resident also required supervision with locomotion on and off the unit. There was no current Care Plan related to wandering. Interview with the Director of Nursing on 10/29/21 at 11:00 a.m., indicated the resident had a history of wandering and a Care Plan should have been initiated. 2. On 10/25/21 at 10:45 a.m., Resident B	F 0656	F656 Resident 3 care plan updated to include wandering. Resident B (121) care plan updated for fragile skin and history of bruises. Restraint was not care planned due to this only occurring for 1 day trail to see how the resident would respond. - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; MDS Coordinator review all Care Plan for each resident. - 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; No other residents noted to be affected. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. D.O.N. and MDS Coordinator will meet weekly to discuss care plans. D.O.N. will monitor Care Plan	11/10/2021

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	was observed reclined in a geri chair. He was wearing a short sleeved shirt. There were many red and purple bruises noted to both forearms and the back of his hands. On 10/27/21 at 9:00 a.m., Resident B was observed sitting in a wheelchair with a lap buddy restraint. The record for the resident was reviewed on 10/25/21 at 4:26 p.m. The resident was admitted on 7/16/21 from the hospital. Diagnoses included, but were not limited to, fractured femur, encephalopathy, sepsis, urinary tract infection, transient ischemic attacks, dysphagia, and Parkinson's disease. The resident was admitted to the hospital for a fractured femur on 7/19/21 and returned to the facility on 7/27/21. The resident was admitted to the hospital on 9/25/21 for severe dehydration and a urinary tract infection. He returned to the facility on 9/28/21. The Admission Minimum Data Set (MDS) assessment, dated 8/5/21, indicated the resident was not cognitively intact. The resident needed extensive assist with 2 person physical assist for transfers and toilet use. The resident needed supervision with set up help for eating. The resident had no oral problems and weighed 140 pounds with no significant loss or gain. He received a mechanically altered and therapeutic diet. He had no pressure ulcers. There were no Care Plans for the restraint or for the bruises. Interview with the Director of Nursing on 10/27/21 at 10:45 a.m., indicated there were no Care Plans for the restraint or bruises.		calendar weekly and address compliance at weekly meetings. MDS Coordinator, Nurse Supervisor and D.O.N. will meet weekly to review progress and concerns related to the Care Plan process of new admissions, changes in treatment plan and quarterly reviews. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and MDS Coordinator will be responsible for reviewing interim care plans and ongoing updating of care plan. Q.A. Committee will review care plan reviews quarterly for next 6 month and assess the need for further training and new staff according to report. - D.O.N. will be responsible to report any deficient practices to the Administrator and Q.A. by what date the systemic changes for each deficiency will be completed: 11/10/21	

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	3.1-35(a)			
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 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 ensure Care Plans were reviewed and revised as needed related to medication use for 1 of 11 residents whose Care Plans were reviewed. (Resident 3). The facility also failed to ensure residents were invited to attend and participate in	F 0657	F657 care plans update and conference 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	11/20/2021

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	care planning conferences for 1 of 1 residents reviewed for participation in care planning. (Resident 16) Findings include: 1. The record for Resident 3 was reviewed on 10/27/21 at 10:21 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, major depressive disorder, and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 9/9/21, indicated the resident was cognitively impaired for daily decision making and wandering occurred 1 to 3 days during the assessment reference period. The resident also required supervision with locomotion on and off the unit. A Care Plan, dated 9/16/20, indicated the resident had a diagnosis of insomnia. Interventions included, but were not limited to, administer Melatonin as ordered. A Physician's Order, dated 6/1/21, indicated the Melatonin had been discontinued. Interview with the Director of Nursing on 10/29/21 at 11:00 a.m., indicated the Care Plan should have been updated related to the Melatonin use. 2. During an interview with Resident 16, on 10/25/21 at 10:53 a.m., he indicated he had not been invited to attend his care plan conferences. The record for Resident 16 was reviewed on 10/26/21 at 12:37 p.m. Diagnosis included, but were not limited to, hemiplegia (muscle weakness), hypertension, and seizure disorder.		Resident 3 Care Plan revised, and Melatonin was removed. Care plan reviewed with Resident 16. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All care plans will be reviewed and updated as needed according to review date. Family will be invited to participate in care plan conference and social worker will provide documentation in resident's record. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Care Plan In-service held with nursing staff by D.O.N. MDS Coordinator will monitor updates for all care plans weekly. D.O.N. Designee will consult with MDS Coordinator for necessary changes and updates. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. Social Worker will have a Care Plan Conferences with residents and family members.	

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	The Quarterly Minimum Data Set (MDS) assessment, dated 7/18/21, indicated the resident was alert and oriented. The "Care Plan Meeting Communication Binder" indicated the resident was not invited to his Care Plan meetings on 7/18/21 and 10/15/21. Interview with the Director of Nursing on 10/29/21 at 10:35 a.m., indicated there was no communication documented regarding care plan conference invitations or meetings. 3.1-35(d)(2)(B)		Nurse Supervisor will monitor updates for all care plans after morning meetings. Nurses will consult with MDS Coordinator for necessary changes and updates. MDS Coordinator will complete the care plan tickler file and submit it to D.O.N. weekly for review. Care plan conference documentation will be reviewed by Q.A. Committee monthly times 3 months and semi-annually. by what date the systemic changes for each deficiency will be completed: 11/20/21	
F 0684 SS=G Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review and interview, the facility failed to ensure elevated blood sugars were monitored, the Physician was notified in a timely manner, and insulin was given as ordered which resulted in a hospitalization for 1 of 2 residents reviewed for hospitalization. (Resident C) The facility also failed to ensure advanced directives were honored for 2 of 2	F 0684	F684 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Proper monitoring of elevated blood sugars was reviewed when	11/12/2021

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	residents reviewed for death (Residents E and D) and that bruising, skin tears and malodorous urine was assessed and monitored for 1 of 1 residents reviewed for change in condition and 1 of 1 residents reviewed for skin conditions (non-pressure related). (Resident B) Findings include: 1. Resident C's record was reviewed on 10/27/21 at 10:00 a.m. Diagnoses included, but were not limited to, hypertension (high blood pressure), Diabetes Mellitus, hemiplegia (paralysis on one side of the body), and seizure disorder. The Quarterly Minimum Data Set assessment, dated 7/11/21, indicated the resident was severely impaired for daily decision making. The resident had received insulin injections 7 times within the last 7 days. The Care Plan, dated 10/12/20 and reviewed on 10/17/21, indicated the resident had diabetes mellitus. Interventions included, but were not limited to, administer medications as prescribed (Metformin), diabetes medication as ordered by the doctor (insulin). Monitor/document for side effects and effectiveness, and obtain accuchecks as ordered by the Physician. A Physician's Order, dated 9/17/21, indicated the resident was to receive Metformin HCl ER (a diabetes medication) give 2000 milligrams (mg) daily for diabetes and Insulin Glargine (lantus) Solution Pen-injector (a long acting insulin), inject 15 units subcutaneously at bedtime for diabetes. A Physician's Order, dated 4/11/21, indicated an accu-check (a test to monitor blood sugar) was to be completed at bedtime.		the event occurred with the LPN responsible for sending the resident to the hospital by the D.O.N. Educational instruction was given to the LPN and she verbalized understanding. This was also used as an educational tool in teaching proper documentation to the licensed nurses. This was already addressed with staff prior to this survey. New code status identifier was developed so that code status could be determined in the resident's room. In-service with entire staff on the new code status identifier to ensure the living will and DNR request from the resident/responsible party are followed. Resident B has a history of bruises upon admission along with fragile skin. Resident has a cushion in his chair and pillows are provided when resident presents a problem with leaning while in his chair. Resident B has a new very plush geri-chair. Resident B (121) diagnosis will be updated to Chronic Skin Fragility of AgingDermatoporosis. Dermatoporosis is thin skin and the appearance of bruises, seemingly unprovoked in elderly patients. It is due to advancing age with genetic susceptibility.	

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	Nurses' Notes, dated 10/9/21 at 6:28 a.m., indicated late entry: resident received in bed alert and weak. He ate 40% of dinner and took all medications without difficulty. At 9:00 p.m., the resident's blood glucose was 389 (a blood sugar greater than 140 is considered high). He received his ordered Lantus insulin and fluids were pushed. Vital signs at 5:00 a.m., indicated his blood pressure was high at 145/98, pulse elevated at 101, respirations 20, and oxygen saturation 94%. His blood glucose remained high. The Physician was called with no answer. Information was given to the incoming nurse for follow up. The resident was up in his chair in front of the nurses' station. The next documented Nurses' Note was on 10/9/21 at 6:25 p.m. The entry indicated the resident was sleepy today and he did not eat well for breakfast or lunch. His blood sugar at 6:00 a.m., registered "hi" (too high to be detectable on the glucometer). At 8:30 a.m., the resident's blood sugar was 550 and his blood pressure was elevated at 145/113, his medications were given and at 10:30 a.m., his blood sugar was 542 and his blood pressure remained elevated at 131/101. At 1:00 p.m., the resident's blood sugar remained "hi". The Physician was then called and orders were received for 8 units of Novolog (a fast acting) insulin. There was no documentation indicating the order for the Novolog insulin had been entered into the computer. The October 2021 Medication Administration Record (MAR), indicated there was no documentation the 8 units of Novolog insulin had been administered. At 4:00 p.m., the resident's blood sugar was 502 and his blood pressure remained elevated at		Dermatoporosis is associated with bleeding and healing complications which include atrophic skin with solar purpura and white pseudoscars on the extremities of elderly patients. Skin lacerations and delayed healing are frequent features in dermatoporotic skin, leaving affected patients susceptible to bleeding complications and cutaneous infections. /p> All nursing staff instructed to use gait belts during all transfers. Resident B (121) has a history of bruises upon admission along with fragile skin. Resident has a cushion in his chair and pillows are provided when resident presents a problem with leaning while in his chair. Resident B has a new very plush geri-chair. Geri-sleeves were ordered for the resident. Resident B (121) will have to wear long sleeves or geri-sleeves because his skin will always be very fragile and due to his movements, he will always be prone to bruising. ***D.O.N. did investigate this issue and did inform surveyor. There is nothing that can be done about improper documentation only clarifications statements in my investigation report. The medical record can not be changed but this was identified by	

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	152/101. The Physician was notified and orders were received to send the resident to the emergency room for evaluation. Nurses' Notes, dated 10/10/21 at 11:58 a.m., indicated the resident had been admitted to the hospital with the diagnoses of hypernatremia (elevated sodium levels), hyperglycemia (elevated blood sugar), and a urinary tract infection. Review of Emergency Room notes following the transfer on 10/9/21, indicated a random blood glucose (sugar) level of 434 (80-120), with admitting diagnosis of Hypernatremia (high sodium in the blood), Hyperglycemia (high blood sugar), and Altered mental status. Interview with the Director of Nursing on 10/29/21 at 2:30 p.m., indicated the Physician should have been notified in a more timely manner and due to the lack of documentation, it could not be determined that the Novolog insulin had been given as ordered. 2. The closed record for Resident E was reviewed on 10/27/21 at 1:15 p.m. Diagnoses included, but were not limited to, hypertension, atrial fibrillation, heart failure, and stroke. The Quarterly Minimum Data Set (MDS) assessment, dated 7/25/21, indicated the resident was moderately impaired for daily decision making. On 5/12/19, Do Not Resuscitate (DNR) orders were obtained. The Advanced Directive form had been signed by the resident and the Physician. On 10/7/20, the Indiana Physician Orders for Scope of Treatment (POST) form indicated the resident remained a DNR.		the D.O.N. and addressed with the L.P.N. The DON was aware of this incident addressed it when it happened with all disciplines. Please correct. DON did miss the foul-smelling urine in the documentation but did in-service all nursing staff on s/s of UTI and proper standards of practice when foul smelling urine is assessed. It is also the practice of the facility for changes in urine with possible signs of UTI be reported to charge nurse immediately. This is also covered each day during shift to shift report. 1. Push Fluids, 2. Contact MD 3. Collect U/A C& S 4. Notify MD for proper treatment if UTI present. 5. Document until symptoms subside. In-service on proper admission, weekly and re-admission skin assessment done with all nursing staff. Proper documentation is continuously reviewed with licensed nurses one on one continuously by the D.O.N. Clinical morning meetings held with D.O.N. to ensure documentation is completed and that orders/tests are being executed in a timely fashion and	

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	A Nurses' Note, dated 8/21/21 at 8:20 a.m., indicated the resident was in good spirits, smiling and he tolerated his night medications without difficulties. The resident went to sleep around 9:30 p.m. He was checked on throughout the night. A urine sample was obtained which was to be picked up that morning by the hospital laboratory. At approximately 5:05 a.m., the resident was found unresponsive. No vital signs were noted. Cardiopulmonary Resuscitation (CPR) was initiated. At 5:07 a.m., 911 was called. At 5:15 a.m., EMS arrived at the facility. At 5:25 a.m., the Physician was notified and the time of death was called. The resident's family was notified at 6:22 a.m. At 8:25 a.m., the resident's body was released to the funeral home. 3. The closed record for Resident D was reviewed on 10/27/21 at 11:15 a.m. Diagnoses included, but were not limited to, end stage renal disease, dementia with behavior disturbance, chronic hepatitis, anxiety disorder, major depressive disorder, type 2 diabetes mellitus, dysphagia (difficulty swallowing), and dependence on renal dialysis. The Discharge Return Anticipated Minimum Data Set (MDS) assessment, dated 8/21/21, indicated the resident had a short term memory problem and had modified independence for daily decision making. The Care Plan, dated 2/27/17 and reviewed on 8/15/21, indicated the resident was a full code. Interventions included, but were not limited to, provide all lifesaving techniques as needed. A Physician's Order, dated 4/11/21, indicated the resident was a Do Not Resuscitate (DNR).		complete documentation is done. Nurse Supervisor was hired to provide one to one teaching with each nurse. D.O.N. and Nurse Supervisor will provide in-service with licensed staff. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. Every resident has the potential to be affected. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Nurses will receive ongoing in-servicing and monitoring of nurse's documentation 3 times a week by D.O.N. ongoing. The nurses have verbalized that they were note taught to document in such detail. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. D.O.N. will continue to seek qualified nursing staff able to perform basic nursing skills adequately. No licensed nurses are applying for jobs at this time,	

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	155845	A. BUILDING 00 B. WING	10/29/2021

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	The Indiana Physician Orders for Scope of Treatment (POST) form, dated 7/20/19, indicated the resident was a DNR. The form was signed by the Physician and the resident's father. Nurses' Notes, dated 8/21/21 at 8:23 a.m., indicated the resident had been checked on throughout the night. At approximately 5:00 a.m., the resident was talking to this nurse and the CNA. The resident's mat was on the floor. At approximately 6:55 a.m., the resident was difficult to arouse, he was grinding his teeth, he was alert but his eyes were closed. Emesis was visible on his linen. His skin was warm to touch and he continued to "squirm" around on the floor mat. His blood pressure was 118/63, his radial pulse was palpable in his left arm and was 59, and his respirations were 14. Upon assessment, the resident became unresponsive. At 7:00 a.m., 911 was called. At 7:07 a.m., EMS arrived at the facility and initiated Cardiopulmonary Resuscitation (CPR) before transporting the resident from the building. The Physician, resident's father, and Director of Nursing were notified. At 7:45 a.m., the hospital notified the facility the resident had expired. Interview with LPN 1 on 10/27/21 at 11:47 a.m., indicated when a resident was being sent out, EMS was notified of their code status. The code status was also listed on their orders which EMS got a copy of for transport. Interview with the Director of Nursing on 10/27/21 at 1:30 p.m., indicated CPR should not have been initiated for either resident. She indicated there should be a list with resident names and code status at the nurses' station. Observation of the nurses' station indicated there was a resident listing present with each resident's name and code		therefore ongoing education for nurses will be given and monitored. D.O.N. will monitor documentation 3 times a week. Q.A. Committee will review licensed nursing staffing needs and performance of nurses monthly ongoing. 5. by what date the systemic changes for each deficiency will be completed: 11/12/21	

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	status. 4. On 10/25/21 at 10:45 a.m., Resident B was observed reclined in a geri chair. He was wearing a short sleeved shirt. There were many red and purple bruises noted to both forearms and the back of his hands. His geri chair was not padded with any extra cushions or pillows. On 10/25/21 at 12:32 p.m., PCA 1 was observed to transfer the resident from the geri recliner to a straight chair. The PCA lifted under his arms and pulled him to a standing position and seated him into the chair. She did not use a gait belt during the transfer. On 10/26/21 at 8:15 a.m., the resident was slouched down in the geri recliner with his feet propped up. He was wearing long sleeves, however, the red and purple bruises were still observed to the back of both hands. The geri chair was not padded. The record for the resident was reviewed on 10/25/21 at 4:26 p.m. The resident was admitted on 7/16/21 from the hospital. Diagnoses included, but were not limited to, fractured femur, encephalopathy, sepsis, urinary tract infection, transient ischemic attacks, dysphagia, and Parkinson's disease. The resident was admitted to the hospital for a fractured femur on 7/19/21 and returned to the facility on 7/27/21. The resident was admitted to the hospital on 9/25/21 for severe dehydration and a urinary tract infection. He returned to the facility on 9/28/21. The Admission Minimum Data Set (MDS) assessment, dated 8/5/21, indicated the resident was not cognitively intact. The resident needed			

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	extensive assist with 2 person physical assist for transfers and toilet use. The resident needed supervision with set up help for eating. The resident had no oral problems and weighed 140 pounds with no significant loss or gain. He received a mechanically altered and therapeutic diet. He had no pressure ulcers. Nurses' Notes, dated 7/18/21 at 8:36 a.m., Late Entry: indicated "Summoned to room [number] by therapist and janitor who stated that resident was found on the floor in room. He had been transferred to wheelchair and was being assessed by therapist. He was found to have a small amount of bleeding from his left elbow from a blister that had ruptured. Wound was cleansed and dry dressing applied. Resident had full ROM [range of motion] to upper and lower extremities and had no complaints of pain or discomfort. Therapist continued her assessment to admit for therapy and he was able to comply. Message left for emergency contact [name]." There was no investigation completed as to why the therapist and janitor picked up the resident after the fall and placed him back into the wheelchair, without having the nurse assess him first. Nurses' Notes, dated 7/19/21 at 1:15 a.m., indicted the resident complained of severe pain to the left lower extremity, hip and femur areas. The resident yelled out in pain during the assessment and indicated "it hurt real bad." The Physician was notified and advised to send to the emergency room for an X-ray. 911 was called and the resident left the facility at 12:57 a.m. He was admitted with a fractured femur. Nurses' Notes, dated 9/18/21 at 8:55 a.m., indicated			

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	"was brought to writers attention that resident had foul smelling urine and that it looked slimy oncoming nurse also aware of situation." The next documented Nurses' Note was on 9/19/21 at 3:20 a.m., the entry indicated there was no documentation or assessment of the resident's urine. Nurses' Notes, dated 9/20/21 at 4:34 a.m., and 9/22/21 at 12:05 a.m., indicated there was no documentation or assessment of the resident's urine. There was no follow up to see if the resident had an urinary tract infection. Nurses' Notes, dated 9/22/21 at 9:50 p.m., indicated "Resident received in room in geri chair alert and responsive. Reported that resident fell yesterday and sustained a bruise on his left lower eyelid. The next documented Nurses' Note was on 9/23/21 at 2:59 p.m., which indicated no documentation or follow up assessment after the fall with an injury. Nurses' Notes, dated 9/25/21 at 7:20 a.m., indicated the resident was in bed, alert and non verbal. He took bites of dinner but drank all the fluids offered. He became weaker and unresponsive even though his blood pressure was 109/62, temperature of 97.7, pulse of 70, respirations of 18, and blood glucose of 126. The Director of Nursing was notified and patient was sent to the emergency room. A History and Physical from hospital admission, dated 9/25/21, indicated an urinalysis was			

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	collected on 9/25/21 which indicated it was abnormal. The final culture report indicated >100,000 proteus mirabilis (urinary tract infection). The resident was admitted to the hospital with severe dehydration, acute kidney injury and urinary tract infection and started on Intravenous antibiotics. Nurses' Notes, dated 9/28/21 at 10:08 p.m., indicated the resident came back to the facility from the hospital at 3:40 p.m., via ambulance in a stretcher with 2 attendants. He was alert and verbal. A complete body assessment was done. His skin was warm and dry, with bruises noted on his left arm from needle pricks during blood draws. He had a pressure sore on the buttock, the dressing was intact and clean. A 10/2/21 skin observation tool assessment, indicated there were multiple bruises on his upper extremities. There was no other documentation or assessment of the bruising until 10/12/21. Nurses' Notes, dated 10/12/21 indicated the resident had some bruising to the left side of the abdomen. The staff stated it was from him leaning over in the chair. Staff were encouraged to pad the sides of the geri chair with pillows to prevent any more injuries. The staff verbalized understanding. A 10/12/21 skin observation tool assessment, indicated the resident's skin was intact with no bruising. Nurses' Notes, dated 10/16/21 at 3:28 p.m., indicated the resident had bruising to bilateral arms.			

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	Nurses' Notes, dated 10/19/21 at 11:26 p.m., indicated the resident was received in the dinning room in his geri chair. The resident had attempted a couple of times throughout the shift to slide out of the chair. Staff assisted him back in the chair. The resident had a skin tear on his right arm covered with a gauze wrap. There were no measurements or physician's orders for the skin tear. A 10/19/21 skin observation tool assessment, indicated the resident's skin was intact with no bruising or skin tears. Nurses' Notes, dated 10/20/21 at 3:29 p.m., 10/21/21 at 2:09 p.m., and 10/23/21 at 3:16 p.m., indicated the resident had bruising to his bilateral arms. A 10/26/22 skin observation tool assessment, indicated the resident's skin was intact with no concerns or bruising. There was no assessment, monitoring, or measurements of the bruising to the bilateral arms. Interview with the Director of Nursing on 10/27/21 at 10:45 a.m., indicated the resident bruised very easily and was supposed to have geri sleeves but they were unable to get them due to all of the shortages. There was no follow up assessment after all the bruises and skin tear. There was no follow up assessment after the falls with injury and she was unaware the therapist and janitor had picked up the resident without having the nurse assess him first. There was no follow up assessment after the foul smelling urine.			

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	This Federal tag relates to Complaint IN00362987. 3.1-37(a)			
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 new ulcers from developing. Based on observation, record review and interview, the facility failed to ensure pressure ulcers were assessed, treated, and monitored for 1 of 1 residents reviewed for pressure ulcers. (Resident B) Finding includes: During an interview with Resident B's friend and emergency contact on 10/28/21 at 9:51 a.m., indicated he and his wife visited the resident 1 week ago. They noted a small open area on the resident's butt. He indicated that was concerning to him, because he did not want that to get any larger. On 10/28/21 at 10:30 a.m., NA 1 and CNA 1 were asked to lay the resident down so a skin	F 0686	F686 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Inquiry was done with admitting RN area had an Allevyn dressing on sacroccygel area that had been applied at the hospital on day of discharge and not to be removed for 72 hours. The RN acknowledged the area but did not remove the dressing. 72 hours later when dressing was removed the area the 1.7 cm x 0.8cm was	11/12/2021

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	assessment could be completed. They transferred the resident into his bed and removed his brief. At that time, the resident's buttocks were reddened, there was a small open area noted on the coccyx/sacrum area. The area was pink, no drainage noted, and was uncovered. Interview with NA 1 at that time, indicated the area was there on Sunday when she last worked. CNA 1 indicated she was unaware the resident had an open area as she had not provided incontinence care for him over the last couple of days. Interview with LPN 1 and LPN 2 at that time, indicated they were both unaware the resident had an open area on his coccyx/sacrum area. The record for the resident was reviewed on 10/25/21 at 4:26 p.m. The resident was admitted on 7/16/21 from the hospital. Diagnoses included, but were not limited to, fractured femur, encephalopathy, sepsis, urinary tract infection, transient ischemic attacks, dysphagia, and Parkinson's disease. The resident was admitted to the hospital for a fractured femur on 7/19/21 and returned to the facility on 7/27/21. The resident was admitted to the hospital on 9/25/21 for severe dehydration and a urinary tract infection. He returned to the facility on 9/28/21. The Admission Minimum Data Set (MDS) assessment, dated 8/5/21, indicated the resident was not cognitively intact. The resident needed extensive assist with 2 person physical assist for transfers and toilet use. He had no pressure ulcers.		not visible. Interview held with N.A. to see which nurse she reported the area to on Sunday, she was not able to identify whom she told; however it was a R.N. on duty that she worked with that day. It is questionable if she did see the area before the surveyor inquiry. The wound nurse assessed the area with the surveyor, and it was not visible to her at first during further examination an area of 0.3 x 0.2 cm was found. Physician was called orders secured. Good skin care was provided for this resident for an area to decrease from a 1.7cm x 0.8cm to a barely visible 0.3cm x 0.2cm area. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No other residents have pressure areas. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. In-service all nursing staff on Skin Assessment of Pressure Injuries, Bruises and treatment. 4. Describe who will be the person(s) responsible for	

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	There was no Care Plan for pressure ulcers or if the resident was at risk for pressure ulcers. A 8/7/21, Braden scale assessment, indicated the resident was a moderate risk for pressure sores. The History and Physical from the hospital, dated 9/27/21, indicated the resident had a stage 2 pressure sore to the sacrococcygeal area. The area was shallow, with a red/pink wound bed with no slough. The ulcer measured 1.7 centimeters (cm) by 0.8 cm. A 9/28/21, nursing admission assessment, indicated the resident had a pressure sore on his sacrum. There were no measurements taken or an assessment of the area. Nurses' Notes, dated 9/28/21 at 10:08 p.m., indicated the resident came back to the facility from the hospital at 3:40 p.m., via ambulance in a stretcher with 2 attendants. He was alert and verbal. A complete body assessment was done. His skin was warm and dry, with bruises noted on his left arm from needle pricks during blood draws. He had a pressure sore on the buttock, the dressing was intact and clean. There were no Physician's Orders for the open area. There were no measurements completed for the open area. A skin observation assessment dated 10/2, 10/12, 10/19, and 10/26/21 all indicated the resident's skin was intact. A skin observation tool, dated 10/28/21, indicated coccyx pressure ulcer. The area was very small with redness to the peri wound. The open area measured 0.3 cm by 0.2 cm and was a stage 2. The		implementing and monitoring the plan for future compliance with the regulations. Charge nurse responsible for weekly skin assessments, contacting physician for proper treatment and notifying the family. D.O.N. will purchase magnifiers to be able to examine the areas since the areas are hard to see and the fact that our nursing staff is more mature and wear glasses. This will make these areas more detectable. D.O.N. will review weekly pressure area wound sheets. D.O.N. will consult with MDS Coordinator to discuss any new and need for revisions of care plans according to each resident's needs. Q.A. Committee will review all care plans and wound sheets monthly times 3 months then quarterly thereafter. 5. by what date the systemic changes for each deficiency will be completed: 11/12/21	

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	Physician was notified and new orders were obtained. Physician's Orders, dated 10/28/21, indicated cleanse area with normal saline apply Allevyn (a wound dressing) and change every 72 hours or as needed. Interview with the LPN 1 on 10/28/21 at 1:45 p.m., indicated she was unaware the resident had a pressure sore upon readmission on 9/28/21. 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure cleaning supplies were not left in resident rooms and elopement assessments were completed for 1 of 2 residents reviewed for accident hazards. (Resident 3) Finding includes: On 10/25/21 at 2:30 p.m., Resident 3 was observed in her room sitting in her wheelchair. The resident was holding a bottle of Ajax bleach disinfecting powder. There was no housekeeping or nursing staff in the resident's room at that time. The	F 0689	F689 - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Custodian staff immediately in-serviced on keeping up with hazardous chemicals. He admitted to leaving the cleanser on the hand railing instead of putting it in his locked janitors closet when someone called him. Wandering assessment	11/01/2021

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	cleanser was removed and given to staff at the nurses' station. At 2:52 p.m., the resident was observed wandering in and out of the dining room and up and down the hall in her wheelchair. The record for Resident 3 was reviewed on 10/27/21 at 10:21 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, major depressive disorder, and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 9/9/21, indicated the resident was cognitively impaired for daily decision making and wandering occurred 1 to 3 days during the assessment reference period. The resident also required supervision with locomotion on and off the unit. There was no current wandering/elopement risk assessment available for review. Interview with the Director of Nursing on 10/29/21 at 11:00 a.m., indicated the Custodian left the cleanser in the room. She indicated no cleaning supplies were to be left in resident rooms. She also indicated a wandering/elopement risk assessment should have been completed. 3.1-45(a)(2)		completed on Resident 3. -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; No other resident affected. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff in-services on placing supplies in proper places away from residents. Designee will monitor resident areas for hazards 5 times a week and log concerns for Administrator. Charge Nurse on all shifts will monitor for hazards in resident areas daily. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Designee will report to Administrator concerns as they occur. DON will monitor all shifts weekly for hazards in resident areas. Q.A. Committee will audit reports	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			quarterly then semi-annually. by what date the systemic changes for each deficiency will be completed: 11/1/21	
F 0692 SS=G Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review and interview, the facility failed to ensure residents maintained acceptable parameters of nutritional status related to weights not obtained or monitored, meal consumption records not completed, and diets changed without assessments which resulted in a significant weight loss for 1 of 1 residents reviewed for nutrition. (Resident B) Finding includes:	F 0692	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Care Plan revised to include: 1. mechanically altered diet and thickened liquids. 2. Monitor weights to ensure resident's Weight BMI remains	11/01/2021

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	155845	A. BUILDING 00 B. WING	10/29/2021

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	On 10/25/21 at 1:00 p.m., Resident B was observed seated at a table in the main dining room. At that time, he was served a pureed diet of chicken, mixed vegetable and rice. PCA 1 prepared his thickened liquids and sat next to him to assist with the meal. The record for Resident B was reviewed on 10/25/21 at 4:26 p.m. The resident was admitted on 7/16/21 from the hospital. Diagnoses included, but were not limited to, fractured femur, encephalopathy, sepsis, urinary tract infection, transient ischemic attacks, dysphagia, and Parkinson's disease. The resident was admitted to the hospital for a fractured femur on 7/19/21 and returned to the facility on 7/27/21. The resident was admitted to the hospital on 9/25/21 for severe dehydration and a urinary tract infection. He returned to the facility on 9/28/21. The Admission Minimum Data Set (MDS) assessment, dated 8/5/21, indicated the resident was not cognitively intact. The resident needed extensive assist with 2 person physical assist for transfers and toilet use. The resident needed supervision with set up help for eating. The resident had no oral problems and weighed 140 pounds with no significant loss or gain. He received a mechanically altered and therapeutic diet. He had no pressure ulcers. The Care Plan, dated 7/31/21, and revised on 9/14/21, indicated the resident had dehydration or potential fluid deficit. The approaches were to encourage the resident to drink fluids of choice. Ensure that all beverages offered comply with diet/fluid restrictions and consistency		between 18.5-24.9. - Interventions will include monitoring weight upon admission, monthly and re-admission. - Residents who refuse weights calf circumference will be used. All new admission weights will be reviewed by D.O.N. along with admission diet orders to ensure all residents receive physician ordered diet and a baseline weight and BMI. Resident B (121) Weight was stable at the time of the survey and had been since August with a steady increase in weight. Ideal BMI range is 18.5-24.9 according to the CDC guidelines: If your BMI is less than 18.5, it falls within the underweight range. If your BMI is 18.5 to <25, it falls within the healthy weight range. If your BMI is 25.0 to <30, it falls within the overweight. The PCC software assessments for the mini nutritional assessment the facility cannot change or alter the software program, however we use the CDC Guidelines to determine BMI and according to these guidelines the resident is not malnourished. His BMI was never lower than 18.5 since admission until now. Conference with resident's	

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	requirements. There was no Care Plan for weight loss or a mechanically altered diet with thickened liquids. A Speech Therapy note from the hospital, dated 7/13/21, indicated the resident continued to aspirate on thin liquids. Continue Dysphagia 2 diet (A level 2 diet was the intermediate level. People on this diet should eat moist and soft-textured foods that were easy to chew. They can also eat pureed, pudding-like foods. They should avoid foods with coarse textures.) with nectar thick liquids. The patient was awaiting skilled nursing placement and it was recommended speech therapy continue at the next level. The resident's weight on 7/14/21 was 165 pounds. There were no Physician's Orders for what kind of diet the resident was to receive at the time of admission on 7/16/21. There was also no speech therapy ordered on admission. There was no admission weight obtained on 7/16/21. A History and Physical from the hospital, dated 7/27/21, indicated a nutritional assessment was completed and the resident weighed 165 pounds. Speech therapy had recommended a pureed diet with nectar thick liquids on 7/22/21. There was no readmission weight on 7/27/21 after his return from the hospital. Physician's Orders, dated 7/28/21, indicated pureed texture diet with nectar thick liquids. This diet was discontinued on 8/19/21.		physician, dietitian, dietary department, and nursing department will be done to see if referral for speech therapy consult is needed. If speech consultation is warranted social services will arrange speech therapy appointment. Once speech consult is performed findings will be shared with all disciplines so that proper plan of care will be done for the resident. In-service held with all licensed nurses to inform them that it is their responsibility to ensure all POC documentation is completed before the change of shift. In-service with CNA's, N.A.'s & P.C.A.'s held to discuss their responsibilities to complete POC documentation before leaving duty. POC documentation will be reviewed weekly by D.O.N. Discussion with staff on deficient practices was held with D.O.N. Charge Nurse responsibilities include: Ensuring every resident receives the proper nutrition and documentation of intake. Properly ordering and administering properly labeled medication. Monitoring residents' weights and consulting with dietician and physician.	

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	There was no speech therapy ordered for the resident after readmission from the hospital. The first Registered Dietitian's (RD) note was on 7/31/21 at 3:37 p.m., which indicated a nutritional assessment for a new admission. The RD addressed the resident's diagnoses, medications and diet. The RD indicated the resident was 70 inches in height and weighed 158 pounds, with a body mass index of 22.6. She addressed his calories and needs and indicated to continue diet as ordered and monitor weight. Follow up as needed. Physician's Orders, dated 8/19/21, indicated the resident's diet was changed to a modified reducing diet of mechanical soft texture and honey consistency liquids. The diet was discontinued on 9/13/21. Nurses' Notes, dated 9/8/21 at 9:39 p.m., indicated "The resident ate watermelon during dinner and threw up some particles of same." An RD note, dated 9/11/21 at 2:34 p.m., indicated follow up on multiple diet orders as noted in hospital, transfer papers of puree/mechanical soft with nectar thick liquids. Observed resident at noon meal today with mechanical soft diet and thin liquids and he had no episodes of coughing. Discussion with staff stated no problems with same diet. Will recommend to discontinue modifying reducing diet with mechanical soft texture and honey thick liquids and give mechanical soft with regular liquids. There was no speech therapy assessment completed prior to this diet change. Nurses' Notes, dated 9/13/21 at 12:47 p.m.,		2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No one else affected but potential noted. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Weekly NAR meetings for all residents that have a >5% weight loss or gain and all new admissions X 4 weeks to ensure weight is stable, however the BMI will be the determining factor for interventions recommended by Dietician and prescribed by Physician. Nutritional policy reviewed and updated with dietician and D.O.N. D.O.N. designee held In-Service held with dietary and nursing departments pertaining to nutritional policy. D.O.N. reviewed monthly weights. Residents will be identified in weekly NAR meetings. Dietary Manager will monitor food intake, weights and review recommended dietary interventions for residents with weight loss. Dietary Manager will consult with RD after weekly NAR meeting. RD will review and make	

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	indicated the Physician was notified to change the resident's diet and new orders were obtained. Physician's Orders, dated 9/13/21, indicated regular mechanical soft diet with thin liquids. The first documented weight after readmission was on 8/29/21, which was 140 pounds. A weight was obtained on 9/4/21 which was 141 pounds. The last documented weight was on 10/28/21 which was 142 pounds. The meal consumption logs for the months of 8/2021, 9/2021, and 10/2021, indicated there was no documentation of any meal on 8/4, 8/9, 8/11-8/20, 8/25, 8/26, 8/30 and 8/31, 9/1, 9/2, 9/5, 9/6, 9/11, 10/1, 10/3, 10/4, 10/7, 10/8, 10/9, 10/12, and 10/15/21. There was no documentation of breakfast on 8/8, 8/10, 9/3, 9/8, 9/10, 9/13, 9/14, 9/22, 9/24, 10/6, 10/16, 10/17, and 10/18/21. There was no documentation of lunch on 9/10, 9/22, 9/24, 10/6, 10/10, 10/16, 10/19, and 10/22/21. There was no documentation of dinner on 8/1, 8/2, 8/3, 8/5, 8/6, 8/7, 8/22, 8/23, 8/24, 8/28, 8/29, 9/4, 9/7, 9/12, 9/16, 10/2, 10/5, 10/21, 10/22, 10/24, 10/25, and 10/26/21. The resident was admitted to the hospital again on 9/25/21 with the diagnoses of severe dehydration and acute kidney injury. The hospital history and physical, dated 9/25/21, indicated the resident weighed 130 pounds. The diet ordered was pureed with honey thickened liquids. The resident's Blood Urea Nitrogen (BUN) was 30 (normal 8-23) Creatine (CR) was 2.2 (normal 0.7-1.2). On 9/26/21, the BUN was 26 and CR was 1.7 and on 9/28/21 the BUN was 18 and CR was 1.3 (both normal ranges). The resident returned on 9/28/21 and there was no		recommendation for dietary supplements for residents at risk (super cereal, increased protein, Medpass supplemental shake, etc). All meal intakes for all residents should be recorded in PCC for every meal. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. Nutritional policy reviewed and updated with dietician and D.O.N. and given to Q.A. Committee for review to ensure compliance. D.O.N. will supply monthly weights for Q.A. Committee review. D.O.N. and Nurse Consultant held In-Service held with dietary staff and nursing staff on weights, dietary supplements, orders, dietary intake documentation and options given to residents. Dietician will provide completed tray accuracy audit for all meals for Q.A. Committee for review quarterly. Q.A. Committee review NAR meeting documentation monthly x 3 months then quarterly. D.O.N. will submit monthly	

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	readmission weight obtained. Physician's Orders, dated 9/28/21, indicated regular pureed diet with honey thick liquids. There were no other supplements or speech therapy ordered at the time of admission. Nurses' Notes, dated 9/28/21 at 4:54 p.m., indicated spoke to RD and advised her of hospital recommended diet of puree and honey thick liquids. RD was ok with this. An RD note, dated 9/30/21 at 7:36 p.m., indicated RD to follow up to phone call received by nurse, informing this writer of resident's hospitalization (9/25 to 9/28/21) and new diet order for puree with honey thick liquids related to diagnosis of dysphagia. There was no readmission assessment, weight, caloric intake, laboratory data or diagnoses addressed by the RD. Physician's Orders, dated 10/8/21, indicated Megace ES (an appetite stimulant) Suspension 625 mg/ml (Megestrol Acetate) give 5 ml (milliliters) one time a day for supplement. A mini nutritional assessment, dated 10/17/21 and completed by licensed staff, indicated the resident had severe dementia, with a decrease in food intake, had a weight loss noted between 2.2 and 6 pounds, and his body mass index was 19 to less than 21. The assessment indicated the resident was malnourished. Nurses' Notes, dated 10/22/21 at 12:20 p.m., indicated the resident continued to have a poor appetite. He would consume 25-50% of meals and		weights to Administrator and Q.A. Committee for review. Interdisciplinary team NAR meeting with DON, RD, Dietary, Admin, and MDS Coordinator will be held and documentation will be available in residents record. 5. by what date the systemic changes for each deficiency will be completed: 11/1/21	

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	complained that he did not like the pureed diet and wanted real food. Pureed diet was ordered related to failed swallow evaluation. He was currently receiving Megace as an appetite stimulant. Spoke to RD and recommended Ensure twice daily. The physician was notified and order received. An RD note, dated 10/22/21 at 10:44 p.m., indicated follow up to phone call received today from nurse informing this writer of resident's pureed diet which he was taking limited amounts. Discussed with nurse and agreed to start on Ensure 1 can twice a day for added calories and protein to help prevent weight loss. Physician also ordered Megace to assist with his appetite and intake. Continue to monitor weight and intake and follow up as needed. There was no assessment of the resident from the RD at that time. Physician's Orders, dated 10/22/21, indicated Ensure 1 can twice a day. Interview with the Director of Nursing on 10/27/21 at 10:45 a.m., indicated the resident did not receive any speech therapy on admission and readmission from the hospital. There was no assessment of the resident to make the decision to change his diet to mechanical soft to regular and to have thin liquids. There were no weights obtained on admission and readmission. There were no supplements added until 10/22/21. The food consumption intakes were blank and incomplete She was unaware the resident weighed 165 pounds on discharge from the hospital on 7/27/21 and 130 pounds on 9/25/21 during hospital admission.			

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F 0697 SS=D Bldg. 00	3.1-46(a)(1) 483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure a resident with complaints of pain received as needed (prn) or scheduled medication to relieve the pain for 1 of 1 residents reviewed for pain. (Resident 8) Finding includes: Interview with Resident 8 on 10/25/21 at 11:40 a.m., indicated she experienced pain in her legs and the level was at a constant 9 on a scale of 1 to 10. The record for Resident 8 was reviewed on 10/26/21 at 9:07 a.m. Diagnoses included, but were not limited to, lupus, anxiety disorder, schizoaffective disorder, major depressive disorder, and chronic pain syndrome. The Quarterly Minimum Data Set (MDS) assessment, dated 8/19/21, indicated the resident was cognitively intact for daily decision making. The resident was extensive assistance for bed mobility and totally dependent for transfers. The resident was not on a scheduled pain medication regimen, did not receive as needed (prn) pain medications, did not receive any non-medication interventions for pain, and had no pain in the last 5 days.	F 0697	F697 Resident 8 Naprosyn medication was d/c due to G.I. side effects. The only time resident 8 complains is when staff wants to give her a shower or to move out of the bed. She has not complained of pain to staff since verbalization with surveyor, however she was referred to PT for pain evaluation. MAR record was changed to where the nurse will document Y-Yes and N-No to indicate if resident's pain, pain level 1-10. D.O.N. and Nurse Consultant reviewed Pain Assessment documentation, medication administration, professional responsibilities, and critical thinking skills of a charge nurse policy with all licensed nurses. Licensed nurses will consult with MD for PRN pain medication. Licensed nurses will document resident’s complaints of pain and responses to interventions.	11/01/2021

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	The Care Plan, dated 5/31/21, indicated the resident was at risk for pain related to fibromyalgia (widespread muscle pain and tenderness), lupus, gout, chronic pain syndrome, and chronic disease process. Interventions included, but were not limited to, anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules, resident satisfaction with results, and impact on functional ability and impact on cognition. Notify the Physician if interventions were unsuccessful or if current complaint was a significant change from resident's past experience of pain. The October 2021 Physician's Order Summary (POS), indicated the resident had no current pain medication orders. The resident was to be assessed for pain every shift. The October 2021 Medication Administration Record (MAR), indicated the resident was assessed for pain every shift and documentation was completed with a check mark. The documentation did not indicate if the resident was experiencing pain. A Physician's Order, dated 3/23/21, indicated the resident's Naprosyn (an anti-inflammatory medication) 250 milligrams (mg) twice a day for chronic pain syndrome had been discontinued. The pain tool, dated 6/17/21, indicated the resident's pain level was a 6. The pain tool, dated 7/17/21, indicated the resident's pain level was a 10.		2.No other residents have complained of pain that do not have pain management plan in place. No other deficient practice noted. 3. Nursing staff will document her complaints of pain and documentation her willingness to accept pain relieving measures. Nursing staff will offer non-pharmacological interventions to help control and/or relieve resident's pain. MDS Coordinator will ensure Care Plan us updated with resident's complaints and interventions she is willing to follow. D.O.N., Physician, N.P., MDS Coordinator and Pharmacy Consultant will perform medication review monthly to ensure proper medical regime for each resident. Q.A. Committee will review reports quarterly and deficient practice addressed.	

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	The pain tools, dated 8/17, 9/17, and 10/17/21, indicated the resident had no complaints of pain. Interview with the Director of Nursing on 10/29/21 at 11:00 a.m., indicated she would talk with the Physical Therapist and the resident about using Biofreeze and any other non-pharmacological pain relief methods. 3.1-37(a)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to provide the necessary care and services for residents who received hemodialysis related to not assessing and monitoring the resident's dialysis access site for 1 of 1 residents reviewed for dialysis. (Resident 9) Finding includes: Resident 9's record was reviewed on 10/25/21 at 4:19 p.m. Diagnoses included, but were not limited to, chronic kidney disease, renal failure and diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 8/17/21, indicated the resident was on dialysis. The current Physician's Order Summary indicated to check right arteriovenous fistula (access site	F 0698	F698 1. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; To Clarify: The wi-fi signal sometimes drops the signal on the East End by the resident's 9 room, however it shows up green to the nurse who has done the assessment of the dialysis site showing completion. So, the nurse would not have automatically rechecked the documentation. The D.O.N. checks documentation on the PCC Dashboard which shows up green for completion, yellow for due and	11/01/2021

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	for hemodialysis) for bruit and thrill (techniques to make sure there is a good blood flow through port) every shift. The October 2021 Treatment Administration Record, lacked an indication for checking the bruit and thrill on the following days and shifts: - 10/2, the 7 a.m.-3 p.m. shift - 10/3, the 7 a.m.-3 p.m. shift - 10/4, the 3 p.m.-11 p.m. shift and the 11 p.m. -7 a.m. shift - 10/5, the 3 p.m.-11 p.m. shift and the 11 p.m. -7 a.m. shift - 10/7, the 7 a.m.-3 p.m. shift - 10/8, the 7 a.m.-3 p.m. shift - 10/9, the 3 p.m.-11 p.m. shift - 10/10, the 11 p.m. -7 a.m. shift - 10/11, the 11 p.m. -7 a.m. shift - 10/15, the 11 p.m. -7 a.m. shift - 10/17, the 7 a.m.-3 p.m. shift - 10/18, the 11 p.m. -7 a.m. shift - 10/19, 11 p.m. -7 a.m. shift - 10/21, 11 p.m. -7 a.m. shift - 10/23, the 11 p.m. -7 a.m. shift - 10/24, the 11 p.m. -7 a.m. shift Interview with the Director of Nursing (DON) on 10/27/21 at 9:30 a.m., indicated the wi-fi (Internet connection for the computers) stopped before Resident 9's room. The Nurse should have gone back to an area that had a wi-fi connection to document the bruit and thrill. The DON indicated there was not a policy on dialysis or how to monitor the dialysis site. 3.1-37(a)		red for incomplete. D.O.N. will go into each dialysis record to verify documentation weekly for dialysis site assessment of bruit and thrill. This was a computer internet issue does not lack nurses doing proper assessment. The Resident 9 shunt was assessed by the nursing staff on all 3 shifts and no problems with her shunt has been noted by the nursing staff, physician, or dialysis center. Policy & Procedure on Dialysis Site Monitoring developed. D.O.N. held in-service with all licensed nurses on TARs (Treatment Administration Records), documentation status of AV Fistula assessment and review of hemodialysis site assessment. Nursing Staff instructed to check all documentation prior to leaving to ensure it is completed. -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. Potential for 1 other dialysis resident on that end for wi-fi signal to be lost. All 3 records of dialysis residents were reviewed. No other problems noted.	

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			-what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. In-service on policy and procedure for Hemodialysis care and documentation and treatment of dialysis access sites with licensed nurses. D.O.N. will review TAR for AV Fistula documentation of licensed nurses weekly by pulling up TAR instead of using the clinical dashboard in PCC, then monthly to ensure proper documentation ongoing. -how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and D.O.N. will weekly monitor residents receiving dialysis x2months then monthly ongoing D.O.N. will provide a monthly listing of dialysis residents and access points to Q.A. Committee. Q.A. Committee will review this issue in 90 days and determine outcome and recommendations. 5. by what date the systemic changes for each deficiency will be completed: 11/1/21	

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F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, record review and interview, the facility failed to ensure medications were provided from the pharmacy in a timely manner for 1 of 5 residents reviewed for	F 0755	F755 - what corrective action(s) will be accomplished for those residents found to have been	11/01/2021

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	unnecessary medications. (Resident 8) The facility also failed to ensure controlled medications were destroyed properly and accounted for, for 1 of 1 medication carts observed for medication storage. This had the potential to affect 5 of 5 residents who received controlled medications. Findings include: 1. The record for Resident 8 was reviewed on 10/26/21 at 9:07 a.m. Diagnoses included, but were not limited to, lupus, anxiety disorder, schizoaffective disorder, major depressive disorder, and chronic pain syndrome. The Quarterly Minimum Data Set (MDS) assessment, dated 8/19/21, indicated the resident was cognitively intact for daily decision making and received anti-anxiety and antidepressant medications. The October 2021 Physician's Order Summary (POS), indicated the resident received Lorazepam (an anti-anxiety medication) 0.5 milligrams three times a day for anxiety. The resident also received Tegretol (a medication used to treat bipolar disorder) 200 mg, 2 tablets daily for schizoaffective disorder, and 200 mg, 3 tablets at bedtime. The October 2021 Medication Administration Record (MAR), indicated the Tegretol had not been given daily as ordered 10/13-10/15/21. The Lorazepam had not been given three times a day as ordered on 10/15 and 10/24/21. The Lorazepam was not given at 6:00 a.m. on 10/16 and it was not given at 6:00 a.m. and 4:00 p.m. on 10/23/21. The medications were not available from the pharmacy.		affected by the deficient practice; Pharmacy had not sent the day dosage of the medication. Pharmacy was notified and they kept sending the night dose instead of the day dose. The nursing department was in communication with the pharmacy to correct the issue and it was resolved. The pharmacy was not taking the time to read that we needed the morning dose of Tegretol 200mg 2 tablets. Lorazepam was ordered timely but not received prior to administration time for the 6:00am dose. A limited refill was sent on the 16th and a new order for Lorazepam was needed on the 10/23/21 this was told to the nurse after inquiry with pharmacy on why we did not receive the medication. N.P. contacted for new order and medication was received. Interview with DON on ordering medications timelier was not discussed. It is our practice to reorder all medications when we get to a 7-day supply to give pharmacy adequate time to send the medications. We have also contracted with a pharmacy that makes 3 deliveries a day instead of one, but we still face occasional delays in medication deliveries.	

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	Interview with the Director of Nursing on 10/29/21 at 11:00 a.m., indicated the medications should have been reordered in a more timely manner.2. Observation of the medication cart and interview with LPN 2 on 10/28/21 at 11:57 a.m., indicated discontinued narcotics were given to the Director of Nursing, counted, and signed by 2 nurses, including the Director of Nursing. Interview with the Director of Nursing on 10/29/21 at 4:48 p.m., indicated when narcotics were discontinued, she has counted them with another nurse, stored them and placed them in a pharmacy bag and returned them to the pharmacy. She indicated she had no documentation of returning narcotic medications to the pharmacy. 3.1-25(a) 3.1-25(o)		The D.O.N. placed the narcotics in a self-closing sealed bag to return for incineration disposal. New policy for narcotic disposal will be followed by D.O.N. D.O.N. will be responsible for all narcotic disposals. The disposal records. The facility does not dispose of narcotics often, but we will crush them and place in medication granules disposal sacks. I t will be witness by another nurse and disposal record kept. - 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; Medication audit done and no resident affected. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Medication audits will continue to occur and reorders by licensed nurses. The pharmacy staff is informed verbally by phone and email but sometimes there is a delay. Facility is considering contracting with another Pharmacy that can meet the needs of the residents in a timely. D.O.N. will research other	

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			pharmacies and report information to Administrator and Q.A. Committee for review and discussion.	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure blood pressures were monitored and medications were given as ordered for 2 of 5 residents reviewed for unnecessary medications. (Residents 3 and 9)	F 0757	F757 - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	11/20/2021

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	Findings include: 1. The record for Resident 3 was reviewed on 10/27/21 at 10:21 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, major depressive disorder, and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 9/9/21, indicated the resident was cognitively impaired for daily decision making and wandering occurred 1 to 3 days during the assessment reference period. The October 2021 Physician's Order Summary (POS), indicated the resident's blood pressure was to be monitored weekly. The October 2021 Medication Administration Record (MAR), indicated the resident's weekly blood pressure was not documented. There were staff initials indicating the resident's blood pressure had been monitored but no results. The last documented blood pressure was located in the vitals section of the electronic medical record on 7/13/21. Interview with the Director of Nursing on 10/29/21 at 11:00 a.m., indicated the blood pressure results should have been documented on the MAR. 2. Resident 9's record was reviewed on 10/25/21 at 4:19 p.m. Diagnoses included, but were not limited to, chronic kidney disease, renal failure and diabetes mellitus. The current Physician's Order Summary indicated to administer: - furosemide (a diuretic) 80 milligrams (mg) two times a day every Tuesday, Thursday, Saturday		Resident 3 MAR record was changed to indicate B/P reading. The MAR did indicate that the nurse had taken the blood pressure by a check, but the reading was not able to be recorded. This was a computer software issue that has been corrected. The Wi-fi signal for this Resident 9 signal will drop the signal. The nursing staff gave the insulin for this resident because her BS was retaken at 2100 with a result of BS 238, if no insulin had been administered the BS would have continued to elevate higher. The Blood Sugar Policy was reviewed with this RN to notify MD when BS is above 400 and below 60. This policy is also posted in the medication room. Resident 9 received the Lantus @ 9pm this area has a wi-fi signal issue. Resident 9 Physician contacted Tobramycin D/C and consultation with physician and dialysis center indicated that resident's B/P remains high during dialysis and Metoprolol Tartrate 50mg is to be given BID. Lasix evening dose was not coming up on the MAR this was a computer error with the time code,	

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	and Sunday. - Novolog insulin to inject per sliding scale: if blood sugar ranges 150 - 200, then administer 2 units of insulin; if blood sugar ranges 201 - 250, then administer 4 units of insulin; if blood sugar ranges 251 - 300, then administer 6 units of insulin; if blood sugar ranges 301 - 350, then administer 8 units of insulin; if blood sugar ranges 351 - 400, then administer 10 units of insulin, if blood sugar is above 401, administer 10 units of insulin and call MD subcutaneously (under the skin) before meals for diabetes - Lantus, inject 17 units of insulin subcutaneously at bedtime for diabetes - Tobramycin solution, an antibiotic eye solution, instill 1 drop in left eye four times a day for bleeding in the eye. - Metoprolol tartrate (a heart medication) 25 mg two times a day for high blood pressure. Hold blood pressure medication on dialysis days Monday, Wednesday and Fridays. The October 2021 Medication Administration Record (MAR) indicated, furosemide, Novolog insulin, Lantus insulin, Tobramycin solution, and Metoprolol Tartrate were not completed as ordered. - furosemide 80 mg was administered only at 9:00 a.m. on Tuesday, Thursdays, Saturdays, and Sundays.		and it was corrected immediately. D.O.N. identified nurses with deficient practices. In-Service held with licensed nursing staff on MAR documentation, reading and proper medication administration. Physician consulted on physician order clarification completed. 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; All resident's medication and physician orders were reviewed. No other residents affected. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; D.O.N./Nurse Supervisor will monitor medication pass weekly with each nurse on all shifts to ensure proper practices. Licensed Nurses will inform Nurse Supervisor for medication problems ongoing so that it can be emailed to the pharmacy for proof of inquiry about problem. D.O.N. will audit all physician orders monthly and ensure licensed nurses have properly transcribed physician orders.	

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	- Novolog insulin: On 10/3/21 at 4:00 p.m. there was no documentation indicating the insulin was administered. The resident's blood sugar was 238 at 5:00 p.m., the resident should have received 4 units of insulin per the sliding scale. On 10/17/21 at 12:30 p.m., there was no documentation indicating the insulin was administered and a blood sugar was taken. On 10/18/21 at 4:00 p.m., there was no documentation indicating the insulin was administered. The resident's blood sugar was 439 at 5:00 p.m., the resident should have received 10 units of insulin and the MD should have been notified. - On 10/5/21 at 9:00 p.m., the record lacked an indication Lantus was administered. - On 10/5 at 9:00 p.m. and 10/17/21 at 1:00 p.m., the record lacked an indication the Tobramycin was administered. - From October 1 through the 28th, there was no documentation indicating the Metoprolol Tartrate was not held on dialysis days of Monday, Wednesdays and Fridays. A Care Plan was revised on 10/12/20 for chronic renal failure related to diabetes mellitus and hypertension (high blood pressure). An intervention was to give medications as ordered by the Physician. Interview with LPN 2 on 10/26/21 at 11:22 a.m., indicated she had only administered the furosemide in the morning.		Nurse Supervisor will report all problems with medication to D.O.N. who will discuss problems immediately with Administrator. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and D.O.N./Nurse Supervisor will monitor medication pass weekly with each nurse on all shifts and ensure order is correctly put in PCC. D.O.N. will audit all physician orders monthly 5 residents weekly and ensure licensed nurses understand all physician orders. Q.A. Committee will review D.O.N. report of medication med pass, physician order audit, medication is received timely quarterly for the next 6 months. 11/20/21	

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	Interview with the Director of Nursing on 10/27/21 at 8:46 a.m., indicated the resident had not received the medications as ordered. The computer system did not populate the scheduled times correctly and sometimes the Nurse did not put in the correct order into the computer system. 3.1-48(a)(3)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order			

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	unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure psychotropic medications were monitored for side effects and effectiveness as well as ensuring Abnormal Involuntary Movement Scale (AIMS) assessments were completed for 3 of 5 residents reviewed for unnecessary medications. (Residents 3, 8, and 20) Findings include: 1. The record for Resident 3 was reviewed on 10/27/21 at 10:21 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, major depressive disorder, and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 9/9/21, indicated the resident was cognitively impaired for daily decision making and she received antidepressant medication.	F 0758	F758 - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; AIMS Assessment completed on Resident 3, 8, and 20 this was discussed with MDS Coordinator to add on the assessment due date which will pop up in the PCC system MDS Coordinator will assign MDS Assessments and ensure assessments are done timely and accurately. Resident 3 monitoring for antidepressant side effects has been on the MAR since 3/29/21.	11/12/2021

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	A Physician's Order, dated 3/29/21, indicated the resident was to receive Prozac (an antidepressant) 10 milligrams (mg) daily for depressive disorder. A Care Plan, dated 5/31/21, indicated the resident used antidepressant medication related to depression. Interventions included, but were not limited to, monitor/document/report as needed (prn) adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL (activities of daily living) ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, weight loss, nausea and vomiting, dry mouth, and dry eyes. There was no documentation on the October 2021 Medication Administration Record (MAR), related to monitoring for antidepressant side effects. Interview with the Director of Nursing on 10/29/21 at 11:00 a.m., indicated antidepressant side effects should have been monitored on the MAR. 2. The record for Resident 8 was reviewed on 10/26/21 at 9:07 a.m. Diagnoses included, but were not limited to, lupus, anxiety disorder, schizoaffective disorder, major depressive disorder, and chronic pain syndrome. The Quarterly Minimum Data Set (MDS) assessment, dated 8/19/21, indicated the resident was cognitively intact for daily decision making and she received antidepressant and anti-anxiety medications.		Recordings were done for each shift however there was a recording for the 3-11 shift 2 times which was a software error. We ask that this deficient practice be removed. Enclosed please find proof of the record. *Copy of MAR attached. Resident 8 monitoring for psychotropic side effects added to MAR, however staff monitored for restlessness and agitation on all 3 shifts which are side effects of anti-psychotic medications. Resident 20 discharged - 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; All residents on psychoactive medication records were audited and the monitoring of side effects were on the MAR. No other residents affected. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; D.O.N./Nurse Supervisor will monthly monitor physician order recap to ensure monitoring for psychoactive medication is on the	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(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
	A Physician's Order, dated 4/6/21, indicated the resident was to receive Lorazepam (an anti-anxiety medication) 0.5 mg three times a day for anxiety. A Physician's Order, dated 9/17/21, indicated the resident received Cymbalta (an antidepressant) 60 milligrams (mg) daily. A Physician's Order, dated 3/29/21, indicated side effects for anti-anxiety medications were to be monitored every shift. The October 2021 Medication Administration Record (MAR), indicated side effects for the Lorazepam and Cymbalta were not being monitored every shift. Interview with the Director of Nursing on 10/29/21 at 11:00 a.m., indicated the side effects for anti-anxiety and antidepressant medications were to be monitored each shift on the MAR. 3. Resident 20's record was reviewed on 10/26/21 at 10:10 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 6/16/21, indicated the resident was cognitively impaired and in the last 7 days he received an antipsychotic medication. The current Physician's Order Summary, indicated Resident 20 was to have received the antipsychotic medication, Risperdal 0.5 milligrams twice a day and risperidone (generic brand of Risperdal) solution 1 milligram/milliliters at bedtime. The record lacked an indication there was monitoring of side effects of the antipsychotic medication or the effectiveness.		MAR. In-Service held with licensed nurses transcribing orders for residents receiving psychotropic medication to include monitoring for side effects. on behavior documentation. /p> Q.A. Committee has determined that it would better to have a pharmacist to visit the facility. It is more cost feasible, and it will be additional monitoring of records to detect errors. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and MDS Coordinator will provide monthly calendar for assessment completion of AIMS. D.O.N. will monitor documentation of MARs, TARs, changes in medication indications and resident outcome. Pharmacist Consultant will review physician orders and the practices monthly and document any deficient practices for Q.A. review. Q.A. Committee will monitor reports from D.O.N. quarterly to assess effectiveness and evaluate compliance of antipsychotic treatments.	

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	A Care Plan, dated 3/18/21, indicated the resident had the potential to be verbally aggressive, an intervention was to administer medications as ordered. Monitor/document for side effects and effectiveness. Interview with the Director of Nursing on 10/27/21 at 9:24 a.m., indicated there should have been a place in the Medication Administration Record to monitor side effects and there should have been an Abnormal Involuntary Movement Scale assessment as well. The Nurse did not complete the process correctly into the computer system, therefore this was missed. Policy title, "Psychotropic Drug Documentation," was provided by the Director of Nursing on 10/29/21 at 3:30 p.m. This current policy indicated Purpose: 1. To document data collected on resident's responded to psychotropic drug administration and assessment of side effects in order to assess therapeutic value of therapy...." 3.1-48(a)(3) 3.1-48 (b)(1)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and			

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	Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure eye drops were labeled and/or discarded after the use by date for 1 of 1 medication carts observed and 2 residents' medications. (Residents 11 and 4) Finding includes: Observation of the medication cart on 10/28/21 at 11:57 a.m. with LPN 2, indicated Resident 11 and Resident 4's eye drops were still in use after the use by date. Resident 11's Latanoprost 0.005% ophthalmic solution (used to treat high pressure inside the eye) had an open date of 6/1/21. Resident 4's Latanoprost 0.005% ophthalmic solution had an open date of 8/19/21. Interview with LPN 2 at that time, indicated both bottles were past the use by date and should be replaced.	F 0761	F761 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 4 & 11 eye drops reordered, and the eye drops according to our former pharmacy the eye drops were good for 90 days. D.O.N. reviewed new instructions for use of eye drops for 42 days only. Eye drops will be re-ordered every 30 days. An update to the eye drop practice was immediately given to all licensed nurses. New audit sheet for eye drops was given to nurses complete so that eye drips would be reordered every 30 days.	11/01/2021

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	According to the pharmaceutical company website, https://www.pfizermedicalinformation.com/en-us/xalatan/storage-handling, "Once a bottle is opened for use, it may be stored at room temperature up to 25°C (77°F) for 6 weeks." 3.1-25(o)		2. All residents reviewed with eye drops and the facility only has 2 residents on the same eye drops for glaucoma. No other deficient practice noted. 3. 11-7 Charge Nurse will monitor medication cart for eye drops nightly to ensure all eye drops are dated and used timely. D.O.N. Designee will monitor eye drop auditing semi-monthly. Pharmacist Consultant will monitor eye drop and medication storage monthly ongoing In-Service on the proper date labeling, usage and storage of eye drops will become part of orientation and will be reviewed semi-annually. Q.A. Committee will review our monitoring pharmacist consultant reports and eye drop logs quarterly then semi-annually. Q.A. Committee will determine the need for increased or decreased monitoring of proper technique for medication storage. 4. DON will review eye drop log and re-orders monthly. DON will research services that will be more beneficial for the facility in regards with the pharmacy and consultant pharmacist. Q.A. Committee will evaluate eye	

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			drop logs and review information on new pharmacy services and consultant pharmacy services. Administrator will determine what is best for the facility and sign new contracts for services.	
F 0805 SS=D Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. Based on observation, record review and interview, the facility failed to follow the recipe for a pureed diet and prepare thickened liquids according to the directions for 1 of 2 residents receiving a pureed diet. (Resident B) Findings include: 1. During the pureed food preparation on 10/26/21 at 8:36 a.m., with the Food Sanitation Supervisor (FSS), the following was observed: - The FSS placed 2 servings of scrambled eggs into the food processor and blended. She added 1 tablespoon of milk, blended again, then added another tablespoon of milk. She turned off the machine and stirred the mixture with a spatula. She added another tablespoon of milk and blended, turned off the machine and added another serving of scrambled eggs to the mixture. She added a 1/2 tablespoon to the mixture, blended again and removed the processor to add another serving of scrambled eggs to the mix. She added another tablespoon of milk and blended the	F 0805	F805 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Pureed Diet is food smooth as pudding. Each resident on a Pureed Diet received the proper form of food. According to the findings a preparation of 4 servings was prepared. There are 3 residents receiving a pureed diet. So, 4 servings was appropriate in case the resident would have wanted an extra serving. Recipe for Scrambled Eggs is attached: 4 servings of Egg and 4 TBSP of Milk. Recipe for Pureed Toast is attached: 4 slices of toast, 6	11/20/2021

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	mixture and placed each serving on the paper plate. -The FSS placed 3 slices of buttered toasted bread into the blender. She added 1 ounce of strawberry jelly to the blender and 2 tablespoons of milk and turned on the machine to blend. She added 2 more tablespoons of milk and blended. She placed another butter toasted bread into the blender and added a 1/2 ounce of strawberry jelly and 1 more tablespoon of milk to the mix. She blended and added 1 more tablespoon of milk and blended again. She placed the pureed toast on plate with pureed eggs. -The FSS placed 3 cooked sausage patties into the blender and added 1 1/2 ounces of white gravy and blended. She added 1 more ounce of white gravy, and blended. She turned off the blender, stirred, and blended again. She added 1 tablespoon of milk and blended, stirred, and added 1 more tablespoon of milk. She placed the pureed sausage on the plate with the other items. During the pureed observation there was no recipe followed. The current pureed scrambled eggs recipe indicated for 2 portions: 2 eggs and 2 tablespoons of milk. Beat eggs, add milk and beat again. Scramble in frying pan. Place eggs in a blender or processor and puree to smooth custard consistency, add milk as needed. The current pureed toast recipe for 2 portions indicated 2 slices of toast, 2 tablespoons of milk, 2 scoops of thickener as needed. Crumble bread into food processor, add milk and puree until smooth. Add additional milk and thickener as needed.		TBSP Milk, Thickener if needed According to the findings a preparation of 4 servings was prepared: 4 slices of toast, 6 TBSP of Milk, No thickener was added however flavor enhancement of Jelly was included which is not contraindicated. Flavor enhancements include the following: Margarine, Butter, Jelly, Syrup, Ketchup, Gravy, Barbeque Sauce. Recipe for Pureed Sausage is attached: 6 oz. sausage, 3 TBSP Milk or Gravy, Thicken 1 TBS. The recipe will vary according to the water and grease content of the meat. 3- 2-ounce sausages patties, 2 ½ ounce gravy, and 2 TBSP Milk The result is for the Pureed Diet to be served Smooth as Pudding and this was done by the FSS. PCA's were immediately informed of the Thickened Liquid Recipe and recipe was reviewed with all Nursing and Dietary Staff. The recipe for Thickened Liquids was printed and posted for staff to see and use. 2. How other residents having the potential to be affected by the same deficient practice will be	

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	The current pureed sausage recipe for 1 portion indicated 1 ounce cooked sausage patty, 1 and 1/2 milk or gravy and 1/2 teaspoon of thickener as needed. Place cooked sausage into blender add hot or cold liquid and puree until smooth. Add thickener if needed. Interview with the FSS on 10/27/21 at 11:00 a.m., indicated she was aware the pureed recipe for eggs, sausage, and toast was not followed correctly. 2. On 10/25/21 at 1:00 p.m., Resident B was served lunch. He received a pureed meal of chicken, mixed vegetables and rice. PCA 1 sat down to feed the resident. She was observed to prepare his thickened liquids. She poured grape kool aide into an 8 ounce styrofoam cup and placed 2 spoonfuls (from a white plastic spoon) of thickener into the cup and stirred. She handed it to the resident to drink. On 10/26/21 at 9:24 a.m., the resident was served breakfast along with an 8 ounce bottle of Ensure. CNA 1 removed the lid from the Ensure and added two spoonfuls of white powdered thickener from a container on the beverage cart. There were no directions for use on the container. The CNA used a white plastic spoon to determine the spoonfuls. She placed the lid back on the container and shook it and handed it back to PCA 2 who was seated next to the resident, who then gave it to the resident to drink. At 9:37 a.m., CNA 1 was observed to prepare a thickened juice for the resident. She added 2 spoonfuls (same white plastic spoon) of thickener and then stirred the juice. She added another teaspoon of thickener, stirred, and handed it to the resident to drink.		identified and what corrective action will be taken. No one was affected. All residents received correctly prepared pureed diet with a consistency smooth as pudding. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. The facility maintains that the food served was prepared in a form to meet the individual needs of the resident. The FSS and Dietician reviewed the facilities pureed recipes and policy/procedure against the findings listed in the summary statement of deficiencies to determine any variance in the procedure and/or recipe used by the FSS to prepare the pureed toast, eggs, and sausage. Observed all residents requiring pureed foods and or thickened liquids according to each resident's diet order. Observations are to determine if any residents are having difficulty chewing or swallowing their food and or drink. The meals were prepared and found to be fit within each recipe's guidelines. Dietician developed a policy on the	

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	On 10/26/21 at 12:58 p.m., the resident was served a pureed meal for lunch. PCA 1 prepared the resident's kool aide with the thickening agent. She add 3 spoonfuls (with the white plastic spoon) of thickener to an 8 ounce styrofoam cup of kool aide and stirred. She added 2 more spoonfuls of thickener to the cup of juice and returned to the table where the resident was seated. At 1:15 p.m., the cup of thickened juice was jello like and clumpy. Interview with PCA 1 at that time, indicated she was unaware what the directions were to prepare the thickened liquids. She was told to put 2 spoonfuls in each serving, however, it depended on if it was hot or cold liquid. The record for the resident was reviewed on 10/25/21 at 4:26 p.m. The resident was admitted on 7/16/21 from the hospital. Diagnoses included, but were not limited to, fractured femur, encephalopathy, sepsis, urinary tract infection, transient ischemic attacks, dysphagia, and Parkinson's disease. Physician's Orders, dated 9/28/21, indicated regular diet with pureed texture and honey consistency for liquids. The thickener directions for use were as follows: -Per 4 ounces for honey consistency: Juices-add 4 1/2 to 5 1/2 teaspoons of thickener. Nutritional supplement drink-add 5 1/2 to 2 tablespoons of thickener. -Stir briskly until thickener has dissolved. Before serving let water, juices stand for at least 1 minute. Let milk and supplements stand for 5 to 10 minutes. Stir and serve.		use of flavor enhancers which is attached it is the same that would apply to a regular, mechanical, and pureed diets. Dietician will monitor thicken liquid preparation at mealtime for meals 2 times monthly during visits. FSS will monitor thicken liquids at mealtime for all meals 3 times a week times 1 month, then weekly times 3 months. Dietician provided in-service on use of recipe book, puree consistency to be smooth texture, flavor enhancements, and thickened liquids to new dietary staff. -Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. Dietary Manager will monitor preparation of pureed diet and thicken liquids 3 times a week Dietician will monitor puree diet and thicken liquid preparation upon each visit. Administrator will monitor preparation and food intake and thicken liquids of residents receiving pureed diets weekly for all meals x 3 months then quarterly. Q.A. Committee will monitor	

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	Interview with the FSS on 10/28/21 at 10:00 a.m., indicated the staff were not preparing the thickened liquids properly. There was a measuring spoon that was to be used to prepare the thickened liquids. 3.1-21(a)(3)		weight record and food intake of residents receiving purred diet 3 months. 5. Completion Date: 11/20/21 for training of new dietary staff.	
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, and interview, the facility failed to prepare food under sanitary conditions related to, not sanitizing the food processor after use and in between different foods for 1 of 1 pureed observations in the main kitchen. Finding includes:	F 0812	F812 - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1. Additional Food Processors purchased so that the work	11/01/2021

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	On 10/26/21 at 8:36 a.m., the Food Sanitation Supervisor, was observed preparing pureed eggs, sausage and toast for the breakfast meal. She prepared the scrambled eggs to a puree consistency and then walked over to the 3 compartment sink and rinsed off the food processor, lid and spatula with hot water and placed it back on the stand to start the pureed preparation of the sausage. She did not sanitize the equipment after use. After preparing the eggs, she placed 3 slices of toast into the processor and continued to puree the mixture. The Food Sanitation Supervisor, walked back over to the 3 compartment sink and rinsed off the processor, lid and spatula with hot water. She did not sanitize the equipment after use. She continued to puree the sausage patties and had not sanitized the equipment after use. Interview with the Food Service Supervisor on 10/28/21 at 10:00 a.m., indicated she was aware she did not sanitize the equipment after use. 3.1-21(i)(3)		production would not be slowed by running the container thru the dishwasher cycle. 2. All food processor containers are sanitized after each meal. 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; No other residents affected. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Dietician in-serviced dietary staff on Sanitizing the Food Processor Equipment. Dietary Manager in- serviced dietary department on food processor sanitizing. Administrator/Designee will monitor sanitation of food processor during all 3 meals weekly times 3 weeks. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Dietician will review food for proper labeling on each visit. Dietician will perform inservice on food processor sanitation	

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			bi-monthly. Dietary Manager will be responsible for ensuring food processor is sanitized daily for all 3 meals 5 times a week times 2 weeks. Administrator/Designee will monitor food processor sanitation during all 3 meals weekly times 3 weeks then monthly x 3 months, then semi-monthly. Q.A. Committee will monitor dietician reports, logs quarterly. Monitoring will continue for 6 months and Q.A. Committee will determine further monitoring. 11/1/21	
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			

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	services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or 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.			

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SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

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	§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to hand hygiene not performed after completing COVID-19 testing, not wearing the appropriate personal protective equipment (PPE) while completing COVID-19 testing, and incomplete staff screening sheets for 1 of 1 COVID-19 testing observations and 1 of 3 staff screening sheets reviewed. (LPN 1, LPN 2, and Custodian 1) Findings include: 1. On 10/29/21 at 8:58 a.m., LPN 1 was observed preparing her supplies for COVID-19 testing. The LPN was wearing a face shield and a surgical mask. LPN 2 entered the building, she proceeded to screen herself and then swab her nose for her bi-weekly COVID-19 test. The LPN placed the swab in the Binax card and then sat down. She did not use hand sanitizer when she was done. She proceeded to sit down and wait for her test results. After waiting approximately 10-15 minutes, the LPN picked up the Binax card, looked at it and proceeded to the nurses' station. Again, the LPN did not use hand sanitizer after handling the Binax card.	F 0880	F880 -what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Handwashing and hand sanitation policy reviewed with all staff during COVID Testing. LPN 2 stated she used hand sanitizer after she completed the testing before leaving the testing area. The facility has been COVID free since the pandemic started in March 2020 and remains COVID free today. The staff has been tested 2 times a week whether vaccinated or unvaccinated. The staff is not considered to be suspected or infected with SARSCoV-2. Excellent practices have been enforced and staff takes our infection control practices remaining free of COVID very seriously. Licensed nurses doing testing will wear N95 mask, shield, gown and gloves in performing COVID	11/01/2021

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	Interview with LPN 1 on 10/29/21 at 11:30 a.m., indicated she was not aware she had to wear an N95 mask while staff testing was being completed. Interview with the Director of Nursing on 10/29/21 at 11:35 a.m., indicated LPN 2 should have sanitized her hands after completing her nasal swab and touching the Binax cards. The updated 7/8/21 CDC guidance for "Guidance for SARS-CoV-2 Point-of-Care and Rapid Testing," indicated "For personnel collecting specimens or working within 6 feet of patients suspected to be infected with SARS-CoV-2, maintain proper infection control and use recommended personal protective equipment (PPE), which could include an N95 or higher-level respirator (or face mask if a respirator is not available), eye protection, gloves, and a lab coat or gown." 2. The staff screening sheets were reviewed on 10/29/21 at 2:30 p.m. There was no screening sheet available for Custodian 1. Interview with LPN 1 at that time, indicated the Custodian's screening sheet was not in the binder. She also indicated the Custodian was not vaccinated for COVID-19. She did provide his bi-weekly test results for the month of October 2021 and they were negative. The LPN indicated a screening sheet should have been completed at the start of the Custodian's shift. The updated 9/28/21 " Long Term Care COVID-19 Clinical Guidance, " indicated "Screen all healthcare personnel (HCP) each shift, and screen all visitors and vendors entering the facility for known diagnosis or symptoms of COVID-19 and for any history of being a close contact or		testing. Procedure posted in COVID Testing Area. Custodian 1 is screened every day that he works. His old screening form was found however his current was not available. Custodian 1 was asked the next day where was his screening form he stated he put it in the bookcase so that he could locate his screening form quickly without having to look for it in the binder. Custodian 1 record did reveal that he had been screened. All staff informed to keep COVID Screening in the binder in alphabetical order according to last name. The screening tool will be monitored monthly to ensure proper organization of records. - 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; No one affected facility has been COVID Free since the pandemic and remains COVID Free. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	

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	exposed to COVID-19 positive or symptomatic person in the preceding 14 days." 3.1-18(b)		D.O.N. reviewed handwashing and hand sanitization policy with all staff. COVID Testing practices will be reviewed by D.O.N. weekly on MON and FRI on all shift's times one week then monthly x 3 months then quarterly or as changes from the CDC occur. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Infection control practices including handwashing and proper PPE will be completed by charge nurse every day and every shift. The monitoring will be located on the nurse rounds log. D.O.N. will audit handwashing and hand sanitization practices of staff ongoing. COVID Testing practices will be reviewed by D.O.N. weekly on MON and FRI on all shift's times one week then monthly x 3 months then quarterly or as changes from the CDC occur. Reports will be given to Q.A. Committee for review quarterly.	
F 0886 SS=D Bldg. 00	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC			

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	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 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			

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	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 bi-weekly COVID-19 staff testing was completed for 1 of 3 staff testing records reviewed. (PCA 1) Finding includes: Interview with the Director of Nursing (DON) on 10/25/21 at 10:30 a.m., indicated staff testing for COVID-19 was completed on Monday and Friday due to high community transmission. PCA 1 was hired on 10/5/21. The DON indicated the PCA was not vaccinated for COVID-19.	F 0886	F886 - What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; PCA 1 was scheduled off 10/8/21 and 10/15/21 which was 2 Fridays she was however tested on 10/9/21 and 10/17/21 when she returned to work for the week. According to the transmission rate COVID testing	11/01/2021

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	The PCA was tested for COVID-19 on 10/11, 10/18, 10/25, and 10/29/21 with negative results. There were no test results for 10/8 and 10/15/21. Interview with LPN 1 on 10/29/21 at 3:00 p.m., indicated there were no test results for the above dates. The updated 9/28/21 "Long Term Care COVID-19 Clinical Guidance," indicated "The facility should test all unvaccinated staff at the frequency prescribed in the Routine Testing table based on the level of community transmission reported in the past week. Facilities should monitor its level of community transmission every other week (e.g., first and third Monday of every month) and adjust the frequency of performing staff testing according to the table above." 3.1-18(b)		once weekly is adequate. The facility will continue to test bi-weekly on Monday and Friday and record testing results on log sheet for all employees. - 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; No other resident affected facility and staff remain COVID Free. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Staff will continue to be tested on Monday and Fridays and COVID Quick Test Log will be completed. Facility will continue COVID protocols since they have been very effective in preventing COVID. The facility continues more aggressive monitoring against COVID than what is recommended by the CDC. All staff will be COVID vaccinated by January 4, 2022, and COVID testing will continue. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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			program will be put into place; and Q.A. Committee will review COVID Testing Logs quarterly and adjust practices as CDC guidelines change. by what date the systemic changes 11/1/21	
F 9999 Bldg. 00	3.1-14 PERSONNEL (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (6) Position in the facility and job description. (7) Documentation of orientation to the facility and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and	F 9999	**F-9999** PERSONNEL - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Currently we do not a Human Resource Staff Member. The orientation and in-service requirements will be re-evaluated and the responsibility of the Social Worker and Nurse Educator until Human Resource position is filled. 5 new hires files were reviewed staff asked to take physical and have signed by MD, Annual TB screening was completed by Infection Control Nurse, Staff completed general orientation, References were secured by phone, job descriptions completed with employees' signature. a. CNA 2 was hired on 10/26/21 received and general orientation	11/25/2021

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	recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) moths, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure personnel records were complete related to lack of references, job description, general orientation, specific job orientation and a physical exam not signed by the physician for 5 of 5 new hires. (CNA 2, CNA 1, CNA 3, Activity		done. b. CNA 1 was hired on 10/5/21 received general orientation. c. CNA 3 was hired on 9/15/21 telephone reference done, and physician signed physical, and she signed the job description. d. Activity Aide 1 was hired on 8/3/21 telephone reference completed, job description signed, and specific orientation completed. e. Dietary Aide 1 was hired on 10/11/21 terminated. Secretary during survey quit. a. Infection Preventionist administered Mantoux to LPN 3, RN1 with results of 0mm of induration, however annual Mantoux are scheduled each January for old employees Mantoux solution has had a shortage in the past but it is also very costly, therefore the facility does the annual Mantoux in January in that way all of the multi vial can be used within the 30 days prior to it having to be thrown away. b. Nurse Supervisor reviewed annual residents' rights policy, dementia training update and abuse for RN1, LPN 3. All annual training is performed in January of each year. January has been picked each year for annual training for employees. c. Annual In-services were	

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	Aide 1, Dietary Aide 1) The employee records also lacked an annual tuberculosis screening, resident rights, dementia, and abuse inservices for 2 of 5 employee records reviewed. (LPN 3 and RN 1) Findings include: The Employee Records were reviewed on 10/29/21 at 11:00 a.m. 1. The New Hires: a. CNA 2 was hired on 10/26/21. Her record lacked references and a general orientation. b. CNA 1 was hired on 10/5/21. Her record lacked a general orientation. c. CNA 3 was hired on 9/15/21. Her record lacked references, a physical exam signed by a Physician, and the job description was not signed. d. Activity Aide 1 was hired on 8/3/21. Her record lacked references, a job description and a specific orientation to her position at the facility. e. Dietary Aide 1 was hired on 10/11/21. Her records lacked references, a job description, general orientation and a specific orientation to her position at the facility. Interview with the Human Resource Director on 10/29/21 at 11:30 a.m., indicated references were not mailed, the general and job specific orientations were not completed and job description and the physical exam was not signed. 2. Other Employees:		updated by Nurse Supervisor and in educational binder. Previous secretary did not have access to these records. New Orientation log developed along with guidelines on form for new HR personnel to use when hired. D.O.N. will do orientation until new staff can be trained which will include: Physical Examination within 1 month prior to employment. Mantoux within 1 month prior to employment. Mantoux 2nd step within 3 weeks on first step Mantoux Mantoux must be repeated annually, and chest x-ray is good for 2 years if employee is allergic to Mantoux. New hires 6-hour Dementia Training Annual 3-hour Dementia Training All employees' resident's rights and abuse policy, dementia training and TB testing was updated. Annual Residents Rights and Abuse Policy Reviewed and will be reviewed every January each year. Annual Dementia Training will be reviewed every January each year. Annual Mantoux will be performed every January of each year for reasons listed above. - how other residents having the potential to be affected by the same deficient practice will be	

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	a. LPN 3 lacked a current tuberculosis screening, resident rights, dementia and abuse inservices for 2020. b. RN 1 lacked a current tuberculosis screening, resident rights, dementia and abuse inservices for 2020. Interview with the Human Resource Director on 10/29/21 at 11:30 a.m., indicated she could not find LPN 3 and RN 1's employee records and the Annual inservices were not completed.		identified and what corrective action(s) will be taken; No residents affected. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; In-Service held employee annual updates and logs reviewed. In-Service held on proper documentation of new employee checklist form and annual review. New Employee Checklist will accompany every employee file. Administrator will review check off list of all new hires and review annual employee records. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Administrator and/or D.O.N. will review all new hires employee checklist form. Administrator and/or D.O.N. will review annually review employees file for updated health information. D.O.N. / Designee will provide Dementia Training for all current employees. Until HR personnel hired. Annual Dementia Training will be provided by Social Services and HR Manager will be responsible for maintain records.	

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			D.O.N. will review Employee files: New hires ongoing and annually. Q.A. Committee will review new policy and checklist for new employees semi-annually to ensure compliance. by what date; 11/25/21	