| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | 155530 | A. BUILDING 00<br>B. WING | 05/31/2022 |

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| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: May 24, 25, 26, 27, and 31, 2022<br><br>Facility number: 000369<br>Provider number: 155530<br>AIM number: 100275190<br><br>Census Bed Type:<br>SNF/NF: 82<br>Total: 82<br><br>Census Payor Type:<br>Medicare: 7<br>Medicaid: 71<br>Other: 4<br>Total: 82<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on 6/2/22. | F 0000 | | |
| F 0554<br>SS=D<br>Bldg. 00 | 483.10(c)(7)<br>Resident Self-Admin Meds-Clinically Approp<br>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.<br>Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders for medications and an assessment to self-administer their own medications for 2 of 2 residents reviewed for self-administration of medication. (Residents 50 and 78) | F 0554 | **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>• Residents 50 and 78 medications were removed from | 06/30/2022 |

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

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| | Findings include:<br><br>1. During random observations on 5/24/22 at 10:40 a.m. and 2:45 p.m., and on 5/25/22 at 9:30 a.m., 1:45 p.m., and 3:05 p.m., Resident 50 was observed in his bed. At those times, there was a bottle of Magnesium Blue and a bottle of Beflexible over the counter vitamins on the resident's night stand.<br><br>During a random observation on 5/26/22 at 9:30 a.m., the resident had the same 2 bottles of vitamins and a bottle of Occuvite eye drops on his over bed table.<br><br>The record for Resident 50 was reviewed on 5/26/22 at 10:05 a.m. The resident had no Physician's Orders for the vitamins or an order to self administer his own medications. There was no self administration of medication assessment available for review.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 4/21/22, indicated the resident was cognitively intact.<br><br>Interview with LPN 3, on 5/26/22 at 10:15 a.m., indicated the resident's girlfriend would bring the bottle of vitamins in for him. The resident had no orders for the vitamins, a self administration of medication assessment or an order to self administer his own medications.<br><br>2. During an interview with Resident 78 on 5/24/22 at 10:52 a.m., a hand held inhaler of Symbicort was observed on the over bed table in a bag with the facility label on it. The resident indicated he used the inhaler when he needed it, about 2 times a day. | | bedside and stored properly in medication cart. Residents and responsible party educated on self-administration of medication policy. Reviewed process of requesting medication review and MD visit with residents and responsible party.<br>• MD was notified and orders obtained for Resident 50's Occuvitie eyedrops and Multivitamin and is being administer by nursing staff<br><br>**2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.**<br>• The IDT will interview each interview able resident in the facility to review the policy related to self-administration of medications, & to ask and observe if the resident has medications in his/her possession.<br>• Residents found to have medications &/or treatments in his/her possession will be asked to surrender the items to be secured in the medication/treatment carts. The MD will be notified for orders for nursing administration as appropriate.<br>• Residents requesting self-administration will be assessed and care planned as appropriate. MD orders will be | |

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| | On 5/24/22 at 2:45 p.m., the hand held inhaler was still observed on the over bed table in the resident's room.<br><br>The record for Resident 78 was reviewed on 5/25/22 at 2:30 p.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), type 2 diabetes, major depressive disorder, high blood pressure, blindness one eye, low vision in other eye, and glaucoma.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 5/5/22, indicated the resident was cognitively intact and his vision was adequate with glasses.<br><br>Physician's Orders, dated 2/6/2020, indicated Symbicort Aerosol 80-4.5 micrograms. Inhale 2 puffs orally two times a day.<br><br>There was no order to self administer his own medications or a self administration of medication assessment.<br><br>Interview with LPN 3 on 5/27/22 at 10:15 a.m., indicated the resident had no order to self administer his medications or a self administration of medication assessment.<br><br>The current and revised 12/2016 "Self Administration of Medications" policy, provided by the Director of Nursing on 5/31/22 at 1:51 p.m., indicated the staff or practitioner would assess each resident's physical and mental ability to determine whether self administering medications was clinically appropriate for the resident. Staff would identify and give to the Charge Nurse any medications found at the bedside that were not | | obtained for self-administration if appropriate.<br><br>**3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.**<br>• Inservice Education will be provided to staff members to include:<br>a) Immediately reporting observation of medications &/or treatments visualized in a resident's possession.<br>b) Charge nurse to immediately respond to reports of medication &/or treatments in resident's possession to assure orders & care plan for self-administration.<br>c) Charge nurse to request surrender of medication &/or treatments to secure until a self-administration of medication assessment is completed followed by MD orders and a care plan if appropriate.<br>d) If it is determined a resident is able to self-administer medication &/or treatments, the resident must also understand & demonstrate securing the items for the safety of other residents.<br>e) Nursing will educate newly admitted residents and their responsible party of our policy related to medications/treatments at the bedside upon admission.<br>• Education to IDT team/angel | |

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| | authorized for self administration, for return to the family or responsible party.<br><br>3.1-11(a) | | care rounds for close monitoring for medications at bedside.<br><br>**4.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.**<br>• DON / designee will complete the Self Administration audit tool with observational rounds to ensure that medications are not kept at bedside, staff are aware of what to do in the event meds are seen and that assessments, orders and care plans are in place for residents with medications at bedside.<br>• Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters.<br>• The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |
| F 0623<br>SS=B<br>Bldg. 00 | 483.15(c)(3)-(6)(8)<br>Notice Requirements Before Transfer/Discharge | | | |

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| | §483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(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.<br>(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<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br>(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 | | | |

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| | (E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br>(i) The reason for transfer or discharge;<br>(ii) The effective date of transfer or discharge;<br>(iii) The location to which the resident is transferred or discharged;<br>(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;<br>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br>(vi) For nursing facility residents with 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<br>(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.<br><br>§483.15(c)(6) Changes to the notice. | | | |

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| | 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.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>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 related to a transfer to the hospital for 4 of 4 residents reviewed for hospitalization. (Residents 21, 34, 55, and 9)<br><br>Findings include:<br><br>1. The record for Resident 21 was reviewed on 5/31/22 at 10:00 a.m. Diagnoses included, but were not limited to, Parkinson's disease and dementia with behavior disturbance.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 3/8/22, indicated the resident was moderately impaired for daily decision making.<br><br>A Nurses' Note, dated 2/18/22 at 1:54 p.m., indicated the resident was complaining of chest pain. The resident was sent to the emergency | F 0623 | **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>Residents 9, 21, 34 and 55 have returned and remain in the facility. Residents9,21 and 34 did not have a negative outcome related to the alleged deficient practice<br><br>**2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br><br>Residents that are discharged from the facility have the potential | 06/30/2022 |

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| | room for evaluation. He was admitted to the hospital and returned to the facility on 3/1/22.<br><br>There was no documentation indicating the resident's Responsible Party was mailed a copy of the state transfer form.<br><br>Nurses' Notes, dated 4/30/22 at 8:30 a.m., indicated the resident was sent to the hospital for complaints of chest pain. The resident was admitted to the hospital and returned to the facility on 5/3/22.<br><br>There was no documentation indicating the resident's Responsible Party was mailed a copy of the state transfer form.<br><br>Interview with the Social Service Director on 5/31/22 at 10:30 a.m., indicated the transfer information went to the front office and the Ombudsman was faxed. She was not aware of who mailed the information to the family.<br><br>Interview with the Director of Nursing on 5/31/22 at 2:20 p.m., indicated the information was sent with the resident to the hospital and the information was also faxed to the Ombudsman. The information was not sent to the family.<br><br>2. The record for Resident 34 was reviewed on 5/26/22 at 3:28 p.m. Diagnoses included, but were not limited to, stroke, type 2 diabetes, heart failure, and dysphagia (difficulty swallowing).<br><br>The 5 day Medicare Minimum Data Set (MDS) assessment, dated 5/12/22, indicated the resident had short and long term memory problems and was severely impaired for daily decision making.<br><br>Nurses' Notes, dated 3/17/22 at 9:20 a.m., indicated | | to be affected by the alleged deficient practice.<br>Residents discharged since 6/1/2022 have been audited to ensure that the resident/responsible party found not to have received it.<br><br>**3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br><br>• Licensed nursing staff educated on Bed Hold Policy, process and procedures<br>• IDT has been educated on the process for sending a copy of the discharge papers with residents who discharged when they are alert and orientated and to provide a copy to the responsible party for residents who are not alert or oriented at the time of discharge via the mail.<br>• Social services/designee will maintain a log for all discharges and log who was provided copies of discharge paperwork.<br>• IDT educated on use of Clinical meeting process with emphasis on IDT discharge review process<br><br>**4. 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?** | |

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| | the resident was sent to the hospital for a change in condition. The resident's son was made aware of his transfer. The resident was readmitted to the facility on 3/25/22.<br><br>There was no documentation indicating the resident's Responsible Party was mailed a copy of the state transfer form.<br><br>Nurses' Notes, dated 5/2/22 at 1:29 p.m., indicated the resident was being transferred to the hospital due to seizure activity. The resident's son was notified about the transfer. The resident returned to the facility on 5/5/22.<br><br>There was no documentation indicating the resident's Responsible Party was mailed a copy of the state transfer form.<br><br>Interview with the Social Service Director on 5/31/22 at 10:30 a.m., indicated the transfer information went to the front office and the Ombudsman was faxed. She indicated she was not aware of who mailed the information to the family.<br><br>Interview with the Director of Nursing on 5/31/22 at 2:20 p.m., indicated the information was sent with the resident to the hospital and the information was also faxed to the Ombudsman. The information was not sent to the family. 3. Resident 55's record was reviewed on 5/25/22 at 9:39 a.m. Diagnoses included, but were not limited to, respiratory failure, congestive heart failure, stroke, tracheostomy status, and Alzheimer's disease with late onset.<br><br>The Discharge Minimum Data Set (MDS) assessment, dated 5/11/22, indicated the resident was severely cognitively impaired. | | SSD/Designee will complete Discharge/Transfer Audit to ensure Bed Hold policy has been followed<br>• Audits will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters.<br><br>• The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | A Nursing Progress Note, dated 4/1/22 at 12:42 p.m., indicated the resident was evaluated by the nurse practitioner who noted a change in the resident's status. The resident was transported to the emergency room for further evaluation.<br><br>The record lacked an indication of the state transfer form being sent to the resident's representative.<br><br>Interview with the Assistant Director of Nursing on 5/27/22 at 10:49 a.m., indicated she was unable to locate the state transfer form in the chart and it should have been sent to the resident's representative.<br><br>4. Resident 9's record was reviewed on 5/24/22 at 10:54 a.m. Diagnoses included, but were not limited to, end stage renal disease, high blood pressure, stroke, and non-Alzheimer's disease.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 5/9/22, indicated the resident was moderately cognitively impaired.<br><br>A Nursing Progress Note, dated 4/21/22 at 10:51 a.m., indicated a small amount of emesis was noted and the resident had complaints of nausea, lack of appetite, and general weakness. The nurse practitioner evaluated the resident and new orders were received to send the resident to the emergency room for evaluation and treatment.<br><br>The record lacked an indication of the state transfer form being sent to the resident's representative.<br><br>Interview with the Assistant Director of Nursing on 5/27/22 at 11:14 a.m., indicated she was unable | | | |

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| | to locate the state transfer form in the chart and it should have been sent to the resident's representative.<br><br>3.1-12(a)(6)(ii)<br>3.1-12(a)(6)(iii) | | | |
| F 0644<br>SS=D<br>Bldg. 00 | 483.20(e)(1)(2)<br>Coordination of PASARR and Assessments<br>§483.20(e) Coordination.<br>A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.<br><br>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.<br>Based on record review and interview, the facility failed to ensure a resident with a significant change in diagnoses and/or psychotropic medication received a new Level 1 PASARR (Preadmission Screening and Resident Review) for 1 of 1 residents reviewed for PASARR. (Resident 14)<br><br>Finding includes:<br><br>The record for Resident 14 was reviewed on | F 0644 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>• Resident 14 is still in the facility and was not affected by alleged deficient practice, PASARR for resident 14 updated with all applicable diagnosis and medications | 06/30/2022 |

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| SOUTH SHORE HEALTH & REHABILITATION CENTER | 353 TYLER ST<br>GARY, IN 46402 |

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| | 5/25/22 at 4:00 p.m. Diagnoses included, but were not limited to, deep vein thrombosis, Parkinson's, stroke, high blood pressure, dementia, major depressive disorder, and psychotic disorder.<br><br>The Significant Change Minimum Data Set (MDS) assessment, dated 3/7/22, indicated the resident was not cognitively intact and needed extensive assist with 2 person physical assist for personal hygiene. The resident had no weight loss or gain. He received a therapeutic diet and oxygen while a resident.<br><br>A Care Plan, updated on 3/2022, indicated the resident used an antidepressant medication related to a medical history of depression.<br><br>A Care Plan, updated 3/2022, indicated the resident had a diagnosis of generalized anxiety disorder.<br><br>A PASARR Level 1 screening was completed on 8/29/17 and indicated no level 2 was needed due to no diagnoses of mental illness or psychotropic medications.<br><br>Physician's Orders, dated 3/1/22, indicated Trazodone HCl (an antidepressant medication) tablet 50 milligrams (mg). Give 50 mg by mouth one time a day for depression.<br><br>Interview with the Social Service Director on 5/26/22 at 11:15 a.m., indicated she had not called the company (name) to notify them the resident had a change of diagnoses and was started on an antidepressant medication.<br><br>3.1-16(d)(1)(A) | | **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents in the facility have the potential to be affected by alleged deficient practice<br>• An Audit of all residents with a significant change in diagnosis and/or psychotropic medication will receive a new Level 1 PASARR , SSD/Designee will review 20 residents weekly x 4 to and 5 residents weekly until 100% of residents reviewed and PASSARR updated as necessary<br><br>**3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br><br>• SSD educated on PASARR process with emphasis of completing/ updating with change in diagnosis or medications ,When a resident with a significant change in diagnosis and/or psychotropic medication social services will notify the PASSAR assistant program of the change.<br>• IDT educated on clinical morning meeting process and SSD to be present for new order review<br><br>**4. How the corrective action (s)** | |

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| | | | **will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br><br>• SSD/Designee to complete audit Diagnosis change/ medication changes to ensure any change in PASSAR completed<br>• Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters.<br>• The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |
| F 0677<br>SS=D<br>Bldg. 00 | 483.24(a)(2)<br>ADL Care Provided for Dependent Residents<br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>Based on observation, record review, and interview, the facility failed to ensure dependent residents received assistance with ADL's (activities of daily living) related to nail care and showers for 3 of 5 residents reviewed for ADL's. (Residents 21, 14, and 43) | F 0677 | **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>• Residents 21, 14 and 43 were provided with ADL care related to | 06/30/2022 |

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| | Findings include:<br><br>1. Interview with Resident 21's family member on 5/26/22 at 9:50 a.m., indicated the resident didn't always get two showers a week.<br><br>The record for Resident 21 was reviewed on 5/31/22 at 10:00 a.m. Diagnoses included, but were not limited to, Parkinson's disease and dementia with behavior disturbance.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 3/8/22, indicated the resident was moderately impaired for daily decision making and was totally dependent on staff for bed mobility and transfers. Bathing had not occurred during the assessment reference period.<br><br>The Care Plan, dated 5/3/22, indicated the resident had an activities of daily living (ADL) self care performance deficit due to limited mobility and tremors due to Parkinson's disease, resistive towards staff with care, impaired cognition due to dementia, refused to perform in self care and wanted staff to perform total care. There was a history of aggression and refusing medications and showers. Interventions included, but were not limited to, the resident preferred showers on Monday and Thursday nights and he required assistance by 1 staff member.<br><br>The May 2022 Physician's Order Summary (POS), indicated shower and skin assessments were to be completed on Tuesday and Friday nights.<br><br>Shower documentation for April and May 2022 was provided by the Director of Nursing. Shower documentation for May stopped on 5/11/22.<br><br>Interview with the Director of Nursing on 5/31/22 | | showers and nailcare and did not have a negative outcome related to the alleged deficient practice<br><br>**2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents in the facility have the potential to be affected by alleged deficient practice<br>• Audit completed of showers to ensure that each resident has scheduled and agreed upon shower days<br><br>**3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**<br><br>• Nursing Staff in serviced related to ADL care for dependent resident, with emphasis on showers, documentation, and nail care<br><br>**4.How will the corrective action (s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br><br>• DON/ designee will complete ADL care Audit to monitor residents ADL status including showers and nailcare | |

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| | at 2:15 p.m., indicated documentation related to the resident's bathing stopped on 5/11/22 and there was no additional documentation related to the resident either receiving or refusing his showers.2. During random observations on 5/25/22 at 9:48 a.m., 1:24 p.m., and 3:05 p.m., Resident 14 was observed sitting in a wheelchair in his room. At that time, his fingernails on both hands were observed to be long and discolored.<br><br>On 5/26/22 at 9:40 a.m. and 12:30 p.m., the resident was observed sitting in his wheelchair. At those times, his fingernails on both hands were observed to be long and discolored.<br><br>The record for Resident 14 was reviewed on 5/25/22 at 4:00 p.m. Diagnoses included, but were not limited to, deep vein thrombosis, Parkinson's, stroke, high blood pressure, dementia, major depressive disorder, and psychotic disorder.<br><br>The Significant Change Minimum Data Set (MDS) assessment, dated 3/7/22, indicated the resident was not cognitively intact and needed extensive assist with 2 person physical assist for personal hygiene.<br><br>The Care Plan, updated on 3/2022, indicated the resident had an ADL (activities of daily living) self-care performance deficit with fluctuation in performance related to impaired mobility. The approaches were to provide extensive assist with personal hygiene.<br><br>There was no documentation the resident's nails had been trimmed. There was no Care Plan indicating the resident refused nail care.<br><br>Interview with CNA 7 on 5/27/22 at 11:20 a.m., indicated she had seen his nails yesterday and | | • Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters.<br>• The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance | |

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| | asked if she could cut them and he refused, however, she did not tell the nurse.<br><br>Interview with LPN 3, also on 5/27/22 at 11:20 a.m., indicated nail care was to be done as needed. The resident did not refuse care to her knowledge.<br><br>3. During an interview with Resident 43 on 5/24/22 at 10:16 a.m., she indicated her nails long were long and in need of trimming on both hands.<br><br>During an interview on 5/25/22 at 3:04 p.m., the resident indicated she received a shower yesterday, however, no staff had trimmed her nails.<br><br>The record for Resident 43 was reviewed on 5/25/22 at 1:50 p.m. Diagnoses included, but were not limited to, hemiplegia (weakness on one side), stroke, high blood pressure, osteoporosis, anemia, liver disease, anxiety, and atrial fibrillation (irregular heartbeat).<br><br>The Annual Minimum Data Set (MDS) assessment, dated 4/22/22, indicated the resident was cognitively intact and was totally dependent on staff with 1 person assist for bathing. The resident needed assistance with personal hygiene. She had a functional range of motion impairment to one side for her upper extremities.<br><br>A Care Plan, updated 4/2022, indicated the resident had an ADL self-care performance deficit related to weakness and stroke. The approaches were the resident preferred to have her shower in the morning on Monday and Thursday. The resident required assistance by 1 staff with bathing/showering and personal hygiene.<br><br>The Shower Book indicated the resident was to be | | | |

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| | bathed on Mondays and Thursdays during the day.<br><br>The Unit Nurse Skin Review Sheet indicated the resident had a shower on 1/24, 2/10, 2/17, 2/24, 3/3, and 3/24/22. On 2/28, 3/17, and 3/28/22 "other" was documented rather than a shower.<br><br>The Head to Toe Weekly Assessments were completed on 4/7, 4/11, 4/14, 4/26, 5/16, and 5/26/22, however, there was no documentation on the above assessments indicating the resident received a shower.<br><br>Interview with RN 1 on 5/26/22 at 10:20 a.m., indicated nursing staff were responsible for documenting if the resident received a shower. The old system assessment "the Unit Nurse Skin Review Sheet" had a drop down box to indicate the resident received a shower. The new system "the Head to Toe Weekly Assessment Sheet", had no place to document if the resident received a shower.<br><br>Interview with the Nurse Consultant on 5/26/22 at 10:20 a.m., indicated residents were to receive a shower at least 2 times a week. There was no documentation on the Head to Toe Weekly Skin Assessments that a shower was completed.<br><br>Interview with CNA 7 on 5/27/22 at 11:20 a.m., indicated she gave the resident a shower yesterday and did not cut her fingernails. She was aware her nails were long on the right hand.<br><br>3.1-38(a)(2)(A)<br>3.1-38(a)(3)(E) | | | |
| F 0684 SS=D | 483.25<br>Quality of Care | | | |

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| Bldg. 00 | § 483.25 Quality of care<br>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.<br>Based on record review and interview, the facility failed to ensure transportation to the wound clinic was available and treatments were completed as ordered for 1 of 2 residents reviewed for skin conditions (non-pressure related). The facility also failed to ensure a timely follow up assessment was completed after a change in condition for 1 of 1 residents reviewed for change in condition. (Residents 2 and 55)<br><br>Findings include:<br><br>1. The record for Resident 2 was reviewed on 5/26/22 at 1:55 p.m. Diagnoses included, but were not limited to, type 2 diabetes with foot ulcer, osteomyelitis (bone infection) left ankle and foot, and end stage renal disease.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 5/6/22, indicated the resident was moderately impaired for daily decision making and he required extensive assistance with bed mobility and total assist with transfers. The resident was identified as having a diabetic foot ulcer.<br><br>The Care Plan, dated 11/1/21 and reviewed 5/2022, indicated the resident had a diabetic ulcer to his left foot related to diabetes. Interventions included, but were not limited to, Wound | F 0684 | **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>•Resident #2 remains in the facility and is followed by wound care team at facility and Wound Care Clinic at Methodist North Lake. All transportation and insurance issues and medical necessity issues have been corrected.<br>•Resident #55 remains in the facility. NP was made aware of resident's change in condition, orders were received and followed.<br><br>**2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br><br>All residents in the facility have the potential to be affected by alleged deficient practice<br><br>•Facility to continue to schedule | 06/30/2022 |

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| | Physician consult and administer treatment as ordered.<br><br>A Skin/Wound Note, dated 12/22/21 at 9:04 a.m., indicated upon assessment of the wound to the left sole of the foot, drainage was improving. No odor was noted. A significant amount of slough remained. The resident missed the wound clinic appointment on 12/21/21 due to transportation canceling. A message was left for the Physician to obtain an order for Santyl along with Calcium Alginate to aid in debridement of slough.<br><br>Nurses' Notes, dated 1/4/22 at 3:57 p.m., indicated the resident had returned from the wound clinic and new orders were noted.<br><br>Physician's Orders, dated 1/7/22, indicated the open area to the sole of the resident's left foot was to be cleansed three times weekly on Monday, Wednesday, and Friday with wound cleanser or normal saline. After patting dry, apply hydrofera blue (an antibacterial dressing) and cover with a dry dressing. The order was discontinued on 2/16/22.<br><br>The January 2022 Treatment Administration Record (TAR), indicated the treatment had not been signed out as ordered on 1/10, 1/12, 1/14, and 1/17/22.<br><br>The February 2022 TAR, indicated the treatment had not been signed out as ordered on 2/7 and 2/16/22.<br><br>A Social Service Progress Note, dated 1/11/22 at 1:57 p.m., indicated the resident's wife was notified that he missed his wound clinic appointment due to transportation issues. | | transport per Medicaid/insurance requirements and facility to utilize its own transportation van that is available for back up transportation<br>•Appointments for last 30 days reviewed and any missing or delayed appointments will be rescheduled as needed<br>•DON/Designee to review facility 24-hour report/progress notes/ vitals for last 30 days to ensure all residents with change of condition have had appropriate follow up completed<br>•TAR audit completed to determine any additional missing treatments for last 30 days<br>•Full house skin sweep completed<br><br>**3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br><br>•Licensed Staff educated on transportation of residents to appointments and back up transport with facility bus driver.<br>•IDT review of appointment and transportation communication system, appointments to be reviewed daily in AM stand up meeting.<br>•All Licensed nursing staff in-serviced Quality of Care and treatment with emphasis on documentation of completed nursing services such as signing | |

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| | Nurses' Notes, dated 1/25/22 at 2:58 p.m., indicated the resident did not attend wound clinic due to the Physician not being available.<br><br>Nurses' Notes, dated 2/1/22 at 11:24 a.m., indicated the resident's wound clinic appointment was rescheduled for 2/8/22 at 10:30 a.m. Transportation was scheduled and the resident was notified.<br><br>Nurses' Notes, dated 2/8/22 at 10:45 a.m., indicated the transportation company was outside waiting for the resident. The transportation company was informed the resident was a stretcher transport, they indicated they were canceling the transport because the resident was booked for a wheelchair transport. The resident and the Unit Manager were made aware. At 1:08 p.m., the wound clinic was contacted and the resident's appointment was rescheduled for the following week. The transportation company was contacted and informed the resident needed stretcher transport.<br><br>A Skin/Wound Note, dated 2/16/22 at 12:40 p.m., indicated the resident's Physician was notified regarding maceration to wound edges along with significant amount of slough to the wound bed. New orders were received to discontinue the current treatment. Treatment changed to start Santyl followed by Calcium Alginate and dry dressing daily and as needed. The resident was made aware of the new orders. The resident had been missing wound care visits due to transportation repeatedly sending accommodations for a wheelchair and not a stretcher. The resident was scheduled to go again the following Tuesday.<br><br>Nurses' Notes, dated 2/16/22 at 3:25 p.m., indicated the transportation company had been | | of EMAR/ETAR<br>•All Licensed nursing staff in serviced on utilizing PCC for EMAR/ETAR and utilizing reports to ensure that task are completed each shift<br>•All Licensed nursing staff in serviced on Change of Condition assessment and documentation<br>•IDT education on daily clinical meeting and 24-hour report review to ensure IDT is capturing and following up with outstanding clinical follow up<br><br>**4.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?**<br>•DNS/ designee will complete "Quality of Care related to Transportation to ensure residents attended appointments as ordered<br>•DNS/designee will complete Quality of Care related to Treatment Audit" to include monitoring of EMAR/ETAR<br>•DNS/designee will complete Quality of Care related to change of condition Audit to ensure all change of conditions have been identified and followed up appropriately<br>•Audits will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 months and then quarterly to | |

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| | notified multiple times between 2/15 and 2/16/22 in regards to them obtaining a letter of medical necessity for the use of a stretcher for his wound care appointment on 2/22/22. The transportation company stated they had not received it and to follow up tomorrow. The resident and Physician were made aware.<br><br>Nurses' Notes, dated 2/17/22 at 2:47 p.m., indicated the transportation company was not able to transport the resident due to insurance issues. A letter of medical necessity was sent to another transportation company.<br><br>Nurses' Notes, dated 2/22/22 at 10:32 a.m., indicated the resident was transported to the wound clinic.<br><br>Nurses' Notes, dated 2/23/22 at 1:29 a.m., indicated the resident had been admitted to the hospital with osteomyelitis.<br><br>Interview with the Director of Nursing (DON) on 5/26/22 at 4:34 p.m., indicated they were having transportation issues and the resident was missing wound clinic appointments.<br><br>Interview with the DON on 5/31/22 at 10:00 a.m., indicated the resident's treatments should have been completed as ordered. She also indicated the resident had been at the wound clinic on 1/4 and 2/22/22. There were no other wound clinic visits in between. 2. Resident 55's record was reviewed on 5/25/22 at 9:39 a.m. Diagnoses included, but were not limited to, respiratory failure, congestive heart failure, stroke, tracheostomy status, and Alzheimer's disease with late onset.<br><br>The Discharge Minimum Data Set (MDS) | | encompass all shifts until continued compliance is maintained for 2 consecutive quarters.<br>•The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | assessment, dated 5/11/22, indicated the resident was severely cognitively impaired.<br><br>A Nursing Progress Note, dated 3/30/22 at 3:25 p.m., indicated the resident presented with a copious amount of tracheal secretions, diminished lung sounds, and congestion. The Nurse Practitioner (NP) was notified and ordered a chest x-ray to rule out pneumonia.<br><br>A Nursing Progress Note, dated 4/1/22 at 12:42 p.m., indicated the resident was assessed by the NP, who noted a change in the resident's status. The resident was transported to the emergency room for evaluation.<br><br>The record lacked an indication of a follow up nursing assessment for change in condition completed between 3/30/22 and 4/1/22.<br><br>Interview with the Director of Nursing on 5/26/22 at 3:12 p.m., indicated she would expect staff to complete a follow up assessment with a change of status, but the record lacked documentation of any follow up assessment on 3/31/22.<br><br>3.1-37(a)<br>3.1-37(b) | | | |
| F 0685<br>SS=D<br>Bldg. 00 | 483.25(a)(1)(2)<br>Treatment/Devices to Maintain Hearing/Vision<br>§483.25(a) Vision and hearing<br>To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident-<br><br>§483.25(a)(1) In making appointments, and<br><br>§483.25(a)(2) By arranging for transportation | | | |

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| | to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.<br>Based on record review and interview, the facility failed to ensure residents with impaired vision received the necessary services related to following up with referrals to an Ophthalmologist and providing transportation to the consultation for 2 of 2 residents reviewed for vision. (Residents 60 and 78)<br><br>Findings include:<br><br>1. During an interview with Resident 60 on 5/24/22 at 1:45 p.m., he indicated he had ordered glasses a couple of years ago and they were not available. He indicated his vision was not good and was "foggy."<br><br>The record for Resident 60 was reviewed on 5/26/22 at 12:29 p.m. Diagnoses included, but were not limited to, heart failure, stroke, end stage renal disease, high blood pressure, hemiplegia, major depressive disorder, vascular dementia, muscle weakness, prostate cancer, anxiety disorder, and dependence on renal dialysis.<br><br>The Significant Change Minimum Data Set (MDS) assessment, dated 5/17/22, indicated the resident was moderately impaired for decision making. The resident was edentulous (no teeth) and his vision was impaired with no corrective lens.<br><br>A Care Plan, updated 5/2022, indicated the resident had impaired visual function related to resident complaints of decline in vision. The approaches were to schedule a visit with the eye doctor for a vision screening. | F 0685 | **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>•Resident #60 remains in the facility and resident #60 appointment to the ophthalmologist has been scheduled for 6/29/2022.<br>•Resident #78 remains in the facility and resident #78 went to his appointment on June 14, 2022<br><br>**2.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br><br>All residents in the facility have the potential to be affected by alleged deficient practice<br><br>•Audit completed to ensure that all residents with need for hearing/vision services have had appointments scheduled as ordered<br>•SSD/Designee will review hearing/vision notes to ensure that all follow up appointments and needs have been arranged and communicated to resident, staff, and families | 06/30/2022 |

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| | An Eye Exam Report, dated 12/17/21, indicated the resident was noted with cataracts to both eyes. Glaucoma was also suspected with borderline findings. The resident indicated he had "fogginess" for some time. The resident wanted to proceed with surgery and cataract surgery was recommended. Ophthalmology consult and follow up in 4-5 months. Referral: Ophthalmology Consult (Cataract) was written.<br><br>Nurses' Notes, dated 3/10/22 at 10:36 a.m., indicated the resident was unable to keep his eye doctor's appointment due to transportation. The appointment was rescheduled for May 31, 2022 at 12:45 p.m.<br><br>Nurses' Notes, dated 5/26/22 at 11:34 a.m., indicated the writer scheduled the resident for an appointment with ophthalmologist. He originally had an appointment scheduled for 5/31/22 at 12:45 p.m., however this was rescheduled due to this was a dialysis day. Appointment rescheduled for 5/29/22 at 10:45 a.m. Unit nurse was aware he will need an escort and transportation, appointment would be about 2 hours long.<br><br>Physician's Orders, dated 4/25/22, indicated may have Dental, Podiatry, Optometry, and Audiological evaluation and treatment as indicated.<br><br>Interview with the Social Service Director (SSD) on 5/27/22 at 3:00 p.m., indicated the resident went to the Ophthalmologist on 1/5/22 and had another appointment scheduled for 3/10/22, which was missed due to transportation issues and was rescheduled on 5/31/22, which was his dialysis day. The appointment was rescheduled for 6/29/22. | | **3.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>•Licensed nursing staff to be educated related to transportation of residents to appointments, appointments process and expectations to communicate with our driver or transportation companies and to assure that their appointment does not conflict with their other appointments for treatment.<br>•SSD/ IDT team will be educated on consult/ referral process and follow up to ensure that hearing/vision needs are met foe each resident<br><br>**4. 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?**<br>•DNS/ designee will complete an appointment audit form to ensure that residents transportation has been arranged and residents attend appointments as ordered<br>•SSD will complete Audit related to vision/ hearing services to ensure that all notes have been reviewed to ensure all referrals and appointments are made<br>•Audits will be completed daily x 5, weekly x 4 weeks, bi-monthly | |

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| | Interview with the Director of Nursing on 5/27/22 at 10:15 a.m., indicated the resident did not go to the eye doctor as originally scheduled on 3/10/22 due to transportation.<br><br>2. During an interview on 5/24/22 at 10:51 a.m., Resident 78 indicated he had glaucoma and was supposed to take eye drops, but he did not. He was observed at that time wearing prescription glasses.<br><br>The record for Resident 78 was reviewed on 5/25/22 at 2:30 p.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), type 2 diabetes, major depressive disorder, high blood pressure, blindness one eye, low vision in other eye, and glaucoma.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 5/5/22, indicated the resident was cognitively intact and his vision was adequate with glasses.<br><br>The Care Plan, updated 5/2022, indicated the resident had impaired visual function due to glaucoma and was at risk of further visual decline due to the disease process. He had reported being blind in the right eye and having impaired vision in the left eye. The approaches were to arrange consultation with eye care practitioner as required.<br><br>An Eye Exam Report, dated 12/17/21, indicated the resident had complaints about not receiving eye drops for glaucoma. The resident indicated he had not seen an Ophthalmologist in 3 plus years. An assessment indicated the resident had glaucoma in both eyes as well as cataracts. The | | for 2 months, monthly for 6 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters.<br>•The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | plan was for the resident to be referred to an Ophthalmologist for glaucoma. The referral was written and to follow up in 3 to 4 months.<br><br>Interview with the Social Service Director (SSD) on 5/26/22 at 11:15 a.m., indicated she was aware of the eye doctor's recommendation. At that time, she took the recommendation to the nurse and provided nursing with the phone numbers and the name of the eye doctor. It was up to nursing to make the appointment for the resident. At the time of the referral, the resident resided on Unit 3. The eye doctor came back in 4/2022, however, did not see the resident because he had not seen the Ophthalmologist yet. At that time, the recommendation was given to the nurse again, however, still no appointment was made.<br><br>3.1-39(a)(1)<br>3.1-39(a)(2) | | | |
| F 0688 SS=D Bldg. 00 | 483.25(c)(1)-(3)<br>Increase/Prevent Decrease in ROM/Mobility<br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility | | | |

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| | with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>Based on observation, record review, and interview, the facility failed to ensure a resident with a limited range of motion did not develop a contracture for 1 of 1 residents reviewed for limited range of motion. (Resident 43)<br><br>Finding includes:<br><br>During an interview with Resident 43 on 5/24/22 at 10:17 a.m., she indicated she was not able to open her right hand. She had not been able to use her right hand since her stroke years ago, however, now she also could not extend her fingers. She did not wear a hand splint.<br><br>The record for Resident 43 was reviewed on 5/25/22 at 1:50 p.m. Diagnoses included, but were not limited to, hemiplegia, stroke, high blood pressure, osteoporosis, anemia, liver disease, anxiety, and atrial fibrillation.<br><br>The Annual Minimum Data Set (MDS) assessment, dated 4/22/22, indicated the resident was cognitively intact and was totally dependent on staff with 1 person assist for bathing. The resident needed assistance with personal hygiene. She had a functional range of motion impairment to one side for her upper extremities.<br><br>There was no Care Plan for limited range of motion to the upper right extremity.<br><br>A Therapy Screen, dated 3/31/22, indicated no significant changes noted, not appropriate for skilled services.<br><br>A Therapy Screen, dated 4/21/22, indicated the | F 0688 | **1.What corrective actions will be accomplished for those residents found to be affected by the alleged deficient practice.**<br>•Resident 43 has been screened and is being seen by Therapy<br><br>**2.How will you identify other residents having the potential to be affected by deficient practice and what corrective action will be taken?**<br><br>All residents with limited range of motion to upper extremities have the potential to affected by the alleged deficient practice. Therapy will screen residents with high risk diagnosis/ risk factors including but not limited to CVA, Hemi therapy will screen 5 residents weekly and then continue quarterly and as needed screening process to capture potently changes<br><br>**3.What measures will be put in place or what systemic changes you will make to ensure that the alleged deficient does not recur**<br>•Nursing staff to be educated on nursing to therapy referral process Nurses will obtain orders from the MD and notify Therapy to screen resident related to changes in ADL | 06/30/2022 |

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| | resident had no changes at this time in ADL (activities of daily living) function.<br><br>Interview with COTA 1 on 5/26/22 at 10:20 a.m., indicated the resident had no complaints regarding her right hand. The resident's right hand was flaccid and a splint had not been indicated due to she was able to use it in repositioning herself and with other ADL care. When asked if she had seen or assessed the resident's right hand recently, she responded "No." The COTA was asked to assess the resident's right hand for a contracture.<br><br>A Therapy Screen, dated 5/26/22, indicated the right hand demonstrated early onset of hand/digits contracture with no complaints of pain and recommend occupational therapy services to address.<br><br>Interview with COTA 1 on 5/26/22 at 12:05 p.m., indicated she screened the resident for occupational therapy and the resident could not open her right hand. She had the start of contractures at her knuckles and when she tried to move them, she felt the tension as well. The resident told her she was no longer using her right hand for anything and it had been like this for the last couple of weeks. Nursing staff should advise therapy of any changes in range of motion or function ability of residents.<br><br>Interview with CNA 7 on 5/26/22 at 12:20 p.m., indicated for as long as she could remember, the resident's right hand had been like that. She opened it to wash it, but her fingers did not extend all the way.<br><br>Interview with RN 1 on 5/26/22 at 12:30 p.m., indicated the resident's right hand had been | | performance as necessary<br>•Nursing to therapy communication forms will be discussed in daily clinical meeting<br><br>**4.How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place?**<br>•DON/Designee to complete "ROM/Mobility" audit to ensure that all residents have been identified and therapy notified<br>•DON/Designee will audit daily x5 weeks, weeklyx4 weeks, bi-monthly for 2 months, monthly for 6 and quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters<br>•The results of these audits will be reviewed CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance | |

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| | contracted like that for "some time now" and she thought the resident used to wear a hand splint.<br><br>3.1-42(a)(2) | | | |
| F 0690<br>SS=D<br>Bldg. 00 | 483.25(e)(1)-(3)<br>Bowel/Bladder Incontinence, Catheter, UTI<br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and | | | |

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| | services to restore as much normal bowel function as possible.<br>Based on observation, record review, and interview, the facility failed to ensure catheter care was signed out as ordered for 1 of 1 residents reviewed for catheters. The facility also failed to ensure treatment was initiated timely for a resident with a urinary tract infection (UTI) related to obtaining a urinalysis and antibiotic use for 1 of 3 residents reviewed for urinary tract infections. (Residents 30 and 55)<br><br>Findings include:<br><br>1. On 5/25/22 at 9:50 a.m., Resident 30 was observed in his room in bed. His urinary catheter drainage bag was on the floor. The drainage bag was not covered with a dignity bag.<br><br>On 5/25/22 at 1:20 p.m., the resident was seated in his wheelchair in the doorway of the bathroom. His urinary catheter drainage bag was on the floor next to his wheelchair.<br><br>The record for Resident 30 was reviewed on 5/26/22 at 10:27 a.m. Diagnoses included, but were not limited to, neurogenic bladder, urinary retention, and dementia without behavior disturbance.<br><br>The Significant Change Minimum Data Set (MDS) assessment, dated 5/4/22, indicated the resident was moderately impaired for daily decision making and had an indwelling catheter in place. The resident had received antibiotics during the assessment reference period.<br><br>The Care Plan, dated 4/28/22, indicated the resident had a urinary catheter related to urinary retention secondary to the diagnosis of | F 0690 | **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>•Resident 30 drainage bag was replaced, and dignity bag provided. Physician orders were reviewed, and all appropriate Foley Catheter orders implemented including when to change the Foley catheter/ drainage system, resident did not have a negative outcome related to the alleged deficient practice<br>•Resident 55 completed all ordered doses of the IV antibiotic with no adverse effects, resident did not have a negative outcome related to the alleged deficient practice<br><br>**2.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents in the facility with Catheters have the potential to be affected by alleged deficient practice<br>•An Audit of residents with catheters to ensure that all residents have all appropriate tubing, dignity bags, appropriate Foley Catheter orders implemented including catheter care | 06/30/2022 |

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| | neurogenic bladder. Interventions included, but were not limited to, urinary catheter care every shift and as needed.<br><br>Physician's Orders, dated 4/28/22, indicated the resident was to have a 14 french/10 cubic centimeter (cc) bulb urinary catheter. Foley catheter care and output were to be recorded every shift.<br><br>Physician's Orders, dated 5/19/22, indicated the resident was receiving Cephalexin (an antibiotic) 500 milligrams (mg) four times a day for 7 days for a UTI.<br><br>Orders for catheter care were not listed on the April and May 2022 Medication Administration Records and Treatment Administration Records.<br><br>Interview with the 200 Unit Manager on 5/26/22 at 4:34 p.m., indicated the orders for catheter care should have been transcribed onto the treatment administration records.<br>2. Resident 55's record was reviewed on 5/25/22 at 9:39 a.m. Diagnoses included, but were not limited to, respiratory failure, congestive heart failure, stroke, tracheostomy status, and Alzheimer's disease with late onset.<br><br>The Discharge Minimum Data Set (MDS) assessment, dated 5/11/22, indicated the resident was severely cognitively impaired.<br><br>A Nursing Progress Note, dated 5/6/22 at 12:24 p.m., indicated the resident presented with a significant amount of hematuria (blood in the urine) and the nurse practitioner was notified. Orders were received to increase water flushes to 300 milliliters (ml) every 24 hours and give a one time bolus dose of 500 ml. Eliquis (an | | **3.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>•IDT/Nursing staff will be educated on Foley Catheter Maintenance Orders and care<br>•Nursing staff will be educated on orders r/t IV antibiotics<br>•IDT/clinical team educated on clinical meeting process with emphasis on new order review and follow up for initiation of Antibiotic orders<br>•IDT will review all new admissions in clinical meeting for catheters and ensure that all Foley Catheter Maintenance orders are implemented<br>•IDT will review all new MD orders in clinical meeting for new catheters and ensure that all Foley Catheter Maintenance orders are implemented<br>•IDT team will review all new IV orders and ensure that all orders are carried out properly.<br><br>**4. 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?**<br>•DON/ designee will complete the Catheter audit tool to ensure that all residents have necessary catheter orders | |

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| | anticoagulant medication) was placed on hold for 4 days, and labs including a comprehensive metabolic panel, complete blood count, urinalysis and culture and sensitivity were ordered for Monday 5/9/22.<br><br>Nurses' Notes, dated 5/9/22 at 6:42 a.m., indicated the lab arrived to the facility to draw blood and pick up the urine specimen.<br><br>Nurses' Notes, dated 5/9/22 at 1:56 p.m., indicated the lab results arrived regarding the blood draw and the resident had an elevated white blood cell count. There were no new orders received.<br><br>A Transfer Form, dated 5/11/22 at 9:00 a.m., indicated the resident was transferred to the emergency room for possible sepsis with abnormal urinalysis and shortness of breath.<br><br>Interview with the Assistant Director of Nursing (ADON) on 5/27/22 at 10:54 a.m., indicated the orders received were to hold the anticoagulant medication and monitor until labs drawn on 5/9/22. The labs were only picked up on Monday and Thursday unless they requested otherwise.<br><br>The resident returned to the facility on 5/15/22 at 8:48 p.m.<br><br>A Physician's Order, dated 5/16/22 at 11:19 a.m., indicated Meropenem (an antibiotic) 1 gram intravenous (IV) every 8 hours for 2 weeks.<br><br>The May 2022 Medication Administration Record (MAR) indicated the first dose of Meropenem was administered on 5/17/22 at 12:00 a.m. The Meropenem was not signed out as administered on 5/17/22 at 8:00 a.m. and 4:00 p.m. | | •DON/ designee will complete an IV audit tool to ensure that all residents have the necessary a IV orders and are initiated per MD orders<br>•DON/designee will complete audit tool related to Antibiotic orders to ensure that Antibiotic ordered are started timely<br>•Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters.<br>•The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | A Physician's Order, dated 5/16/22 at 10:04 a.m., indicated Vancomycin (an antibiotic) 750 milligrams (mg) IV two times a day for two weeks. The order was discontinued on 5/17/22 at 2:11 p.m.<br><br>The May 2022 MAR indicated the resident did not receive the 9:00 p.m. dose on 5/16/22 and the 9:00 a.m. dose on 5/17/22 due to the drug not being available.<br><br>A Physician's Order, dated 5/17/22 at 2:11 p.m., indicated Vancomycin 750 mg IV two times a day for two weeks. The order was discontinued on 5/20/22 at 12:28 p.m.<br><br>The May 2022 MAR indicated the resident did not receive the medication on 5/17/22 at 9:00 p.m. due to the drug not being available.<br><br>A Physician's Order, dated 5/20/22 at 12:28 p.m., indicated Vancomycin 1 gram IV two times a day for two weeks.<br><br>The May 2022 MAR indicated the resident did not receive the medication on 5/20/22 at 9:00 p.m. due to the drug not being available.<br><br>Interview with the ADON on 05/27/22 at 10:42 a.m., indicated the emergency drug kit (EDK) contained Vancomycin and Meropenem, however, the resident did not have an IV site upon admission. The resident did not have an IV site placed until 5/18/22.<br><br>3.1-41(a)(2) | | | |
| F 0692<br>SS=D<br>Bldg. 00 | 483.25(g)(1)-(3)<br>Nutrition/Hydration Status Maintenance<br>§483.25(g) Assisted nutrition and hydration. | | | |

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| | (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>§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;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>Based on observation, record review, and interview, the facility failed to consistently monitor food intake for at risk residents for 2 of 3 residents reviewed for nutrition. (Residents 14 and 60)<br><br>Findings include:<br><br>1. On 5/26/22 at 12:30 p.m., Resident 14 was observed in his room. At that time, he was served a chef salad, a magic cup, sandwich, and grapes. A CNA entered the room to feed him.<br><br>Interview with LPN 3 on 5/27/22 at 11:30 a.m., indicated the resident was required to be fed at all meals due to his decline.<br><br>The record for Resident 14 was reviewed on 5/25/22 at 4:00 p.m. Diagnoses included, but were | F 0692 | **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>•Residents 14 and 60 were not affected by alleged deficient practice<br>**2.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br><br>All residents in the facility have the potential to be affected by alleged deficient practice<br>•An Audit of all residents Food | 06/30/2022 |

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| | not limited to, deep vein thrombosis, Parkinson's, stroke, high blood pressure, dementia, major depressive disorder, and psychotic disorder.<br><br>The Significant Change Minimum Data Set (MDS) assessment, dated 3/7/22, indicated the resident was not cognitively intact and needed extensive assist with 2 person physical assist for personal hygiene. The resident weighed 209 pounds and had no weight loss or gain. He received a therapeutic diet and oxygen while a resident.<br><br>A Care Plan, updated 3/2022, indicated the resident had a nutritional problem and had some significant weight loss. The approaches were to monitor intake and record every meal.<br><br>The resident currently weighed 204 pounds on 5/10/22. His weight on 11/8/21 was 235 pounds and on 4/5/22 the resident weighed 196 which was a 13% weight loss in 6 months.<br><br>A Registered Dietitian's (RD) Note, dated 4/14/22 at 6:53 p.m., indicated the recommendation of adding the percentage of consumed meals to monitor acceptability closely.<br><br>The Food Consumption Log from 4/25/22 to 5/25/22 indicated there was no documentation from 4/25-5/14/22 for all meals. There was no documentation of breakfast on 5/15, 5/17, 5/20, and 5/23/22. There was no documentation of lunch on 5/15, 5/17, 5/20, and 5/23/22 and no documentation of dinner on 5/19-5/23/22.<br><br>Interview with CNA 7 on 5/27/22 at 11:20 a.m., indicated after a resident ate, they were to document their food consumption in the computer. | | consumption logs completed, monthly weights obtained and reviewed by IDT team and any residents with weight loss triggers will be followed by facility NAR program.<br><br>**3.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>•Nurses/CNAs will be educated on POC documentation related to food consumption<br>•Audit completed to ensure All staff present in the facility, including agency have POC login and have been educated on POC documentation process<br>•IDT team educated on clinical meeting process with emphasis on documentation follow up related to POC documentation<br><br>**4.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?**<br>•DNS/Designee to completed will audit food consumption documentation audit<br>•Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is | |

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| | Interview with LPN 3 on 5/27/22 at 11:23 a.m., indicated CNA's were to document how much food the resident consumed for meals in the computer. There were many agency CNA's who worked Unit 5 and for some reason they had not been able to get into the computer.<br><br>2. During an interview with Resident 60 on 5/24/22 at 1:43 p.m., he indicated the food was horrible and tasted bad. The resident's lunch tray was observed on his over bed table. He was served 2 hamburgers on buns. Both hamburgers were hard and extremely over cooked. The burgers could not be cut into 2 pieces.<br><br>The record for Resident 60 was reviewed on 5/26/22 12:29 p.m. Diagnoses included, but were not limited to, heart failure, stroke, end stage renal disease, high blood pressure, hemiplegia, major depressive disorder, vascular dementia, muscle weakness, prostate cancer, anxiety disorder, and dependence on renal dialysis.<br><br>The Significant Change Minimum Data Set (MDS) assessment, dated 5/17/22, indicated the resident was moderately impaired for decision making. The resident was edentulous (no teeth) and his vision was impaired with no corrective lens. The resident had no oral problems and weighed 146 pounds. He had a significant weight loss and received a therapeutic diet.<br><br>The resident weighed 168 pounds on 4/12/22 and on 5/10/22 he weighed 146 pounds.<br><br>Physician's Orders, dated 5/10/22, indicated hospice care.<br><br>The Food Consumption Log from 4/25/22 to 5/25/22, indicated there was no documentation | | maintained for 2 consecutive quarters.<br>•The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | from 4/25-5/14/22 for all meals. There was no documentation of breakfast on 5/15, 5/17, 5/20, and 5/23/22. There was no documentation of lunch on 5/15, 5/17, 5/20, and 5/23/22 and no documentation of dinner on 5/19-5/23/22.<br><br>Interview with CNA 7 on 5/27/22 at 11:20 a.m., indicated after a resident ate, they were to document their food consumption in the computer.<br><br>Interview with LPN 3 on 5/27/22 at 11:23 a.m., indicated CNA's were to document how much food the resident consumed for meals in the computer. There were many agency CNA's who worked Unit 5 and for some reason they had not been able to get into the computer.<br><br>The current 5/31/22 "Meal Service" policy, provided by the Director of Nursing on 5/31/22 at 2:20 p.m., indicated the refusal and percentage eaten would be documented by staff.<br><br>3.1-46(a)(1) | | | |
| F 0693 SS=D Bldg. 00 | 483.25(g)(4)(5)<br>Tube Feeding Mgmt/Restore Eating Skills<br>§483.25(g)(4)-(5) Enteral Nutrition (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-<br><br>§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and | | | |

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| | consented to by the resident; and<br><br>§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.<br>Based on record review and interview, the facility failed to ensure bolus feedings and residual checks were signed out as being completed for 1 of 1 residents reviewed for tube feeding. (Resident 34)<br><br>Finding includes:<br><br>The record for Resident 34 was reviewed on 5/26/22 at 3:28 p.m. Diagnoses included, but were not limited to, stroke, dysphagia (difficulty swallowing), and attention to gastrostomy (a tube inserted through the stomach for feeding purposes).<br><br>The 5 day Medicare Minimum Data Set (MDS) assessment, dated 5/12/22, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. He was dependent on staff for eating and had a feeding tube.<br><br>The Care Plan, dated 4/7/22, indicated the resident had a nutritional problem/potential nutritional problem related to NPO (nothing by mouth) diet with dependence on tube feed of Glucerna 1.5 and flushes as ordered to meet nutritional needs. The resident had significant weight loss x 30 days and was undesired. Interventions included, but were not limited to, provide tube feeding of Glucerna | F 0693 | **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>•Resident 34 did not have a negative outcome related to the alleged deficient practice<br><br>**2.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents in the facility with enteral tubes have the potential to be affected by alleged deficient practice**<br><br>•An Audit of residents with enteral tubes completed to ensure that all residents have all appropriate enteral orders and that residuals are being documented.<br><br>**3.What measures will be put into place or what systemic changes you will make to ensure that the deficient** | 06/30/2022 |

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| | 1.5 and flushes as ordered.<br><br>The Care Plan, dated 4/8/22, indicated the resident required a tube feeding related to dysphagia, NPO status, and history of aspiration pneumonia. Interventions included, but were not limited to, check for tube placement and gastric contents/residual volume per facility protocol and record. Hold feeding per physician orders of aspirate.<br><br>Physician's Orders, dated 5/5/22, indicated the resident was to receive Glucerna 1.2, 300 milliliters (ml) every 4 hours and residuals were to be checked and recorded each shift.<br><br>The April 2022 Medication Administration Record (MAR), indicated the resident's bolus feeding was not signed out as follows:<br><br>2:00 a.m.: 4/11 and 4/24/22<br><br>6:00 a.m.: 4/11, 4/18, and 4/24/22<br><br>10:00 a.m.: 4/8/22<br><br>2:00 p.m.: 4/8 and 4/16/22<br><br>6:00 p.m.: 4/8/22<br><br>10:00 p.m.: 4/4, 4/8, and 4/25/22<br><br>The May 2022 MAR indicated the resident's residual was not signed out as being checked on the day shift on 5/12, the evening shift on 5/11 and 5/12, and the night shift on 5/11/22.<br><br>The May 2022 MAR, indicated the resident's bolus feeding was not signed out as follows: | | **practice does not recur?**<br>•Licensed Nursing Staff will be educated on appropriate enteral feeding maintenance with emphasis on bolus feedings and residual documentation.<br>•Licensed Nursing Staff will be educated on EMAR compliance and documentation<br><br>**4.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?**<br>•DON/ Designee will complete the Enteral Feeding audit tool to ensure that all residents have necessary enteral orders, and that documentation is completed.<br>•Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters.<br>•The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | 2:00 a.m.: 5/12/22<br><br>6:00 a.m.: 5/12 and 5/16/22<br><br>10:00 a.m.: 5/12/22<br><br>2:00 p.m.: 5/11 and 5/12/22<br><br>6:00 p.m.: 5/11 and 5/12/22<br><br>10:00 p.m.: 5/11 and 5/12/22<br><br>Interview with the 200 Unit Manager on 5/31/22 at 11:30 a.m., indicated the bolus tube feeding, as well as checking for residual, should have been signed out as ordered.<br><br>3.1-44(a)(2) | | | |
| F 0695 SS=D Bldg. 00 | 483.25(i)<br>Respiratory/Tracheostomy Care and Suctioning<br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>Based on observation, record review, and interview, the facility failed to ensure oxygen was administered at the correct flow rate and oxygen tubing was dated for 3 of 3 residents reviewed for oxygen. (Residents 64, 14, and 1)<br><br>Findings include: | F 0695 | **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>•Residents 1, 14 and 64 did not have a negative outcome related to the alleged deficient practice | 06/30/2022 |

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| | 1. On 5/24/22 at 11:45 a.m., Resident 64 was observed in her room in bed. She was wearing oxygen by the way of a nasal cannula. Her oxygen concentrator was set at 2 1/2 liters.<br><br>On 5/25/22 at 9:20 a.m. and 1:26 p.m., the resident's oxygen concentrator was set at 2 1/2 liters. The resident was not wearing her oxygen at those times.<br><br>On 5/26/22 at 10:00 a.m. and 12:20 p.m., the resident was wearing her oxygen. The oxygen concentrator was set at 2 1/2 liters.<br><br>The record for Resident 64 was reviewed on 5/25/22 at 1:35 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), atrial fibrillation, and obstructive sleep apnea.<br><br>The Admission Minimum Data Set (MDS) assessment, dated 4/29/22, indicated the resident was cognitively intact for daily decision making and she received oxygen therapy.<br><br>The Care Plan, dated 4/22/22, indicated the resident had altered respiratory status/difficulty breathing related to COPD and sleep apnea. Interventions included, but were not limited to, administer oxygen per physician's order.<br><br>Physician's Orders, dated 4/22/22, indicated the resident was to receive 3 liters of oxygen via nasal cannula continuously every shift related to COPD.<br><br>Interview with the 200 Unit Manager on 5/26/22 at 4:34 p.m., indicated the resident's oxygen concentrator should have been set at 3 liters as ordered.<br>2. On 5/24/22 at 11:01 a.m., Resident 14 was | | •Resident 64 oxygen was set at the correct rate did and not have a negative outcome related to the alleged deficient practice<br>•Resident 14 oxygen tubing and humidification bottle were changed and dated correctly and resident did not have a negative outcome related to the alleged deficient practice<br>•Resident 1 oxygen flow rate was set at the correct rate, did not have a negative outcome related to the alleged deficient practice<br><br>**2.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br><br>All residents in the facility with oxygen / nebulizers have the potential to be affected by alleged deficient practice<br><br>•An Audit of residents with oxygen or use of nebulizers completed to ensure that all residents have all appropriate orders for routine changing of equipment and that all oxygen and nebulizer equipment is labeled and dates in residents' rooms. Audit completed to ensure that all residents with oxygen have flow rate set correctly per MD order.<br><br>**3.What measures will be put into place or what systemic** | |

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| | observed sitting in his wheelchair in his room. At that time, the oxygen tubing and water humidifier bottle on the oxygen tank was dated 5/14/22.<br><br>On 5/25/22 at 9:48 am., 1:24 p.m., and 3:05 p.m., the resident's oxygen tubing and water humidification bottle was dated 5/14/22. At those times, the water humidification bottle was empty.<br><br>The record for Resident 14 was reviewed on 5/25/22 at 4:00 p.m. Diagnoses included, but were not limited to, deep vein thrombosis, Parkinson's, stroke, high blood pressure, dementia, major depressive disorder, and psychotic disorder.<br><br>The Significant Change Minimum Data Set (MDS) assessment, dated 3/7/22, indicated the resident was not cognitively intact and needed extensive assist with 2 person physical assist for personal hygiene. He received a therapeutic diet and oxygen while a resident.<br><br>A Care Plan, updated on 3/2022, indicated the resident had oxygen therapy.<br><br>Physician's Orders, dated 2/28/22, indicated change and date oxygen tubing weekly on Friday on the 11-7 shift.<br><br>The Treatment Record for 5/2022, indicated the oxygen tubing was signed out as being changed on 5/20/22.<br><br>Interview with LPN 3 on 5/26/22 at 10:15 a.m., indicated she just changed the humidification bottle and the oxygen tubing today. The old bottle and tubing were dated 5/14/22.<br><br>Interview with the Director of Nursing on 5/26/22 at 10:15 a.m., indicated oxygen tubing and bottles | | **changes you will make to ensure that the deficient practice does not recur?**<br><br>•Licensed Nursing Staff were educated on appropriate necessary respiratory orders, following MD Orders related to o2 use, oxygen and nebulizer maintenance with emphasis on changing, labeling, and dating the equipment<br>•Angel Care Representatives educated on checking residents with oxygen or nebulizer equipment to ensure that labeling and dating is present during rounds<br>•DON/designee to conduct weekly rounds to ensure oxygen and nebulizer equipment is labeled and dated appropriately<br><br>**4.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?**<br><br>•DON/ designee will complete the Respiratory Equipment audit tool to ensure that all residents have necessary respiratory orders are in place and followed per MD Order, and that bags/ feeding is labeled appropriately<br>•Audit will be completed weekly x | |

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| | were to be changed weekly.3. On 5/24/22 at 10:42 a.m. and 5/27/22 at 9:29 a.m., Resident 1 was observed seated in his room with his oxygen on. The oxygen concentrator was set on 1.5 liters per minute (lpm). The humidification water bottle was dated 5/24/22 and oxygen tubing was dated 5/22/22.<br><br>The resident's record was reviewed on 5/27/22 at 8:57 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), thyroid disorder, anxiety, and schizophrenia.<br><br>A Physician's Order, dated 3/4/21, indicated to monitor oxygen saturation every shift. If oxygen saturation was under 93%, apply oxygen at 2 lpm and notify Physician.<br><br>Interview with the Assistant Director of Nursing (ADON) on 5/27/22 at 11:18 a.m., indicated the oxygen should have been set to the ordered rate of 2 lpm. She immediately sent in a nurse to assess the resident and correct the oxygen flow rate.<br><br>3.1-47(a)(6) | | 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters.<br>•The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |
| F 0698 SS=D Bldg. 00 | 483.25(l)<br>Dialysis<br>§483.25(l) Dialysis.<br>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.<br>Based on record review and interview, the facility failed to ensure transportation was provided for a resident receiving dialysis and the pre and post dialysis assessments were completed for 1 of 1 | F 0698 | **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient** | 06/30/2022 |

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| | residents reviewed for dialysis. (Resident 60)<br><br>Finding includes:<br><br>During an interview with Resident 60 on 5/24/22 at 1:43 p.m., he indicated there were times when he did not have transportation to take him to dialysis.<br><br>The record for Resident 60 was reviewed on 5/26/22 at 12:29 p.m. Diagnoses included, but were not limited to, heart failure, stroke, end stage renal disease, high blood pressure, hemiplegia, major depressive disorder, vascular dementia, muscle weakness, prostate cancer, anxiety disorder, and dependence on renal dialysis.<br><br>The Significant Change Minimum Data Set (MDS) assessment, dated 5/17/22, indicated the resident was moderately impaired for decision making. The resident received dialysis as a resident.<br><br>A Care Plan, updated 5/2022, indicated the resident received dialysis. The approaches were to complete pre and post dialysis assessments.<br><br>Nurses' Notes, dated 3/5/22 at 11:23 a.m., indicated the resident was unable to go for his dialysis treatment due to not having transportation.<br><br>Nurses' Notes, dated 4/26/2022 at 9:06 a.m., indicated the resident was unable to go for dialysis today due to him now being in a wheelchair and the transportation company was unable to transport him.<br><br>The Dialysis Sheets in the binder at the nurses' station indicated the pre dialysis forms to be completed by nursing staff prior to going were not completed on 4/5, 4/9, 4/12, 4/28, 4/30, 5/17, 5/19, 5/21, 5/24 and 5/26/22. | | **practice?**<br>•Resident 60s access site assessed with no abnormal findings, resident attending dialysis per MD orders. Resident did not have a negative outcome related to the alleged deficient practice<br>**2.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents in the facility that are receiving dialysis have the potential to be affected by alleged deficient practice<br>•An Audit of residents with dialysis completed to ensure that all residents have a dialysis binder in place with communication forms present.<br>•An Audit of residents with dialysis completed to ensure that all residents have pre/post dialysis monitoring orders in place<br>•A pre and post dialysis assessment has been added to the resident's MAR<br>•Transportation has been scheduled to accommodate the resident's wheelchair.<br>•DON/Designee spoke with dialysis center related to communication to ensure that communication expectations and requirements were reviewed and understood.<br>**3. What measures will be put into place or what systemic** | |

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| | Physician's Orders, dated 4/25/22, indicated complete dialysis pre assessment prior to leaving and post assessment upon returning, two times a day every Tuesday, Thursday, and Saturday.<br><br>There was no documentation of the pre and post dialysis assessments on the May 2022 Medication Administration Record.<br><br>Interview with the Director of Nursing on 5/27/22 at 10:15 a.m., indicated the resident did not go to dialysis on 3/5 and 4/26/22 due to no transportation. On 4/26/22, he did not go to dialysis due to being in a wheelchair and the transportation company could not accommodate him. The pre and post assessment was to be documented on the MAR before he left and when he returned.<br><br>3.1-37(a) | | **changes you will make to ensure that the deficient practice does not recur?**<br>•Licensed Nursing Staff will be educated on End Stage Renal Disease Care To include Pre and post -Dialysis: Nurse to complete the pre-dialysis evaluation before the resident leaves for dialysis, post-dialysis evaluation upon return from the dialysis center. Any abnormal or unusual occurrence resident reports while at dialysis center will be reviewed and reported to the physician if necessary. The care of the resident receiving dialysis services will include ongoing communication, coordination and collaboration between the dialysis center and the facility.<br>•Licensed Nursing Staff educated on transportation process and utilization of facility bus for back up transport if available<br><br>**4. 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?**<br>•DON/ designee will complete the Dialysis audit tool to ensure that all residents have necessary dialysis assessments and communication forms in place and transportation in place<br>•Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 | |

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| | | | months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters.<br>•The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |
| F 0728<br>SS=E<br>Bldg. 00 | 483.35(d)(1)-(3)<br>Facility Hiring and Use of Nurse Aide<br>§483.35(d) Requirement for facility hiring and use of nurse aides-<br>§483.35(d)(1) General rule.<br>A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless-<br>(i) That individual is competent to provide nursing and nursing related services; and<br>(ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or<br>(B) That individual has been deemed or determined competent as provided in §483.150(a) and (b).<br><br>§483.35(d)(2) Non-permanent employees.<br>A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section.<br><br>§483.35(d)(3) Minimum Competency | | | |

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| | A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual-<br>(i) Is a full-time employee in a State-approved training and competency evaluation program;<br>(ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or<br>(iii) Has been deemed or determined competent as provided in §483.150(a) and (b). | | | |
| | Based on record review and interview, the facility failed to ensure CNAs who were working in the facility were in good standing and had current certificates for 7 of 35 CNAs reviewed. (CNA 1, CNA 2, CNA 3, CNA 4, CNA 5, CNA 6, and CNA 7)<br><br>Findings include:<br><br>1. The Employee files were reviewed on 5/31/22 at 2:00 p.m. The following CNA certificates were reviewed:<br><br>a. CNA 3 hired on 4/10/03 had an expired CNA certificate dated 5/23/21. The last day worked was 5/31/22.<br><br>b. CNA 1 hired on 5/4/22 had an expired CNA certificate dated 5/28/22. The last day worked was 5/29/22.<br><br>c. CNA 7 hired on 4/25/16 had an expired CNA certificate dated 10/22/21. The last day worked was 5/27/22.<br><br>d. CNA 6 hired on 2/24/12 had an expired CNA certificate dated 3/31/22. The last day worked was | F 0728 | **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>•C N A # 3 no longer works as a C N A at the facility. Employee now works in Laundry.<br>•C N A #1 no longer works at the facility.<br>•C N A #7 AND # 6 no longer works at the facility.<br>•C N A # 5 now has an active certificate that expires 5/4/2024<br>•C N A # 2 no longer works as a C N A at the facility.<br>•C N A # 4 had to change her address on the P L A website and is now active.<br><br>**2.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents in the facility have the potential to be affected by | 06/30/2022 |

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| | 5/7/22.<br><br>e. CNA 5 hired on 7/29/20 had an expired CNA certificate dated 5/4/22. The last day worked was 5/30/22.<br><br>f. CNA 2 hired on 6/5/20 had an expired CNA Certificate dated 9/9/21. The last day worked was 5/31/22.<br><br>g. CNA 4 hired on 1/13/21 had a CNA certificate from the state of Nevada. There was no documentation the CNA had obtained a certificate from Indiana within 8 months of hire. The last day worked was 5/31/22.<br><br>Interview with the Human Resources Director on 5/31/22 at 3:30 p.m., indicated she was unaware the above employees had expired certificates. She indicated her date of hire was in 6/2021. She was unaware of the need to keep track of the expiration dates on the certificates.<br><br>Interview with the Director of Nursing on 5/31/22 at 3:40 p.m., indicated she was unaware the CNAs had expired certificates.<br><br>3.1-14(e) | | alleged deficient practice<br>•An audit of all licensed staff completed to ensure that all staff have active and valid licenses, any staff with invalid or inactive licenses removed from schedule immediately<br>•Licenses binder and tracking was implemented<br><br>**3.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>•HR Director educated on Licenses Verification Policy<br>•Licenses Binder/Tracking implemented<br>•New employees as they are hired their license/ certificate will be printed out to put in the license binder, their name will be added to the spread sheet.<br>•License binder/ tracking must be maintained. HR Director, or other designee must maintain tracking and review at minimum, monthly to ensure that all applicable employees have appropriate license or certifications that remain current, in good standing and up to date.<br>•HR Director, or designee will notify staff if licenses is nearing expiration. Licensed/Certified staff responsible to renew license, submit all required CUEs etc. | |

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| | | | **4.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?**<br>•Human resources / designee to complete Licenses Verification Audit to ensure that all applicable employees have appropriate license or certifications that remain current, in good standing and up to date.<br>•Audit will be completed weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters.<br>•The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |
| F 0757<br>SS=D<br>Bldg. 00 | 483.45(d)(1)-(6)<br>Drug Regimen is Free from Unnecessary Drugs<br>§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-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or | | | |

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| | §483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br>Based on record review and interview, the facility failed to ensure cardiac medications were held per parameters, blood sugar levels were obtained prior to administering insulin, and medications were signed out as ordered for 4 of 5 residents reviewed for unnecessary medications. (Residents 64, 78, 1, and 9)<br><br>Findings include:<br><br>1. The record for Resident 64 was reviewed on 5/25/22 at 1:35 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), atrial fibrillation, and obstructive sleep apnea.<br><br>The Admission Minimum Data Set (MDS) assessment, dated 4/29/22, indicated the resident was cognitively intact for daily decision making and she received oxygen therapy.<br><br>Physician's Orders, dated 4/22/22, indicated the resident was to receive Amiodarone HCl (a heart medication) 200 milligrams (mg) one time daily for atrial fibrillation (an irregular heartbeat). The medication was to be held if the resident's systolic | F 0757 | **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>•Residents 64, 78,1 and 9 did not have a negative outcome related to the alleged deficient practice.<br><br>**2.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents in the facility have the potential to be affected by alleged deficient practice<br>•Audit of EMAR compliance to be reviewed for last 60 days, MD to be notified of audit results.<br>•Facility to complete audit of all residents reviewing MD orders with, facility will audit 20 Residents weekly x 4 and 5 residents weekly until 100% of Resident orders reviewed to | 06/30/2022 |

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| | (top number) blood pressure was less than 110 and her heart rate was less than 60.<br><br>The April 2022 Medication Administration Record (MAR), indicated the resident's heart rate was below 60 and the medication was administered on the following dates:<br>-4/23 heart rate 56<br>-4/28 heart rate 51<br>-4/29 heart rate 51<br>-4/30 heart rate 55<br><br>The May 2022 MAR, indicated the resident's heart rate was below 60 and the medication was administered on the following dates:<br>-5/1 heart rate 58<br>-5/8 heart rate 58<br>-no documentation on 5/12<br>-5/14 heart rate 52<br>-5/15 heart rate 55<br>-5/16 heart rate 52<br>-5/17 heart rate 52<br><br>On 5/23/22, the resident's blood pressure was 105/63 and the Amiodarone was administered.<br><br>Interview with the 200 Unit Manager on 5/26/22 at 4:34 p.m., indicated the resident's Amiodarone should have been held as ordered. 2. The record for Resident 78 was reviewed on 5/25/22 at 2:30 p.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), type 2 diabetes, major depressive disorder, high blood pressure, blindness one eye, low vision in other eye, and glaucoma.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 5/5/22, indicated the resident was cognitively intact. | | ensure parameters are in place as ordered.<br>•IDT team will review EMAR compliance report in daily clinical meeting to identify any late or missed medication administrations.<br><br>**3.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>•Licensed Nursing Staff will be educated on Medication Administration policy with emphasis MD orders, insulin administration, correct time and completing documentation on the MARs and following hold parameters as ordered<br>•Clinical IDT team educated on clinical morning meeting and reviewing EMAR reports daily<br><br>**4.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?**<br>•DON/ designee will complete the Medication Administration audit tool to ensure that residents are receiving medication appropriately<br>•Facility to complete audit of all residents reviewing MD orders with, facility will audit 20 | |

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| | Physician's Orders, dated 2/20/20, indicated Novolog insulin. Inject as per sliding scale: if 0 - 150 = 0, 151 - 200 = 5 units; 201 - 250 = 7 units; 251 - 300 = 9 units; 301-350 = 11 units, 351-400 = 13 units, subcutaneously three times a day.<br><br>Physician's Orders, dated 4/29/22, indicated Insulin Glargine Solution 100 units, inject 10 units subcutaneously one time a day for diabetes. The scheduled time was 9:00 p.m.<br><br>The Medication Administration Record (MAR) for 5/2022, indicated the 5:00 p.m. insulin was signed out as being administered on:<br>5/3 at 6:47 p.m.<br>5/4 at 6:59 p.m.<br>5/5 at 7:36 p.m.<br>5/6 at 9:45 p.m.<br>5/7 at 9:50 p.m.<br>5/8 at 8:22 p.m.<br>5/10 at 9:48 p.m.<br>5/11 blank<br>5/12 blank<br>5/13 at 7:26 p.m.<br>5/14 at 7:02 p.m.<br>5/15 at 8:09 p.m.<br>5/16 at 7:31 p.m.<br>5/17 at 8:03 p.m.<br>5/19 7:10 p.m.<br>5/20 blank<br>5/21 8:01 p.m.<br>5/22 7:02 p.m.<br>5/24 11:09 p.m.<br>5/25 7:32 p.m.<br><br>The 5/2022 MAR, indicated the Glargine insulin was administered at 9:00 p.m., however, there was no documentation of a blood sugar level being checked before the administration of the insulin. | | Residents weekly x 4 and 5 residents weekly until 100% of Resident orders reviewed.<br>•IDT team will review EMAR compliance report in daily clinical meeting to identify any late or missed medication administrations.<br>•The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | Interview with the Director of Nursing on 5/27/22 at 9:10 a.m., indicated the Novolog insulin was to be administered as ordered by the doctor. The nursing staff were to obtain the resident's blood sugar before the administration of insulin.3. Interview with Resident 1 on 5/24/22 at 10:44 a.m., indicated he did not get his medications as ordered.<br><br>Resident 1's record was reviewed on 5/27/22 at 8:57 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), thyroid disorder, anxiety, and schizophrenia.<br><br>The Annual Minimum Data Set (MDS) assessment, dated 3/9/22, indicated the resident was cognitively intact.<br><br>The Physician's Order, dated 4/2/21, indicated levothyroxine sodium (treatment for an underactive thyroid gland) 125 microgram (MCG) by mouth one time a day.<br><br>The May 2022 Medication Administration Record (MAR), lacked an indication the levothyroxine tablet was signed out as administered at 6:00 a.m. on 5/12, 5/13, and 5/14/22.<br><br>Interview with the Assistant Director of Nursing (ADON) on 5/27/22 at 2:07 p.m., indicated the medications were not administered as ordered per the record.<br><br>4. Resident 9's record was reviewed on 5/27/22 at 2:26 p.m. Diagnoses included, but were not limited to, end stage renal disease, heart failure, high blood pressure, and non-Alzheimer's disease.<br><br>The Quarterly Minimum Data Set (MDS) | | | |

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| | assessment, dated 5/9/22, indicated the resident was moderately cognitively impaired.<br><br>The Physician's Order, dated 5/2/22, indicated methimazole (treat excess thyroid hormone) 5 milligram (mg) tablet by mouth one time a day.<br><br>The May 2022 Medication Administration Record (MAR), indicated the methimazole tablet was not signed out as administered at 6:00 a.m. on 5/7, 5/8, 5/9, 5/10, 5/12, 5/13, and 5/14/22.<br><br>Interview with the Assistant Director of Nursing on 5/27/22 at 2:03 p.m., indicated she had no further documentation to indicate the medications were administered.<br><br>3.1-48(a)(3) | | | |
| F 0758 SS=D Bldg. 00 | 483.45(c)(3)(e)(1)-(5)<br>Free from Unnec Psychotropic Meds/PRN Use<br>§483.45(e) Psychotropic Drugs.<br>§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:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§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 | | | |

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| | documented in the clinical record;<br><br>§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;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§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.<br><br>§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.<br>Based on record review and interview, the facility failed to ensure prn (as needed) anti-anxiety medications were not ordered beyond 14 days for 1 of 5 residents reviewed for unnecessary medications. (Resident 60)<br><br>Finding includes:<br><br>The record for Resident 60 was reviewed on 5/26/22 at 12:29 p.m. Diagnoses included, but were not limited to, heart failure, stroke, end stage | F 0758 | **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>•Resident 60 did not have a negative outcome related to the alleged deficient practice and medication was reviewed with hospice provider | 06/30/2022 |

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| | renal disease, high blood pressure, hemiplegia, major depressive disorder, vascular dementia, muscle weakness, prostate cancer, anxiety disorder, and dependence on renal dialysis.<br><br>The Significant Change Minimum Data Set (MDS) assessment, dated 5/17/22, indicated the resident was moderately impaired for decision making. The resident received dialysis as a resident and in the last 7 days he received an anti-anxiety medication 1 time.<br><br>A Care Plan, updated 5/2022, indicated the resident was prescribed anti-anxiety medications.<br><br>Physician's Orders, dated 1/27/22, indicated Xanax (an anti-anxiety medication) 0.25 milligrams (mg). Give 0.25 mg by mouth every 8 hours as needed for anxiety/restlessness. The medication was discontinued on 4/22/22.<br><br>Physician's Orders, dated 4/25/22, indicated Xanax 0.5 mg. Give 0.5 mg by mouth every 8 hours as needed at night prn for sleep.<br><br>The 2/2022 Medication Administration Record (MAR), indicated the resident received the Xanax on 2/12 and 2/27/22. The 4/2022 MAR, indicated he received the Xanax on 4/27/22 and the 5/2022 MAR, indicated he received the Xanax on 5/2/22.<br><br>Interview with the Director of Nursing on 5/31/22 at 1:30 p.m., indicated prn psychotropic medication was only to be ordered for 14 days.<br><br>3.1-48(a)(2) | | •Resident 60 had PRN medication discontinued and resident received an order for a scheduled medication to aide in sleep<br><br>**2.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br><br>All residents on psychotropic medications for PRN use in the facility have the potential to be affected by alleged deficient practice<br><br>•Facility to complete audit of all residents on psychotropic medications for PRN use and required follow up to be completed with MD as necessary<br><br>**3.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br><br>•IDT team to be educated on daily clinical meeting process and daily order reviews<br>•IDT team review orders daily on AM clinical meeting to ensure that any new PRN medication orders receive appropriate IDT follow up<br>•Licenses nursing staff educated on PRN psychotropic orders. Policy and procedure | |

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| | | | **4.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?**<br><br>•SSD/ designee will complete the Unnecessary Psychotropic audit tool to ensure that residents are receiving anti- psychotic medications appropriately<br>•Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters.<br>•The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |
| F 0761<br>SS=D<br>Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§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.<br><br>§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.<br>Based on observation and interview, the facility failed to ensure emergency drug kits were secured after opening for 1 of 2 medication rooms observed. (300 Unit Medication Room)<br><br>Finding includes:<br><br>On 5/31/22 at 1:19 p.m., two emergency drug kits (EDK) were stacked on top of each other and observed on top of a portable closet in the 300 Unit Nurses' Station/Medication Room.<br><br>Both EDK boxes had been opened and they were not locked at the time of the observation.<br><br>Interview with RN 1 at that time, indicated one of the EDK boxes had been opened that morning. She was not aware when the other box was opened. She proceeded to take 2 zip ties out of the EDK box and secure both kits.<br><br>Interview with the Director of Nursing on 5/31/22 at 3:47 p.m., indicated the EDK boxes should have been secured after opening. | F 0761 | **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>Emergency drug kits were secured, No Residents effected related to the alleged deficient practice<br><br>**2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br><br>All residents in the facility have the potential to be affected by alleged deficient practice<br>-Facility audited all EDK to ensure that they are all secured after opening<br><br>**3.What measures will be put** | 06/30/2022 |

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| | 3.1-25(m) | | **into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br><br>•Licensed Nursing Staff were educated on Medication Storage with emphasis on emergency kit securement<br><br>**4.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?**<br><br>•DON/ designee will complete medication storage audits to ensure compliance.<br>•Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters.<br>•The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |
| F 0791<br>SS=D<br>Bldg. 00 | 483.55(b)(1)-(5)<br>Routine/Emergency Dental Srvcs in NFs<br>§483.55 Dental Services<br>The facility must assist residents in obtaining routine and 24-hour emergency dental care. | | | |

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| | §483.55(b) Nursing Facilities.<br>The facility-<br><br>§483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident:<br>(i) Routine dental services (to the extent covered under the State plan); and<br>(ii) Emergency dental services;<br><br>§483.55(b)(2) Must, if necessary or if requested, assist the resident-<br>(i) In making appointments; and<br>(ii) By arranging for transportation to and from the dental services locations;<br><br>§483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;<br><br>§483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and<br><br>§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. | | | |

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| | Based on record review and interview, the facility failed to provide dental services to a resident requesting dentures for 1 of 1 residents reviewed for dental care. (Resident 60)<br><br>Finding includes:<br><br>During an interview with Resident 60 on 5/24/22 at 1:41 p.m., he indicated he had no teeth, and a couple of years ago he ordered dentures, but they were not available yet.<br><br>The record for Resident 60 was reviewed on 5/26/22 at 12:29 p.m. Diagnoses included, but were not limited to, heart failure, stroke, end stage renal disease, high blood pressure, hemiplegia, major depressive disorder, vascular dementia, muscle weakness, prostate cancer, anxiety disorder, and dependence on renal dialysis.<br><br>The Significant Change Minimum Data Set (MDS) assessment, dated 5/17/22, indicated the resident was moderately impaired for decision making. The resident was edentulous (no teeth). The resident had no oral problem and weighed 146 pounds. He had a significant weight loss and received a therapeutic diet.<br><br>A Care Plan, updated 5/2022, indicated the resident had oral/dental problems.<br><br>A Dental Visit Report, dated 12/30/19, indicated the resident had been edentulous for greater than 3 years and was requesting dentures. The plan was to follow up in 1 to 2 weeks for impressions.<br><br>A Dental Visit Report, dated 2/19/20, indicated impressions were completed for dentures.<br><br>During March 2020, no outside dentists were | F 0791 | **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>· Resident # 60 remains in the facility. The resident's guardian was called to explain that his client wants to see the dentist to be able to get impressions for dentures and to gave authorization for services. The dentist was called to be able to put resident #60 to be seen<br>**2.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br><br>· All residents have the potential to be affected by the alleged deficient practice.<br>•Audit completed to ensure that all residents with need for dental services have received appropriate follow up<br><br>**3.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br><br>SSD/ IDT team will be educated on consult/ referral process for dental care and follow up to ensure that dental are met foe each resident | 06/30/2022 |

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| | allowed in the facility due to COVID-19.<br><br>The next documented dental visit was on 8/30/21, which indicated the resident was not seen due to being at dialysis.<br><br>Physician's Orders, dated 4/25/22, indicated may have Dental, Podiatry, Optometry, and Audiological evaluation and treatment as indicated.<br><br>Interview with the Social Service Director (SSD) on 5/27/22 at 9:15 a.m., indicated she was in contact with the dental facility and they indicated the resident' guardian had canceled the insurance policy for the dentist. The old dental agency had "folded" during COVID-19 and did not provide any information or follow up for the residents who had been seen by them. The new dental agency saw residents in 2021 and they had been coming to facility every 2 to 3 months.<br><br>Interview with the SSD on 5/31/22 at 2:30 p.m., indicated she contacted the new dental company and they indicated they attempted to see the resident on 8/30/2021, however, he was at dialysis. She indicated the dentist told her they did not see the resident on 10/7/21 due to he was not authorized to see the dentist. She had no idea he had to be authorized by the dentist in order to seen. She interviewed the resident and explained what had happened to his dental impressions and he still wanted dentures.<br><br>3.1-24(a)(1) | | **4.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?**<br>•SSD will complete Audit related to dental services to ensure that all notes have been reviewed to ensure all referrals, follow up and appointments are made<br>•Audits will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters.<br>•The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |
| F 0804<br>SS=D<br>Bldg. 00 | 483.60(d)(1)(2)<br>Nutritive Value/Appear, Palatable/Prefer Temp<br>§483.60(d) Food and drink | | | |

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| | Each resident receives and the facility provides-<br><br>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;<br><br>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.<br>Based on observation and interview, the facility failed to serve food that was palatable and attractive for 1 of 4 residents reviewed for food quality. (Resident 60)<br><br>Finding includes:<br><br>During an interview with Resident 60 on 5/24/22 at 1:43 p.m., he indicated the food was horrible and tasted bad. The resident's lunch tray was observed on his over bed table. He was served 2 hamburgers on buns. Both hamburgers were hard and extremely over cooked. The burgers could not be cut into 2 pieces. The burgers were taken to the Administrator to observe. He took the plate and went to the kitchen. The resident was served 2 new hamburgers.<br><br>The record for Resident 60 was reviewed on 5/26/22 at 12:29 p.m. Diagnoses included, but were not limited to, heart failure, stroke, end stage renal disease, high blood pressure, hemiplegia, major depressive disorder, vascular dementia, muscle weakness, prostate cancer, anxiety disorder, and dependence on renal dialysis.<br><br>The Significant Change Minimum Data Set (MDS) assessment, dated 5/17/22, indicated the resident was moderately impaired for decision making. The resident was edentulous (no teeth) and his vision | F 0804 | **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>Resident # 60 was offered food that was palatable and attractive. Resident #60 was given two new Hamburgers with lettuce and tomatoes.<br><br>**2.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br><br>All residents residing at the facility have the potential to be affected by the alleged deficient practice.<br><br>•Food Committee meeting will be held to identify any resident concerns on or before 6/24/2022<br>•DM/designee will conduct skills validations with all dietary staff on following recipes, and proper temping<br>•Dietary staff educated on food | 06/30/2022 |

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| | was impaired with no corrective lens. The resident had no oral problem and weighed a 146 pounds. He had a significant weight loss and received a therapeutic diet.<br><br>The resident weighed 168 pounds on 4/12/22 and on 5/10/22 he weighed 146 pounds.<br><br>Physician's Orders, dated 5/10/22, indicated hospice care.<br><br>Interview with the Dietary Food Manager on 5/31/22 at 11:00 a.m., indicated she was aware the Administrator brought back the hamburgers that were served to the resident. The hamburgers were unacceptable and she would not have eaten them. She had a talk with cook after the incident.<br><br>3.1-21(a)(2) | | presentation, palatable and attractiveness being ensured before<br><br>**3.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>•Dietary staff were educated on appropriate food temperatures, food attentiveness and following recipes<br>•Food will be served that is palatable and at the appropriate temperature.<br>•Food Committee will be hosted 1x monthly to ensure residents satisfaction.<br><br>**4.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?**<br><br>•DM/Designee will complete a Recipe Compliance audit tool and Test Tray audit tool to ensure that food served is palatable and attractive<br>•Audits will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. | |

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| | | | •The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |
| F 0812<br>SS=D<br>Bldg. 00 | 483.60(i)(1)(2)<br>Food<br>Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>Based on observation and interview, the facility failed to ensure food was served and stored under sanitary conditions related to dirty food equipment, vents, and shelves for 1 of 1 kitchens. (The Main Kitchen)<br><br>Findings include: | F 0812 | **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>•The vent above the steam table | 06/30/2022 |

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| | 1. During the Kitchen sanitation tour on 5/31/22 with the Dietary Food Manager (DFM), the following was observed:<br><br>a. The vent above the steam table had a large accumulation of dust and dirt noted.<br><br>b. The sides of the oven and deep fryer had a heavy accumulation of grease noted.<br><br>c. The shelves below the food prep sink and the steam table were dirty with dry food or beverage stains. Both shelves housed clean pots and pans.<br><br>d. The shelf where the microwave was observed was dirty.<br><br>Interview with the DFM on 5/31/22 at 11:15 a.m., indicated the above was in need of cleaning.<br><br>3.1-21(i)(3) | | has been cleaned of the dust and dirt.<br>•The grease on the sides of the oven and deep fryer have been cleaned.<br>•The dirt and stain on the shelves below the food prep sink and the steam table have been cleaned.<br>•The shelf where the microwave is has been cleaned.<br><br>**2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents have the potential to be affected by the alleged deficient practice.<br>•Dietary staff were provided immediate education on cleaning schedule on areas to be cleaned, and the importance of a safe and clean work environment.<br>•Deep clean of kitchen completed<br><br>**3.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>•RD/DM/Designee will complete in-service of all dietary staff on cleaning schedule, on areas to be to cleaned, cleaning schedule and a clean work environment.<br>•DM/Designee to complete observational rounds related to kitchen sanitization. | |

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| | | | **4. 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?**<br>·DM or designee will utilize the Kitchen Sanitization QAPI tool to ensure compliance<br>·Audit to be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters.<br>·The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed. | |
| F 0880<br>SS=E<br>Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: | | | |

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| | §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident | | | |

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| | contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>Based on random observations, 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 masks not worn correctly and not wearing the correct personal protective equipment in isolation rooms for 1 of 1 residents observed for intravenous (IV) medication administration, 1 of 1 residents reviewed for tracheostomy care, and 1 of 2 treatments observed. (Residents 55 and 138)<br><br>Findings include:<br><br>1. On 5/27/22 at 9:26 a.m., the Assistant Director of Nursing (ADON) was observed donning personal protective equipment (PPE) prior to entering Resident 55's room for medication administration. The ADON donned a gown, gloves, and a face shield. She was already wearing an N95 mask. The signage on the door to the resident's room, indicated she was in contact/droplet precautions. | F 0880 | F 880<br>The Remedy of a Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424 effective June 23, 2022. The DPOC and any supporting documentation should be submitted to ltcproviderservices@isdh.in.gov. South Shore Health & Rehabilitation Center must include the following as part of the submitted POC for the deficient practice cited at F880:<br><br>Specific/Immediate: Immediately implement specific plan for resident/residents/area/others identified in the deficiency to correct.<br><br>1). The Director of Nursing (DON), Infection Preventionist (IP) or Designee will educate the facility | 06/30/2022 |

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| | After connecting the resident's IV medication, the ADON proceeded to remove her gown, gloves, and face shield. She washed her hands using soap and water and exited the room. The ADON did not remove her N95 mask after leaving the room.<br><br>At 11:20 a.m., the ADON was donning PPE prior to entering the resident's room to disconnect the IV medication. She donned a gown, gloves, and face shield. She was already wearing an N95 mask.<br><br>After disconnecting the resident's IV medication, the ADON proceeded to remove her gown, gloves, and face shield. She washed her hands using soap and water and exited the room. The ADON did not remove her N95 mask after leaving the room.<br><br>Interview with the Infection Preventionist (IP) on 5/31/22 at 1:07 p.m., indicated the N95 mask should have been discarded after leaving the room and a clean surgical or N95 mask was to be worn.<br><br>2. During a random observation, on 5/27/22 at 10:20 a.m., CNA 2 was observed removing his N95 mask after exiting a resident room. The CNA was wearing a surgical mask underneath his N95 mask.<br><br>3. During a random observation, on 5/31/22 at 11:53 a.m., the Dietary Food Manager (DFM) entered Resident 138's room to deliver his lunch tray. LPN 1 also entered the room at that time. The signage on the door indicated the resident was in contact/droplet isolation.<br><br>Neither staff member donned any PPE prior to entering the resident's room. | | staff on how to complete proper infection control practices related to:<br>¿ How and when to don and doff PPE with return demonstration, including, but not limited to, mask, respirator devices, gloves, gown, and eye protection. Follow CDC and facility policy.<br>¿ Infection control practices regarding wound care, including, but not limited to dressing changes.<br>¿ The need to maintain face covering over the mouth and nose, as well as the appropriate covering to be used, at all times when in use.<br>¿ Infection control practices during medication administration to prevent possible contamination of medication.<br>¿ The correct procedure for tracheostomy care.<br>¿ The proper care of a Peripherally Inserted Central Catheter (PICC) and any intravenous access devices.<br>For this education and return demonstration, the following resources will be used:<br><br>• Facility Policy- Use of PPE<br>• Facility Policy PPE Donning and Doffing PPE<br>• CDC guidance Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) | |

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| | 4. During a random observation, on 5/31/22 at 12:05 p.m., LPN 1 was observed in the doorway of a contact/droplet isolation room. The LPN was removing his N95 mask at that time, he was wearing a surgical mask underneath his N95 mask.<br><br>Interview with the LPN at that time, indicated he was not aware he couldn't wear his N95 mask over his surgical mask.<br><br>Interview with the Infection Preventionist on 5/31/22 at 1:07 p.m., indicated the LPN should not have put an N95 over his surgical mask and he and the DFM should have worn PPE when entering the isolation room.5. On 5/27/22 at 11:39 a.m., wound care was observed for Resident 55. The Wound Nurse and CNA 8 both applied hand sanitizer, donned a gown, an N95 mask was placed over their surgical masks, and a face shield was worn before entering the contact/aerosol precautions room. The two staff members went to the restroom to wash their hands with soap and water and then donned gloves. The wound care was performed. The Wound Nurse and CNA 8 doffed the gown, gloves, face shield, and N95 mask and washed their hands with soap and water before exiting the room. Both staff members left the surgical mask on as they exited.<br><br>Interview with the ADON on 5/27/22 at 12:20 p.m., indicated the two staff members were incorrect in wearing the surgical mask underneath the N95 as it did not create the proper seal. She would be providing them education.<br><br>6. On 5/27/22 at 11:50 a.m., tracheostomy care was observed for Resident 55. The Assistant Director of Nursing (ADON) applied hand sanitizer, donned a gown, N95 mask, eye protection, and entered the contact/droplet precautions room. The | | • CDC guidance SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)<br>• CDC Education- Understanding the Difference Surgical VS N95 Respirator<br>• Facility policy- Wound Care/ Treatment Change<br>• CDC Education- Facemask Do's and Don'ts<br>• Facility Policy- Medication Administration<br>• Facility Policy- Tracheostomy Care<br>• Facility Policy- PICC Management/ IV Care<br><br>2). The DON, IP or Designee will ensure all staff involved are educated on infection control practices regarding but not limited to, wound care, PPE use, Use of Face mask/n95, Tracheostomy Care, Medication Pass, PICC/IV care . The DON, IP, or designated facility leadership will conduct facility rounds at a minimum of daily to ensure Infection Control practices are being followed related to PPE use, appropriate Mask/n95 use, during treatments, med pass and PICC/IV care. The DON, IP or designated facility leadership will enforce corrective measures and education if deficiencies are observed. | |

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| | ADON entered the restroom, washed her hands with soap and water, and donned gloves. The ADON performed and completed the tracheostomy care. She doffed the gown, gloves, and eye protection and washed her hands with soap and water. The ADON did not remove the N95 mask upon exiting the room.<br><br>Interview with the ADON on 5/27/22 at 12:20 p.m., indicated she was unsure how she was supposed to remove the N95 mask without exposing herself to the isolation room, so she kept it on upon exiting the room.<br><br>CDC website guidance from "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," last updated on 2/2/2022, indicated, "Source control options for HCP include: a NIOSH-approved N95 or equivalent or higher-level respirator ... If they are used during the care of patient for which a NIOSH-approved respirator or facemask is indicated for personal protective equipment (PPE) during the care of a patient with SARS-CoV-2 infection, facemask during a surgical procedure or during care of a patient on Droplet Precautions, they should be removed and discarded after the patient care encounter and a new one should be donned."<br><br>3.1-18(b) | | A. Systemic<br><br>1). A root cause analysis (RCA) was conducted by the Infection Preventionist (IP), with input and review from the Medical Director, Executive Director, Director of Nursing, Unit Manager and VP of Clinical Operations to determine the root cause resulting in the facilities Infection Control citation.<br>• Through staff interviews, it was determined that ADON did not understand the policy related to PPE use and discarding n95 mask appropriately<br>• Through staff interviews, it was determined that CNA 2 and LPN 1 did not understand appropriate use of N95 and Surgical mask.<br>• Through staff interviews, it was determined that Dietary Food Manager and LPN 1 failed to follow isolation signage prior to entering room.<br>• Through staff interviews, it was determined that Wound Nurse and CNA 8 did not understand the policy related to proper PPE use related to appropriate used of N95 and surgical mask.<br>• Lack of staff understanding of policy proper PPE use and infection control practices related to PPE use<br>• The facility leadership team failed to ensure that staff were educated regarding appropriate | |

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| | | | infection control practice related to PPE use<br><br>b). The solutions and systemic changes developed by the DON, ADON and facility IP include:<br>The Director of Nursing (DON), Infection Preventionist (IP) or Designee will educate the facility staff facility staff related to but not limited to, wound care, PPE use, Use of Face mask/n95 , Tracheostomy Care, Medication Pass, PICC/IV care<br>For this education and return demonstration, the following resources will be used:<br>• Facility Policy- Use of PPE<br>• Facility Policy PPE Donning and Doffing PPE<br>• CDC guidance Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19)<br>• CDC guidance SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)<br>• CDC Education- Understanding the Difference Surgical VS N95 Respirator<br>• Facility policy- Wound Care/ Treatment Change<br>• CDC Education- Facemask Do's and Don'ts<br>• Facility Policy- Medication Administration<br>• Facility Policy- Tracheostomy Care<br>• Facility Policy- PICC | |

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| | | | Management/ IV Care<br><br>The DON, IP, or designated facility leadership will conduct facility rounds at a minimum of daily to ensure Infection Control practices are being followed related to PPE use, appropriate Mask/n95 use, during treatments, med pass and PICC/IV care. The DON, IP or designated facility leadership will enforce corrective measures and education if deficiencies are observed.<br><br>2). The DON, IP Nurse, and VP of Clinical Operations reviewed the LTC Infection Control Self-Assessment. Changes were made to so the assessment would now be an accurate reflection of the facility. This assessment will be submitted with the DPOC documentation.<br><br>B. Training:<br><br>1).Per the LTC infection control assessment review and Root Cause Analysis ,VP of Clinical, ED, Medical Director , UM , facility IP and DON. The following training needs were identified and implemented by facility IP and DON with training resources and polices provided and submitted as | |

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| | | | part of the DPOC documentation.<br><br>The Director of Nursing (DON), Infection Preventionist (IP) or Designee will educate the facility staff facility staff related to but not limited to, wound care, PPE use, Use of Face mask/n95 , Tracheostomy Care, Medication Pass, PICC/IV care<br><br>A. Monitoring: Monitoring of approaches to ensure Infection Control Practices are maintained.<br><br>The DON, IP, or designated facility leadership will conduct facility rounds at a minimum of daily to ensure Infection Control practices are being followed related to PPE use, appropriate Mask/n95 use, during treatments, med pass and PICC/IV care. The DON, IP or designated facility leadership will enforce corrective measures and education if deficiencies are observed.<br><br>E. Quality Assurance and Performance Improvement (QAPI):<br><br>The IP Nurse/Director of Nursing | |

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| | | | will present the results of these audits monthly to the QAPI committee for no less than 6 months. The facility through the QAPI program will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required. | |
| F 0921 SS=E Bldg. 00 | 483.90(i)<br>Safe/Functional/Sanitary/Comfortable Environ<br>§483.90(i) Other Environmental Conditions<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>Based on observation and interview, the facility failed to ensure the residents' environment as well as the kitchen area was clean and in good repair related to dirty floors, marred walls and doors, and food build up on pipes on 4 of 4 units and 1 of 1 kitchen areas. (Units 200, 300, 400, 500, and the Main Kitchen)<br><br>Findings include:<br><br>1. During the Environmental Tour with the Maintenance Supervisor on 5/31/22 at 1:50 p.m., the following was observed:<br><br>The 200 Unit<br><br>a. The wall behind bed 2 in Room 202 was observed to be scratched and marred. Two | F 0921 | **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>·The wall trim behind Bed 2 in Room 202 has been cleaned, patched and painted.<br>·Bathroom door in room 207 has been fixed to stay closed. The trim on the rights side of the door has been fixed. The hole in the wall underneath the bathroom sink has been patched.<br>·The floor tile in room 305 has been stripped and waxed. The base of the bathroom door has been cleaned and painted. The | 06/30/2022 |

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| | residents resided in this room.<br><br>b. The bathroom door in Room 207 would not stay closed. The trim on the right side of the door was loose. There was also a hole in the wall underneath the bathroom sink. Two residents shared the bathroom.<br><br>The 300 Unit<br><br>a. The floor tile in Room 305 was dirty and discolored. The base of the bathroom door was marred and there was a large rust stain on the wall underneath the bathroom sink. The caulk around the bathroom sink was also discolored and missing in sections. Two residents resided in the room and shared the bathroom.<br><br>The 400 Unit<br><br>a. The edge of the bathroom door was scratched and marred. The door frame of the bathroom had areas of chipped paint and the toilet bowl was discolored. Three residents shared the bathroom.<br><br>The 500 Unit<br><br>a. The walls in Room 501 were marred and the floor tiles were dull and scuffed. One resident resided in the room.<br><br>b. The wall behind bed 2 in Room 503 was scratched and marred. The floor tile next to the entry way of the bathroom had an accumulation of dirt. Two residents resided in this room.<br><br>c. The wall next to bed 2 in Room 507 was scratched and marred. The floor tile was scuffed and dingy in appearance. Two residents resided in this room. | | Rust stain on the wall underneath the bathroom sink has been cleaned away. The caulk around the bathroom sink has been scraped and recalked.<br>·The edge of the bathroom door in room 405 has been cleaned and painted from the chipped pain. The toilet bowl has been replaced.<br>·The walls in room 501 have been cleaned and painted and the floor tiles have been stripped and waxed.<br>·The wall behind the bed in room 503 and has cleaned and painted. The dirt on the floor tile next to the entry way to the bathroom has been cleaned from the accumulation of dirt.<br>·The wall next to bed 2 in room 507 has been cleaned and painted. The floor tile has been stripped and waxed.<br>·The floor behind bed 2 in room 508 has been stripped and waxed and the wall next to the bed has been cleaned and painted. The rust ring around the base of the toilet will cleaned and recalked.<br>·The wall behind bed 2 in room 509 will be cleaned and repainted. The floor tile will stripped and waxed.<br>·The floor tile in room 512 will be stripped and waxed.<br>·In the kitchen the floor tile and grout on the tile has been cleaned,<br>·In the kitchen the white PVC pipes under the 3-compartment sink have been cleaned. | |

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| | d. The floor behind bed 2 in Room 508 was dirty and the wall next to the bed was discolored. There was a rust ring around the base of the toilet and the caulk was discolored. Two residents resided in this room and 4 shared the bathroom.<br><br>e. The wall behind bed 2 was scratched and marred. The floor tile was dirty and scuffed. Two residents resided in this room.<br><br>f. The floor tile in Room 512 was dirty and scuffed. Two residents resided in this room.<br><br>Interview with the Maintenance Supervisor at the time, indicated the above areas were in need of cleaning and/or repair.<br>2. During the Kitchen sanitation tour on 5/31/22 with the Dietary Food Manager (DFM), the following was observed:<br><br>a. The floor and grout on the tile were stained and dirty.<br><br>b. The white PVC pipes were dirty under the 3 compartment sink.<br><br>c. There was adhered dirt and grease on the floor by the baseboard throughout the kitchen under the counter tops, the steam table, and in the dish room.<br><br>Interview with the DFM on 5/31/22 at 11:15 a.m., indicated all of the above was in needing of cleaning.<br><br>3.1-19(f) | | ·In the kitchen the dirt and grease by the baseboard throughout the kitchen and under the countertops, the steam table and in the dish room have been stripped and cleaned.<br><br>**2.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br><br>· All residents have the potential to be affected by the alleged deficient practice.<br>· All resident rooms in the facility and the kitchen have been assessed and repairs have been performed or scheduled as needed.<br><br>**3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br><br>·An all staff in-service will be conducted by ED/designee for all maintenance issues to be reported to the Maintenance Director for repairs via the maintenance request form log.<br>·Maintenance/Housekeeping/ food service supervisor will perform facility rounds to identify problems or needed repairs via the form. | |

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| | | | **4.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?**<br><br>·A “Maintenance Rounds Audit Tool” will be completed by Maintenance director/ Food service supervisor for kitchen sanitation audit will be completed.<br>·Audits will be completed daily x 5, weekly x 4, and monthly x 3 months, the quarterly thereafter until compliance is maintained for at least two consecutive quarters.<br>·From the results of the checklist, problems or needed repairs will be assigned to the responsible employee for correction. Follow up will be overseen by the ED and Maintenance director. Checklist trends will be discussed during QAPI committee meetings. An action plan will be developed for repeat checklist findings. | |