STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00384204, IN00386749, IN00391758, and IN00393305. Complaint IN00384204 - Substantiated. Federal/State deficiencies related to the allegations are cited at F554, F656, F677, and F689. Complaint IN00386749 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677, F689, and F694. Complaint IN00391758 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677, F689, and F695. Complaint IN00393305 - Substantiated. Federal/State deficiencies related to the allegations are cited at F602, F656 and F755. Survey dates: November 28, 29, and 30, 2022 Facility number: 010739 Provider number: 155764 AIM number: 200856890 Census Bed Type: SNF/NF: 16 SNF: 34 Residential: 35 Total: 85 Census Payor Type: Medicare: 22 Medicaid: 16 Other: 12 Total: 50	F 0000	This plan of correction shall serve as this facilities' credible allegation of compliance Preparation, submission, and implementation of the plan of corrections does not constitute an admission of or agreement with the facts and conclusions set forth in this survey report Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements The facility respectfully request paper compliance Thank you for your consideration, Respectfully, Kevin Mehay Spring Mill Health Campus 219-756-0744	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rosa McGowen	Regional Director of Operations	01/03/2023

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

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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/5/22.			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §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. Based on observation, record review, and interview, the facility failed to ensure a resident had a Physician's Order and an assessment to self-administer their own medications for 1 of 24 resident rooms observed for medications at the bedside. (Resident H) Finding includes: During an observation on 11/28/22 at 8:53 a.m., Resident H was lying in bed with the head of her bed elevated. Located on the bedside dresser was a container of fluticasone salmeterol (respiratory inhaler) 100 micrograms/50 milligrams. She indicated it was kept in the room so she could administer the medication herself. Resident H's record was reviewed on 11/28/22 at 1:23 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease. A Nursing Admission Assessment, dated 11/21/22 at 6:22 p.m., indicated the resident's cognitive status was intact. A Care Plan, dated 11/21/22, indicated shortness of breath was present when lying flat. The	F 0554	**F554 Resident Self-Admin Meds-Clinically Approp** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** A self-medication administration assessment was completed for Resident H	12/22/2022

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	interventions included medication was to be administered as ordered. A Physician's Order, dated 11/21/22, indicated an order for fluticasone salmeterol 100 micrograms/50 milligrams, one puff inhaled orally twice a day. There was no self administration assessment completed and no Physician's Order that indicated the resident could keep the medication at the bedside for self administration. A facility policy for medication storage, dated 10/1/15, and received as current from the Director of Nursing, indicated all medications were to be stored securely in a locked cabinet/cart or locked medication room. A facility policy for self-administration of medication, dated 2/15/21, and received as current from the Director of Nursing, indicated, the facility would allow a resident to self-administer medications if the interdisciplinary team had determined it was safe. A Self-Administration of Medication Evaluation would be completed. This Federal tag relates to Complaint IN00384204. 3.1-25(m)		**2) How the facility identified other residents:** All residents who receive medications have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** Licensed staff will be re-educated on proper storage of medications and if a resident requests to self-administer medication(s), nurse must immediately notify the director of nursing and/or administrator. The IDT team will complete assessment and will determine if it is safe for the resident to self-administer. No medications should be left at bedside without prior approval from the IDT team **4) How the corrective actions will be monitored:** Director of Nursing or designee will complete med pass observations audits on 2 nurses per week for 4 weeks then 1 nurse per week for 4 weeks then monthly thereafter until substantial compliance is met to ensure nurses are not leaving medication unattended. The Director of Nursing is responsible for compliance of this deficiency. **The results of these audits will be reviewed in**	

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			Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 12-22-2022**	
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Based on record review and interview, the facility failed to ensure residents were free from misappropriation of resident property, related to missing narcotic/controlled medication. The facility also failed to report the missing controlled medication in a timely manner and failed to include a thorough summary of the incident to the Indiana Department of Health (IDOH) and Local Law Enforcement. The facility failed to complete a timely and thorough investigation of the missing controlled substances for 2 of 2 residents with misappropriation of property. (Residents L & M) Findings include:	F 0602	**F602 Free from Misappropriation/Exploitation** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set*	12/22/2022

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	An IDOH Reported Incident, indicated the incident date was 11/2/22 and the facility Administration and Consultant were made aware of an allegation of misappropriation of medications made against an employee on 11/3/22. The alleged staff member was suspended pending an investigation. The Administrator had been made aware of the allegations on 8/7/22 and 10/17/22 and had not reported either incident. The Initial IDOH Reported Incident had not identified which residents were affected by the misappropriation, which staff member(s) were involved in the allegation, who had reported the allegation, and the name of the medication. The facility investigation, dated 11/3/22, indicated the alleged incident dates were 8/7/22 and 10/17/22, the Administrator had been made aware of the incidents on 8/7/22 and 10/17/22, and had not reported either incident. 1) The written facility investigation of the 8/7/22 allegation, dated 11/3/22, indicated: The Regional Vice President (RVP) and the Regional Nurse Consultant (RNC) met with the Director of Nursing (DON) and discussed concerns related to missing narcotics on 11/3/22. The DON had indicated on 8/7/22, a former nurse (Employee 4) reported a resident had a missing bottle of lorazepam (anti-anxiety). The DON indicated she had contacted the nurse from the previous shift (Employee 5). Employee 5 had informed the DON she had accidentally placed the bottle of lorazepam in her pocket and had taken the medication home with her. The DON drove to Employee 5's home, retrieved the lorazepam, and		*forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Narcotics for Resident L and M were reordered. **2) How the facility identified other residents:** All residents who receive medications have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** The DON and Administrator were both placed on Performance Improvement Plans related to lack of reporting and investigating abuse allegations. Nursing staff will be re-educated on misappropriation of resident's property to include medications. All staff will be re-in serviced on the abuse reporting policy. **4) How the corrective actions will be monitored:**	

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	returned the bottle of lorazepam to the facility. The DON and Employee 4 counted the amount of lorazepam in the bottle and none of the lorazepam was missing. The DON indicated Employee 5 was no longer employed at the facility and she had reported the incident to the Administrator. The lorazepam was returned to the facility and there was no lorazepam missing. The DON had not thought it needed to be reported to IDOH. The DON had instructed Employee 4 to destroy the lorazepam but had not followed up to ensure the lorazepam had been destroyed. The RVP and RNC interviewed the Administrator on 11/3/22 and discussed the allegations related to the missing narcotics. The Administrator indicated on 8/7/22, the DON had notified him about the missing bottle of lorazepam, Employee 5 had accidentally placed the bottle of lorazepam in her pocket. The lorazepam was retrieved from Employee 5's home by the DON and brought back to the facility. The amount of lorazepam in the bottle was counted by the DON and Employee 4 and none was missing. The Administrator indicated he had not thought the incident needed to be reported since the medication had been returned to the facility and none of the lorazepam was missing. During interviews with the RVP, RNC, DON, and Administrator on 11/30/22 at 2:04 p.m., the RVP indicated she and the RNC were notified of the incidents on 11/2/22 after a letter was sent to the DON from the Attorney General's Office. She had not been informed of any names of employees, residents, or medications until she started the investigation on 11/3/22. The DON indicated Employee 4 had worked the night shift on 8/7/22. The lorazepam was in liquid		Director of Nursing or designee will complete narcotic count audits 5 times a week for 4 weeks then weekly thereafter until substantial compliance is met to ensure that the licensed staff is completing the narcotic count ledger per facility policy and to ensure that the narcotic count is accurate. The Administrator is responsible for compliance of this deficiency. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 12-22-2022**	

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	form, belonged to Resident L, and was stored in the refrigerator in the Medication Room. There was a narcotic count sheet for the lorazepam and Employee 4 was unable to locate the bottle to reconcile the amount left. Employee 5 had worked on the evening shift and had not counted with Employee 4 at the change of shift. When the lorazepam was returned to the facility from Employee 5's house by the DON, the amount was reconciled by the DON and Employee 4. The amount of liquid matched the amount on the count sheet. The DON indicated she had instructed Employee 4 to destroy the liquid, since it had been out of the building. She had not followed up to ensure it had been destroyed by two licensed nurses and was unable to locate the medication destruction sheet. She was unsure how much liquid was left in the bottle since the destruction sheet has still not been found. The Administrator had been notified of the incident immediately. The Administrator indicated he had been informed of the incident immediately and since the medication was returned, had not thought it needed reported. 2) Investigation of the 10/17/22 allegation: The RVP and RNC had interviewed the DON on 11/3/22 about the alleged incident on 10/17/22. The DON indicated Employee 4 had reported that the narcotic count for Resident M was incorrect and there had been a green pen that had written over her signature and deducted two narcotic cards from her count. The Administrator was notified of the missing cards/narcotics and the falsification of documentation allegation. The medication carts were checked and the medication cards with the narcotics were not located. She			

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	indicated she was "working on" an investigation and staff had been interviewed, pain assessments had been completed to ensure the resident was not in pain. She was unable to determine who had written over Employee 4's signature and acknowledged when she had worked the Unit on 10/17/22, there had been a green pen located at the Nurse's Desk. She indicated she had not written over Employee 4's signature and had not changed any numbers on the count form. The RVP and RNC had interviewed the Administrator on 11/3/22 about the alleged incident of missing narcotics and the allegation of falsification of documentation on 10/17/22. He indicated the DON had made him aware of the the missing Norco and alleged falsification of documentation, and the resident was not having pain and would continue to be monitored. He had not reported the allegation because he had been informed the resident had pain medication and it was effective. A copy of a text from Employee 4 indicated on 10/17/22 at 5:21 a.m., the DON was notified by text indicating Resident M had received a card of Norco and it was added to the narcotic sheet in the front of the binder and the form had been signed off confirming the count of cards. Now the whole card of Norco was missing and so was the sheet used to sign it out. The delivery form for the Norco was also missing. She indicated someone had subtracted two cards on the count she had completed and had signed her name. Another text indicated there were 28 Norco's missing and someone had written over her signature in green and had falsified her name. During interviews on 11/30/22 at 2:04 p.m., the DON indicated staff count the amount of			

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	controlled medication, and then count how many cards/containers are in the lock box, the amount of cards/containers was documented on the Controlled Drug form and the form was to be signed at the beginning and end of the shift by the two staff who counted. The signatures indicated all medications/cards were accurate. She indicated staff were interviewed and "most of the staff had no idea what I was talking about." Employee 4 had signed a new card of Norco in, which was delivered due to reorder of the medication, so when the DON checked the cart, the count looked accurate. The Administrator indicated he "misunderstood" the DON when she had informed him of the missing Norco's. The Local Law Enforcement had not been notified until 11/3/22. The policy states Law Enforcement was to be notified for misappropriation of resident property. The RVP indicated she and the RNC had tried to contact Employee 4 to interview her, and she had not returned their phone calls. Review of a copy of the Controlled Drug Record for Resident M indicated a green pen had been used on the count form, written over the signature. The signature was difficult to read. there was a darker color written over a signature with a "minus 2" in the received from Pharmacy column, though the amount of cards in the drawer had not changed. The follow up to the IDOH Reportable was completed on 11/10/22 and indicated 28 tablets of Norco for Resident M was unaccounted for. The facility was unable to substantiate the allegation against the DON. The Police were notified and a case number was received.			

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	A facility abuse policy, dated 9/1/20 and received from the RNC as current, indicated allegations of abuse, which included misappropriation of resident property, were to be immediately reported to the Administrator. The allegation would result in an investigation. The investigation was to be documented. All alleged violations were to be reported immediately, but not later than 24 hours to the Administrator and to other officials, which included the IDOH and Adult Protective Services. Local Law Enforcement were to be notified if there was reasonable suspicion of a crime. This Federal tag relates to Complaint IN00393305. 3.1-28(a)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's			

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	exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.			
	Based on record review and interview, the facility failed to ensure residents' plans of care were implemented related to medication administration for 3 of 10 residents reviewed for implementation of plans of care. (Residents D, K, and L) Findings include: 1. Resident D's record was reviewed on 11/29/27 at 12:43 p.m. The diagnoses included, but were not limited to, Parkinson's disease and dementia.	F 0656	**F656 Develop/Implement Comprehensive Care Plan** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not*	12/22/2022

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	A Quarterly Minimum Data Set (MDS) assessment, dated 9/7/22, indicated a severely impaired cognitive status. A Care Plan, dated 6/9/22, indicated an impaired cognitive and thought process. The interventions included medications would be administered as ordered by the Physician. A Physician's Order, dated 8/25/22, indicated Provigil (stimulant), 100 milligrams daily for chronic sleepiness and cognitive decline. The Medication Administration Records, dated 10/2022 and 11/2022, indicated the Provigil had been administered as ordered daily at 8 a.m. The Controlled Drug Record, indicated the Provigil had not been signed out as given on October 27 and 28, 2022 and November 15, 2022. The Record indicated the resident received the medication on November 18, 2022 at 8 a.m. and 12 a.m. During an interview on 11/28/22 at 9:05 a.m., LPN 2 indicated the Provigil had not been administered as ordered by the Physician. 2. Resident K's record was reviewed on 11/30/22 at 11:45 a.m. The diagnoses included, but were not limited to, fractured left femur, dementia, and metastatic cancer of the spine. A MDS assessment, dated 9/30/22, indicated a long and short term memory problem, had no pain, and an opioid had been administered in the past seven days. A Care Plan, dated 6/23/22, indicated opioid medication was prescribed. The interventions		*constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The physician was notified that Resident D missed medication 3 times with no negative outcome. Resident K no longer resides in the facility The physician was made aware that resident L missed medications on 11/24/22 with no negative outcome. **2) How the facility identified other residents:** All residents who receive medications have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** Licensed staff will be reeducated on medication administration as it relates to following physicians' orders.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	include the medication would be administered as ordered by the Physician. A Care Plan, dated 10/25/21, indicated a risk for pain. The interventions included pain medications would be administered as ordered by the Physician. A Physician's Order, dated 9/29/22, indicated morphine sulfate (narcotic pain medication), 20 milligrams (mg) per milliliter (ml), 0.25 ml was to be administered by mouth three times a day for pain. The MAR, dated 11/2022, indicated the morphine sulfate was scheduled for 8 a.m., 1 p.m., and 8 p.m. daily and was documented as administered three times a day until 11/24/22. The Controlled Drug Record for the morphine sulfate solution, dated 11/14/22 through 11/23/22, indicated the morphine sulfate had not been signed out and administered on 11/15/22 at 8 a.m. and 1 p.m., 11/17/22 at 8 a.m., and 11/23/22 at 1 p.m. 3. Resident L's record was reviewed on 11/30/22 at 12:22 p.m. The diagnoses included, but were not limited to, stroke. A Quarterly MDS assessment, dated 9/1/22, indicated a short and long term memory problem, no pain, and received hospice care. A Care Plan, dated 11/9/21, indicated a risk for pain. The interventions included the pain medication would be administered as ordered by the Physician. A Physician's Order, indicated Norco (narcotic pain medications) 5-325 mg, 1 tablet was to be		**4) How the corrective actions will be monitored:** Director of Nursing or designee will review scheduled narcotic medication 5 times a week for 4 weeks then 2 times a week until substantial compliance is met to ensure that narcotics have been given per physician's orders. The Director of Nursing is responsible for compliance of this deficiency. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance:** **12-22-2022**	

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	administered twice a day. The MAR, dated 11/2022, indicated the Norco had been administered twice a day as ordered. The Controlled Drug Record, dated 11/18/22, indicated the on 11/24/22, the Norco had not been signed out and administered at 8 a.m. During an interview on 11/28/22 at 9:57 a.m., RN 1 indicated Residents K and L had not received the pain medication had not been signed out and administered as ordered by the Physician. This Federal tag relates to Complaint IN00384204 and IN00393305. 3.1-35(g)(2)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §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; Based on observation, record review, and interview, the facility failed to ensure residents who required extensive to total care with activities of daily living (ADL's), were provided necessary services to maintain good grooming and personal hygiene, related to hair not combed,shaving of facial hair, and thorough incontinence care, for 2 of 5 residents reviewed for ADL care. (Resident B and G) Finding includes: 1) During an observation on 11/28/22 at 9:19 a.m., Resident B was lying in bed, his hair had not been	F 0677	**F 677 ADL Care for Dependent Resident** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set*	12/22/2022

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	combed and there was a heavy growth of facial hair on his upper lip, lower cheeks, and chin. CNA 1 and CNA 3 were in the room. CNA 1 indicated he was last checked and care provided for incontinence at 7:30 a.m. The incontinent brief was removed by CNA 1 and CNA 3 due to urinary incontinence. CNA 1 washed the peri-area and buttock with disposable cloths and a clean brief was reapplied. No cream/ointment was applied to the skin of the buttocks after the incontinent care was completed. A clean top sheet was applied and the bed was lowered. CNA 1 and CNA 3 then exited the room. Resident B was observed with the heavy growth of facial hair and uncombed hair on 11/28/22 at 9:40 a.m., 11:37 a.m., 12:40 p.m., and 2:40 p.m. During observation on 11/29/22 at 8:39 a.m., the heavy growth of facial hair continued. During an observation on 11/30/22 at 9:39 a.m., he was lying in bed, his hair was combed and the facial hair had been shaved. CNA 2 indicated she had shaved the resident on 11/29/22 and facial hair was to be shaved when the growth of whiskers were present. Resident B's record was reviewed on 11/28/22 at 1:38 p.m. The diagnoses included, but were not limited to, acute respiratory failure, diabetes mellitus, and cognitive communication deficit. A Quarterly Minimum Data Set (MDS) assessment, dated 11/10/22, indicated a severely impaired cognitive status, required extensive assistance of one for hygiene and was dependent for bathing. He was always incontinent of bowel and bladder.		*forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Immediate action taken for those residents identified.** Resident B's hair was combed and he was shaved. Resident G was shaved How the facility identified other residents? All dependent residents residing in the facility have the potential to be affected by this alleged deficient practice. **What measures put into place/ Systemic changes?** Staff was re-educated on the importance of providing ADL care to include shaving and assisting residents with hair care as needed. **How will the corrected action be monitored?** Director of Nursing or Designee will complete observation on 5 residents once a day 5 times weekly for 4 weeks, and 5	

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	A Care Plan, dated 5/16/22 and revised on 11/17/22, indicated he required assistance with ADL's. The interventions included he would be assisted with personal hygiene as needed. A Care Plan, dated 5/16/22 and revised on 5/28/22, indicated a risk for pressure related skin breakdown related to incontinence. The interventions included, incontinence care would be provided routinely and treatments were to be completed as ordered. A Physician's Order, dated 5/16/22, indicated a moisture barrier cream was to be applied after each incontinent episode and was to be kept at the bedside for the CNA's to apply as needed. A Physician's Order, dated 5/27/22, indicated A&D Ointment was to be applied to the buttock and peri area after every incontinent episode and was to be kept at the bedside. 2) Resident G was observed on 11/29/22 at 8:44 a.m. and 1:20 p.m. and 11/30/22 at 8:42 a.m. and 9:37 a.m. with a heavy growth of facial hair on the upper lip, chin, and lower cheek areas. During an interview on 11/30/22 at 9:37 a.m., the resident indicated he did not like the growth of hair on his face and wanted it shaved. Resident G's record was reviewed on 11/30/22 at 9:33 a.m. The diagnoses included, but were not limited to, stroke and chronic obstructive pulmonary disease (COPD). A Significant Change MDS assessment, dated 10/27/22, indicated a severely impaired cognitive status, required extensive assistance for hygiene and was dependent for bathing.		residents 2x weekly thereafter to ensure ADL care compliance. The Director of Nursing is responsible for compliance. **The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **Date of Completion: 12-22-2022**	

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	A Care Plan, dated 4/22/22, indicated he was resistive to hygiene and ADL care. The interventions included, he would be allowed to make decisions about treatment regime and a clear explanation of care activities would be provided during care. A facility policy, titled, "Morning Care (AM-CARE)" dated 9/1/20, and received as current from the Director of Nursing, indicate if the resident was unable to brush or comb their own hair, the task would be completed by the staff. This Federal tag relates to Complaints IN00384204, IN00386749, and IN00391758. 3.1-38(a)(3)(B) 3.1-38(a)(3)(D)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure interventions were in place and safe transfers were performed to prevent falls/accidents and injuries for 2 of 4 residents reviewed for accidents/falls. (Residents B and G) Findings include:	F 0689	**F689 Free of Accident Hazards/Supervision Devices** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of*	12/22/2022

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	1. Resident B was observed lying in a wide mattress bed on 11/28/22 at 9:19 a.m., 9:40 a.m., 11:37 a.m., 12:40 p.m., and 2:04 p.m. , 11/29/22 at 11 a.m., and 11/30/22 at 9:39 a.m. There were no bolsters on the mattress/bed and no floor mats next to the bed. Resident B's record was reviewed on 11/28/22 at 1:38 p.m. The diagnoses included, but were not limited to, acute respiratory failure, diabetes mellitus, and cognitive communication deficit. A Quarterly Minimum Data Set (MDS) assessment, dated 11/10/22, indicated a severely impaired cognitive status, required extensive assistance of one for bed mobility and transfers, was unable to stand from a sitting position without stabilization assistance from the staff, had no impairments of the upper and lower extremities, had a fall with no injury and a fall with a non-major injury. A Care Plan, dated 5/16/22 and revised on 9/26/22, indicated a risk for falls. An intervention, dated 6/13/22, indicated the resident had not liked the air mattress and a new bariatric mattress (mattress for larger residents) with bolsters was still required. An intervention, dated 9/26/22, indicated the bed was to be in the lowest position and floor mats were to be placed on the floor. A Fall Observation Report, dated 6/12/22 at 2:16 p.m., indicated a non-witnessed fall from bed with no injuries. An Interdisciplinary Team (IDT) Progress Note, dated 6/13/22 at 9:52 a.m., indicated a poor safety awareness and the bed type would be changed.		*compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident B floor mats was placed beside the bed and bolsters mattress applied. The physician was also notified that labs ordered on 10/11/22 were not obtained. Resident G had bolsters mattress placed on bed. CNA 2 was reeducated about proper mechanical lift transfers. **2) How the facility identified other residents:** All residents who utilize fall interventions have the potential to be affected by the allege deficiency. A fall risk audit was completed to ensure that all interventions were in place	

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	A Fall Observation Report, dated 9/25/22 at 9:05 p.m., indicated a non-witnessed fall from bed with no injuries. An IDT Progress Note, dated 9/26/22 at 10:31 a.m., indicated floor mats would be initiated. A Fall Observation Report, dated 10/10/22 at 9:23 a.m., indicated a non-witnessed fall from bed which resulted in a skin tear to the left knee. A Fall Observation Report, dated 10/10/22 at 5:36 p.m., indicated a non-witnessed fall from the bed which resulted in a skin tear to the left lower leg, and he had continued attempts to get out of bed on his own. A Fall Observation Report, dated 10/11/22 at 5:08 a.m., indicated a non-witnessed fall from bed which resulted in a left knee skin tear. An IDT Progress Note, dated 10/11/22 at 12:22 p.m., indicated the falls on 10/10/22 and 10/11/22 were reviewed for a root cause, which was determined to be an impaired judgement and disorientation. The Nurse Practitioner was consulted and a new order/intervention to obtain laboratory tests of a basic metabolic panel (electrolytes), a complete blood count, and an urinalysis was received. The results of the laboratory tests were not located in the resident's record. During an interview on 11/29/22 at 9:05 a.m., the Director of Nursing (DON) indicated the orders for the laboratory tests were not written and the tests had not been completed. She acknowledged the bolsters were not on the bed and the mats were not the floor next to the bed.		**3) Measures put into place/ System changes:** Staff will be re-educated on falls, fall interventions and prevention. Staff will also be educated on safety with mechanical lift transfers. **4) How the corrective actions will be monitored:** Director of Nursing or designee will complete rounds on 3 residents at least once a day 5 times per week then 3 times per week for 4 weeks then weekly until substantial compliance is met to ensure that residents have their fall interventions in place. The DON or designee will also witness 3 mechanical lift transfers a week for 4 weeks then 1 weekly thereafter until substantial compliance is met to ensure that the task is being performed correctly. The Director of Nursing is responsible for compliance of this deficiency. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	During an interview on 11/30/22 at 11:11 a.m., the DON indicated she had just ordered the bolsters for the bed. 2. Resident G was observed lying in bed on 11/28/22 at 9:08 a.m. and 12:46 p.m., 11/29/22 at 1:20 p.m., and 11/30/22 at 10 a.m. There were no bolsters on the bed. During an observation on 11/30/22 at 9:37 a.m., CNA 2 used the mechanical lift and transferred the resident from the wheelchair to the bed without being assisted by a second staff member. The mechanical lift pad was attached to the lift, the resident was raised from the wheelchair and CNA 2 walked around the lift and removed the wheelchair from under the resident, who was raised and sitting in the pad and was not supported by another staff member. CNA 2 then went to the front of the lift, leaving the resident unsupported and moved the lift over the bed and lowered him onto the mattress. During an interview after the transfer was completed, CNA 2 indicated there were supposed to be two staff members when the mechanical lift was used, but it was easier to use the mechanical lift on her own when the facility was "short handed". She indicated there was another CNA on the Unit and the nurses would help with mechanical lift transfers if asked. Resident G's record was reviewed on 11/30/22 at 9:33 a.m. The diagnoses included, but were not limited to, stroke and chronic obstructive pulmonary disease (COPD). A Significant Change MDS assessment, dated 10/27/22, indicated a severely impaired cognitive status, required extensive assistance of one for		**5) Date of compliance:** **12-22-2022**	

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	bed mobility and transfers, had impairments of one side of the upper and lower extremities, and had no falls. A Care Plan, dated 9/3/21 and revised on 11/2/22, indicated limited physical mobility related to a stroke, which resulted in right sided hemiplegia and required assistance with transfers. An intervention indicated assistance with transfers would be completed with a mechanical lift per policy A Care Plan, dated 9/3/21 and revised on 5/24/22, indicated a high risk for falls due to a stroke with right sided hemiparesis, unaware of safety needs, and history of falls. The interventions included bolsters were to be placed on the bed and a mechanical lift was to be used for all transfers. During an interview on 11/30/22 at 10:05 a.m., the DON indicated the facility policy was to use two staff for all mechanical lift transfers. During an interview on 11/30/22 at 11:20 a.m., the DON indicated she was unaware bolsters were to be applied to the bed. A facility mechanical lift policy, dated 1/19/18 and received from the DON as current, indicated a mechanical lift was to be used for any resident who required two person assistance with transfers. The transferring needs would be assessed on an ongoing basis and the mechanical lift transfers required two caregivers. A facility fall reduction policy, dated 2/12/21, and received from the DON as current, indicated care plans would be created and implemented based on the risk factors to aid in the prevention of falls.			

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	This Federal tag relates to Complaints IN00384204, IN00386749, and IN00391758. 3.1-45(a)(2)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, record review, and interview, the facility failed to care for PICC (peripherally inserted central catheter) lines in accordance with professional standards of practice, related to lack of assessments of the insertion site, measurements of the catheter length, measurements of the arm circumference, dressing changes, and assessment of the catheter after the discontinuation of the PICC line, for 2 of 2 residents reviewed for PICC line usage. (Residents F and C) Findings include: 1) Resident F was observed and interviewed on 11/28/22 at 1:08 p.m. She was sitting up in her electric wheelchair. She indicated she had a PICC line in her right upper arm and the dressing had not been changed since being admitted into the facility. The date on the dressing that covered the PICC line insertion was 11/4/22. Resident F's record was reviewed on 11/30/22 at 8:57 a.m. The diagnoses included, but were not limited to, acute osteomyelitis of the right tibia and fibula. She was admitted into the facility from	F 0694	**F694 Parenteral/IV Fluids** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident F no longer resides in the facility	12/22/2022

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	an Acute Care Facility on 11/11/22. An Admission Minimum Data Set (MDS) assessment, dated 11/17/22, indicated an intact cognitive status and received intravenous (IV) medications. A Care Plan, dated 11/22/22, indicated a PICC line was present and IV medications were required. The interventions included, the insertion site would be assessed before, during and after each use of the PICC line, the external catheter length was to be measured weekly when the dressing was changed. A Physician's Order, dated 11/11/22, indicated the PICC line was to be flushed with 10 cc's (cubic centimeters) of 0.9% of normal saline every 12 hours. This order was discontinued on 11/29/22. A Physician's Order, dated 11/11/22, indicated a start date of 11/12/22 for ceftriaxone sodium (antibiotic) 2 grams to be administered through the PICC daily until 11/26/22. The Medication (MAR) and Treatment (TAR) Administration Records, dated 11/2022, indicated the PICC line was flushed as ordered at 8 a.m. and 8 p.m. and the ceftriaxone sodium was administered daily at 8 a.m. There was no documentation on the MAR and TAR, the insertion site had been assessed before, during and after each use, the external catheter length and arm circumference had been measured weekly with the dressing change, and a dressing change had been completed upon admission and weekly. An Admission Observation Form, dated 11/11/22		Resident C no longer has a PICC line. **2) How the facility identified other residents:** All residents who peripherally inserted central venous catheters have the potential to be affected by this deficient practice **3) Measures put into place/ System changes:** Licensed Staff will be re-educated on care of and assessment of PICC. DON or designee will complete record review of residents with PICC Line to ensure insertion site assessment and measurements are completed. Will complete weekly observation to ensure dressing changes and will review documentation once PICC is discontinue to ensure assessment was completed. **4) How the corrective actions will be monitored:** Director of Nursing or designee will review physicians' orders 5 times a week to ensure that all appropriate orders are in place for the care and assessment of a peripherally inserted central venous catheter. The Director of Nursing is responsible for compliance of this deficiency. **The**	

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	at 11:48 a.m., indicated an IV was present. The PICC line was not identified on the form. A Nurse's Progress Note, dated 11/11/22 at 2:59 p.m., indicated there was a right upper extremity central line. The insertion site, measurement of the length of the catheter and circumference of the arm were not assessed. There was no documentation that indicated the dressing had been changed. The next documented Nurse's Progress Note that identified the PICC line as being present was on 11/21/22 at 9:28 p.m., which indicated the PICC line in the right upper extremity was patent and flushed without issues. A Nurse's Progress Note, dated 11/24/22 at 6:23 a.m., indicated a single lumen PICC line to the right upper extremity was patent and intact and the line flushed easily. During an interview on 11/29/22 at 9:05 a.m., the Director of Nursing (DON) acknowledge the PICC line dressing had not been changed and there were no assessments of the site or the measurements of the circumference of the arm and length of the catheter. 2. Resident C's record was reviewed on 11/29/22 at 10:10 a.m. The diagnoses included, but were not limited to, osteomyelitis of the right ankle and foot, sepsis, urinary tract infection, and stroke. A discontinued Care Plan, dated 6/30/22, indicated a PICC line was present and was used to administer IV medications. The interventions included, the external catheter length was to be measured on admission and weekly with dressing changes.		**results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 12-22-2022**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	11/30/2022

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	An Admission Observation, dated 6/30/22 at 11:45 a.m., indicated a PICC line was present in the left upper extremity. A Physician's Order indicated, on 6/30/22, the PICC line site was to be assessed and the Physician was to be notified if abnormalities, ertapenem sodium (antibiotic) 1 gram was to be infused in 50 cc's of normal saline one time daily and to be started on 7/1/22 and stopped on 8/15/22. A Physician's Order, dated 7/1/22, indicated the PICC line dressing was to be changed every seven days and the circumference of the arm and length of the exposed catheter was to be measured when the dressing was changed. The MAR, dated 7/2022, indicated the PICC dressing had been changed on July 9, 16, 23, and 30, 2022. The area for the used to document the circumference of the arm and length of the catheter had NA (non-applicable) marked for July 9, 16, 23, and 30, 2022. The MAR indicated the dressing change and measurements had not been completed on July 2, 2022. The MAR, dated 8/2022, indicated The dressing change had been completed on the August 6, 13, and 20, 2022. The area used to document the circumference of the arm and length of the catheter had a zero marked on August 6, 2022, and dashes on August 13 and 20, 2022. A Physician's Order, dated 8/31/22, indicated the PICC line was to be discontinued. A Nurse's Progress Note, dated 8/31/22 at 9:04 p.m., indicated the PICC had been removed with			

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	no difficulty and there had been no bleeding. There was no assessment of the length of the catheter removed or an assessment of the tip of the catheter. During an interview on 11/29/22 at 12:04 p.m., the DON indicated if the resident is admitted with a PICC line they would not measure the circumference of the arm or the length of the PICC line on admission. She acknowledged the measurements had not been completed weekly. A facility policy, titled, "PICC Line Removal", dated 2/15/21, and identified as current by the DON, indicated, the condition of the catheter was to be evaluated, measured and confirm that it was fully intact. A facility policy for the PICC line dressing change, dated 9/1/20 and identified as current by the DON, indicated the dressing changes were to be completed upon admission, at least weekly, and if the integrity of the dressing had been compromised. The length of the external catheter and upper arm circumference at least three inches above the insertion site was be obtained upon admission, with dressing changes, and if signs or symptoms of complications are present. The date, time, site assessment, length of the external catheter, upper arm circumference were to be documented in the medical record. This Federal tag relates to Complaint IN00386749. 3.1-47(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning			

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	§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review and interview, the facility failed to ensure oxygen was administered to residents as ordered by the Physician for 2 of 3 residents reviewed for oxygen therapy. (Residents B and G) Finding includes: 1) During an observation 11/28/22 at 9:19 a.m. through 9:33 a.m., the resident was lying in bed. The oxygen concentrator was running and set at four liters. The tubing and nasal cannula were on the floor. During an interview on 11/28/22 at 9:33 a.m., RN 1 indicated the resident had an order for the oxygen to be administered continuously and he continued to take the oxygen off when it was applied. On 11/28/22 at 9:40 a.m., RN 1 entered the room and observed the tubing and nasal cannula on the floor and exchanged the tubing and nasal cannula with a clean set and placed the cannula in the resident's nares. The resident was observed on 11/28/22 at 12:40 p.m. with the nasal cannula on and the oxygen being administered at four liters. Resident B's record was reviewed on 11/28/22 at	F 0695	**F695 Respiratory/Tracheostomy Care and Suctioning** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident B's order for oxygen was discontinued due to not needing it continuously as ordered. Resident G's order for oxygen was discontinued due to not needing it	12/22/2022

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	1:38 p.m. The diagnoses included, but were not limited to, acute respiratory failure, diabetes mellitus, and cognitive communication deficit. A Quarterly Minimum Data Set (MDS) assessment, dated 11/10/22, indicated a severely impaired cognitive status and oxygen was used. A Care Plan, dated 5/16/22, indicated oxygen therapy was required. The interventions included, oxygen would be administered as ordered. A Physician's Order, dated 5/16/22, indicated oxygen was to be administered continuously through a nasal cannula at four liters per minute. 2) Resident G was observed on 11/28/22 at 9:08 a.m. and 12:54 a.m. and 11/30/22 at 8:42 a.m., 9:32 a.m., 9:37 a.m., and 10:05 a.m. without oxygen being administered. During an interview on 11/30/22 at 9:37 a.m., CNA 2 indicated the resident had oxygen ordered but he would take the oxygen off. The concentrator was observed in the room and running at two liters per minute. The cannula was not on the resident. CNA 2 completed care and left the room without placing the nasal cannula on the resident. The Director of Nursing (DON) was informed on 11/30/22 at 10:05 a.m., the resident's oxygen was not being administered. No further information was received from the DON. Resident G's record was reviewed on 11/30/22 at 9:33 a.m. The diagnoses included, but were not limited to, stroke and chronic obstructive pulmonary disease (COPD). A Significant Change MDS assessment, dated		continuously as ordered. **2) How the facility identified other residents:** All residents who use oxygen have the potential to be affected by this alleged deficient practice. **3) Measures put into place/ System changes:** Staff will be re-educated on the importance of following the doctor orders to ensure the residents who have orders for oxygen have on as ordered. **4) How the corrective actions will be monitored:** Director of Nursing or Designee will observe five oxygen dependent residents once a day at various times, 5 times weekly for 4 weeks, and 2x weekly thereafter to ensure oxygen is in use per MD order. The Director of Nursing is responsible for compliance of this deficiency. **The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the**	

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	10/27/22, indicated a severely impaired cognitive status, was short of breath when laid flat in bed, and used oxygen therapy. A Care Plan, dated 4/21/22, indicated shortness of breath when laid flat and with exertion. the interventions included, oxygen was to be administered as ordered. A Physician's Order, dated 4/20/22, indicated oxygen was to be administered continuously through a nasal cannula at two liters per minute. This Federal tag relates to Complaint IN00391758. 3.1-47(a)(6)		**plan of correction as indicated.** **5) Date of compliance:** **12-22-2022**	
F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-			

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	§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on record review and interview, the facility failed to ensure records of receipt and disposition of controlled drugs had accurate reconciliation, related to controlled drugs not reconciled at the start and end of every shift daily, for 4 of 4 Medication Carts observed. (HC2 Front, HC2 Back, TCU, and HC1) Findings include: 1) The controlled medications on HC2 front hall Medication Cart were observed and counted on 11/28/22 at 9:05 a.m. with LPN 1. The Narcotic Count Sheets located in the front of the Controlled Medication Count Record Binder, indicated the controlled drugs were not reconciled on 10/31/22 before and after the evening shift on 10/31/22 and 11/4/22, 11/24/22, 11/25/22, 11/27/22, and 11/28/22. The controlled drugs were not reconciled before and after the day shift on 11/24/22. There was no reconciliation completed on the day, evening, and night shift on 11/26/22. LPN 1 acknowledged the lack of signatures that indicated the controlled drugs were reconciled. 2) The controlled medications on HC 2 back hall Medication Cart were observed and counted on	F 0755	**F755 Pharmacy Srvcs/Procedures/Pharmacist/Records** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Narcotic Count Sheets located in	12/22/2022

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	11/28/22 at 9:57 a.m. with RN 1. The Narcotic Count Sheets indicated the controlled drugs were not reconciled before and after the evening shift on 11/11/22 and 11/18/22. RN 1 acknowledged the lack of signatures that indicated the controlled drugs were reconciled. 3) The controlled medications on the TCU Unit were observed and counted on 11/28/22 at 10:37 a.m. with LPN 1. The Narcotic Count Sheets indicated the controlled drugs were not reconciled before and after the day shift on 11/22/22, 11/25/22, and 11/26/22. LPN 1 acknowledged the lack of signatures that indicated the controlled drugs were reconciled. 4) The controlled medications on the HC1 Unit were observed and counted on 11/28//22 at 10:46 a.m. with LPN 1. The Narcotic Count Sheets indicated the controlled drugs were not reconciled before and after the day shift on 11/22/22, 11/23/22, and 11/25/22. A controlled substance policy, dated 9/1/20 and received as current from the Director of Nursing, indicated at each shift change or when the keys were transferred, a physical inventory of all controlled substances was to be conducted by two licensed nurses or one QMA. This Federal tag relates to Complaint IN00393305. 3.1-25-(e)(3)		the front of the book have been updated. **2) How the facility identified other residents:** No residents had the potential to be affected by this deficient practice **3) Measures put into place/ System changes:** Staff will be re-educated on narcotic sheet accountability and proper disposition of narcotics. **4) How the corrective actions will be monitored:** Director of Nursing or designee will complete narcotic count audits 5 times a week for 4 weeks then weekly thereafter until substantial compliance is met to ensure that the licensed staff is completing the narcotic count ledger per facility policy and to ensure that the narcotic count is accurate. The Administrator is responsible for compliance of this deficiency. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee**	

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			will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 12-22-22**	