

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/13/2023	
NAME OF PROVIDER OR SUPPLIER ROSEWALK AT LUTHERWOODS		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 N RITTER AVE, INDIANAPOLIS, , 46219					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: July 11, 12, and 13, 2023 Facility Number: 011587 Residential: 79 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 18, 2023	R 0000					
R 0187	Physical Plant Standards - Deficiency 410 IAC 16.2-5-1.6(k) (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees	R 0187	What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice: Water control valve corrected 7/13/23. Resident 54 water temperature on 7/13/23 was 113.7 degrees. Resident 52 water temperature on 7/13/23 was 113.9 degrees. Resident 56 water temperature on 7/13/23 was 112.8 degrees. Resident 83 water			08/08/2023	

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	Fahrenheit. Based on observation, interview, and record review, the facility failed to maintain water temperatures between 100 and 120 degrees F (Fahrenheit) for 4 of 6 residents whose water temperatures were retrieved. (Residents 52, 54, 56, and 83) Findings include: An environmental tour of the facility and interviews were conducted with the Maintenance Director and AIT (Administrator in Training) on 5/12/23 at 11:00 a.m. During the tour, the Maintenance Director retrieved the water temperature from Resident 54's kitchen sink at 125.7 degrees Fahrenheit and bathroom sink at 122.5 degrees Fahrenheit. During the tour, the Maintenance Director retrieved the water temperature from Resident 52's kitchen sink at 125 degrees Fahrenheit and bathroom sink at 123.6 degrees Fahrenheit. The Maintenance Director indicated they got a new water heater last month, but he hadn't had water temperatures this high since he'd began working at the facility approximately 6 weeks ago. He checked 2 residents' water temperatures per day per		temperature on 7/13/23 was 114.6 degrees. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. No resident was adversely affected. Maintenance supervisor reeducated 7/27/23. All apartments water temperatures reviewed with all water temperatures taken at point of use by 8/2/23. All apartments were in compliance with temperatures between 100- and 120 degrees Fahrenheit. What measures will be put into place or what systemic changes the facility will make to ensure that deficient practice does not recur: Maintenance supervisor reeducated 7/27/23 to include but not limited to resident apartment and facility water temperatures will be recorded on a rotating basis in the water temperature log. With any noted discrepancies, water heater settings will be adjusted as required and temperatures retested as necessary to ensure compliance. 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: Water temperatures will be	
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floor.

After retrieval of Resident 52's water temperatures, the environmental tour was paused until 7/12/23 at 2:30 p.m. so the facility could address the high water temperatures. Upon continuation of the tour, the Maintenance Director retrieved the water temperature from Resident 83's bathroom sink at 122.5 degrees Fahrenheit; Resident 56's kitchen sink at 125.4 degrees Fahrenheit; and Resident 56's bathroom sink at 123.8 degrees Fahrenheit.

The clinical record for Resident 56 was reviewed on 7/13/23 at 2:55 p.m. Her diagnoses included, but were not limited to: dementia, peripheral neuropathy, and peripheral vascular disease.

The 5/4/23 BIMS (brief interview for mental status) assessment for Resident 56 indicated a score of 7, indicating she was severely cognitively impaired.

The 5/4/23 service plan for Resident 56 indicated she did not require any assistance with hygiene, toileting, ambulation, or transfers and was forgetful.

The water temperature logs from 11/21/22 to present were provided by the ED (Executive Director) on 7/12/23 at 3:08 p.m. None of the documented temperatures exceeded 120

reviewed at monthly safety meeting, A water temperature monitoring tool will be completed weekly x 4 weeks, then monthly x 3 months. If 100% threshold is not met, then disciplinary action and new action plan will be completed. Monitoring tool will be completed by Executive Director/designee.

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degrees Fahrenheit, but Resident 52's room water temperatures hadn't been retrieved since 12/2/22, and Resident 83's hadn't been retrieved since 12/30/22. Resident 54's and Resident 56's room water temperatures were not included in the logs as having been retrieved since 11/21/22.

The Water Temperatures procedure was provided by the ED on 7/13/23 at 10:23 a.m. It read, "The purpose of recording your water temperatures is to assure the Surveyor that your facility is remaining as free from accidental burns and scalds as possible and that any issues are addressed in a prompt and consistent manner."

Based on observation, interview, and record review, the facility failed to maintain water temperatures between 100 and 120 degrees F (Fahrenheit) for 4 of 6 residents whose water temperatures were retrieved. (Residents 52, 54, 56, and 83)

Findings include:

An environmental tour of the facility and interviews were conducted with the Maintenance Director and AIT (Administrator in Training) on 5/12/23 at 11:00 a.m.

During the tour, the Maintenance Director retrieved

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the water temperature from Resident 54's kitchen sink at 125.7 degrees Fahrenheit and bathroom sink at 122.5 degrees Fahrenheit.

During the tour, the Maintenance Director retrieved the water temperature from Resident 52's kitchen sink at 125 degrees Fahrenheit and bathroom sink at 123.6 degrees Fahrenheit. The Maintenance Director indicated they got a new water heater last month, but he hadn't had water temperatures this high since he'd began working at the facility approximately 6 weeks ago. He checked 2 residents' water temperatures per day per floor.

After retrieval of Resident 52's water temperatures, the environmental tour was paused until 7/12/23 at 2:30 p.m. so the facility could address the high water temperatures. Upon continuation of the tour, the Maintenance Director retrieved the water temperature from Resident 83's bathroom sink at 122.5 degrees Fahrenheit; Resident 56's kitchen sink at 125.4 degrees Fahrenheit; and Resident 56's bathroom sink at 123.8 degrees Fahrenheit.

The clinical record for Resident 56 was reviewed on 7/13/23 at 2:55 p.m. Her diagnoses included, but were not limited to:

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dementia, peripheral neuropathy, and peripheral vascular disease.

The 5/4/23 BIMS (brief interview for mental status) assessment for Resident 56 indicated a score of 7, indicating she was severely cognitively impaired.

The 5/4/23 service plan for Resident 56 indicated she did not require any assistance with hygiene, toileting, ambulation, or transfers and was forgetful.

The water temperature logs from 11/21/22 to present were provided by the ED (Executive Director) on 7/12/23 at 3:08 p.m. None of the documented temperatures exceeded 120 degrees Fahrenheit, but Resident 52's room water temperatures hadn't been retrieved since 12/2/22, and Resident 83's hadn't been retrieved since 12/30/22. Resident 54's and Resident 56's room water temperatures were not included in the logs as having been retrieved since 11/21/22.

The Water Temperatures procedure was provided by the ED on 7/13/23 at 10:23 a.m. It read, "The purpose of recording your water temperatures is to assure the Surveyor that your facility is remaining as free from accidental burns and scalds as possible and that any issues are

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	addressed in a prompt and consistent manner."			
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to administer residents' medications, as ordered, to 3 of 5 residents whose medications were reviewed and to complete a readmission assessment for 1 of 1 resident reviewed for death. (Residents 12, 25, 46, and 60) Findings include: 1. The clinical record for Resident 12 was reviewed on 7/13/23 at 10:00 a.m. Her diagnoses included, but were not limited to, atrial fibrillation. She was readmitted to the facility from the hospital on 7/8/23. The 6/20/23 service plan for Resident 12 indicated she required coordination of physician/specialist visits/consultations. The 6/23/23 nurse's note read, "The resident reported that she has a cardiac procedure on 7/6/2023 and that a family	R 0240	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 25, Resident 46, and Resident 60 had no adverse reactions from medications not documented as administered. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. No resident was adversely affected. Staff qualified to administer medications reeducated by 8/2/23. Qualified staff will document necessary medication administration/observation/treatment information on appropriate forms per physician order, and all medication administration records reviewed by 8/2/23. Licensed nurses will be reeducated by 8/2/23 on hospital return policy including but not limited to initiating 72-hour follow-up charting upon return, and documentation of resident's return. What measures will be put into place or what systemic changes the facility will make to ensure that deficient practice does not recur: Staff qualified to administer	08/08/2023

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member will transport her.
[Name of Resident 12]
presented this writer with pre-op
[pre-operation] instructions.
Information forwarded."

The 7/8/23 hospital after visit
summary read, "Post Watchman
implant [parachute-shaped
device implanted in the left atrial
appendage of the heart that
reduces stroke risk in patients
with atrial fibrillation] discharge
instructions: 1. If you develop
chest pain, shortness or [sic]
breath, or are passing out
please do not leave a voicemail
message at the office. Either
ask to speak to the physician on
call, go to the nearest
emergency room, or call 911. 2.
Keep a log of your daily weights
and call if more than a 2 pound
weight gain in a day or 5
pounds in a week. 3. Keep your
puncture site clean and dry. Do
not add any lotions, creams,
powders, etc. as those may
introduce infection. 4. Close
follow up is essential to your
recovery..." The hospital
discharge medication list
indicated she was last given a
medication in the hospital on
7/8/23 at 9:48 a.m.

The facility's progress notes did
not include a 7/8/23 note
indicating a return from the
hospital for Resident 12. There
was no readmission
assessment or documentation
of any vital signs in the clinical

medications reeducated by 8/2/23
to include but not limited to
necessary documentation of
medication
administration/observations/treatm
ent on appropriate records.
Licensed nurses will be reeducated
by 8/2/23 on hospital return policy
including but not limited to initiating
72-hour follow-up charting upon
return, and documentation of
resident's return.

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:

Physicians' orders/medication
administration record and Hospital
return monitoring tools will be
completed weekly x 4 weeks, then
monthly x 3 months. If 95%
threshold is not met, then
disciplinary action and new action
plan will be completed. Monitoring
tool will be completed by Director
of Nursing or Executive
Director/designee.

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record for Resident 12 after her 7/8/23 return to the facility from the hospital.

The 7/8/23, 7:40 p.m. progress note, recorded as a late entry by LPN (Licensed Practical Nurse) 2 on 7/9/23 at 4:46 a.m., read, "CNA found resident on the floor and call for writer to assist. Upon assessment resident noted to be pulseless and breathless lying on her back, lips cyanotic body was cool to touch. CPR initiated, and 911 called. Unable to obtain b/p [blood pressure] or pulse. Paramedics arrived and was unable to resuscitate resident....resident had rhc'd. [respirations have ceased.]"

An interview was conducted with the CS (Clinical Support) on 7/13/23 at 11:01 a.m. She indicated from what she understood, Resident 12 had her procedure at the hospital on 7/7/23 and was brought back to the facility by family on 7/7/23. The CS reviewed Resident 12's 7/8/23 hospital after visit summary at this time and indicated she needed to speak with LPN 3, who worked on 7/8/23, because everything she was told must be wrong.

An interview was conducted with the CS on 7/13/23 at 11:19 a.m. She indicated LPN 2 informed her that when he left the facility at 2:30 p.m. on

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7/8/23, LPN 2 was unaware Resident 12 had returned to the facility.

An interview was conducted with LPN 2 by telephone in the presence of the CS on 7/13/23 at 11:21 a.m. She indicated her shift began at 2:00 p.m. on 7/8/23 and was informed by LPN 3 during shift change report that Resident 12 had returned from the hospital. She normally assessed residents upon return from the hospital, which triggered routine monitoring of their vital signs and symptoms. She did not complete a readmission assessment for Resident 12 on 7/8/23, because Resident 12 returned before her shift started, during LPN 3's shift. LPN 2 saw Resident 12 within a couple of hours of the start of her shift, at which time, Resident 12 "seemed to be okay." LPN 2 indicated she completed vitals and documented them, which should be in a progress note.

There was no documentation of any vital signs in the clinical record for Resident 12 after her return to the facility from the hospital on 7/8/23.

An interview was conducted with the ED (Executive Director) on 7/13/23 at 12:37 p.m. She indicated there was nothing in the 24 hour report indicating vitals or assessment of Resident

12 upon her hospital return on 7/8/23.

The Hospital Return policy was provided by the CS on 7/13/23 at 12:34 p.m. It read, "Procedure: ...7. The skilled nurse will initiate the 72-hour follow-up charting upon return. 8. Document the resident's return in the Progress Notes. Documentation should include the resident's temperature, pulse, and blood pressure daily times seventy-two (72) hours."

2. The clinical record for Resident 25 was reviewed on 7/11/23 at 11:20 a.m. His diagnoses included, but were not limited to: hypertension, supraventricular tachycardia, vitamin D deficiency, and constipation.

The 5/22/23 service plan for Resident 25 indicated he required assistance with daily medication administration.

The physician's orders indicated to administer a 5 mg tablet of Eliquis twice daily, effective 12/22/22; a 40 mg capsule of Omeprazole DR twice daily, effective 6/8/23; and one 1250 mcg capsule of Vitamin D2 every week, effective 4/7/22.

The June, 2023 MAR (medication administration record) indicated the Eliquis was only given once on 6/14/23, once on 6/15/23, and once on

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6/16/23. The Omeprazole was only given once on 6/14/23 and once on 6/15/23. The Vitamin D2 was given on 6/4/23 and 6/11/23, but was not given on 6/18/23 or 6/25/23.

An interview was conducted with the CS (Clinical Support) on 7/11/23 at 3:08 p.m. She indicated she had to assume the Eliquis, Omeprazole, and Vitamin D2 weren't given as ordered, since they weren't signed off as given on the MAR.

3. The clinical record for Resident 60 was reviewed on 7/12/23 at 10:00 a.m. Her diagnoses included, but were not limited to: osteoporosis, hyperlipidemia, and hypothyroidism.

The 6/12/23 service plan for Resident 60 indicated she required assistance with daily medication administration.

The physician's orders indicated to administer one 70 mg tablet of Alendronate Sodium every week, effective 6/12/23; one 10 mg tablet of Atorvastatin once a day, effective 6/12/23; one 600 mg tablet of Calcium with Vitamin D every morning, effective 6/12/23; and one 25 mcg tablet of Levothyroxine once a day, effective 6/12/23.

The June, 2023 MAR (medication administration record indicated the

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Alendronate was given on 6/16/23 and 6/23/23, but not given on 6/30/23. The Atorvastatin was not given on 6/23/23 or 6/28/23. The Calcium with Vitamin D was not given on 6/18/23 or 6/19/23. The Levothyroxine was not given on 6/29/23 or 6/30/23.

An interview was conducted with the CS (Clinical Support) on 7/12/23 at 11:08 a.m. She indicated she wasn't sure what to say about the MAR not being signed off and was unsure was was happening at that time, as she was not present in the facility on those dates.

4. The clinical record for Resident 46 was reviewed on 7/11/23 at 3:08 p.m. The Resident's diagnosis included, but were not limited to, diabetes and constipation.

A service plan, completed 5/5/23, indicated Resident 46 required staff assistance with medication administration.

A physician's order, dated 1/23/23, indicated he was to receive Metamucil fiber single packet one packet daily.

A physician's order, dated 5/20/23, indicated he was to receive Vitamin D2 50,000 IU (International Unit) 1 time weekly.

The June 2023 MAR

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(Medication Administration Record) did not contain initials indicating that the Metamucil packet had been administered on 6/16, 6/21, 6/22, 6/23, 6/28, 6/29, and 6/30/2023. The Vitamin D 2 have not been documented as administered on 6/18 and 6/25/23.

During an interview on 7/12/23 at 11:08 a.m., CS (Clinical Support) indicated she had spoken with the staff about the missing signatures on the MAR's. She was unsure why the medications had not been signed off as given.

The General Dose Preparation and Medication Administration policy was provided by the CS on 7/12/23 at 11:06 a.m. It read, "Procedure...6. Observe thee resident's consumption of the medication(s). 7. After Medication Administration: 7.1 Community should: 7.1.1 Document necessary medication administration/observation/treatment information (e.g., when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN [as needed] medications, application sight) on appropriate forms."

Based on interview and record review, the facility failed to administer residents'

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medications, as ordered, to 3 of 5 residents whose medications were reviewed and to complete a readmission assessment for 1 of 1 resident reviewed for death. (Residents 12, 25, 46, and 60)

Findings include:

1. The clinical record for Resident 12 was reviewed on 7/13/23 at 10:00 a.m. Her diagnoses included, but were not limited to, atrial fibrillation. She was readmitted to the facility from the hospital on 7/8/23.

The 6/20/23 service plan for Resident 12 indicated she required coordination of physician/specialist visits/consultations.

The 6/23/23 nurse's note read, "The resident reported that she has a cardiac procedure on 7/6/2023 and that a family member will transport her. [Name of Resident 12] presented this writer with pre-op [pre-operation] instructions. Information forwarded."

The 7/8/23 hospital after visit summary read, "Post Watchman implant [parachute-shaped device implanted in the left atrial appendage of the heart that reduces stroke risk in patients with atrial fibrillation] discharge instructions: 1. If you develop chest pain, shortness or [sic] breath, or are passing out

please do not leave a voicemail message at the office. Either ask to speak to the physician on call, go to the nearest emergency room, or call 911. 2. Keep a log of your daily weights and call if more than a 2 pound weight gain in a day or 5 pounds in a week. 3. Keep your puncture site clean and dry. Do not add any lotions, creams, powders, etc. as those may introduce infection. 4. Close follow up is essential to your recovery..." The hospital discharge medication list indicated she was last given a medication in the hospital on 7/8/23 at 9:48 a.m.

The facility's progress notes did not include a 7/8/23 note indicating a return from the hospital for Resident 12. There was no readmission assessment or documentation of any vital signs in the clinical record for Resident 12 after her 7/8/23 return to the facility from the hospital.

The 7/8/23, 7:40 p.m. progress note, recorded as a late entry by LPN (Licensed Practical Nurse) 2 on 7/9/23 at 4:46 a.m., read, "CNA found resident on the floor and call for writer to assist. Upon assessment resident noted to be pulseless and breathless lying on her back, lips cyanotic body was cool to touch. CPR initiated, and 911 called. Unable to obtain b/p

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[blood pressure] or pulse.
Paramedics arrived and was
unable to resuscitate
resident....resident had rhc'd.
[respirations have ceased.]"

An interview was conducted
with the CS (Clinical Support)
on 7/13/23 at 11:01 a.m. She
indicated from what she
understood, Resident 12 had
her procedure at the hospital on
7/7/23 and was brought back to
the facility by family on 7/7/23.
The CS reviewed Resident 12's
7/8/23 hospital after visit
summary at this time and
indicated she needed to speak
with LPN 3, who worked on
7/8/23, because everything she
was told must be wrong.

An interview was conducted
with the CS on 7/13/23 at 11:19
a.m. She indicated LPN 2
informed her that when he left
the facility at 2:30 p.m. on
7/8/23, LPN 2 was unaware
Resident 12 had returned to the
facility.

An interview was conducted
with LPN 2 by telephone in the
presence of the CS on 7/13/23
at 11:21 a.m. She indicated her
shift began at 2:00 p.m. on
7/8/23 and was informed by
LPN 3 during shift change report
that Resident 12 had returned
from the hospital. She normally
assessed residents upon return
from the hospital, which
triggered routine monitoring of

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their vital signs and symptoms. She did not complete a readmission assessment for Resident 12 on 7/8/12, because Resident 12 returned before her shift started, during LPN 3's shift. LPN 2 saw Resident 12 within a couple of hours of the start of her shift, at which time, Resident 12 "seemed to be okay." LPN 2 indicated she completed vitals and documented them, which should be in a progress note.

There was no documentation of any vital signs in the clinical record for Resident 12 after her return to the facility from the hospital on 7/8/23.

An interview was conducted with the ED (Executive Director) on 7/13/23 at 12:37 p.m. She indicated there was nothing in the 24 hour report indicating vitals or assessment of Resident 12 upon her hospital return on 7/8/23.

The Hospital Return policy was provided by the CS on 7/13/23 at 12:34 p.m. It read, "Procedure: ...7. The skilled nurse will initiate the 72-hour follow-up charting upon return. 8. Document the resident's return in the Progress Notes. Documentation should include the resident's temperature, pulse, and blood pressure daily times seventy-two (72) hours."

2. The clinical record for Resident 25 was reviewed on 7/11/23 at 11:20 a.m. His diagnoses included, but were not limited to: hypertension, supraventricular tachycardia, vitamin D deficiency, and constipation.

The 5/22/23 service plan for Resident 25 indicated he required assistance with daily medication administration.

The physician's orders indicated to administer a 5 mg tablet of Eliquis twice daily, effective 12/22/22; a 40 mg capsule of Omeprazole DR twice daily, effective 6/8/23; and one 1250 mcg capsule of Vitamin D2 every week, effective 4/7/22.

The June, 2023 MAR (medication administration record) indicated the Eliquis was only given once on 6/14/23, once on 6/15/23, and once on 6/16/23. The Omeprazole was only given once on 6/14/23 and once on 6/15/23. The Vitamin D2 was given on 6/4/23 and 6/11/23, but was not given on 6/18/23 or 6/25/23.

An interview was conducted with the CS (Clinical Support) on 7/11/23 at 3:08 p.m. She indicated she had to assume the Eliquis, Omeprazole, and Vitamin D2 weren't given as ordered, since they weren't signed off as given on the MAR.

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3. The clinical record for Resident 60 was reviewed on 7/12/23 at 10:00 a.m. Her diagnoses included, but were not limited to: osteoporosis, hyperlipidemia, and hypothyroidism.

The 6/12/23 service plan for Resident 60 indicated she required assistance with daily medication administration.

The physician's orders indicated to administer one 70 mg tablet of Alendronate Sodium every week, effective 6/12/23; one 10 mg tablet of Atorvastatin once a day, effective 6/12/23; one 600 mg tablet of Calcium with Vitamin D every morning, effective 6/12/23; and one 25 mcg tablet of Levothyroxine once a day, effective 6/12/23.

The June, 2023 MAR (medication administration record indicated the Alendronate was given on 6/16/23 and 6/23/23, but not given on 6/30/23. The Atorvastatin was not given on 6/23/23 or 6/28/23. The Calcium with Vitamin D was not given on 6/18/23 or 6/19/23. The Levothyroxine was not given on 6/29/23 or 6/30/23.

An interview was conducted with the CS (Clinical Support) on 7/12/23 at 11:08 a.m. She indicated she wasn't sure what to say about the MAR not being

signed off and was unsure was was happening at that time, as she was not present in the facility on those dates.

4. The clinical record for Resident 46 was reviewed on 7/11/23 at 3:08 p.m. The Resident's diagnosis included, but were not limited to, diabetes and constipation.

A service plan, completed 5/5/23, indicated Resident 46 required staff assistance with medication administration.

A physician's order, dated 1/23/23, indicated he was to receive Metamucil fiber single packet one packet daily.

A physician's order, dated 5/20/23, indicated he was to receive Vitamin D2 50,0000 IU (International Unit) 1 time weekly.

The June 2023 MAR (Medication Administration Record) did not contain initials indicating that the Metamucil packet had been administered on 6/16, 6/21, 6/22, 6/23, 6/28, 6/29, and 6/30/2023. The Vitamin D 2 have not been documented as administered on 6/18 and 6/25/23.

During an interview on 7/12/23 at 11:08 a.m., CS (Clinical Support) indicated she had spoken with the staff about the missing signatures on the

MAR's. She was unsure why the medications had not been signed off as given.

The General Dose Preparation and Medication Administration policy was provided by the CS on 7/12/23 at 11:06 a.m. It read, "Procedure...6. Observe thee resident's consumption of the medication(s). 7. After Medication Administration: 7.1 Community should: 7.1.1 Document necessary medication administration/observation/treatment information (e.g., when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN [as needed] medications, application sight) on appropriate forms."

Based on interview and record review, the facility failed to administer residents' medications, as ordered, to 3 of 5 residents whose medications were reviewed and to complete a readmission assessment for 1 of 1 resident reviewed for death. (Residents 12, 25, 46, and 60)

Findings include:

1. The clinical record for Resident 12 was reviewed on 7/13/23 at 10:00 a.m. Her diagnoses included, but were not limited to, atrial fibrillation. She was readmitted to the

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facility from the hospital on 7/8/23.

The 6/20/23 service plan for Resident 12 indicated she required coordination of physician/specialist visits/consultations.

The 6/23/23 nurse's note read, "The resident reported that she has a cardiac procedure on 7/6/2023 and that a family member will transport her. [Name of Resident 12] presented this writer with pre-op [pre-operation] instructions. Information forwarded."

The 7/8/23 hospital after visit summary read, "Post Watchman implant [parachute-shaped device implanted in the left atrial appendage of the heart that reduces stroke risk in patients with atrial fibrillation] discharge instructions: 1. If you develop chest pain, shortness or [sic] breath, or are passing out please do not leave a voicemail message at the office. Either ask to speak to the physician on call, go to the nearest emergency room, or call 911. 2. Keep a log of your daily weights and call if more than a 2 pound weight gain in a day or 5 pounds in a week. 3. Keep your puncture site clean and dry. Do not add any lotions, creams, powders, etc. as those may introduce infection. 4. Close follow up is essential to your

recovery..." The hospital discharge medication list indicated she was last given a medication in the hospital on 7/8/23 at 9:48 a.m.

The facility's progress notes did not include a 7/8/23 note indicating a return from the hospital for Resident 12. There was no readmission assessment or documentation of any vital signs in the clinical record for Resident 12 after her 7/8/23 return to the facility from the hospital.

The 7/8/23, 7:40 p.m. progress note, recorded as a late entry by LPN (Licensed Practical Nurse) 2 on 7/9/23 at 4:46 a.m., read, "CNA found resident on the floor and call for writer to assist. Upon assessment resident noted to be pulseless and breathless lying on her back, lips cyanotic body was cool to touch. CPR initiated, and 911 called. Unable to obtain b/p [blood pressure] or pulse. Paramedics arrived and was unable to resuscitate resident....resident had rhc'd. [respirations have ceased.]"

An interview was conducted with the CS (Clinical Support) on 7/13/23 at 11:01 a.m. She indicated from what she understood, Resident 12 had her procedure at the hospital on 7/7/23 and was brought back to the facility by family on 7/7/23.

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The CS reviewed Resident 12's 7/8/23 hospital after visit summary at this time and indicated she needed to speak with LPN 3, who worked on 7/8/23, because everything she was told must be wrong.

An interview was conducted with the CS on 7/13/23 at 11:19 a.m. She indicated LPN 2 informed her that when he left the facility at 2:30 p.m. on 7/8/23, LPN 2 was unaware Resident 12 had returned to the facility.

An interview was conducted with LPN 2 by telephone in the presence of the CS on 7/13/23 at 11:21 a.m. She indicated her shift began at 2:00 p.m. on 7/8/23 and was informed by LPN 3 during shift change report that Resident 12 had returned from the hospital. She normally assessed residents upon return from the hospital, which triggered routine monitoring of their vital signs and symptoms. She did not complete a readmission assessment for Resident 12 on 7/8/23, because Resident 12 returned before her shift started, during LPN 3's shift. LPN 2 saw Resident 12 within a couple of hours of the start of her shift, at which time, Resident 12 "seemed to be okay." LPN 2 indicated she completed vitals and documented them, which should be in a progress note.

There was no documentation of any vital signs in the clinical record for Resident 12 after her return to the facility from the hospital on 7/8/23.

An interview was conducted with the ED (Executive Director) on 7/13/23 at 12:37 p.m. She indicated there was nothing in the 24 hour report indicating vitals or assessment of Resident 12 upon her hospital return on 7/8/23.

The Hospital Return policy was

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provided by the CS on 7/13/23 at 12:34 p.m. It read, "Procedure: ...7. The skilled nurse will initiate the 72-hour follow-up charting upon return. 8. Document the resident's return in the Progress Notes. Documentation should include the resident's temperature, pulse, and blood pressure daily times seventy-two (72) hours."

2. The clinical record for Resident 25 was reviewed on 7/11/23 at 11:20 a.m. His diagnoses included, but were not limited to: hypertension, supraventricular tachycardia, vitamin D deficiency, and constipation.

The 5/22/23 service plan for Resident 25 indicated he required assistance with daily medication administration.

The physician's orders indicated to administer a 5 mg tablet of Eliquis twice daily, effective 12/22/22; a 40 mg capsule of Omeprazole DR twice daily, effective 6/8/23; and one 1250 mcg capsule of Vitamin D2 every week, effective 4/7/22.

The June, 2023 MAR (medication administration record) indicated the Eliquis was only given once on 6/14/23, once on 6/15/23, and once on 6/16/23. The Omeprazole was only given once on 6/14/23 and once on 6/15/23. The Vitamin

D2 was given on 6/4/23 and 6/11/23, but was not given on 6/18/23 or 6/25/23.

An interview was conducted with the CS (Clinical Support) on 7/11/23 at 3:08 p.m. She indicated she had to assume the Eliquis, Omeprazole, and Vitamin D2 weren't given as ordered, since they weren't signed off as given on the MAR.

3. The clinical record for Resident 60 was reviewed on 7/12/23 at 10:00 a.m. Her diagnoses included, but were not limited to: osteoporosis, hyperlipidemia, and hypothyroidism.

The 6/12/23 service plan for Resident 60 indicated she required assistance with daily medication administration.

The physician's orders indicated to administer one 70 mg tablet of Alendronate Sodium every week, effective 6/12/23; one 10 mg tablet of Atorvastatin once a day, effective 6/12/23; one 600 mg tablet of Calcium with Vitamin D every morning, effective 6/12/23; and one 25 mcg tablet of Levothyroxine once a day, effective 6/12/23.

The June, 2023 MAR (medication administration record indicated the Alendronate was given on 6/16/23 and 6/23/23, but not given on 6/30/23. The

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Atorvastatin was not given on 6/23/23 or 6/28/23. The Calcium with Vitamin D was not given on 6/18/23 or 6/19/23. The Levothyroxine was not given on 6/29/23 or 6/30/23.

An interview was conducted with the CS (Clinical Support) on 7/12/23 at 11:08 a.m. She indicated she wasn't sure what to say about the MAR not being signed off and was unsure was was happening at that time, as she was not present in the facility on those dates.

4. The clinical record for Resident 46 was reviewed on 7/11/23 at 3:08 p.m. The Resident's diagnosis included, but were not limited to, diabetes and constipation.

A service plan, completed 5/5/23, indicated Resident 46 required staff assistance with medication administration.

A physician's order, dated 1/23/23, indicated he was to receive Metamucil fiber single packet one packet daily.

A physician's order, dated 5/20/23, indicated he was to receive Vitamin D2 50,000 IU (International Unit) 1 time weekly.

The June 2023 MAR (Medication Administration Record) did not contain initials indicating that the Metamucil

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packet had been administered on 6/16, 6/21, 6/22, 6/23, 6/28, 6/29, and 6/30/2023. The Vitamin D 2 have not been documented as administered on 6/18 and 6/25/23.

During an interview on 7/12/23 at 11:08 a.m., CS (Clinical Support) indicated she had spoken with the staff about the missing signatures on the MAR's. She was unsure why the medications had not been signed off as given.

The General Dose Preparation and Medication Administration policy was provided by the CS on 7/12/23 at 11:06 a.m. It read, "Procedure...6. Observe thee resident's consumption of the medication(s). 7. After Medication Administration: 7.1 Community should: 7.1.1 Document necessary medication administration/observation/treatment information (e.g., when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN [as needed] medications, application sight) on appropriate forms."

Based on interview and record review, the facility failed to administer residents' medications, as ordered, to 3 of 5 residents whose medications were reviewed and to complete

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a readmission assessment for 1 of 1 resident reviewed for death. (Residents 12, 25, 46, and 60)

Findings include:

1. The clinical record for Resident 12 was reviewed on 7/13/23 at 10:00 a.m. Her diagnoses included, but were not limited to, atrial fibrillation. She was readmitted to the facility from the hospital on 7/8/23.

The 6/20/23 service plan for Resident 12 indicated she required coordination of physician/specialist visits/consultations.

The 6/23/23 nurse's note read, "The resident reported that she has a cardiac procedure on 7/6/2023 and that a family member will transport her. [Name of Resident 12] presented this writer with pre-op [pre-operation] instructions. Information forwarded."

The 7/8/23 hospital after visit summary read, "Post Watchman implant [parachute-shaped device implanted in the left atrial appendage of the heart that reduces stroke risk in patients with atrial fibrillation] discharge instructions: 1. If you develop chest pain, shortness or [sic] breath, or are passing out please do not leave a voicemail message at the office. Either ask to speak to the physician on

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call, go to the nearest emergency room, or call 911. 2. Keep a log of your daily weights and call if more than a 2 pound weight gain in a day or 5 pounds in a week. 3. Keep your puncture site clean and dry. Do not add any lotions, creams, powders, etc. as those may introduce infection. 4. Close follow up is essential to your recovery..." The hospital discharge medication list indicated she was last given a medication in the hospital on 7/8/23 at 9:48 a.m.

The facility's progress notes did not include a 7/8/23 note indicating a return from the hospital for Resident 12. There was no readmission assessment or documentation of any vital signs in the clinical record for Resident 12 after her 7/8/23 return to the facility from the hospital.

The 7/8/23, 7:40 p.m. progress note, recorded as a late entry by LPN (Licensed Practical Nurse) 2 on 7/9/23 at 4:46 a.m., read, "CNA found resident on the floor and call for writer to assist. Upon assessment resident noted to be pulseless and breathless lying on her back, lips cyanotic body was cool to touch. CPR initiated, and 911 called. Unable to obtain b/p [blood pressure] or pulse. Paramedics arrived and was unable to resuscitate

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resident....resident had rhc'd.
[respirations have ceased.]"

An interview was conducted with the CS (Clinical Support) on 7/13/23 at 11:01 a.m. She indicated from what she understood, Resident 12 had her procedure at the hospital on 7/7/23 and was brought back to the facility by family on 7/7/23. The CS reviewed Resident 12's 7/8/23 hospital after visit summary at this time and indicated she needed to speak with LPN 3, who worked on 7/8/23, because everything she was told must be wrong.

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Resident 12 on 7/8/12, because Resident 12 returned before her shift started, during LPN 3's shift. LPN 2 saw Resident 12 within a couple of hours of the start of her shift, at which time, Resident 12 "seemed to be okay." LPN 2 indicated she completed vitals and documented them, which should be in a progress note.

There was no documentation of any vital signs in the clinical record for Resident 12 after her return to the facility from the hospital on 7/8/23.

An interview was conducted with the ED (Executive Director) on 7/13/23 at 12:37 p.m. She indicated there was nothing in the 24 hour report indicating vitals or assessment of Resident 12 upon her hospital return on 7/8/23.

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2. The clinical record for Resident 25 was reviewed on 7/11/23 at 11:20 a.m. His

diagnoses included, but were not limited to: hypertension, supraventricular tachycardia, vitamin D deficiency, and constipation.

The 5/22/23 service plan for Resident 25 indicated he required assistance with daily medication administration.

The physician's orders indicated to administer a 5 mg tablet of Eliquis twice daily, effective 12/22/22; a 40 mg capsule of Omeprazole DR twice daily, effective 6/8/23; and one 1250 mcg capsule of Vitamin D2 every week, effective 4/7/22.

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An interview was conducted with the CS (Clinical Support) on 7/11/23 at 3:08 p.m. She indicated she had to assume the Eliquis, Omeprazole, and Vitamin D2 weren't given as ordered, since they weren't signed off as given on the MAR.

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diagnoses included, but were not limited to: osteoporosis, hyperlipidemia, and hypothyroidism.

The 6/12/23 service plan for Resident 60 indicated she required assistance with daily medication administration.

The physician's orders indicated to administer one 70 mg tablet of Alendronate Sodium every week, effective 6/12/23; one 10 mg tablet of Atorvastatin once a day, effective 6/12/23; one 600 mg tablet of Calcium with Vitamin D every morning, effective 6/12/23; and one 25 mcg tablet of Levothyroxine once a day, effective 6/12/23.

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An interview was conducted with the CS (Clinical Support) on 7/12/23 at 11:08 a.m. She indicated she wasn't sure what to say about the MAR not being signed off and was unsure was was happening at that time, as she was not present in the

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facility on those dates.

4. The clinical record for Resident 46 was reviewed on 7/11/23 at 3:08 p.m. The Resident's diagnosis included, but were not limited to, diabetes and constipation.

A service plan, completed 5/5/23, indicated Resident 46 required staff assistance with medication administration.

A physician's order, dated 1/23/23, indicated he was to receive Metamucil fiber single packet one packet daily.

A physician's order, dated 5/20/23, indicated he was to receive Vitamin D2 50,0000 IU (International Unit) 1 time weekly.

The June 2023 MAR (Medication Administration Record) did not contain initials indicating that the Metamucil packet had been administered on 6/16, 6/21, 6/22, 6/23, 6/28, 6/29, and 6/30/2023. The Vitamin D 2 have not been documented as administered on 6/18 and 6/25/23.

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During an interview on 7/12/23 at 11:08 a.m., CS (Clinical Support) indicated she had spoken with the staff about the missing signatures on the MAR's. She was unsure why the medications had not been signed off as given.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR
PROVIDER/SUPPLIER REPRESENTATIVE'S
SIGNATURE

TITLE

(X6) DATE