STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HANOVER NURSING CENTER	410 W LAGRANGE RD HANOVER, IN 47243

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00401987, IN00401922, IN00401322, IN00401375 and a State Residential Licensure Survey. Complaint IN00401987 - No deficiencies related to the allegations are cited. Complaint IN00401922 - Federal/State deficiency related to the allegation is cited at F584. Complaint IN00401322 - No deficiencies related to the allegations are cited. Complaint IN00401375 - No deficiencies related to the allegations are cited. Survey dates: February 21, 22, 23, 24, and 27, 2023. Facility number: 000115 Provider number: 155208 AIM number: 100291080 Census Bed Type: SNF/NF: 71 Residential: 8 Total: 79 Census Payor Type: Medicare: 4 Medicaid: 66 Other: 1 Total: 71 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	The creation and submission of this Plan of Correction (POC) does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies/2567, or of any violation of regulation	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Mace	Consultant	03/21/2023

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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	Quality review completed on March 6, 2023.			
F 0557 SS=D Bldg. 00	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Based on observation, interview, and record review, the facility failed to treat residents with dignity related for 2 of 22 residents reviewed. (Residents 61 and 4) Findings include: 1. During a continuous observation on 02/20/23 from 12:56 P.M. to 1:17 P.M., Resident 61 was sitting on the floor in the dining room, his pants were down to his thighs, and he was wearing a disposable brief. He was sitting near a table that QMA (Qualified Medication Aide) 5 was sitting at while she and CNA (Certified Nurse Assistant) 6 assisted other residents with their meals. Resident 61 had intermittent coughing episodes and was hitting the backside of QMA 5 with his hand. QMA 5 indicated multiple times to Resident 61 "Please stop hitting me, you already had your lunch." At 1:03 P.M., the resident was still on the floor with his pants down to his thighs with his disposable brief showing. Several staff members walked through the unit, looked at the resident and kept walking. At 1:07 P.M., the ADON (Assistant Director of Nursing) also walked through the unit and asked, "Is that Resident 61	F 0557	The residents residing in Hanover nursing are treated with respect and dignity. R61 and 4 are treated with dignity and respect All residents had the potential to be affected by this alleged deficient practice Res. 61 care plan was reviewed and updated. Facility will attempt to trial suspenders and/or overalls if resident permits, to assist in keeping pants from scooting down when resident is moving around on floor. The Administrator/AIT have assessed the DR on the Huntington's unit to determine if more chairs were needed. Staff will have an adequate number of chairs available for feeding residents. Administrator and AIT's phone numbers are posted for staff to report all allegations of abuse. Re-education in servicing will be	04/05/2023

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	coughing?", and kept going off the unit, never stopping. At 1:11 P.M., the Scheduler walked onto the unit and asked the resident if he needed something. She donned gloves and assisted the resident with pulling up his pants. The MDS (Minimum Data Set) Coordinator assisted the Scheduler with assisting the resident off the floor into a wheelchair. The scheduler stayed with the resident and asked questions to figure out what he wanted. At 1:17 P.M., the resident indicated he wanted more food. The resident was assisted to the table and offered more to eat. During an observation on 02/21/23 at 3:16 P.M., Resident 61 was sitting on the floor in the common area. His pants were down and showing the majority of his disposable brief. He was trying to pull himself up on one of the half doors into the nurse's station. There were staff at the nurse's station, including staff that had walked past the resident without assisting him with his pants. At 3:18 P.M., the MDS Coordinator walked past the resident and fixed his pants. During an observation on 02/22/23 at 12:43 P.M., Resident 61 crawled from his room to the common area towards the dining room. Several staff walked by the resident without any acknowledgment. QMA 7 asked the resident if he wanted to get up to a table to eat his lunch. The resident indicated "yes." The QMA asked the resident a second time if he wanted to get up to the table to eat his lunch. The resident did not respond. QMA 7 retrieved the resident's lunch tray from the cart and a folding chair from behind the nurse's station. She sat in front of the resident in the folding chair while he sat on the floor and assisted him with his meal. During an observation on 02/23/23 at 9:07 A.M.,		completed for staff in all departments on resident rights Including, but not limited to, dignity, assisting when clothing is off or down, or any dignity issues that are observed or seeking the proper person that can assist, feeding at eye level, asking residents what they need, assisting them and communicating properly with residents. Re- education in-serving will be completed for staff in all departments regarding the facilities policy on abuse that includes that the administrator must immediately be notified of all allegations of abuse. This in-service will also alert staff to where these phone numbers are located. The Administrator, AIT or their designee will perform walking rounds to observe that resident rights and dignity are being respected and that Administrator/AIT numbers are posted and randomly selected staff verbalize where to find them. This will be completed five days a week times four weeks, weekly times 5 months. Concerns will be addressed if observed. If any patterns are identified at the monthly QAPI meeting ,an action plan will be written by the committee. Any written action plan will be monitored by the administrator or his/her designee monthly until resolved and	

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	the resident's room door was closed. After knocking, CNA 9 indicated it was okay to enter the room. CNA 9 was sitting on a mattress assisting his roommate, Resident 49, with his meal. Resident 61 was sitting on the floor behind the door, watching the CNA assist his roommate with eating. His pants were down around his thighs. His disposable brief was very wet and there was urine all over the floor where the resident was scooting around. A hospice staff came in and assisted the resident to the shower. During an interview on 02/23/23 at 9:14 A.M., LPN (Licensed Practical Nurse) 3 indicated the resident's breakfast tray was in the fridge because he was sleeping. If the staff were assisting the residents roommate with eating and the resident was sitting there awake and watching, he should have been offered his meal. During an interview on 02/23/23 at 10:50 A.M., QMA 7 indicated if the resident was not motivated to get up, he won't. If the residents' pants were pulled down in the common area the staff should offer to pull the residents pants up as he will allow. If the resident was trying to get a staff member's attention, they should stop what they are doing and see what he needs. The resident has some nonverbal commands. The resident was hungry most of the time. He received double portions at meals. During an interview on 02/27/23 at 10:26 A.M., LPN 3 indicated when staff were assisting a resident with their meal they should sit at the resident's level and not above them. Sometimes there weren't enough chairs for the staff to sit down with the resident, so they must stand. The clinical record for Resident 61 was reviewed		substantial compliance is achieved at 95% or greater.	

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	on 02/23/23 at 9:23 A.M. A Quarterly MDS assessment, dated 02/02/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, Huntington's disease, non-Alzheimer dementia, anxiety, and psychotic disorder. The resident was incontinent of bowel and bladder. 2. During an interview on 02/22/23 at 9:15 A.M., the AIT (Administrator in Training) indicated an incident had occurred the previous night. CNA 11 had reported that QMA 12 had called Resident 4 a heifer. During an interview on 02/22/23 at 11:18 A.M., Resident 4 indicated QMA 12 had called her a brat the previous night. She felt safe in the building and had no other concerns. During an interview on 02/23/23 at 9:58 A.M., CNA 11 indicated the on the night of the incident Resident 4 had her call light on and QMA 12 was walking out of the resident's room when she asked her to answer the light. Before she could get the door closed, QMA 12 had called the resident a heifer. Resident 4 overheard her and yelled "I'm not a da** heifer", the QMA said you are a heifer. She then closed the door to diffuse the situation. She then reported it to the nurse that morning as she didn't have any phone numbers of anyone to call. During an interview on 02/23/23 at 10:05 A.M., QMA 12 indicated she had been in Resident 4's room checking her blood sugar. The resident was on the bedside commode and wanted the CNA to assist her, she didn't want help from the QMA. She never called the resident any names. She was polite and nice as possible to the resident.			

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	During an interview on 02/27/23 at 9:30 A.M., the AIT indicated she had spoken with Resident 4 and the resident told her that QMA 12 had called her a brat. It made her feel kind of sad. The AIT spoke with QMA 12, and she said she did call Resident 4 a brat, but it was in a joking manner. The QMA was inserviced on abuse and proper speaking with residents. The clinical record for Resident 4 was reviewed on 02/22/23 at 10:10 A.M. An Annual MDS assessment, dated 01/29/23, indicated the resident was cognitively impaired. The diagnoses included, but were not limited to, anemia, hypertension, renal insufficiency, diabetes, non-Alzheimer's dementia, anxiety, and depression. The current facility policy titled, "Quality of Life-Dignity" with a revised date of 2009, was provided by the MDS Coordinator on 02/24/23 at 10:48 A.M. The policy indicated, "...Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality...Residents are treated with dignity and respect at all times..." 3.1-3(t)			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;			

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	(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations			

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	under §483.15(c)(9). Based on observation, interview, and record review, the facility failed to notify the MD of blood glucose levels that were out of range for 1 of 22 residents reviewed. (Resident 35) Findings include: During an observation on 02/22/23 at 9:05 A.M., Resident 35 was awake in his room. He was getting ready to leave for dialysis. The clinical record for Resident 35 was reviewed on 02/22/23 at 11:03 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 02/12/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, hypertension, renal insufficiency, diabetes, and dependence on renal dialysis. A physician's order, dated 12/15/22 through 02/09/23, indicated the staff were to administer Insulin Lispro per sliding scale. They were to notify the MD if the blood glucose was greater than 400. An open-ended physician's order, with a start date of 02/09/23, indicated the staff were to administer Insulin Lispro per sliding scale. They were to notify the MD if the blood glucose was greater than 400. The January and February 2023 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the resident blood glucose was greater than 400 the following dates: - 01/03/23, at 8:00 A.M., the blood glucose was 500,	F 0580	The facility does notify the physician when blood glucose levels are out of range R35's Has had no adverse effects from this finding. The physician is now called when glucose levels are out of parameters. R35's MAR/TAR has been updated to check fistula every shift for bruit and thrill, swelling, redness, pain, warmth and or drainage. Residents with blood glucose parameters and/or AV fistulas are at risk from this alleged deficient practice. No other residents with AV fistulas. An audit was completed of all residents with blood glucose parameters and any other concerns were corrected as well. Re-education in servicing was conducted involving Nurses/QMA's regarding alerting doctors when blood glucose is out of parameters and checking AV fistulas every shift. The Admin/AIT/ADON and/or designees will audit 5 residents with blood glucose parameters daily x 5 days a week for four weeks then weekly for four weeks then monthly for four months. The Admin/AIT/ADON and/or designee will audit MAR for checking of AV fistula daily x 5 days a week for four weeks then weekly for four weeks then	04/05/2023

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	- 01/04/23, at 8:00 A.M., the blood glucose was 567, - 01/05/23, at 8:00 A.M., the blood glucose was 456, - 01/09/23, at 8:00 A.M., the blood glucose was 546, - 01/10/23, at 8:00 A.M., the blood glucose was 548, at 12:00 P.M., the blood glucose was 488, at 5:00 P.M., the blood glucose was 428, - 01/12/23, at 8:00 A.M., the blood glucose was 500, - 01/15/23, at 8:00 A.M., the blood glucose was 409, - 01/16/23, at 8:00 A.M., the blood glucose was 430, - 01/17/23, at 8:00 A.M., the blood glucose was 429, - 01/18/23, at 8:00 A.M., the blood glucose was 468, - 01/19/23, at 5:00 P.M., the blood glucose was 508, - 01/20/23, at 8:00 A.M., the blood glucose was 406, at 12:00 P.M., the blood glucose was 406, - 01/24/23, at 8:00 A.M., the blood glucose was 504, - 01/26/23, at 8:00 A.M., the blood glucose was 428. - 01/29/23, at 8:00 A.M., the blood glucose was 446, - 02/07/23, at 8:00 A.M., the blood glucose was 407, - 02/09/23, at 12:00 P.M., the blood glucose was 424, - 02/11/23, at 12:00 P.M., the blood glucose was 417, - 02/13/23, at 8:00 A.M., the blood glucose was 500, - 02/16/23, at 8:00 A.M., the blood glucose was 477, - 02/17/23, at 8:00 A.M., the blood glucose was		monthly for four months. This audit will be presented to the QAPI meeting. An action plan will be written by the committee if any patterns are identified. An action plan will be monitored by the administrator and or his or her designee monthly until resolved and substantial compliance is achieved at 95% or greater.	

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	500, - 02/18/23, at 8:00 A.M., the blood glucose was 500 and at 12:00 P.M., the blood glucose was 477, - 02/19/23, at 8:00 A.M., the blood glucose was 500, and at 12:00 P.M., the blood glucose was 441, and - 02/21/23, at 12:00 P.M., the blood glucose was 478, and at 5:00 P.M., the blood glucose was 478. The clinical record lacked documentation that the MD had been notified of the blood glucose levels greater than 400. The resident had not been sent to the hospital related to the blood glucose levels. During an interview on 02/22/23 at 11:25 A.M., LPN (Licensed Practical Nurse) 2 indicated the resident required dialysis. He was a brittle diabetic and refused care often. The resident had a fistula in the left upper arm. The staff should check it each shift for bruit and thrill and document in the EMAR/ETAR. The staff should follow the physician's orders. The current facility policy titled, "Physician Orders", dated 10/2014, was provided by the AIT (Administrator in Training) on 02/27/23 at 1:36 P.M. The policy indicated, "...Physician's orders are administered upon the clear, complete and signed order of an individual lawfully authorized to prescribe..." The current facility policy titled, "Notification of Change", dated 10/2014, was provided by the AIT on 02/27/23 at 1:36 P.M. The policy indicated, "...To keep resident, legal representative (or interested family member), and physician (when applicable) aware of changes which directly affect the care and welfare of the resident...Facility personnel shall immediately inform resident, consult with resident's physician; and, if known,			

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	notify the resident's legal representative or an interested family member when there is:...a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment)..." 3.1-5(a)(2)			
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each			

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	resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview, and record review, the facility failed to maintain a homelike setting for 1 of 24 resident rooms reviewed. (Room 17) Findings include: During an observation and interview on 02/20/23 at 12:30 P.M., Resident 57 was lying in his bed in Room 17. The wall next to his bed had an area approximately 3' (feet) x 8" (inches) that had black and brown speckled stains and four large white areas of chipped paint that were about the size of a silver dollar. The wall was painted gray. The resident indicated the wall had been that way since he had moved into the room. During an observation and interview on 02/24/23 at 12:07 P.M., the wall remained as before. The resident indicated maintenance personnel had never come in to touch up or fix the wall. During an interview on 02/24/23 at 12:09 P.M., LPN (Licensed Practical Nurse) 3 indicated the resident had been in his current room for several months. When a resident moved out of a room, generally, maintenance would come in and touch	F 0584	The facility does provide a homelike setting. R57's room was cleaned, and the wall was painted. Housekeeping completed a deep cleaning on the resident's room. All residents have the potential to be affected by this finding. Re-education in services will be conducted with housekeeping staff on cleaning and deep cleaning and turning in maintenance work orders when issues noticed. The Administrator/ AIT, or their designee will select 5 rooms weekly until all rooms have been audited for cleanliness and need of repairs. If all rooms have been audited prior to 6 months time, then a random selection of 5 rooms per week will continue until 6 months has been reached. The audit will be presented to the QAPI committee meeting. An action plan will be written by the committee if any patterns are identified, The action plan that is	04/05/2023

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	up the paint and housekeeping came in and did a deep clean of the room. The resident's bed had always been against the wall. The previous resident had his bed coming out from the wall. The staff completed a work order in "TELS" that went to maintenance and to corporate when there was an environment concern. The clinical record for Resident 57 was reviewed on 02/21/23 at 9:57 A.M. An Annual MDS (Minimum Data Set) assessment, dated 12/10/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, Huntington's disease and seizure disorder. The resident had lived in his current room since 11/02/22. During an interview on 02/24/23 at 12:34 P.M., the AIT (Administrator In Training) indicated she had asked the Maintenance Supervisor to inform her of room conditions that needed addressed. They had a corporate maintenance person. During an interview on 02/27/23 at 10:06 A.M., the AIT indicated housekeeping generally deep cleaned rooms before a new resident moved in. Everything should have been cleaned, the walls, blinds, and window sills. During an interview on 02/27/23 at 10:18 A.M., Housekeeper 8, a recent new hire, indicated he was trained to deep clean rooms after a resident left, that included cleaning the walls, all the pictures, windows, bed frame, pulling the bed away from the wall, and checking the wall behind the bed for food spills. They referred to maintenance for damaged walls. The current undated "Preventative Maintenance / Environmental Services" policy was provided by		written will be monitored by the administrator or his or her designee monthly until resolved and substantial compliance is achieved at 95% or greater	

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	the AIT on 02/27/23 at 5:28 P.M. The policy indicated, "...The facility shall maintain buildings...in a clean condition, in good repair..." This Federal tag relates to Complaint IN00401922. 3.1-19(a)(4) 3.1-19(f)(5)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to accurately complete MDS (Minimum Data Set) assessments related to falls for 2 of 19 residents reviewed. (Residents 60 and 67) Findings include: 1. During an observation and interview on 02/20/23 at 11:59 A.M., Resident 60 indicated she had fallen recently and was supposed to ask for help when getting into bed. The resident was awake, alert, and sitting in her wheelchair. The Progress Notes for December 2022, were provided by the MDS Coordinator on 02/27/23 at 4:30 P.M., and included, but were not limited to, the following: - a note, dated 12/25/22 at 3:15 P.M., indicated the resident had fallen, neurological assessments had been initiated, the resident's pupils were unequal, and the right pupil had a sluggish reaction. The family was notified of the fall with injury and the facility had a new physician's order to send the resident to the emergency room.	F 0641	The facility does accurately assess and complete MDS assessments related to falls R60'S and 67's MDS assessments were modified and re-submitted to accurately reflect their falls Any resident with falls has the potential to be affected by this alleged deficient practice An audit was conducted on the last 3 months of falls for all residents and compared to their MDS assessments. Any discrepancies or lacking information was modified to reflect the correct falls for any identified resident Falls from the prior day(s) will be brought up during the Facility Daily QA Meeting via review of 24 HR sheets and Risk Management in PCC. An in service was presented to MDS Regarding accurately recording falls on MDS the	04/05/2023

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	The "ACCIDENT & INCIDENT REPORT AND INVESTIGATION" record, dated 12/25/22, was provided by the ADON (Assistant Director of Nursing) on 02/23/23 at 3:25 P.M. The record indicated the resident had attempted to transfer herself from her wheelchair to her bed without assistance and was found face down on the floor. The resident acquired four bruises, three skin tears, and three abrasions. The clinical record was reviewed on 02/23/23 at 10:31 A.M. A Quarterly MDS assessment, dated 12/29/22, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, Huntington's disease, depression, and hypertension. The record indicated the resident had not had any falls since admission/entry or reentry or prior assessment. During an interview on 02/23/23 at 1:52 P.M., the ADON indicated the resident had only the one fall on 12/25/22. 2. During an observation and interview on 02/20/23 at 2:21 P.M., Resident 67 indicated he had fallen recently and hit his head. He was sent to the hospital about a week ago. He was wearing a helmet and had a chair alarm on his wheelchair. The clinical record was reviewed on 02/23/23 at 11:45 A.M. A Quarterly MDS assessment, dated 01/07/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, Huntington's disease. The resident had not had any falls since the previous MDS assessment, the Admission assessment, that was completed on 10/07/22. The Progress Notes were provided by the ADON on 02/23/23 at 3:25 P.M., and included, but were		assessment. The Admin/AIT/Regional MDSC or designee, will audit 5 randomly selected MDS assessments weekly x 4 weeks, then 3 weekly x 4 weeks and then 5 monthly x 4 months, (the residents most current MDS will be used) and will ensure fall coding was done correctly. Discrepancies will be modified by the MDSC and further education provided if needed If any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. any written action plan will be monitored by the administrator or her designee monthly until resolved and substantial compliance is achieved 95% or greater.	

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	not limited to: - a note, dated 11/19/2022 at 6:41 P.M., indicated the resident's roommate came to the nurses station and reported that the resident was bleeding. Upon entering the room, he had dried blood on his forehead. The resident reported that he had fallen from his bed hitting his head on the floor. He said he had lost his balance. He had a very small laceration to his forehead. - a note, dated 11/18/2022 at 7:12 A.M., indicated a CNA (Certified Nurse Aide) had heard a muffled sound and the resident walked out of his room with visible blood on his face. The resident had a small abrasion with scant blood to his left forehead. The resident's family and MD were notified of the fall and abrasion. During an interview on 02/24/23 at 12:43 .P.M., the MDS Coordinator indicated residents' falls should be documented on the MDS assessments. A corporate staff member had been assisting with completing the MDS assessments. During an interview on 02/27/23 at 10:36 A.M., the MDS Coordinator indicated the Corporate Regional had been assisting with completing the MDS assessments. The did not have a specific facility policy for completing the MDS assessments. They followed the RAI manual. 3.1-31(d)			
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			

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

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	arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record review, the facility failed to develop care plans for residents that received hospice services, dialysis treatments, and psychotropic medications for 3 of 20 residents reviewed for care plans. (Residents 48, 35, and 11) Findings include: 1. During an interview on 02/21/23 1:07 P.M., Resident 48's family member indicated the resident had received hospice services for the last few months. The resident's clinical record was reviewed on 02/24/23 at 1:25 P.M. A Significant Change MDS (Minimum Data Set) assessment, dated 01/04/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, Huntington's disease, anxiety, and depression. The resident received hospice services. The current physician's orders included an open-ended order, with a start date of 12/28/22, for the resident to be evaluated and treated by a local Hospice service. The resident's complete Care Plan was provided by the MDS Coordinator on 02/27/23 at 5:13 P.M. The complete Care Plan lacked a plan of care for hospice services. 2. The clinical record for Resident 35 was reviewed on 02/22/23 at 11:03 A.M. A Quarterly MDS assessment, dated 02/12/23, indicated the resident was cognitively intact. The diagnoses included,	F 0656	The facility does develop care plans for resident that receive hospice services, dialysis treatments and psychotropic medications. R 48's Care plan has been updated to include Hospice services. R35's Care plan has now been updated to include dialysis. R11's Care plan is now current addressing psychotropic Med use Any resident on Hospice, Dialysis or using Psychotropic Medications have the risk to be affected by this alleged, deficient practice. Re-education in-servicing is to be conducted to the MDS coordinator regarding accuracy of care plans. An audit was done on all residents. Those receiving Hospice, Dialysis and/or using Psychotropic Medications all have Care Plans reflecting this. The Admin/AIT/Regional MDSC or designee, will audit 5 randomly selected MDS assessments weekly x 4 weeks, then 3 weekly x 4 weeks and then 5 monthly x 4 months. The audit will check to be sure Hospice, Dialysis and/or Psychotropic Care Plans are present if applicable. Discrepancies will be modified by the MDSC and further education provided if needed.	04/05/2023

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	but were not limited to, hypertension, renal insufficiency, diabetes, and dependence on renal dialysis. During an observation and interview on 02/22/23 at 9:05 A.M., Resident 35 was awake in his room. He was getting ready to leave for dialysis. An open-ended physician's order, with a start date of 12/20/22, indicated the resident was to go to dialysis every Tuesday. The complete Care Plan for Resident 35 was provided by the MDS Coordinator on 02/24/23 at 10:34 A.M. The complete Care Plan lacked a dialysis care plan. During an interview on 02/27/23 at 4:54 P.M., the MDS Coordinator indicated residents should have a care plan for hospice, dialysis, and psychotropic medications. 3. The clinical record for Resident 11 was reviewed on 02/27/23 at 10:36 A.M. A Quarterly MDS assessment, dated 01/04/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease, hypertension, dementia, diabetes, depression, and psychotic disorder. The resident received an antipsychotic and an antidepressant medication for seven of seven days of the assessment review period. The EMAR/ETAR for February 2023 was provided by the MDS Coordinator on 02/27/23 at 4:30 P.M., and indicated the resident received the following medications: - Sertraline (an antidepressant) 150 mg (milligrams) one time a day, with a start date of 01/21/23,		This audit tool will be presented to the QAPI meeting. If any patterns are identified the committee will write an action plan this action plan will be monitored by the administrator or her designee monthly until resolved and substantial compliance is achieved at 95% or greater	

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	- Risperdal tablet (an antipsychotic) 1 mg two times a day, with a start date of 12/27/22, - Risperdone microspheres ER (extended release) (an antipsychotic) 25 mg every 14 days, with a start date of 02/02/23. The complete Care Plan was provided by the MDS Coordinator on 02/27/23 at 4:30 P.M. The Care Plan lacked documentation that the resident received psychotropic medications. The "CARE PLAN DEVELOPMENT AND REVIEW" policy, with a revision date of 9/17, was provided by Human Resource on 02/27/23 at 5:04 P.M. The policy indicated, "...This facility shall then develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs are identified in the comprehensive assessment..." 3.1-35(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives			

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	necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to monitor and administer treatments for a pressure ulcer for 1 of 3 residents reviewed for pressure ulcers. (Resident 25) Findings include: The clinical record for Resident 25 was reviewed on 02/22/23 at 11:22 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 01/31/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, hypertension, dementia, seizure disorder, and infection in her right foot. The resident required supervision and set up for most ADLs (Activities of Daily Living). The resident had one Stage 3 (full thickness skin loss) pressure ulcer. During an observation on 02/22/23 at 11:39 A.M., PT (Physical Therapist) 6 donned gloves, removed the old dressing from the resident's right foot, changed gloves, cleansed the wound with wound cleanser, applied a gauze pad soaked with acetic acid to the wound, covered with a dry gauze pad, wrapped the foot with gauze, and secured it with tape. The wound measured 0.7 cm (centimeters) x (by) 0.5 cm x 0.4 cm deep. A PT Note, dated 12/26/22, indicated the wound measured 0.1 cm x 0.1 cm x 0.1 cm with a scant amount of drainage and no signs of infection. Discharge recommendations were for the nursing department to continue wet to dry dressings with acetic acid, cover with gauze or conforming bandage every Monday, Wednesday, and Friday.	F 0686	The facility does monitor and administer treatments for pressure ulcers. R25 now has monitoring and treatments completed as ordered to pressure ulcer Any resident with a pressure ulcer is potentially at risk from this alleged, deficient practice An audit was done of all residents with Pressure Ulcers to be sure treatments are being completed as ordered A re-education in -service was provided for all nurses' r/t checking treatment records daily to ensure documentation is completed. The DON/ADON or her designee will audit TARs for completion of pressure ulcer treatment daily times 4 weeks then weekly times four weeks and then monthly times four months. Re-education and/or disciplinary action will follow for failure to complete treatments. Any concerns will be addressed as discovered. If any patterns are identified at the monthly QAPI meeting an action plan will be written by the QAPI committee. Any written action plan will be monitored by the administrator or her designee monthly until resolved and substantial compliance is achieved at 95%	04/05/2023

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	A Non-pressure skin condition report, dated 01/17/23, indicated the resident had a callus on the ball of her right foot that was previously healed. The area measured 0.5 cm x 0.5 cm x 0.7 cm. A note was added that PT completed wound care and the area was wrapped with gauze until PT returned. The clinical record lacked documentation of dressing changes or weekly monitoring completed from 12/27/22 to 01/17/23. During an interview on 02/22/23 at 11:39 A.M., PT 6 indicated the wound was closed when she left for vacation in December and when she returned in January it was opened with drainage and an odor. During an interview on 02/24/23 at 10:37 A.M., the Assistant Director of Nursing indicated nursing was to assume skin checks and dressing changes in PT 6's absence. On 01/24/23 a wound culture was obtained and indicated the resident had MRSA (Methicillin-resistant Staphyloccus) infection requiring an antibiotic. The current facility policy titled "PRESSURE ULCER" dated 10/2014, was provided by the Minimum Data Set Coordinator on 02/27/23 at 2:28 P.M. The policy indicated "...To assure residents with pressure ulcers will receive necessary care and treatment to promote healing, prevent new ulcers from developing and prevent infection..." 3.1-40(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence.			

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	§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, interview, and record review, the facility failed to obtain a urinalysis in a timely manner for 1 of 1 residents reviewed for UTI. (Resident 6) Findings include:	F 0690	The facility does obtain urinalysis in a timely manner R6s will have future urinalysis completed in a timely manner or the physician will be notified and a progress note made notating why.	04/05/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an observation on 02/22/23 at 11:15 A.M., Resident 6 was sitting in her wheelchair in the hallway. She was working with therapy. The clinical record for Resident 6 was reviewed on 02/24/23 at 2:12 P.M. An Admission MDS (Minimum Data Set) assessment, dated 01/06/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, acute and chronic respiratory failure, anemia, hypertension, pneumonia, UTI (Urinary Tract Infection), diabetes, and anxiety. A Progress Note, dated 02/02/23 at 8:51 P.M., indicated the resident had increased confusion that day. A new order was received for a UA (Urinalysis) and C/S (Culture and Sensitivity) if indicated. The residents POA (Power of Attorney) was called and informed. The order was submitted to the laboratory. A Progress Note, dated 02/03/23 at 4:09 A.M., indicated the staff were unable to obtain a urine sample for the laboratory due to the resident sleeping and being non-cooperative. A second attempt was unsuccessful. The resident still needed a urine sample to send to the laboratory. A Progress Note, dated 02/10/23 at 2:13 P.M., indicated the resident was seen by the Nurse Practitioner and a new order was received to start Augmentin (an antibiotic) 875 mg (milligrams) and Cipro (an antibiotic) 500 mg by mouth, twice a day, for 10 days for a UTI. A UA with culture result, indicated the specimen was collected on 02/06/23 and reported 02/09/23. During an interview on 02/27/23 at 2:01 P.M., LPN		Resident had another urine sample sent off 3/13 All resident requiring a UA will have it performed in a timely manner or the physician will be notified and a progress made notating why. A facility wide lab audit was conducted and no other resident noted to have an order for Urinalysis at that time. Nurses received re-education in-servicing on timely collection of UA's. Nurses were reminded that if a specimen cannot be obtained in 24 hours, they are to contact the physician and document a progress note. DON/ADON and/or designee will bring a list of new orders from the prior day/day(s) to each facility daily QA meeting held M-F. Every urinalysis order noted in the first 4 weeks will be followed up on and any non-compliance will be addressed at that time. For the next 5 months, at least 1 urinalysis order noted per day will be followed up on to ensure completion and /or documentation. If any patterns are identified at the monthly QAPI meeting and action plan will be written by the committee. Any written action plan will be monitored by the administrator and or her designee monthly until resolved and substantial compliance is achieved at 95% or greater.	

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	(Licensed Practical Nurse) 2 indicated when she received an order to obtain a UA, she would input the order in the laboratory system. She would attempt to get a clean catch urine unless it was specified different. The urine would be put in the Wing 1 refrigerator and the laboratory would pick it up from there. The UA should be obtained in a timely manner and no later than 24 hours. If she wasn't able to obtain it within 24 hours then she would contact the MD and document a progress note. The current facility policy titled, "Laboratory Orders, Timely Draw", with a revision date of 10/2014, was provided by Human Resources on 02/27/23 at 5:04 P.M. The policy indicated, "...Laboratory testing shall be conducted in a timely manner per physician's orders..." 3.1-41(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake			

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	to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to adequately monitor a resident with a significant weight loss for 1 of 3 residents reviewed for nutrition. (Resident 21) Findings include: On 02/21/23 at 2:00 P.M., Resident 21 was observed in her room. The resident indicated she had lost some weight but was tired and did not want to talk anymore at that time. On 02/22/23 at 12:43 P.M., Resident 21 was observed eating lunch in the dining room. The resident was eating without assistance and had lidded cups for her drinks. During an interview on 02/23/23 at 11:14 A.M. LPN (Licensed Practical Nurse) 3 indicated the resident had lost weight. The staff provided snacks and she received nutritional supplements. They encouraged the resident to wake up and eat, and they offered substitute meals if the resident didn't like what they were serving. The Registered Dietician followed her, and she was in the NAR (Nutritionally At Risk) program. The resident's clinical record was reviewed on 02/27/23 at 1:40 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 02/06/23, indicated the resident was moderately cognitively intact. The resident exhibited no behaviors, including refusal of care during the assessment review period. The diagnoses included, but were not limited to, Huntington's disease, hyperlipidemia,	F 0692	The facility does monitor residents with significant weight loss R21 is on the NAR program and documentation of the program is now kept. Any refusal by the resident to weigh is now documented. The NAR program is updated weekly. Each resident on the program is monitored and documentation is kept. A facility wide audit was conducted to ensure that residents with significant weight loss are on the program. Nurses will receive re-education in-servicing regarding monitoring of weight loss and the NAR program; including keeping documentation for any resident on the program, documenting refusal to weigh. Inservice to include weighing residents monthly and as required per NAR program. The Administrator/AIT or designee will attend NAR meeting weekly x 4 weeks and ensure protocol is followed and documentation is made, then 2 times a month for 2 months then monthly x 3 months. Any patterns identified at the monthly QAPI meeting and action plan will be written by the committee. Any written action plan will be monitored by the	04/05/2023

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	dementia, psychotic disorder, and dysphagia. The resident weighed 148 lbs. The resident had lost 5% (percent) or more of her body weight in the last month or 10% or more of her body weight in the last 6 months and was not on a physician prescribed weight-loss regimen. The weights recorded for the last several months in the resident's clinical record were as follows: 05/24/2022 174.0 lbs. 06/3/2022 174.0 lbs. 07/13/2022 173.0 lbs. 08/29/2022 163.0 lbs. 11/7/2022 151.0 lbs. 01/9/2023 148.0 lbs. 02/6/2023 146.0 lbs. On 08/29/2022, the resident weighed 163 lbs. On 02/06/2023, the resident weighed 146 lbs. which was a 10.43 % weight Loss. A document titled "INDIVIDUAL SWAT RECORD" was provided by the MDS Coordinator on 02/27/23 at 5:18 P.M. The document listed the resident's name. The section titled "Weight/Nutritional Monitoring" indicated an intervention of adding benecalorie (a nutritional supplement) to the resident's red flavored drink three times a day with meals. During an interview on 02/27/23 at 4:54 P.M., the MDS Coordinator indicated a resident with weight loss should be on the NAR program. They should be weighed weekly for 4 weeks and then reassessed. They have had changes with management, and missing documentation related to their NAR program. This resident had been on the NAR program for some time. The resident sometimes refused to be weighed, but not always,		administrator or her designee monthly until resolved and substantial compliance is achieved at 95% or greater	

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	and any refusals should be documented. There have been times weights had not been obtained on the resident's unit for the whole month. There was no indication in the resident's clinical record she refused to be weighed. The facility could not provide documentation of the resident being on the NAR program prior to the 02/20/23 documentation. The current facility policy, titled "Interdisciplinary Team Process", dated 10/2010, was provided by the AIT (Administrator in Training) on 02/27/23 at 5:27 P.M. The policy indicated, "...Residents who are nutritionally at risk are reviewed through the interdisciplinary nutrition at risk (NAR) meeting...Residents will be reviewed bi-weekly...The resident will remain in the NAR program until the condition as stabilized...The IDT should review the clinical record...weight logs..." 3.1-46(a)(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 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, interview, and record review, the facility failed to appropriately manage a resident's respiratory needs related to	F 0695	The facility does manage a resident's respiratory needs by maintaining oxygen equipment.	04/05/2023

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	maintaining oxygen equipment for 1 of 1 resident reviewed for respiratory care. (Resident 27) Findings include: On 02/20/23 at 11:58 A.M., Resident 27 was observed in his room in bed. The resident indicated he received oxygen therapy all the time. The resident's nasal cannula was in place and attached to an oxygen concentrator next to his bed. A piece of tape wrapped around the tubing was dated 01/30. The refillable water container attached to the oxygen concentrator was nearly empty and was not labeled. On 02/21/23 at 3:27 P.M., the resident was observed with CNA (Certified Nurse Aide) 4. The resident was in bed. The resident's nasal cannula was in place and attached to the oxygen concentrator next to his bed. The tubing was dated 01/30, and the water container remained nearly empty. The resident indicated staff would refill the water container if he asked them to. CNA 4 indicated the nurses were responsible for changing oxygen tubing and refilling the water containers. On 02/22/23 at 10:48 A.M., the resident's oxygen tubing attached to the concentrator was still dated 01/30 and the water container was empty. The resident's clinical record was reviewed on 02/22/23 at 12:31 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 02/03/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease), pneumonia, and diabetes. The resident was receiving hospice services.		R27's tubing and water container was changed immediately and is now changed every week per protocol and as ordered. Any resident utilizing oxygen equipment is at risk for this alleged, deficient practice. A facility wide audit was conducted to identify all residents requiring oxygen equipment and ensure equipment is maintained properly. Any tubing found not to be compliant with facility protocol and/or physician order was changed. Nurses received re-education in-servicing r/t changing and dating oxygen equipment weekly and documenting accordingly. The DON/ADON and/or designee will select 3 random residents weekly times 4 weeks that are utilizing oxygen equipment and visualize tubing and water bottles to ensure they are changed as ordered, then 3 residents every other week times 4 weeks and then 3 residents monthly times 4 months. Non-compliance will be corrected immediately when noted with continuing education and/or disciplinary action as needed. if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee any written action plan will be monitored by the administrator or her designee monthly until resolved and substantial compliance is	

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	The resident's current physician's orders included, but were not limited to the following: - An open-ended order, with a start date of 09/29/2022, indicated staff were to change the oxygen humidifier every Sunday on dayshift and as needed, and - An open-ended order, with a start date of 10/2/2022, indicated staff were to change the oxygen tubing every Sunday on evening shift. The February 2023 ETAR (Electronic Treatment Administration Record) documentation indicated the resident's oxygen tubing and humidifier were marked as changed on 02/05, 02/12, and 02/19. The oxygen tubing observed connected to the resident's oxygen concentrator was dated as changed on 01/30. During an interview on 02/27/23 at 2:13 P.M., LPN (Licensed Practical Nurse) 2 indicated oxygen tubing should be changed once a week, night shift usually changed out the tubing. The current facility policy, titled "OXYGEN THERAPY", and dated 10/2014, was provided by the MDS Coordinator on 02/27/23 at 2:37 P.M. The policy indicated, "...All oxygen delivery devices shall be replaced weekly and PRN [as needed]...humidifier bottles shall be replaced weekly and PRN..." 3.1-47(a)(6)		achieved at 95% or greater	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who			

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	require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to monitor a dialysis access site for 1 of 1 resident reviewed for dialysis. (Resident 35) Findings include: During an observation and interview on 02/22/23 at 9:05 A.M., Resident 35 was awake in his room. He was getting ready to leave for dialysis. He indicated he had a fistula in his left arm. The clinical record for Resident 35 was reviewed on 02/22/23 at 11:03 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 02/12/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, hypertension, renal insufficiency, diabetes, and dependence on renal dialysis. An open-ended physician's order, with a start date of 12/15/22, indicated the resident was not to received laboratory or blood pressure in the left arm related to his fistula. During an interview on 02/22/23 at 11:25 A.M., LPN (Licensed Practical Nurse) 2 indicated the resident required dialysis. He was a brittle diabetic and refused care often. The resident had a fistula in the left upper arm. The staff should check it each shift for bruit and thrill and document in the EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record). She always monitored it on her shift. The staff should follow the physician	F 0698	The facility does monitor dialysis access sites R35's MAR has been updated to check AV fistula every shift for bruit and thrill, swelling, redness, pain, warmth and or drainage. No other residents with AV fistulas. Re-education in servicing was conducted involving Nurses regarding checking AV Fistulas every shift and notify physician immediately if negative findings or no bruit and/or thrill present. The Admin/AIT/ADON and/or designee will audit MAR for checking of AV fistula daily x 5 days a week for four weeks then weekly for four weeks then monthly for four months. This audit will be presented to the QAPI meeting. An action plan will be written by the committee if any patterns are identified. An action plan will be monitored by the administrator and or his or her designee monthly until resolved and substantial compliance is achieved at 95% or greater.	04/05/2023

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	orders. During an interview on 02/24/23 at 9:48 A.M., LPN 13 indicated the resident had orders to be weighed before and after dialysis, which he often refused. They would fill out a dialysis communication form each day of dialysis and the forms went into a binder. The resident had a fistula in his right upper arm. The nurse should access the site before and after dialysis and every shift. It should be monitored for bleeding, bruising, bruit, and thrill. Staff should document in the EMAR/ETAR that the site was monitored. The EMAR/ETAR was observed with no physician orders to monitor the site. The clinical record lacked orders for a dialysis access site and orders to monitor the access site in the facility. The current facility policy titled, "Dialysis, Renal" with a revised date of 11/14/2015, was provided by the AIT (Administrator in Training) on 02/24/23 at 12:06 P.M. The policy indicated, "...To inform staff, families, and residents of procedure in dealing with a resident that requires Renal Dialysis...Residents with an AV fistula will have the site checked every shift for bruit and thrill-notify the primary care physician immediately of negative findings..." The current facility policy titled, "Dialysis Coordination/Facility Services", with a revised date of 9/17, was provided by the AIT on 02/24/23 at 12:06 P.M. The policy indicated, "...To ensure effective communication between the facility and dialysis center providing service to the resident...Review physician's orders for the resident receiving dialysis to confirm: -Type of access site and location, -Orders for care or			

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	access sire, if any specified...Licensed nursing personnel will monitor the resident with a shunt/access or central line utilized for dialysis every shift. Notation shall be made on the medication administration record to denote bruit (heard) and thrill (palpated) each shift...The following should be addressed on the Treatment Administration Record every shift of the resident on dialysis who has a shunt in place: -Bruit (heard), -Thrill (palpated), -Site observed for bleeding, edema, warmth, redness..." 3.1-37(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.			

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	Based on observation, interview, and record review, the facility failed to follow physician's orders related to medication administration parameters for cardiac medications and monitor for adverse side effects of an anticoagulant medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 16) Findings include: Resident 16 was observed in his room on 02/20/23 at 12:43 P.M. The resident was sitting on his bed drinking a soda. The resident's clinical record was reviewed on 02/27/23 at 10:28 A.M. An Annual MDS (Minimum Data Set) assessment, dated 02/03/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease), atrial fibrillation, heart failure, hypertension, orthostatic hypotension, and schizophrenia. The resident's current physician's orders included the following: An open-ended order, with a start date of 09/13/22, for Cardizem CD Capsule Extended Release, 180 mg (milligram) capsule. The medication was to be administered daily at 7:00 A.M., related to cardiac arrhythmia. The nurse was to hold the medication if the sbp (systolic blood pressure) was less than 110. The medication was administered when the sbp was less than 110 on the following dates: - 01/22/23, the blood pressure was 104/62, - 02/06/23, the blood pressure was 98/66, - 02/18/23, the blood pressure was 90/32,	F 0757	The facility follows physicians' orders related to medication administration parameters for cardiac medications and monitors for side effects of anti coagulant medications. R16's cardiac medications are now administered following the parameters as listed. This is resident is now monitored for SEs of anti-coagulant every shift. Any resident with parameters on their cardiac medication and/or receiving anti-coagulant medication are at risk for this alleged, deficient practice. A resident audit was completed to identify other residents with parameters on their cardiac medication and those on anti-coagulants. Corrections made to identified non-compliance at that time. Nurses/'QMA's received re-education in servicing on following medication parameters as ordered and ensuring resident's with anti-coagulants are being monitored for side effects. The DON/ADON/Designee will select 3 residents daily, 5x week x 4 weeks, then 3 residents weekly x 4 weeks then 3 residents monthly x 4 months, that were identified from the audit and will check to ensure parameters being followed and/or resident is being monitored for side effects of anti coagulant. Non-compliance will be addressed immediately and staff	04/05/2023

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	- 02/21/23, the blood pressure was 105/58, and - 02/27/23, the blood pressure was 106/64. An open-ended order, with a start date of 11/29/22, for Midodrine HCL, 5 mg tablet. The medication was to be administered two times daily, at 11:00 A.M. and 5:00 P.M., related to hypotension. The nurse was to hold the medication if the sbp was greater than 130. The medication was administered when the sbp was greater than 130 on the following dates and times: - 01/05/23, the blood pressures were 144/76 at 11:00 A.M., and 140/78 at 5:00 P.M., - 01/10/23, the blood pressure was 157/72 at 11:00 A.M., - 01/12/23, the blood pressure was 132/78 at 5:00 P.M., - 01/26/23, the blood pressure was 146/74 at 5:00 P.M., - 01/27/23, the blood pressure was 132/68 at 5:00 P.M., - 01/29/23, the blood pressure was 136/79 at 11:00 A.M., - 02/04/23, the blood pressures were 140/70 at 11:00 A.M., and 140/70 at 5:00 P.M., - 02/25/23, the blood pressures were 144/82 at 11:00 A.M., and 134/76 at 5:00 P.M., and - 02/26/23, the blood pressures were 140/70 at 11:00 A.M., and 134/68 at 5:00 P.M. An open-ended order, with a start date of 12/15/22, for Eliquis (an anticoagulant medication) 5 mg two times a day related to cardiac arrhythmia. During an interview on 02/27/23 at 2:13 P.M., LPN 2 indicated a resident taking an anticoagulant should be monitored for side effects of the		will receive re-education and/or disciplinary action. if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. Any written action plan will be monitored by the administrator or her designee's monthly until resolved and substantial compliance is achieved at 95% or greater.	

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	medication, including bleeding and bruising. Nurses document monitoring side effects of medications every shift on the EMAR/ETAR. The resident's January and February 2023 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) was provided by the MDS Coordinator on 02/27/23 at 3:27 P.M. The EMAR/ETARs indicated the anticoagulant medication was administered twice a day as ordered. There was no indication the resident was monitored for side effects of the anticoagulant medication. The resident's Care Plans were reviewed on 02/27/23 at 2:23 P.M. A nursing intervention from a current care plan related to anticoagulant use indicated staff were to monitor for signs and symptoms of anticoagulant complications. The current facility policy titled, "Physician Orders", dated 10/2014, was provided by the AIT (Administrator in Training) on 02/27/23 at 1:36 P.M. The policy indicated, "...Physician's orders are administered upon the clear, complete and signed order of an individual lawfully authorized to prescribe..." 3.1-48(a)(6)			
F 0758 SS=E Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:			

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	(i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident			

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	for the appropriateness of that medication. Based on observation, interview, and record review, the facility failed to adequately monitor residents for adverse side effects of psychotropic medications for 4 of 5 residents reviewed for unnecessary medications. (Residents 16, 11, 15, and 36) Findings include: 1. Resident 16 was observed in his room on 02/20/23 at 12:43 P.M. The resident indicated he heard voices at times. He took Haldol (an antipsychotic medication) for the voices, and regularly saw a therapist. The resident's clinical record was reviewed on 02/27/23 at 10:28 A.M. An Annual MDS (Minimum Data Set) assessment, dated 02/03/23, indicated the resident was cognitively intact. There were no behaviors observed during the assessment review period. The diagnoses included, but were not limited to, schizophrenia and depression. The resident's January and February 2023 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) was provided by the MDS Coordinator on 02/27/23 at 3:27 P.M. The EMAR/ETARs indicated the following medications were administered as ordered by the physician on the following dates: - Haldol Decanoate Solution (Haloperidol), inject 75 mg (milligrams) intramuscularly every two weeks related to schizoaffective disorder. The order started on 12/12/2022 and was discontinued on 01/12/23. The resident received the medication on 01/09/23.	F 0758	The facility does adequately monitor residents for adverse side effects of psychotropic medication R16, 11, 15 and 36's 's Mars were updated to include observation for side effects related to the use of antipsychotic medication Any resident that receives a psychotropic medication has the potential to be affected by this alleged, deficient practice. A facility wide audit was conducted and all residents receiving psychotropic medications were identified. MARs were updated on all residents necessary to ensure staff are monitoring for SE of psychotropic medications. Nurse's and QMA in-serviced on monitoring for side effects of psychotropic medications when a resident has an order for one or more. The DON/ADON and/or Designee will randomly select 5 residents per week x 4 weeks, then 5 residents every other week x 4 weeks and then 5 residents monthly x 4 months, from the audited list and ensure side effects are being monitored If any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee any written action plan will be monitored by the administrator or her designee monthly until resolved and	04/05/2023

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	- Haldol Decanoate Solution (Haloperidol), inject 100 mg intramuscularly every two weeks related to schizoaffective disorder. The current, open-ended order started on 01/23/23. The resident received the medication on 01/23/23, 02/06/23, and 02/20/23. During an interview on 02/27/23 at 2:13 P.M., LPN (Licensed Practical Nurse) 2 indicated a resident taking Haldol should be monitored for side effects of the medication, including sedation. Nurses document monitoring side effects of antipsychotic medications every shift on the EMAR/ETAR. The EMAR/ETAR lacked documentation the resident was monitored for adverse side effects of the antipsychotic medication. The NAMI (National Alliance on Mental Illness) electronic document titled "Haloperidol (Haldol)", updated January 2023, was reviewed on 02/27/23 at 4:00 P.M. The document indicated "...common side effects...rapid heartbeat, constipation, blurry vision, dry mouth, drop in blood pressure upon standing, extrapyramidal symptoms...feeling drowsy, dizzy, or restless...some people may develop muscle related side effects while taking haloperidol...the technical terms for these are "extrapyramidal symptoms" (EPS) and "tardive dyskinesia" (TD)... symptoms of EPS include restlessness, tremor, and stiffness...TD symptoms include slow or jerky movements that one cannot control, often starting in the mouth with tongue rolling or chewing movements..." 2. The clinical record for Resident 11 was reviewed on 02/27/23 at 10:36 A.M. A Quarterly MDS assessment, dated 01/04/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease, hypertension,		substantial compliance is achieved at 95% or greater	

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	dementia, diabetes, depression, and psychotic disorder. The resident received an antipsychotic and an antidepressant medication for seven of seven days of the assessment review period. The EMAR/ETAR for February 2023 was provided by the MDS Coordinator on 02/27/23 at 4:30 P.M., and indicated the resident received the following medications: - Sertraline (an antidepressant) 150 mg (milligrams) one time a day, with a start date of 01/21/23. - Risperdal tablet (an antipsychotic) 1 mg two times a day, with a start date of 12/27/22. - Risperdone microspheres ER (extended release) (an antipsychotic) 25 mg every 14 days, with a start date of 02/02/23. The record lacked orders to monitor for possible ASE (Adverse Side Effects) to the antipsychotic medications listed above. 3. The clinical record for Resident 15 was reviewed on 02/22/23 at 12:55 P.M. A Quarterly MDS assessment, dated 01/25/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease, hypertension, dementia, and anxiety. The resident received an antianxiety and an antidepressant medication for seven of seven days of the assessment review period. The EMAR/ETAR for February 2023 was provided by the MDS Coordinator on 02/27/23 at 4:30 P.M., and indicated the resident received the following medications: - Sertraline (an antidepressant) 150 mg every			

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	morning, with a start date of 12/18/22. - Trazodone (an antidepressant) 50 mg at bedtime, with a start date of 12/18/22, (the dosage was reduced on 02/10/23 to 25 mg at bedtime). - Clonazepam (an antianxiety) 1 mg at bedtime, with a start date of 12/18/22. The Care Plan for the use of psychoactive medications was provided by the MDS Coordinator on 02/27/23 at 4:30 P.M., interventions included, but were not limited to, "Observe for side effects...". The current facility policy titled, "ANTIPSYCHOTIC DRUG USE POLICY", with a revision date of 5/09, was provided by Human Resources on 02/27/23 at 5:04 P.M. The policy indicated, "...Ongoing monitoring will occur to assess risk/benefit relationship of anti-psychotic drug therapy including the appropriateness of drug selection and dose and to monitor adverse consequences related to anti-psychotic medication use..." 4. The clinical record for Resident 36 was reviewed on 02/24/23 at 1:21 P.M. An Annual MDS assessment, dated 02/12/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, anxiety, bipolar disorder, and psychotic disorder. The resident received an antipsychotic and an antianxiety medication for seven of seven days of the assessment review period, and an antidepressant for six of seven days of the assessment review period. The EMAR/ETAR for February 2023 was provided by the MDS Coordinator on 02/27/23 at 10:59 A.M., and indicated the resident received			

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	the following medications: - Remeron (an antidepressant) 7.5 mg at bedtime, with a start date of 02/07/23. - Trazodone (an antidepressant) 125 mg at bedtime, with a start date of 02/09/23, (the dosage was reduced on 02/09/23, the resident had received the medication since 10/26/22. - Diazepam (an antianxiety) 5 ml (milliliters) two times a day, with a start date of 11/11/22. - Ziprasidone (an atypical antipsychotic) 40 mg two times a day, with a start date of 07/06/22. The record lacked orders to monitor for possible ASE to the above listed medications. The Care Plan for the use of psychoactive medications was provided by the MDS Coordinator on 02/27/23 at 4:30 P.M., interventions included, but were not limited to, "Assess for side effects and complications". During an interview on 02/27/23 at 10:09 A.M., QMA (Qualified Medication Assistant) 7 indicated in regard to medication's side effects, they monitored them on the ETAR. ASE were on the ETARS for psychotropic medications including antianxiety, antidepressant, and antipsychotic medications. During an interview on 02/27/23 at 10:30 A.M., the MDS Coordinator indicated for ASE the residents usually had orders in the EMAR/ETAR. They should have the possible side effect examples listed to monitor. The resident should have had orders to monitor the ASE to the antidepressant, antianxiety, and antipsychotic medications.			

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	The current Psychotropic Management policy, with a revised date of March 2015, was provided by the MDS Coordinator on 02/27/23 at 10:59 A.M. The policy indicated, "...Qualified staff will monitor for potential undesirable side effects that are associated with the use of psychoactive drugs...each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used...Without adequate monitoring..." 3.1-48(a)(3)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit			

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	package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to store medications appropriately related to insulin pens for 2 of 4 medication carts reviewed (Green Cart and Red Cart), failed to return medications to the pharmacy in a timely manner for 1 of 2 medication rooms reviewed (Wing 2 medication room), and failed to lock medication carts for 2 of 8 observations (Unit 3 medication cart and Wing 3 Medication carts). Findings include: 1. The Green Medication Cart on Wing 3 was observed on 02/23/23 at 9:15 A.M., with LPN (Licensed Practical Nurse) 2 and contained the following: - a Lispro insulin pen, with an opened date of 01/21/23, for Resident 6 that was 2/3 full. The nurse indicated the resident did not receive the insulin every day. - a Basaglar insulin pen, with no open date and delivered on 01/23/23, for Resident 6 that was 1/4 full. The nurse indicated the resident received the insulin every day. - a Lispro insulin vial, with no open date and delivered on 12/14/22, for Resident 35 that was 1/4 full. The nurse indicated the resident received the insulin every day. - a Lispro insulin vial, with an opened date of 12/06/22, for Resident 35 that was 1/2 full. The nurse indicated the resident received the insulin every day.	F 0761	The facility does label and store insulin pens appropriately, returns medications to the pharmacy in a timely manner and locks medication carts. R6's Lispro and Basaglar insulin pens were replaced and dated and labeled upon opening. R35's Lispro insulin pens were replaced and dated and labeled upon opening. R68's Lispro insulin pen was replaced and dated and labeled upon opening. R250'S medications were returned to pharmacy. Unlocked med carts were locked. All residents receiving insulin or any medication have the potential to be affected by this alleged deficient practice as well as any residents in the vicinity of an unlocked, unsupervised medication cart Nurses and QMA's, when applicable, will receive re-education in- servicing on: a) proper storage, labeling and dating of insulin pens; b) return/ destruction of medications in a timely manner; and c) locking medication/ treatment carts when out of eyesight The DON/ADON/Designee will audit medication carts containing insulin pens weekly x 4 weeks,	04/05/2023

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	2. The Red Medication Cart on Wing 3 was observed on 02/23/23 at 9:33 A.M., with LPN 2 and contained the following: - a Lispro insulin vial, with no open dated and delivered on 12/20/22, for Resident 68 that was 3/4 full. The plastic medication bottle the vial was stored in was dated 12/28/22. The nurse indicated the resident was on a sliding scale and received the insulin on most days. LPN 2 indicated insulin pens and vials were good for 28 days after opening or brought out of the refrigerator. The staff were supposed to label insulin when retrieved from the refrigerator. The residents had not been sent out for high blood glucose levels. The package insert for Lispro insulin was provided by the ADON on 02/27/23 at 5:11 P.M., and indicated, "...Storage and Handling...Do not use after the expiration date...In-use Insulin...vials and...pens...must be used within 28 days of be discarded, even if they still contain Insulin..." The package insert for Basaglar insulin was provided by the ADON on 02/27/23 at 5:11 P.M., and indicated, "...Storage and Handling...In-use...pens...must be used within 28 days of be discarded, even if they still contain Basaglar..." 3. The medication room on Wing 2 was observed on 02/27/23 at 2:37 P.M., with the MDS (Minimum Data Set) Coordinator. A box was sitting on the floor and contained the following medications for Resident 250: - Tetrabenezine 25 mg (milligrams) tablets, one card of 3, and one card of 29,		then every other weeks x 4 weeks and then monthly x 4 months to ensure insulin pens are being labeled and stored properly The DON/ADON/Designee will audit all medication rooms for expired medications weekly x 4 weeks, then every other weeks x 4 weeks and then monthly x 4 months to ensure discontinued medications are returned in a timely manner The Administrator/AIT/DON/Designee perform walking rounds to observe that unsupervised medication carts are not left unlocked. If found, carts will be locked immediately and staff responsible will be reeducated and potential disciplinary action. Any patterns identified by the monthly QAPI meeting, an action plan will be written by the committee. any written action plan will be monitored by the administrator or her designee monthly until resolved and substantial compliance is achieved at 95% or greater.	

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	- Haldol 2 mg, one card of 12 tablets, one card of 30 tablets, - Omeprazole 20 mg, one card of 5 capsules, one card of 30 tablets, - Singular 10 mg, one card of 25 tablets, - Senna 8.6 mg tablets, one card of 24 tablets, one card of 30 tablets, - Zoloft 100 mg, one card of 17 tablets, one card of 30 tablets, - Trazodone 50 mg, one card of 18 tablets, - Tylenol 325 mg, one card of 7 tablets, - Immodium 2 mg, one card of 9 capsules, and one card of 30 capsules. The MDS Coordinator indicated Resident 250 had passed away on 11/29/22. Her medications should have been returned to the pharmacy within two weeks of her passing. Medications appropriate for return should be returned to the pharmacy on a weekly basis. The night shift staff were to perform that duty when the pharmacy delivered medications at night. The current "MEDICATION RETURN/DESTRUCTION GUIDANCE" policy, dated 10/2014, was provided by the MDS Coordinator on 02/27/23 at 3:29 P.M. The policy indicated, "...All discontinued medications...should be returned to the pharmacy..." 4. Medication administration was observed on 02/24/23 at 8:17 A.M., with the DON, on Unit 3. The DON, while standing at the medication cart that was parked next to the nurse's station desk, drew up insulin for Resident 10, left the medication cart unlocked, and walked into the resident's room out of sight of the medication cart. Several residents were in the area around the medication cart located at the nurse's station.			

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	5. During a random observation on 02/21/23 at 3:20 P.M., two medication carts on Wing 3 were at the nurses' station. The nurse was not present and both carts were unlocked. On 02/21/23 at 3:21 P.M., an Activities Aide and a CNA (Certified Nurse Aide) walked past the unlocked carts. On 02/21/23 at 3:26 P.M., an office staff member and two CNAs walked by the unlocked carts. On 02/21/23 at 3:28 P.M., the DON came back and and locked the carts. During an interview on 02/27/23 at 2:13 P.M., LPN 2 indicated medication carts were supposed to be locked at all times. If the nurse stepped away from the cart, it should be locked. The current facility policy, titled "Storage of Medications", with a revision date of 08/2020, was provided by the MDS Coordinator on 02/27/23 at 2:13 P.M. The policy indicated, "...Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier...medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications...outdated...medications...are immediately removed from inventory...Drugs dispensed in the manufacturer's original container will be labeled with the manufacturer's expiration date...When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated...The nurse shall place a "date opened" sticker on the medication and record the date opened and a new date of expiration...If a vial or container is found without a stated date			

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	opened, the date opened will automatically default to the date dispensed and the expiration date will be calculated accordingly...The nurse will check the expiration date of each medication before administering it...No expired medication will be administered to a resident...All expired medications will be removed from the active supply and destroyed in accordance with facility policy..." 3.1-25(j) 3.1-25(m) 3.1-25(o)			
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. Based on observation, interview, and record review, the facility failed to schedule an appointment for a biopsy for (Resident 10) and failed to follow physician orders for laboratory services for (Resident 57) for 2 of 22 residents reviewed for laboratory services. Findings include: 1. During an observation and interview on 02/20/23 at 12:20 P.M., Resident 10 was sitting on the side of his bed, he indicated he had a lesion on his liver, and he hadn't been able to get anyone to schedule him an appointment for a biopsy, and he had been sick.	F 0770	The facility does schedule appointments when ordered and follows physician orders for laboratory services R10's liver biopsy has been rescheduled R57'S labs were re-drawn and subsequent labs will be collected as per orders Any resident who requires lab monitoring or has ordered appointments, has the potential to be affected by this alleged, deficient practice A facility wide audit was	04/05/2023

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	A Hospital Progress Note, dated 12/20/22, indicated the resident had a liver mass that was not a hematoma, and would likely need a biopsy once discharged. A Nurse Practitioner Note, dated 12/26/22, indicated the resident was noted to have a new liver mass show up on his scan. He was to follow up outpatient for a biopsy. A Nurse Practitioner Note, dated 12/27/22, indicated the resident was noted to have a new liver mass show up on his scan. He was to follow up outpatient for a biopsy. The resident was to have CBC (Complete Blood Count) and CMP (Complete Metabolic Panel) labs drawn in one week. A Nurse Practitioner Note, dated 12/30/22, indicated the resident was noted to have a new liver mass show up on his scan. He was to follow up outpatient for a biopsy. The resident was to have CBC and CMP labs drawn on Tuesday (01/03/23). A Hospital Health Summary, admission date 12/31/22 and discharge date 01/02/23, indicated the resident was brought to the emergency department from the extended care facility due to nausea and vomiting with abdominal pain. The symptoms began the morning prior. The resident was admitted recently for similar symptoms. He was found to have a hepatic lesion at that time and was recommended to have and outpatient follow-up. He had another CT scan that evening that showed a worsening hepatic lesion. The Assessment and Plan indicated the liver mass needed further evaluation on an outpatient basis and was a high priority.		completed to identify residents with lab orders and/or ordered appointments. Items out of compliance were corrected. Nurses will receive reeducation in-servicing related to timely lab draws, scheduling appointments and documenting when unable to adhere to schedules. The Admin/AIT/DON/ADON/Designee will select 3 residents daily, 5x week x 4 weeks, then 3 residents weekly x 4 weeks then 3 residents monthly x 4 months, and check to ensure ordered appointments were scheduled and completed and ordered labs were drawn as scheduled. if any patterns are identified at the monthly QAPI meeting The committee will write an action plan this written action plan will be monitored by the administrator or his designee monthly until resolved and substantial compliance is achieved at 95% or greater	

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	A Nurse Practitioner Note, dated 01/03/23, indicated the resident was recently found to have a hepatic lesion that was recommended outpatient follow-up. He had another CT scan with the most recent hospital admission which showed a worsening hepatic lesion. The resident was to follow up with gastrointestinal outpatient services. A Nurse Practitioner Note, dated 01/6/23, indicated the resident was recently found to have a hepatic lesion that was recommended outpatient follow-up. He had another CT scan with the most recent hospital admission which showed a worsening hepatic lesion. The resident was to follow up with gastrointestinal outpatient services. A Nurse Practitioner Note, dated 01/10/23, indicated the resident was recently found to have a hepatic lesion that was recommended outpatient follow-up. He had another CT scan with the most recent hospital admission which showed a worsening hepatic lesion. The resident was to follow up with gastrointestinal outpatient services. The clinical record lacked any indication that the resident was scheduled an appointment to follow-up related to the hepatic lesion. During an interview on 02/27/23 at 10:22 A.M., the ADON (Assistant Director of Nursing) indicated she scheduled resident appointments. She had been working with the Medical Director with getting the resident an appointment for a liver biopsy. The local specialist didn't perform them anymore, so they were having to look into going out of town. She had never documented the			

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	conversations but had text messages and would have to look through her shred box for faxes. The ADON provided printouts of undated text messages on 2/27/23 at 11:17 A.M. The messages indicated the following: - a handwritten message, date of 01/17/23, "Did the nurse look into who Resident 10 can be sent to for a liver biopsy?" - a handwritten message, date of 01/18/23, "Did the nurse look into where Resident 10 can be sent for a liver biopsy?" - a handwritten message, date of 02/02/23, "Can the nurse call regarding Resident 10's liver biopsy?" - a handwritten message, date of 02/15/23, a response message indicated the nurse was out that day and she would remind her in the morning. She thought they were going to have to refer him somewhere else because their radiologist didn't provide that service anymore. During an interview on 02/27/23 at 4:15 P.M., the ADON indicated she could not provide any further information or documentation regarding scheduling the resident for a liver biopsy. She had made several phone calls and text messages and should have documented every time she called. 2. The clinical record for Resident 57 was reviewed on 02/21/23 at 9:57 A.M.. An Annual MDS assessment, dated 12/10/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, Huntington's disease and seizure disorder. The current physician's orders were provided by the MDS Coordinator on 02/27/23 at 4:30 P.M., and included, but were not limited to, the following laboratory tests to be completed:			

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	- Lab (laboratory): CBC with differential, CMP, lipid panel, TSH (Thyroid Stimulating Hormone), and Vitamin D level, every six months related to Huntington's Disease, with an active date of 06/01/22. The resident's most recent lab reports, dated 06/21/22, for the CMP, Lipid profile, CBC with differential, TSH, and Vitamin D levels, were provided by the ADON on 02/24/23 at 1:53 P.M. The clinical record lacked documentation for the prescribed labs that should have been completed six months after the labs drawn in June of 2022. During an interview on 02/24/23 at 12:56 P.M., LPN (Licensed Practical Nurse) 3 indicated she could not find labs for December 2022. During an interview on 02/27/23 at 3:43 P.M., the AIT (Administrator in Training) indicated she could not find recent labs for Resident 57. The labs should have been done in December per the physician's orders. The current "LABORATORY ORDERS, TIMELY DRAWS" policy, dated 10/2014, was provided by HR (Human Resources) on 02/27/23 at 5:04 P.M. The policy indicated, "...Laboratory testing shall be conducted in a timely manner per physician's orders...This facility shall ensure that physicians' orders requesting laboratory services to be rendered are followed as specified in the order..." 3.1-25(b)			
F 0803 SS=D Bldg. 00	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed			

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	§483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. Based on observation, interview, and record review, the facility failed to provide palatable meals and provide menus for 3 of 24 residents reviewed for food. (Residents 6, 51, and 10) Findings include: 1. During an observation on 02/20/23 at 12:40 P.M. The Menu Board outside the main dining room was left blank. During and observation and interview on 02/20/23 at 12:43 P.M., Resident 6 indicated the food didn't taste good and they didn't get menus. They didn't	F 0803	The facility does provide palatable meals and menus for resident Menu boards now have meals posted Resident 6 is now made aware of the menu, including alternates. Her meal ticket has been updated with her preferences, which are now followed Food is now appealing and flavored Wing 2 hot foods will now be served from the steam table so that temps are maintained	04/05/2023

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	know what they were getting on their tray until it came. She was also unaware of what the alternate food choices were. Sometimes the alternate food would be worse than the original. She would always get Cheerios for breakfast and never any oatmeal, which she preferred. During an observation on 02/21/23 at 12:36 P.M., a test tray was provided. The tray contained pureed Salisbury steak, mechanical soft Salisbury steak, mashed potatoes with brown gravy, peas, and pureed peas. The food was not appealing and lacked flavor. During an interview on 02/21/23 at 1:30 P.M., the Dietary Manager was made aware that Resident 6 wanted oatmeal for breakfast. She indicated that the resident did get oatmeal every day. During an observation and interview on 02/22/23 at 9:01 A.M., Resident 6 was sitting on the side of her bed eating her breakfast. The resident had a half-eaten omelet and an empty bowl on her tray. She indicated she had gotten oatmeal that morning and it was great. During an observation and interview on 02/23/23 at 9:01 A.M., Resident 6 was sitting on the side of her bed. The resident was eating her breakfast of pancakes, sausage, and a bowl of Cheerios. She indicated she just wanted oatmeal every day. During an observation on 02/24/23 at 12:58 P.M., a test tray was provided on a plastic plate and the following was observed: - au gratin potatoes that were starchy, and pasty with a temperature of 158, - mashed potatoes that were cool, starchy, and pasty with a temperature of 116		Resident 51 is now made aware of the menu, including alternates and receives palatable meals Resident 10 is now receives palatable food, in proper portions and per preference All residents were at risk from this alleged, deficient practice A facility wide audit was conducted in order to correct residents current preferences Menu boards (i.e. White boards) have been ordered for 3 of 4 DRs that did not have them. Menus will be posted on the boards daily with alternates listed. Each nurse's station will receive a written copy of the daily menu, including alternates. The nurses and/or QMAs will review the menu with residents who routinely receive room trays and others as needed. If any resident prefers an alternate to the standard menu, nursing/QMA will alert dietary staff prior to the meal service. Dietary staff, nurses and QMAs will be in-serviced. DM and dietary staff will be in-serviced by the RD to include following recipes, cooking food and adding flavor, proper portion sizes, following meal tickets and preferences and food temperatures. The Administrator/AIT/Designee will request a test tray daily M-F to include each meal service at least 1 time per week. Identified areas will be addressed at the	

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	- puree chicken that was thick with a temperature of 134, - mechanical soft chicken that was cool and pasty with a temperature of 115, - regular chicken that was warm and flavorful with a temperature of 126, and - spinach that was warm and flavorful with a temperature of 128. The Dietary Manager indicated that she liked the food to be over 135 degrees. All the residents on Wing 2 were served on the same plastic plates. The food was always served on a cold plate because she couldn't put them in the warmer. During an interview on 02/24/23 at 1:19 P.M., the Dietary Manager indicated the menus were usually posted outside the main dining room. For Wing 1 and Wing 2 the nurses would have to call to the kitchen to and see what was being served. If the resident didn't like what they were having they could get an alternate meal. The residents didn't get individual menus and didn't know what the meal was unless the nurse called down and asked. She liked to taste the food while she was cooking it. She always knew what the residents preferred. She didn't always right them down she just knew what they were. She would let her staff know while they were serving. If she wasn't there, her staff wouldn't know what the residents' preferences were because she didn't have them written down. The staff should follow the residents' meal tickets. The clinical record for Resident 6 was reviewed on 02/24/23 at 2:12 P.M. An Admission MDS (Minimum Data Set) assessment, dated 01/06/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, acute and chronic respiratory failure,		time noted. The Admin/AIT/Designee will do walking rounds to verify meals have been posted on the meal/white board, including alternates for All 3 daily meals, 5 days per week x 1 month, then 3 days per week x 1 month, then1 day weekly x 4 months Rounds will also include verifying that nursing staff have received copies of the menu from dietary department with alternates listed and these have been reviewed with routine residents receiving room trays Any concerns will be addressed as discovered any patterns identified at the monthly QAPI meeting an action plan will be written by the committee any written action plan will be monitored by the administrator or her designee monthly until resolved and substantial compliance is achieved at 95% or greater	

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	anemia, hypertension, pneumonia, diabetes, and anxiety. 2. During an interview and observation on 02/20/23 at 12:51 P.M., Resident 51 indicated her cookie was hard and her potato soup was salty. The resident was unable to break the cookie into two pieces due to it being hard. She indicated they didn't get menus. They didn't know what was being served until it came to their room. During an observation and interview on 02/22/23 at 9:01 A.M., Resident 51 was sitting on the side of her bed. Her breakfast was untouched. On her tray was and omelet that was approximately 1 inch wide and the length of an ink pen, and a bowl of dry cereal. During an observation and interview on 02/23/23 at 9:01 A.M., Resident 51 was sitting on the side of her bed. Her breakfast tray was on her over the bed table. Her scrambled eggs were untouched. She indicated she was only supposed to get egg whites for breakfast because she didn't like scrambled eggs. Her meal ticket indicated the resident was to have egg whites for breakfast. The clinical record for Resident 51 was reviewed on 02/24/23 at 2:30 P.M. An Admission MDS assessment, dated 02/10/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, heart failure, hypertension, and anxiety. 3. During an interview on 02/20/23 at 12:16 P.M., Resident 10 indicated the food was "lousy". During an interview on 02/21/23 at 3:11 P.M., Resident 10 indicated he had waffles, ham, and oatmeal for breakfast. The oatmeal was a small			

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	portion and was gone in four bites. He never knew what he was getting until it came on his tray. During an observation and interview on 02/22/23 at 9:03 A.M., Resident 10 was sitting on the side of his bed. His breakfast plate was empty. He indicated he had gotten a very small omelet and a bowl of cereal. There was no meat or toast that morning. His meal ticket indicated the resident was supposed to get a slice of toast and sausage with breakfast. During an interview on 02/22/23 at 11:35 A.M., LPN (Licensed Practical Nurse) 2 indicated Resident 10 was alert and oriented. The resident didn't get menus anymore. They had gotten them for a while and was not sure why they didn't have them anymore. She would try to let the residents know what the meal was before it came to the unit, so she could get them an alternate. If the residents' got their tray and they didn't like what was on it, they would have to wait until everyone else was served before the kitchen would make them something else. The clinical record for Resident 10 was reviewed on 02/24/23 at 2:42 P.M. A Quarterly MDS assessment, dated 01/27/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, anemia, hypertension, diabetes, seizure disorder, anxiety, and depression. The current facility policy titled, "Menus and Food Preparation" dated 06/2018, was provided by the AIT (Administrator in Training) on 02/27/23 at 6:04 P.M. The policy indicated, "...Food will be prepared in a way to conserve nutritive value, flavor, and appearance...Food and drink will be served that is palatable, attractive			

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	and at a safe appetizing temperature...Menus will be posted in the facility..." 3.1-21(a)(1) 3.1-21(a)(2) 3.1-37(a)			
F 0881 SS=E Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on interview and record review, the facility failed to implement their protocol for antibiotic use for 2 of 2 months reviewed for antibiotic stewardship. This deficient practice affected 29 of 71 residents residing in the facility. Findings include: The January 2023 infection control log indicated 18 residents were documented with infections within the facility. Documentation indicated the surveillance log of resident infections and antibiotic use was not utilized for any of the residents. The February 2023 infection control log indicated 11 residents were documented with infections within the facility, as of 02/17/23. Documentation indicated the surveillance log of resident infections and antibiotic use was not utilized for any of the residents.	F 0881	The facility does implement their protocol for antibiotic use Surveillance logs have been completed for the 18 residents identified with infections in January 2023 Surveillance logs have been completed for the 11 residents identified with infections in February 2023 All residents with infections have the potential to be affected by this alleged, deficient practice A facility wide audit was completed listing anyone with an infection and surveillance logs were updated accordingly. The ABT binder is current and up to date at this time. The Admin/AIT/Don or designee will review the Infection	04/05/2023

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	During an interview on 02/27/23 at 2:21 P.M., the ADON (Assistant Director of Nursing) indicated she was newly responsible for the Antibiotic Stewardship Program. Part of their program included, but was not limited to, using the surveillance log to track patterns of infection, determining if an infection met McGeer's criteria, bacteria culture results, etc. She hadn't had time to fill out the monthly surveillance logs for antibiotic usage. The current facility policy, titled "Antibiotic Stewardship", with a revision date of 12/2016, was provided on 02/20/23 at entrance conference. The policy indicated, "...The purpose of our...program is to monitor the use of antibiotics in our residents..." 3.1-18(b)		Control/ABT use binder weekly x 2 months then every other weeks x 2 months and then monthly x 2 months to ensure surveillance forms and protocol are kept up to date. Any concerns will be addressed as discovered if any patterns are identified at the monthly QAPI meeting and action plan will be written by the committee any written action plan will be monitored by the administrator or her designee monthly until resolved and substantial compliance is achieved at 95% or greater	
F 9999 Bldg. 00	3.1-4 Notice of Rights and Services (f) The facility must do the following. (11) If the facility is required to submit an Alzheimer's and dementia special care unit disclosure form under IC 12-10-5.5, provide the resident at the time of admission to the facility with a copy of the completed Alzheimer's and dementia special care unit disclosure form. This State rule was not met as evidence by: Based on record review and interview, the facility failed to complete and submit the "Alzheimer's / Dementia Special Care Unit" form	F 9999	The facility does complete and submit the “Alzheimer’s /Dementia Special Care Unit” form The form has been completed and submitted Residents residing on the Alzheimer /Dementia care unit have the potential to be affected by this alleged, deficient finding Administrator /AIT were Inserviced on completing and submitting the “Alzheimer’s /Dementia Special Care Unit” form in a timely manner (i.e. on or before December 31st each year) The QAPI Meeting form has a line	04/05/2023

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	findings include: During an interview on 02/24/23 at 1:17 P.M., the AIT (Administrator in Training) indicated that the completed State form for the dementia care unit could not be located. She had reached out to her corporate support and they could not find the form either. During an interview on 02/27/23 at 5:33 P.M., the AIT indicated the dementia form had not been filled out. The form was located online and would be filled out and sent to the state office.		added at the top to help serve as a reminder that the form is due on or before December 31st each year. The facility RDO will review each months QAPI meeting notes and observe in December to be sure the form has been sent.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Complaints IN00401987, IN00401922, IN00401322, and IN00401375. Complaint IN00401987 - No deficiencies related to the allegations are cited. Complaint IN00401922 - Federal/State deficiency related to the allegation is cited at F584. Complaint IN00401322 - No deficiencies related to the allegations are cited. Complaint IN00401375 - No deficiencies related to the allegations are cited. Survey dates: February 21, 22, 23, 24, and 27, 2023. Facility number: 000115 Residential Census: 8	R 0000	The creation and submission of this Plan of Correction (POC) does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies/2567, or of any violation of regulation	

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	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on March 6, 2023.			
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview the facility failed to regularly conduct fire drills for 3 of the 12 months reviewed (August 2022, December 2022, and January 2023), and failed to contact the fire department at least twice a year. Findings include:	R 0092	The facility does regularly conduct fire drills and contacts the fire department at least 2 times per year Fire drills are now conducted per a rotating schedule to include all shifts at least once per quarter	04/05/2023

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	The fire drills records were provided by the Business Office Manager on 02/27/23 at 3:41 P.M. The records lacked documentation the required fire drills were conducted for the following months: - August 2022, - December 2022, and - January 2023. The fire drill reports indicated the local fire department was only contacted on 04/07/22. During an interview on 02/27/23 at 3:10 P.M., the AIT (Administrator in Training) indicated fire drills should have been conducted monthly and she had no additional documentation the fire department had been contacted. The current undated "Fire" policy was provided by the AIT on 02/27/23 at 3:35 P.M. The policy indicated "...Specific procedures shall be outlined and followed by staff and residents in the case of fire. These procedures shall be reviewed with the staff periodically to ensure a clear understanding and to ensure the safety and well-being of the residents of the facility..."		and the Fire Dept. has been contacted for the first of two times this year. Documentation is kept on the fire drills and communication with the fire department All residents have the potential to be affected by this alleged, deficient practice Fire drills are listed in the facilities TELS service (an electronic service utilized to help monitor regulatory and preventative maintenance) by varying shifts each quarter The Admin/AIT/Designee will monitor every month to be sure all fire drills are conducted according to the facilities written disaster preparedness plan and that the fire department is contacted at least 2 x per year. This will be an ongoing audit. if any patterns are identified at the monthly QAPI meeting an action plan will be written by the QAPI committee any written action plan will be monitored by the administrator or her designee monthly until resolved and substantial compliance is achieved at 95% or greater	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following:			

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	(1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview, and record review, the facility failed to ensure residents that self-administered medications were assessed for self-medication administration for 3 of 7 residents reviewed for medication administration. (Residents 304, 311, and 312) Findings include: 1. A continuous observation of medication administration was conducted on the Residential Hall, Unit 5, on 02/24/24 at 7:05 A.M., with the DON (Director of Nursing). The DON walked into Resident 304's room with an unlabeled cup of pills, left them at the bedside for the resident who was in her room, and went back to the medication cart located in the hallway outside of the resident's room. The resident's clinical record lacked documentation she was assessed or had a physician's order to self administer medications. 2. The DON took a prefilled unlabeled cup of nine pills from the top drawer of the cart and entered Resident 311's room. The nurse took the resident's vital signs then left medications in the cup on the over the bed table that was sitting next to the resident, who was sitting in her chair, and	R 0216	The facility does ensure that residents that self-administer medication are assessed for self-medication administration Residents 304, 311 and 312 are no longer expected to self administer medication No residents on the AL have expressed the desire to self administer medication All residents on the AL who receive medications were at risk for this alleged, deficient practice Nurses and QMA's have been in-serviced on staying with residents and observing them take medications and that any resident who does desire to self administer medications, must have a self administration assessment and physician order to do so. DON/ADON/Admin/AIT/Designee will observe randomly selected AL medication passes 3 x week x 4 weeks, 1 x week x 4 weeks then 1 x month x 4 months to ensure staff are not leaving medications in rooms for resident to self-administer who have not been assessed and designated to do	04/05/2023

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	returned to the medication cart. The resident's clinical record lacked documentation she was assessed or had a physician's order to self administer medications. 3. The DON took went into Resident 312's room, set up a nebulizer treatment in the machine, told the resident to use it whenever he was ready, and left the room. She returned to the cart in the hallway and documented medications in the MAR (Medication Administration Record). The resident came out to the doorway of the room to verify that he was to use his nebulizer treatment when he was ready and the nurse indicated, "Yes sir, whenever you are ready." The resident's clinical record lacked documentation he was assessed or had a physician's order to self administer medications. During the Entrance Conference on 02/23/23 at 1:30 P.M., the AIT (Administrator In Training) indicated there were no residents who self-administered their medications on the Residential Hall, Unit 5. The current "MEDICATIONS, SELF-ADMINISTRATION" policy, with a reviewed date of 09/2017, was provided by HR (Human Resources) on 02/27/23 at 5:07 P.M. The policy indicated, "...Should the resident indicate a desire to self-administer medication(s), the interdisciplinary team shall evaluate the resident for the cognitive, physical and visual ability to accomplish this task...If the evaluation reveals the resident is capable of participation in self-administration, a physician order reflecting the same shall be obtained to specify which medications may be self-administered by the		so. Any concerns will be addressed as discovered if any patterns are identified at the monthly qapi meeting an action plan will be written by the committee any written action plan will be monitored by the administrator or her designee monthly until resolved and substantial compliance is achieved at 95% or greater	

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	resident. Medication self-administration shall be addressed on the resident's plan of care..."			
R 0301 Bldg. 00	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation and interview, the facility failed to label preset cups of medications for 7 of 7 residents (Residents 304, 305, 310, 311, 312, 302, 306), and had an unlabeled cup of non-resident pills (DON) observed in the medication cart during medication administration. Findings include: A continuous observation of medication administration was conducted on the Residential Hall, Unit 5, on 02/24/24 at 7:05 A.M., with the DON (Director of Nursing). The DON walked into Resident 304's room with an unlabeled cup of pills, left them at the bedside for the resident who was in her room, and went back to the medication cart located in the hallway outside of the resident's room.	R 0301	The facility will label preset cups of medications and will not have personal medications/supplements on the medication carts 304, 305, 310, 311, 312, 302, and 306 no longer have medications administered from preset, unlabeled cups Any residents receiving medications on the AL were at risk from this alleged, deficient practice Nurses/QMAs were in serviced related to facility protocol that medications are not to be preset. If a medication is refused and is set back for another attempt, it must be properly labeled. The Inservice included not having your	04/05/2023

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	The DON took a prefilled unlabeled cup of pills from the top drawer of the medication cart that had a second cup nested in the first. She indicated she put the residents' narcotics in a separate cup. She went into Resident 305's room, administered the medications, and returned to the cart. The DON took another prefilled unlabeled cup of seven pills from the top drawer of the cart. She indicated she set up the residents' medications when she arrived in the morning. She did not label the cups because she would place the cups in different areas of the drawer and that was how she knew which pill cup was for each resident. She entered Resident 310's room. The resident refused her medications indicating she would not take them until she received her breakfast. The nurse took the cup of pills back to the medication cart and labeled it with the resident's name and that she had refused. The nurse took another prefilled unlabeled cup of nine pills from the top drawer of the cart and entered Resident 311's room. The nurse took the resident's vital signs then left medications in the cup on the over the bed table that was sitting next to the resident, who was sitting in her chair, and returned to the medication cart. The nurse took another prefilled unlabeled cup of four pills from the top drawer of the cart, entered Resident 312's room, administered the medications, and returned to the cart. The nurse took another prefilled unlabeled cup of crushed medications from the top drawer of the cart, entered Resident 302's room, administered the medications, and returned to the medication cart.		own personal medications in the Med cart DON/ADON/Admin/AIT/Designee will observe randomly selected AL medication passes 3 x week x 4 weeks, 1 x week x 4 weeks then 1 x month x 4 months to ensure staff are not pre-setting medications for med. Passes and/or properly labeling if medication(s) are set back for a 2nd attempt to administer. Medication carts will also be checked to ensure personal medications are not left in med. Carts. Any concerns will be addressed as discovered if any patterns are identified at the monthly QAPI meeting and action plan will be written by the committee any written action plan will be monitored by the administrator or her designee monthly until resolved and substantial compliance is achieved at 95% or greater.	

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	At 7:49 A.M., the DON returned to the medication cart in the hallway, took an unlabeled preset cup containing several pills from the top drawer, indicated they were her breakfast vitamins, poured them in her mouth, and took a drink of water. At 8:06 A.M., the DON took an unlabeled prefilled cup of pills from the top drawer of the medication cart and entered Resident 306's room. The resident refused her medications, the nurse labeled the cup and placed it back in the top drawer of the medication cart for later. During an interview on 02/24/23 at 9:28 A.M., The AIT (Administrator In Training) indicated it was a problem that the DON had her own medications in the facility medication cart. The current "MEDICATION ADMINISTRATION" policy, was provided by Human Resources on 02/27/23 at 5:07 P.M. The policy indicated, "...Medications are administered as prescribed in accordance with good nursing principles and practices..."			
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition.			

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	(7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on observation and interview, the facility failed to dispose of medications appropriately for 1 of 2 medication administration observations. Findings include: A continuous observation of medication administration was conducted on the Residential Hall, Unit 5, on 02/24/24 at 7:05 A.M., with the DON (Director of Nursing). At 8:04 A.M., the DON was at the medication cart. She had an unlabeled cup of pills she indicated were loose pills that she had gathered from the drawers in the cart because she knew they had a previous deficiency related to the medication carts. She left the unlabeled cup in the top drawer where she had placed several other unlabeled cups of medications for the residents and continued administering medications to a resident. She returned to the medication cart and indicated it was a shame to throw the cup of loose pills away because she knew which residents took those specific pills and started naming off the pills and which resident took them. She put the cup of medications back in the top drawer of the cart, pushed the cart to Unit 3 near the Nurse's Station, and started administering medications to residents on Unit 3 from a different medication cart. During an interview at 9:17 A.M., the DON was asked what she was going to do with the loose pills she had gathered from the medication cart for Unit 5, and she indicated she probably wasn't supposed to throw them in the sharps container,	R 0306	The facility does dispose of medications appropriately Unlabeled medications and stray pills found in the car will be disposed of according to proper drug disposal protocol Nurses/QMA's will receive reeducation in servicing on proper drug disposal DON/ADON/Admin/AIT/Designee will observe randomly selected AL medication passes 3 x week x 4 weeks, 1 x week x 4 weeks then 1 x month x 4 months to ensure staff are disposing of loose pills and unlabeled medications appropriately (i.e. not storing cups of loose pills from the cart, in cups on the cart) Any concerns will be addressed as discovered if any patterns are identified at the monthly Q API meeting and action plan will be written by the committee any written action plan will be monitored by the administrator or her designee monthly until resolved and substantial compliance is achieved at 95% or greater	04/05/2023

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	she could flush them down the toilet, "but that probably wouldn't be good either." They did not have a Drug Buster (drug disposal container) on the unit. She took the cup of pills down the hall and around the corner to the ADON's (Assistant Director of Nursing) office and poured the cup of pills into the drug disposal bottle. The ADON was sitting at her desk in the office. The DON did not consult or inform the ADON of her actions.			