STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE ST MARY OF THE WOODS, IN 47876

(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 a State Residential Licensure Survey. This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00393738 completed November 10, 2022. Complaint IN00393738 - Corrected Survey dates: January 23, 24, 25, 26, 27, 30, 31, and February 1, 2023 Facility number: 003624 Provider number: 155802 AIM number: 200429840 Census Bed Type: SNF/NF: 63 Residential: 35 Total: 98 Census Payor Type: Medicare: 13 Medicaid: 35 Other: 15 Total: 63 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 14, 2023.	F 0000		
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mandy Lynch	Administrator	02/25/2023

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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	The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on interview and record review, the facility failed to ensure resident shower choices were met for 1 of 24 residents reviewed for choices (Resident 25). Findings include: During the initial pool interview, on 1/24/23 at 10:50 a.m., Resident 25 indicated his preference was to receive at least 1 shower a week but had	F 0561	I. Corrective Action Taken Related to this Finding: On 1/30/23 Resident 25 received a shower. Resident has since received a shower on 2/3, 2/6, 2/9, 2/13, 2/15, and 2/19 per his preferences. His care plan has also been updated to reflect his preference for showers.	02/08/2023

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	only been getting one every-other-week. Resident 25's record was reviewed on 1/30/23 at 2:42 p.m. The profile indicated the resident had been admitted to the facility on 6/22/22, for diagnoses which included, but were not limited to, acute respiratory failure with hypoxia (acute or chronic impairment of gas exchange between the lungs and the blood causing hypoxia [a state in which oxygen is not available in sufficient amounts at the tissue level]) and acute kidney failure (when the kidneys suddenly become unable to filter waste products from your blood). A quarterly Minimum Data Set (MDS) assessment, dated 12/12/22, indicated the resident had no cognitive deficit and required physical help in part of bathing of 1-person physical assistance. An Activities of Daily Living (ADL-activities related to personal care) preferences care plan, dated 6/23/22, lacked documentation of the resident's preferences for receiving showers. The resident's task list, from the electronic medical record (EMR) indicated the resident was to receive baths 3 times weekly and as needed (PRN). Review of shower sheets, for December 2022 through January 30, 2023, indicated the resident had received showers on 12/8/22, 12/12/22, 12/20/22, 12/29/22, 1/2/23, 1/10/23, and 1/20/23, which averaged to 1 shower per week. During an interview, on 1/31/23 at 9:16 a.m., the Director of Nursing (DON) indicated she was not completely sure as to why the resident had not received the number of showers that he preferred		II. Other residents with Potential to be Affected by this Finding will be Identified by: On 02/08/23, the IDT reviewed preferences for showers for all current in-house residents to ensure shower schedule and care plan reflect the preference for showers, and shower documentation was reviewed on 02/08/2023 to ensure that showers were provided to each resident per resident preference. The shower was immediately offered to any resident identified to not receive showers per preference. III. Measures and Systematic Changes put into place to assure deficient practices do not recur are as follows: 1. The IDT will review resident shower preferences during admission and quarterly care plan meetings with residents and their families to ensure that shower preferences are being honored. 2. Care plans and CNA tasks will be revised accordingly to reflect the resident preference for showers. IV. Corrective Actions will be Monitored to Ensure Compliance by: A preliminary monitoring system will be put in place to randomly audit 5 residents per week x 4 weeks, then 3 residents per week x4 weeks, then 2 residents per	

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	and why the documented amount on his task reports indicated 3 baths per week. She deferred the question to the Unit Manager to determine if it was a scheduling issue. During an interview, on 1/31/23 at 9:23 a.m., Unit Manager 3 indicated the resident was supposed to receive 2 shower per week and she was unsure why the documentation indicated 3 per week. He was scheduled for a night shift shower and if, for some reason, the staff did not get to his shower (because he was asleep) they would complete the shower in the morning when he got up. She believed that the staff were not very consistent with completing the shower sheets. On 1/31/23 at 11:07 a.m., the DON provided a document, dated 2/9/22, titled, "Procedures for Implementation of Resident Rights," and indicated it was the policy currently being used by the facility. The policy indicated, "...Purpose: To ensure that...protects and supports the rights of all residents...4...shall, to the maximum extent possible, encourage and assist residents in exercising their rights of autonomy and choice, deciding how they wish to live their everyday lives and receive care...." 3.1-3(a) 3.1-3(u)(1)		week x 4 weeks, and then 1 resident per week x4 weeks to ensure showers are provided per resident preference. The outcome of the audit tool will be reviewed at the Quality Assurance meetings to determine if any additional action is warranted. Providence Health Care will review, update and make changes to this plan of correction as needed for sustaining compliance for no less than six months.	
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family			

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	members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. A. Based on interview and record review, the facility failed to address grievances in a manner which could be tracked for 5 of 5 months reviewed for grievance resolutions of the Resident Council and the facility's grievance log. This potentially affected 63 of 63 residents who resided in the facility.	F 0565	It is the policy of PHC to consider the views of a resident group and act promptly on the grievances and recommendations of such groups concerning issues of resident care and life in the facility.	02/07/2023

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	B. Based on observation, interview, and record review, the facility failed to ensure a grievance provided during resident council was resolved for 1 of 1 resident reviewed for grievances (Resident 40). Findings include: A1. Resident Council minutes were provided by the Activity Director (AD) on 1/24/23 at 10:28 a.m. The minutes indicated the following concerns by the Resident Council: a. Cold food temperatures of the residents' meals b. Call lights taking too long to be answered by staff During the Resident Council meeting, on 1/26/23 at 9:30 a.m., the residents indicated the facility had not acted promptly upon the grievances of the cold food temperatures of the residents' meals and the call lights taking too long to be answered by staff. During an interview with the Activities Director (AD), on 1/26/23 at 10:12 a.m., she indicated she took minutes for the Resident Council meetings and then spoke with the Administrator (ADM), who was the facility's grievance officer, the department heads, and staff about the Resident Council's concerns. Food temperatures and call light concerns have been brought up at several of the Resident Council meetings. There was not a written follow-up for the Resident Council's concerns. On 1/31/23 at 11:20 a.m., a lunch meal test tray was requested from the Dietary Manager (DM) in the kitchen. Dietary Aide (DA) 25 temped the food on		I. Corrective Action Taken Related to this Finding: On February 2, 2023, the IDT consisting of the Activity Director, Director of Quality, and Administrator reviewed resident council minutes for the past 6 months to identify any unresolved grievance. A grievance report was completed for any unresolved grievances, with the final resolution of the grievance documented and entered on the grievance log. II. Other residents with Potential to be Affected by this Finding will be Identified by: On 2/7/2023, a resident council meeting was held to identify any unresolved concerns needing to be addressed by the facility. All identified concerns were documented with written documentation of when and how the concerns presented by the residents were being addressed and resolved by staff. III. Measures and Systematic Changes put into place to assure deficient practices do not recur are as follows: 1. On 2/7/2023, the Administrator educated the Activity Director and department managers on the facility policy related to Grievances, which requires that a resident grievance form is used to track issues and	

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	the steam table, while the DM wrote onto a food temperature log the temperatures of: green beans at 153.3 Fahrenheit (F), salmon at 188.4 F, and rice at 173.4 F. DA 25 then began plating the food onto a plate with a warming pellet underneath the plate and a plastic cover on top of the plate. She placed the plate onto a tray and placed the tray into a tray cart. The last four plates did not have a warming pellet underneath, only the plastic cover on top of the plate. On 1/31/23 at 12:43 p.m., DM observed the four meal trays without warming pellets underneath the plates and indicated the kitchen was short on four warming pellets for the residents' lunches. When the staff do not bring back the warming pellets after a meal, the kitchen was short on the warming pellets for the next meal. The test tray food temperatures were green beans at 114.8 F, rice at 120.7 F, and salmon at 113.9 F. The DM indicated the test tray food temperatures were cold and should have been at least 125 F. On 1/27/23 at 10:25 a.m., the Administrator indicated the dietary department had completed test trays and have requested the residents to notify the staff immediately if they had a concern with their meal being cold. She was the grievance officer. They had told the Resident Council verbally resolutions to the concerns with the cold food concerns, but the facility had not provided the Resident Council a written follow-up response to the residents' concerns. A2. On 1/27/23 at 11:05 a.m. the Administrator (ADM) provided a grievance log, dated September 2022 to January 2023, and indicated Resident 35's daughter had contacted the facility and had a grievance about the call light times taking too long for staff to answer for her mother,		their resolutions and that the facility department related to any issues will be responsible for addressing the item(s) of concern. The Grievance form was updated on 2/7/2023, to include a designated place to indicate when and how the concerns presented by the residents were being addressed and resolved by the staff. The Activity Director, or designee, will be responsible for reviewing the previous meeting Resident Council Response form and how concerns expressed were addressed and resolved at each Resident Council meeting. 2. All grievances voiced during Resident Council will be documented on a Grievance form by the Activity Director and provided to the Grievance Official for review. The Grievance Official will provide the grievance report to the appropriate department head for investigation and resolution of the concern. 3. The Department Heads will have one week to address the grievance. A detailed explanation of the follow-up from the Department Head will be provided and the Department Head filling out the form, Administrator, and the Resident making the grievance will sign the forms to acknowledge that the grievance has been resolved. 4. The Activity Director will file the forms with the Resident	

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	due to a fall from the toilet Resident 35 had sustained with a skin tear on 10/18/22. The ADM provided a call light log, titled "Past Calls 10/18/22," and indicated Resident 35 had pressed her call light, on 10/18/22 at 7:15 p.m., and waited fifty minutes for the call light to be answered, had pressed her call light, on 10/18/22 at 10:11 p.m. and waited seven minutes and fifty-two seconds, and pressed her call light for assistance, on 10/18/22 at 10:57 p.m., and waited thirteen minutes when she fell off of the toilet due to trying to get up by herself without staff assistance. The ADM had completed and provided a document, titled "Providence Health Care, INC. Concern/Suggestion Report," which indicated, Resident 35's daughter had a concern about Resident 35's fall, on 10/18/22, after having waited too long on the toilet for staff assistance after pressing the call light. Action taken and results indicated follow up on 10/24/22 would investigate the fall and call light time responsiveness. ADM documented on the concern grievance, the daughter was called on 10/24/22 to discuss and left a message. No additional follow up documentation was noted with a grievance resolution for the call light time responsiveness. On 1/27/23 at 10:25 a.m., the Administrator indicated she was the grievance officer and reviewed the daily (24 hours) and monthly log of the call light system via email. If she had found a concern of a delayed call light, she would go directly to the staff assigned to the unit and find out the reasoning for the delay in answering a call light. The after-supper call lights had a pattern of delayed response times, due to everyone wanted to go to bed and the staff shift change between 6:00 p.m. and 6:30 p.m. We have told the Resident Council verbally resolutions to the delayed response times for the call lights, but the facility		Council minutes and they will be reviewed at the following Resident Council as part of the minutes. IV. Corrective Actions will be Monitored to Ensure Compliance by: The corrective action will be monitored to ensure the deficient practice will not recur through the quality assurance program by the development and implementation of a Quality Assurance tool to monitor that concerns voiced by the resident council are addressed and resolved by the staff. This tool will be completed for 6 months until compliance is maintained by the Administrator. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted. The facility, through the QAPI program, will review, update, and make changes to this plan of correction as needed for sustaining compliance for no less than six months.	

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	had not provided the Resident Council a written follow-up response to the residents' concerns.B. On 1/23/23 at 11:50 a.m., Resident 40 was observed putting together a jigsaw puzzle in her room on a desk located at the foot of her bed. She indicated she was concerned her call button reached her when she was in bed and in her recliner, but if she fell by the desk where she often sat putting together puzzles, or by her television she would have to crawl to get to the cord on her recliner. She had tripped over her oxygen tubing on multiple occasions but caught herself by grabbing onto furniture before she fell. Resident 40 had reported her concerns to the Activity Director among peers during a resident council meeting, but she had never been given another cord. The resident's call light was observed where she indicated clipped to the arm of her recliner, and when stretched would reach the end of the bed but was taut approximately 3 feet off the ground creating a hazard. Resident Council Minutes, dated September 6, 2022, indicated, a resident said she would rather have a call light that she could wear since her call light wasn't always within her reach. Unit Manager (UM) 3 let the resident know that she had an idea about her call light since she sits on both sides of the room. She would let maintenance know about her idea to see if it would work. Resident Council Minutes dated October 2022 - January 2023 lacked documentation the call light request was followed up. Grievance Logs, dated September 2022 through January 2023, indicated there were no concerns documented for Resident 40. During an interview on 1/26/23 at 10:54 a.m., the AD indicated during a resident council meeting in			

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	September 2022, Resident 40 had reported when doing puzzles, the call light was not long enough to go from one side of the room to the other. UM 3 indicated she had an idea already so she would go to maintenance to get a double headed call cord. Maintenance was supposed to go in per UM 3's request to get a 2 prong call light, one for each side of the room. The AD indicated if a resident had a complaint reported during a resident council meeting, she would tell the responsible department head, who was supposed to address the issue. There was no current system of assuring issues were addressed such as being signed off. At this time, she was responsible for assuring concerns were addressed. During an interview on 1/26/23 at 11:01 a.m., UM 3 indicated the facility had recently installed a new call light system and she was not sure the system would handle split call light cords. Maintenance was supposed to be looking into it. During an interview on 1/26/23 at 11:15 a.m., the Maintenance Supervisor indicated, he did not recall getting a request to provide Resident 40 with a longer or split call cord, and upon observation of repair request cards, dated 2022, indicated there was no request card found. He indicated as he had no request card and had no email, to him, so this meant no request was passed on to him. The Maintenance Supervisor indicated if a resident requested a split call cord and one was available, the resident could have it. UM 3 should have filled out an orange maintenance request card and put it in the box at the nurse's station where he picked them up twice a day. Once a request was finished, he would then sign off on the card and file it away. He was supposed			

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	to receive requests or concerns on orange tickets at the nurse's station, but staff or residents/resident representatives often would call him, text, e-mail or just catch him in the hallway and report issues. During an interview on 1/26/23 at 11:34 a.m., the Administrator (ADM) indicated, residents were told at every resident council meeting that she was the grievance officer, and residents could get a grievance form by asking for one from the nurses on the floor. Once the ADM received a grievance form, she would fill out the grievance log and make sure it was followed up. She had never heard about Resident 40 requesting a different call cord. On 1/26/23 at 2:40 p.m., AD provided and identified a document as a current facility policy, titled, "Resident Council Policy," dated 2/21/22. The policy indicated, " ...Purpose: To establish guidelines for assisting residents with the development and facilitation of a Resident Council in order to voice grievances, make recommendations, and participate in resolution of concerns ...The facility must consider the views of a resident to family group and act promptly up the grievances and recommendation of such groups concerning issues of resident care and life in the facility. The facility must be able to demonstrate their responses and rationale for such response. This should not be construed to mean that the facility must implement as recommended every request of the resident or family group ...." On 1/31/23 at 10:35 a.m., the Director of Nursing (DON) provided a Registration and Disposition of Complaints Policy, dated 7/9/22, and indicated the policy was the one currently being used by the facility. The policy indicated, "Purpose: To ensure			

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	that residents and representatives have the opportunity to have complaints heard, reviewed, and when possible, receive resolution and/or appropriate disposition ...The Director of Health Services shall be responsible for assuring grievances/resolutions are resolved and for informing appropriate individuals ...Any facility staff member receiving a concern/suggestion is responsible to report the concern/suggestion to their supervisor and/or Department Manager, or to the Charge Nurse on duty and complete a Concern/Suggestion form ...The Department Manager of the involved service will investigate the concern and as appropriate meet with the resident or responsible party to discuss resolution. Measures will be taken to ensure the concern is not repeated. Documentation of this investigation and resolution will be make on the report and returned to the Director of Health Care Services for review and filing ...All resolution conferences will be documented and attempt make to have all parties, including residents or their representatives, sign the report indicating attendance ...Grievances and concerns received from the Resident or Family Councils will also be recorded in the minutes or recorded on a Concern/Suggestion Form and promptly addressed by the Director of Health Care Services. A written response will be given to the Council at their next meeting ..." 3.1-3(l) 3.1-3(v)(1)			
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 0641	1.On 1/30/23, Resident #32	02/02/2023

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	Based on observation, record review, and interview, the facility failed to ensure the accuracy of a resident's Minimum Data Set (MDS) assessment for 1 of 18 MDS assessments reviewed (Resident 32). Findings include: During a random observation, of the breakfast meal, on 1/24/23 at 9:18 a.m., a feeding tube was observed extending from underneath Resident 32's shirt. Resident 32's record was reviewed on 1/30/23 at 11:16 a.m. The profile indicated the resident had been admitted on 11/11/21, for diagnoses which included, but were not limited to, cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it) and dysphagia (difficulty swallowing food or liquid). A physician's order, dated 7/26/22, indicated enteral feed (a form of nutrition that is delivered into the digestive system as a liquid), two times a day, at 40 milliliters (ml) per hour with 50 ml per hour continuous feed from 10:00 p.m., to 6:00 a.m. The order had been discontinued on 1/16/23. An annual MDS assessment, dated 9/19/22, indicated the resident had severe cognitive deficit and had a feeding tube (a way of giving medicines and liquids, including liquid foods, through a small tube placed through the nose or mouth into the stomach or small intestine). Documentation on the quarterly MDS assessment, dated 12/15/22, indicated the resident did not have a feeding tube.		12/15/22 Quarterly MDS was modified to reflect the presence of the feeding tube and transmitted to CMS. 2.On 1-30-23, all MDS completed in the past 12 mo for all residents with feeding tubes were reviewed to ensure accurate coding per RAI guidelines is present for the presence of feeding tubes. 3.On 1-30-23, the MDS coordinator and dietician were re-educated on RAI guidelines related to the coding of feeding tubes. 4.The Director of Nursing or her designee will conduct an audit of 5 random residents each week for 4 weeks and then monthly to ensure that Section K of MDS is coded accurately. The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement Committee for review at least monthly for three (3) months. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, and Dietary Services Manager with the Medical Director attending at least quarterly.	

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	During an interview, on 1/30/23 at 2:25 p.m., the MDS Coordinator indicated the assessment had been coded incorrectly. She had not completed the 12/15/22, MDS assessment, as she had not been hired as the MDS Coordinator until late in December 2022. On 1/30/22 at 2:25 p.m., the MDS Coordinator provided copies of a document titled, "CMS's (Center for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual, Section K0510," dated October 2019, and indicated it was the policy currently being used by the facility. The policy indicated, "...K0510: Nutritional Approaches...B. Feeding tube...Feeding tube: Presence of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system...Coding Instructions for Column 2...Check all that apply...K0510B, feeding tube...." 3.1-31(a)(5)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure nail care was provided to a dependent resident for 1 of 24 residents reviewed for activities of daily living (ADL) (daily tasks related to resident care and hygiene) (Resident 50). Finding includes:	F 0677	It is the policy of PHC to promote personal dignity by providing good personal grooming and appropriate assistance with bathing, dressing, hair, and nail care which reflects the resident's personal preferences. I. Corrective Action Taken Related to this Finding:	02/08/2023

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	On 1/23/23 at 11:57 a.m., Resident 50 was observed with long, untrimmed fingernails with dark debris underneath the fingernails on both hands, while lying in bed watching television. On 1/24/23 at 10:11 a.m., Resident 50 was observed with long, untrimmed fingernails with dark debris underneath the fingernails on both hands, while lying in bed watching television. On 1/25/23 at 1:31 p.m., Resident 50 was observed, with long, untrimmed fingernails with dark debris underneath the fingernails on bilateral (both) hands, while lying in bed, feeding himself from a bedside table. On 1/26/23 at 10:57 a.m., Resident 50 was observed with long, untrimmed fingernails with dark debris underneath the fingernails on both hands, while lying in bed watching television. On 1/27/23 at 11:25 a.m., Resident 50 was observed with long, untrimmed fingernails with dark debris underneath some of the fingernails on both hands. Resident 50's clinical record was reviewed on 1/31/23 at 9:36 a.m. The resident was admitted to the facility, on 12/14/22, with diagnoses included, but were not limited to, hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting the right dominant side (a mini stroke caused by a temporary disruption in the blood supply to part of the brain), hypertension (high blood pressure), and apraxia (difficulty with skilled movement, speaking, or doing everyday activities). An admission Minimum Data Set (MDS) assessment, dated 12/21/22, indicated the resident		On 1/31/2023 Resident 50's nails were cleaned of debris to correct the deficient practice. II. Other residents with Potential to be Affected by this Finding will be Identified by: On 2/8/2023, observation of fingernails of each resident residing in the facility was completed to identify any additional residents with long, untrimmed nails or debris underneath the fingernails. Nail care was provided to any identified resident and documented on the nail care audit sheet. III. Measures and Systematic Changes put into place to assure deficient practices do not recur are as follows: 1. On Feb. 8, 2023, the Director of Nursing re-educated nursing staff on the requirement to provide nail care per established shower/bathing schedule for each resident. 2. New shower sheets have been created to provide a reminder of the importance of nail care and a place to document that nail care was provided. IV. Corrective Actions will be Monitored to Ensure Compliance by: A preliminary monitoring system will be put in place to randomly audit 5 residents per week x 4	

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	had a moderate cognitive impairment; had no documented behaviors nor rejection of care; required extensive assistance of two persons for bed mobility, transfers, toilet use, and personal hygiene, required total dependence of two persons for bathing, required supervision-oversight with encouragement or cueing with one person physical assistance when eating, had impairment on one side of the upper extremity and impairments on both sides of the lower extremities. A care plan, dated 12/27/22, indicated the resident had a self-care deficit with bed mobility, dressing, personal hygiene/oral care, eating, toileting, transfers, and locomotion on/off the unit with interventions included, but not limited to, encourage the resident to do as much for self as able in ADL areas daily to maintain current level of self-performance. On 1/27/23 at 3:15 p.m., the Administrator (ADM) provided Resident 50's shower schedule and shower sheets, which included nail care, for December 2022 and January 2023. The ADM indicated Resident 50 was on the shower schedule for three showers a week and nail care of trimming and cleaning underneath the fingernails should be provided with each shower. Nail care was documented as completed on 12/28/22 and 1/11/23. During an observation with the Director of Nursing (DON) of Resident 50, on 1/31/23 at 9:35 a.m., Resident 50 indicated staff had trimmed his fingernails the previous evening. Resident 50's fingernails were trimmed but were observed with dark debris underneath some of the fingernails on both hands. The DON observed the dark debris underneath Resident 50's fingernails and indicated		weeks, then 3 residents per week x4 weeks, then 2 residents per week x 4 weeks, and then 1 resident per week x4 weeks to ensure nail care is provided as scheduled. The outcome of the audit tool will be reviewed at the Quality Assurance meetings to determine if any additional action is warranted. Providence Health Care will review, update and make changes to this plan of correction as needed for sustaining compliance for no less than six months.	

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	Resident 50's fingernails needed to be soaked and the dark debris underneath the fingernails should have been removed when staff trimmed his fingernails. On 2/1/23 at 9:50 a.m., ADM provided and identified a document as a current facility policy, titled "Procedures for Implementation of Resident Rights Policy," updated 2/9/22. The policy indicated, "...Purpose: To ensure that Providence Health Care protects and supports the rights of all residents in the hope that they will contribute to the physical and mental well-being of residents and the affirmation of human dignity as specifically outlined in the Resident Rights Policy...26. Providence Health Care's policies, procedures, staff training, resident care, and business conduct will all reflect a philosophy that promotes maintenance or enhancement of quality of life and promotes dignity and respect of each individual person...a. Personal dignity will be promoted by good personal grooming and the appropriate assistance with bathing, dressing, hair and nail care which reflects the resident's personal preferences...." 3.1-38(a)(3)(E)			
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			

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	Based on observation, interview, and record review, the facility failed to ensure an effective fall management program and failed to ensure fall interventions were personalized, implemented, and care planned for 4 of 4 residents reviewed for accidents (Residents 36, 31, 40, and 35). Findings include: 1. During an initial pool interview on 1/24/23 at 11:16 a.m., Resident 36 indicated she had multiple falls, but she was not sure when the last fall had occurred. Pointing to her head, she indicated she had pain in a bump on the back of her head and on her leg. The resident's private bathroom was observed to have pieces and strips of toilet paper on the floor around the toilet, and a clean brief on the sink with pieces torn out of it. Resident 36's record was reviewed on 1/27/23 at 1:24 p.m. Diagnoses on Resident 36's profile included, but were not limited to, history of falls, hemiplegia and hemiparesis (paralysis of one side) of left dominant side, anxiety disorder, age-related debility, difficulty walking, and lack of coordination. Resident 36's electronic medical record (EMR) indicated the following recent falls, a. On 11/5/22 at 1:00 p.m. while attempting to self-toilet. On 11/5/22 a new order for Macrobid (antibiotic) 100 milligrams (mg) 1 capsule by mouth two times daily for a urinary tract infection (UTI) for 5 days was started. Resident record lacked documentation a physician's order had been obtained for a urinary analysis (UA) that had been obtained on 10/27/22 before the fall. b. On 11/15/22 at 6:15 p.m. while attempting to self-toilet. On 11/19/22 a new order for Bactrim DS	F 0689	It is the policy of PHC to ensure care plans are updated timely to provide an environment safe and free from accidents and care plans to be revised to accurately address the resident needs by the interdisciplinary team. I. Corrective Action Taken Related to this Finding: On 2-3-23, the IDT consisting of, Director of Nursing, Unit Managers, Director of Quality, Social Services and therapy reviewed all falls occurring in the past 12 months for Residents 36, 31, 40, and 35 and updated fall care plans to include personalized interventions based on the root cause of falls and ensured that all fall care plan interventions were appropriately implemented. Each resident's physician and responsible party were notified of all fall occurrences and revisions made to fall plans of care. On 1-27-23, Resident 40 was provided a call light that reaches the area where she frequently sits and the room was assessed for tripping hazards. II. Other residents with Potential to be Affected by this Finding will be Identified by: On 2-5-23, the IDT reviewed all residents currently residing in the facility with falls in the past 12 months to ensure that fall care plans include personalized interventions based on the root cause of falls and that all fall care	02/08/2023

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	(antibiotic) 800-160 mg 1 tablet by mouth two times daily for a UTI for 7 days was started. Resident record lacked documentation a UA had been obtained to diagnose the UTI. c. On 11/27/22 at 9:30 a.m. while attempting to self-toilet. d. On 11/30/22 at 9:45 a.m. while attempting to self-toilet. e. On 12/20/22 at 7:45 p.m. while attempting to self-toilet. On 12/21/22 a new order for Macrobid 100 mg 1 capsule by mouth two times daily for a UTI for 10 days was started. Resident record lacked documentation a physician's order had been obtained for a UA that had been obtained on 12/15/22 before the fall. f. On 1/14/23 at 7:25 p.m. while attempting to self-toilet. On 1/8/23 a new order for a UA with culture and sensitivity (UA C&S) one time only for burning urination, increased confusion, and increased fatigue. Resident record lacked documentation the UA had been completed before the resident fell on 1/14/23. On 1/19/23 a new order for Bactrim DS 800 - 160 mg 1 tablet by mouth two times daily for UTI for 7 days was started. g. On 1/23/22 at 9:35 a.m. while attempting to self-toilet. h. On 1/27/23 at 4:00 p.m. while attempting to self-toilet. The resident record lacked documentation the physician and/or resident representative was notified of resident falls on 11/5/22, 11/15, 11/30, 12/20, 1/14/23, 1/23, and 1/27. No further		plan interventions are appropriately implemented and no tripping hazards exist in the room and that residents have access to means to call for help in their preferred sitting areas. III. Measures and Systemic Changes put into place to assure deficient practices do not recur are as follows: a. All nursing Staff were educated at mandatory in-service on 2-8-23 regarding the fall prevention program policy that outlines who needs assistance during transferring, and toileting as well the requirement to ensure that immediate interventions are implemented following each fall and to validate that fall interventions are implemented for residents as indicated in the plan of care. As well as educated on proper documentation of notification appropriate personnel and proper documentation of unwitnessed falls. b. The IDT team will review all falls the next business day during the daily clinical meeting to ensure the fall care plan is updated and includes appropriate interventions based on the root cause of the fall and that the physician and responsible party were notified of the fall. c. A resident council follow-up form was created to help facilitate requests that are made to mitigate	

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	documentation was provided during the survey. The resident record lacked documentation neuro check assessments were completed for resident falls on 12/20/22 and 1/27/23. No further documentation was provided during the survey. A Fall Risk Assessment, dated 12/20/22, indicated history of falls in the last 6 months, 1-2. This was an error in documentation as the resident record indicated over 5 falls at that time. A quarterly minimum data set (MDS) assessment completed on 11/15/22, assessed the resident as being cognitively intact. The resident required limited assistance of 2+ persons physical assist for bed mobility, and transfers, supervision of one person physical assist for walking in room, and extensive assistance of 2+ persons physical assist for toilet use. Mobility devices included a wheelchair. Occasionally incontinent of bladder and always continent of bowel. No trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) had been attempted since urinary incontinence was noted in this facility. 2 or more falls since the prior assessment. A care plan for falls visible in the EMR, indicated Resident 36 was at risk for falls related to requiring assistance with Activities of Daily Living (ADL's), medication use, bladder and bowel incontinence, and history of falls. The goal was for her to be free of falls with injury through the review date. Care plan intervention updates included, a. 5/17/21 anticipate and meet her needs; encourage her to participate in activities that promote exercise, physical activity for strengthening and improved mobility; ensure she is wearing appropriate footwear when ambulating		potential hazards. Managers have 1 week to complete and follow-up form and give it to the administrator and the resident council president. IV. Corrective Actions will be Monitored to Ensure Compliance by: The Director of Nursing, or her designee, will be conducting fall care plan audits (see attached) to ensure that appropriate interventions are care planned based on the root cause of past falls and that all care planned fall interventions are implemented in accordance with the fall care plan 5x per week times 4 weeks, then 3 x per week x 4 weeks, then 2 x per week x 4 weeks, then 1 x per week x 3 months. The outcome of the audit tool will be reviewed at the Quality Assurance meetings to determine if any additional action is warranted. Providence Health Care will review, update, and make changes to this plan of correction as needed for sustaining compliance for no less than six months.	

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	or mobilizing in wheelchair, ensure her call light is within reach while in room and encourage her to use it. Promptly respond to all requests for assistance; follow facility fall protocol, PT/OT (physical therapy/occupational therapy) and evaluate and treat as ordered or PRN (as needed). b. 5/26/21 review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter/remove any potential causes if possible. c. 11/10/22 PT evaluate and treat as ordered or PRN. d. 11/16/22 review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter/remove any potential causes if possible. Resident needs a safe environment with: (Specify: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; Slide fails as ordered, handrails on walls, personal items within reach). Educate resident/family/caregivers about safety reminders and what to do if a fall occurs. Ensure that resident is wearing appropriate footwear (Specify and describe correct client footwear i.e. brown leather shoes, tartan bedroom slippers, black non-skid socks) when ambulating or mobilizing in w/c. On 1/31/23 at 11:35 a.m. the Director of Nursing (DON) provided a fall care plan for Resident 36 with additional interventions and indicated she could not explain why the interventions could not be viewed on the EMR by others. The interventions included, a. 11/5/22 education provided on transfers. b. 11/23/22 offer toileting every 2 hours until finished with antibiotics. c. 11/27/22 OT (occupational therapy) and treatment for safety awareness.			

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	d. 11/30/22 2 hour safety checks until therapy is completed. e. 12/20/22 Urinary analysis (UA) culture and sensitivity (C&S) pending. f. 1/14/23 obtain repeat UA C&S. The resident record lacked documentation individualized interventions related to falls in the bathroom while attempting to self-toilet had been attempted or added to the care plan. During an interview on 1/30/23 at 2:20 p.m., Unit Manager (UM) 3 indicated, Resident 36 was capable of self-transferring and ambulating independently, but she was not supposed to. She would use her call light for assistance but would not always call for assistance when toileting. During an interview on 1/31/23 at 10:24 a.m., Registered Nurse (RN) 11 indicated, if a resident had an unwitnessed fall, the nurse would complete a head to toe assessment looking for injury to include vital signs. If the resident had an injury neuro checks were initiated, the physician notified, and the resident sent to the emergency department (ED). Fall documentation included a Risk Management Report and a Coms Post Fall Evaluation, both which fed documentation into the nurse's notes. The nurse was to notify the facility management, physician (MD), and family. Care plans on the rehab unit were updated by unit manager (UM) 19 and/or the care plan team. If the resident had a witnessed fall with no injury, the assessments, and documentation remained the same with follow up for 72 hours. Laboratory tests were completed only after contacting the MD for an order, writing the order, contacting the contracted lab company, and obtaining the sample.			

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	During an interview on 1/31/23 at 11:18 a.m., the DON indicated, at the time of a resident fall the nurse was responsible for implementing a new fall intervention. The interdisciplinary team (IDT) then reviewed all fall documentation and would determine the appropriateness of the intervention and change or add as needed. 2. During the initial tour on 1/23/23 at 2:28 p.m., Resident 31 was observed to be toileting independently in her private bathroom. Resident's walker was parked near the door to the hallway with a sign indicated, press call light for staff to help you walk. Please do not walk without staff. The resident call light was not activated. On 1/23/23 at 2:40 p.m., Resident 31 was observed exiting her bathroom in a wheelchair (wc) using her feet to propel and entering the common area in the hallway outside her room. The resident was sitting on a gait belt, had anti-tipper bars on the back of her wc, and a wanderguard bracelet (used to trigger an alarm and prevent an elopement or unauthorized leaving of the unit) on her right ankle. Resident 31 indicated she could go to the bathroom on her own. On 1/24/23 at 10:53 a.m., Resident 31 was observed sitting in her wc in the hallway outside her room, coat in hand, and indicated she was not sure if she had an appointment that day. Indicated the wanderguard on her right ankle was used so they could find her in case she got outside alone, had an accident, or got lost. On 1/26/23 at 10:18 a.m., Resident 31 was observed in the dining/activity common area asleep in her wc, with her head hung down towards her chest.			

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	On 1/27/23 at 9:53 a.m., Resident 31 indicated she was unsure why she'd had 2 falls in the past 2 days, but thought one was from getting up on the side of the bed, the wc was too far away to reach, the call light was on the back side of the bed, and when the mattress ultimately gave way, she slid to the floor. Indicated, thought she had a urine test, maybe yesterday. Resident 31's record was reviewed on 1/26/23 at 1:51 p.m. Diagnoses on Resident 31's profile included, but were not limited to, unspecified dementia, history of falling, repeated falls, lack of coordination, difficulty walking, unsteady on feet, and need for assistance with personal care. Post Fall Evaluation notes on 1/25/23 at 6:43 a.m., indicated on 1/25/23 at 5:40 a.m., Resident 31 had an unwitnessed fall in her room while attempting to self-toilet. The reason for the fall was not evident. The bathroom call light was not on at the time of the fall. Place resident on 30 minute safety checks. An Interdisciplinary Team (IDT) note, dated 1/25/23 at 9:12 a.m., indicated the IDT met to discuss the resident occurrence. Initiated 30 minute safety checks while on Neuros (for 72 hours). Post Fall Evaluation notes on 1/26/23 at 7:08 a.m., indicated on 1/26/23 at 6:30 a.m., Resident 31 had an unwitnessed fall in her room, resident was in a hurry/rush at the time of the fall. The reason for the fall was not evident. The resident had current medical conditions that contributed to the fall. Unable to ambulate per self, a history of falls, and a history of falls at the facility. Resident had a similar fall when she slid out of her wheelchair the prior morning.			

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An annual MDS assessment, completed on 10/21/22, assessed the resident as being cognitively intact. Limited assistance of one person physical assist for bed mobility and transfers. Independent with no set up or physical help for walking in the room, corridor, and locomotion off the unit. Supervision with no setup or physical help from staff for locomotion on the unit. Supervision and one person physical assist with toileting and personal hygiene. Assistive devices included a wc and walker. 1 fall without injury since admission/entry or reentry or the prior assessment.

A fall care plan for Resident 31 indicated she was at risk for falling related to requiring assistance with ADL's (daily tasks related to resident care and hygiene), medication use, history of falls, and bowel and bladder incontinence. The goal was for the resident to be free of falls with injury. Interventions updates included on 1/6/23 encourage the resident to go to her room when she falls asleep in wc, and on 1/25/23 30 minute checks while on neuro's.

During an interview on 1/27/23 at 10:00 a.m., UM 3 indicated, she had sent out a UA sample for the resident related to her falls in the past 2 days. She thought the root cause of the falls were related to the resident getting up to go to the bathroom on her own. She could not answer if the resident got up independently during off shifts. Indicated the resident would use her call light for assistance. Observation of the resident medical record with UM 3 indicated there was no MD order for a UA, and no documentation in the progress notes the MD or responsible party had been notified of both falls. Observation of the electronic communication system for the contracted

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	laboratory with UM 3 indicated there was no documentation a UA sample had been received by the lab or was being processed. The facility provided no laboratory results dated January 2023. During an interview on 1/27/23 at 10:06 a.m., Certified Nursing Assistants (CNA's) 16 and 17 indicated they routinely cared for Resident 31. She did not use her call light for assistance as she preferred to be independent. The resident would transfer out of bed to her wc then to the toilet, taking her clothing with her to dress. Staff would sometimes catch her in the middle of care and assist her with dressing and transfers. On 1/27/23 at 11:30 a.m., UM 3 presented a laboratory form for Resident 31, dated 1/26/23 at 5:54 p.m. indicated UA with culture, and a handwritten physician's order, dated 1/26/23, indicated UA C&S. UM 3 indicated, there was no MD order initially for the UA as the nurse yesterday did not know how to write the physician's order. A nurse on the rehabilitation hall later placed the lab order and wrote the handwritten MD order. UM 3 did not provide documentation the MD or resident representative had been notified of the falls, or a physician had given the order for the UA. 3. During the initial tour on 1/23/23 at 11:50 a.m., Resident 40 was observed putting together a jigsaw puzzle in her room on a desk located at the foot of her bed. She indicated, she could transfer and ambulate on her own but would call for assistance in the evening to toilet due to past falls with injury before her admission. She was concerned her call button reached her when she was in bed and in her recliner, but if she fell by the desk where she often sat putting together puzzles,			

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	or by her television she would have to crawl to get to the cord on her recliner. Resident 40 indicated she had reported her concerns to the Activity Director among peers during a resident council meeting, but she had never been given another cord. The resident call light was observed where she indicated clipped to the arm of her recliner, and when stretched would reach the end of the bed but was taut approximately 3 feet off the ground creating a hazard. An oxygen concentrator was also observed behind the resident bed attached to a 20+ foot oxygen tubing with nasal cannula the resident was wearing. When the resident stood up to sit on her rollator walker seat she was observed to step on and around the tubing which was laying haphazardly on the floor. The resident indicated she had tripped over her oxygen tubing on multiple occasions but caught herself by grabbing onto furniture before she fell. Resident 40's record was reviewed on 1/25/22 at 1:46 p.m. Diagnoses on Resident 40's profile included, but were not limited to, chronic obstructive pulmonary disease (COPD), difficulty walking, need for assistance with personal care, and weakness. A physician's order dated 1/8/23, indicated oxygen at 2 liters (L) via nasal cannula (NC), may titrate to keep oxygen saturations (sat) greater than 92% two times a day. Resident Council Minutes, dated September 6, 2022, indicated, a resident said she would rather have a call light that she could wear since her call light wasn't always within her reach. Unit Manager (UM) 3 let the resident know that she had an idea about her call light since she sits on			

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	both sides of the room. She would let maintenance know about her idea to see if it would work. Resident Council Minutes dated October 2022 - January 2023 lacked documentation the call light request was followed up. A quarterly MDS assessment completed on 1/23/23 assessed the resident was cognitively intact. Independent with set up help only for bed mobility, and locomotion off the unit. Supervision and one person physical assist for transfers. Supervision and set up only for walking in room and corridor, locomotion on the unit. Mobility devices included a walker. Oxygen while a resident. A care plan for Resident 40, dated 4/26/22, indicated she had a diagnosis of Congestive Heart Failure. The goal was for her to have clear lung sounds and her heart rate and rhythm to be within normal limits. Interventions included oxygen therapy as ordered. A fall care plan for Resident 40, dated 5/5/22, indicated the resident was at risk for falls related to requiring assistance for ADL's, bladder, and incontinence. The goal was for the resident to be free of falls with injury. The intervention was to encourage call light was within reach while in room and encourage her to use it. Promptly respond to all requests for assistance. During an interview on 1/26/23 at 10:54 a.m., the AD indicated, during a resident council meeting in September 2022, Resident 40 had reported when doing puzzles, the call light was not long enough to go from one side of the room to the other. UM 3 indicated she had an idea already so she would go to maintenance to get a double headed call cord.			

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	During an interview on 1/26/23 at 11:15 a.m., the Maintenance Supervisor indicated, he did not recall getting a request to provide Resident 40 with a longer or split call cord, and observation of repair request cards, dated 2022, indicated there was no request card found. During an interview on 1/26/23 at 11:34 a.m., the Administrator (ADM) indicated, she had never heard about Resident 40 requesting a different call cord. During an interview on 1/26/23 at 11:42 a.m., Respiratory Therapist (RT) 14 indicated, Resident 40 received breathing treatments per the nursing staff. The RTs went out weekly to change out oxygen tubing and oxygen equipment. To her knowledge no fall concerns related to the oxygen tubing had been identified or documented. 4. Resident 35's clinical record was reviewed on 1/27/23 at 1:16 p.m. The resident was admitted to the facility, on 4/20/21, with diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (a mini stroke caused by a temporary disruption in the blood supply to part of the brain), hypertension (high blood pressure), anxiety (feelings of fear, dread, and uneasiness that may occur as a reaction to stress), depression (mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily life), insomnia (difficulty sleeping or staying asleep), and heart failure. An annual Minimum Data Set (MDS) assessment, dated 12/29/22, indicated the resident had a moderate cognitive impairment, had no behaviors or wandering, required limited assistance of one person for bed mobility, transfer, walking in the			

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	room, dressing and personal hygiene, required extensive assistance of one person for toilet use, and was occasionally incontinent of bladder, received scheduled and prn (as needed) pain medication, utilized a walker and wheelchair for mobility, had two or more falls with injury since her admission into the facility, and received oxygen therapy. A fall risk assessment, completed on 10/13/22, indicated the resident was a high risk for falls and a fall risk assessment, completed on 10/18/22, indicated the resident was a moderate risk for falls. A care plan, initiated on 4/21/21, indicated the resident had the potential for pain and received pain medications. Interventions included, but were not limited to, observe for side effects of pain medication. Observe for constipation, new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria, nausea, vomiting, dizziness, and falls. Report occurrences to the physician. A care plan, initiated on 4/21/21 and revision on 10/18/22, indicated the resident was at risk for falls related to requiring assistance with Activities of Daily Living (ADL) (daily tasks related to resident care and hygiene), medication use, bladder and bowel incontinence, and a history of falls. Intervention on the care plan included, but were not limited to, anticipate and meet her needs, ensure the call light was within reach while in her room and encourage her to use it, and to promptly respond to all requests for assistance. A post fall evaluation progress note, dated 10/18/22 at 10:45 p.m., indicated Resident 35 had an unwitnessed fall in the bathroom when the resident attempted to transfer herself from the			

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	toilet to a wheeled walker. A skin tear, measuring 5.08 centimeters (cm) by 3.81 cm, injury to the right outer calf was noted with the fall. The resident's call light was on when the resident was found by staff on the bathroom floor. On 1/27/23 at 11:05 a.m. the Administrator (ADM) provided a grievance log, dated September 2022 to January 2023, and indicated Resident 35's daughter had contacted the facility and had a grievance about the call light times taking too long for staff to answer for her mother, due to a fall from the toilet Resident 35 had sustained with a skin tear on 10/18/22. The ADM provided a call light log, titled "Past Calls 10/18/22," and indicated Resident 35 had pressed her call light, on 10/18/22 at 7:15 p.m., and waited fifty minutes for the call light to be answered, had pressed her call light, on 10/18/22 at 10:11 p.m. and waited seven minutes and fifty-two seconds, and pressed her call light for assistance, on 10/18/22 at 10:57 p.m., and waited thirteen minutes when she fell off of the toilet due to trying to get up by herself without staff assistance. The ADM had completed and provided a document, titled "Providence Health Care, INC. Concern/Suggestion Report," which indicated, Resident 35's daughter had a concern about Resident 35's fall, on 10/18/22, after having waited too long on the toilet for staff assistance after pressing the call light. Action taken and results indicated follow up on 10/24/22 would investigate the fall and call light time responsiveness. ADM documented on the concern grievance, the daughter was called on 10/24/22 to discuss and left a message. No additional follow up documentation was noted with a grievance resolution for the call light time responsiveness. On 1/31/23 at 11:16 a.m., the Director of Nursing			

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	(DON) indicated, Resident 35 should not have been left on the toilet by herself, because she was a high fall risk. On 1/30/23 at 10:21 a.m., the Director of Nursing provided a Fall Prevention Program policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, it was the policy of the facility, "to have a Fall Prevention Program to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls, and implementation of appropriate interventions to provided necessary supervision and assistive devices are utilized as necessary ...Care Plan incorporates: a. Identification of all risk/issue, b. Addresses each fall, c. Interventions are changed for each fall as appropriate, d. Preventative measures ...2. At the time of admission and in accordance with the plan of care the resident will be oriented to use the nurse call device. The nurse call device will be placed within the resident's reach at all times ...6. The resident's environment will be kept clear of clutter which would affect ambulation and remove hazards ...8. Call lights are answered promptly ...Residents at moderate risk of falling will be assisted with toileting needs in accordance with voiding patterns identified during the assessment process and as addressed on the plan of care ..." 3.1-45(a)(1) 3.1-45(a)(2)			
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			

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	from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure pharmacy recommendations were acted upon by the physician in a timely manner and that the physician provided rationale for decisions made on pharmacy recommendations, for 2 of 5 residents reviewed for unnecessary medications (Residents 21 and 35). Findings include: 1. Resident 21's record was reviewed on 1/26/23 at 11:45 a.m. The profile indicated the resident's diagnoses included, but were not limited to, stage 5 chronic kidney disease (when the kidneys are getting very close to failure or have already failed) and dependence on renal dialysis (a procedure to remove waste products and excess fluid from the	F 0757	It is the policy of PHC to adequately show timely documentation of pharmacy to physician recommendation with rational if declined. I. Corrective Action Taken Related to this Finding: A. On, 2/1/23 the DON reviewed all unresolved pharmacy recommendations made since Jan 2022 for Resident #21 and # 35 with physician and physician documented response for each recommendation with rationale for decisions made II. Other residents with potential to be affected by this finding will be identified by:	02/10/2023

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	blood when the kidneys stop working properly). An annual Minimum Data Set (MDS) assessment, dated 12/6/22, indicated the resident had no cognitive deficit, received routine pain medications, and received dialysis services. A physician's order, dated 11/30/22, indicated atorvastatin calcium tablet (drug used to lower the amount of cholesterol in the blood), 20 milligrams (mg). Give 1 tablet, by mouth, at bedtime. A physician's order, dated 11/30/22, indicated ergocalciferol capsule (a medication that works by helping the body to use more of the calcium found in foods), 1.25 mg. 1 capsule, by mouth, in the morning every Friday. A physician's order, dated 11/30/22, indicated gabapentin capsule (a medication used to treat seizures, but also taken for nerve pain), 100 mg. 1 capsule, by mouth, at bedtime for pain and 1 capsule, by mouth, once a day on Monday, Wednesday, and Friday for pain. On 1/26/23 at 9:50 a.m., the Director of Nursing (DON) provided pharmacy recommendations, for the resident, from January 2022 through January 25, 2023. Review of the pharmacy recommendations, indicated the following: a. A pharmacy recommendation, dated 3/16/22, indicated the resident was receiving atorvastatin and ergocalciferol 50,000 units every week. The Pharmacist was unable to locate recent labs for lips levels (fat in the blood) and Vitamin D levels. Requested to consider obtaining the labs with next lab orders. The recommendation lacked documentation that the physician had reviewed the recommendation, had written any new orders,		On 2/3/23, DON reviewed all pharmacy recommendations made in the past 30 days to identify any pharmacy recommendations that were not acted on timely or lacked physician documentation of rationale for decisions made on pharmacy recommendations. Any unresolved pharmacy recommendations or any lacking physician rationale for decisions were reviewed with physician for response and documentation of rationale. III. Measures and Systemic changes put into place to assure deficient practices do not recur are as follows: A. On 2/10/23, the Administrator and Director of Nursing provided education to all attending physicians on the facility policy and procedure for responding to pharmacy recommendations and the timeline for responding to recommendations and requirements to document the rationale for decisions, if necessary. IV. Corrective Actions will be Monitored to Ensure Compliance by: The Director of Nursing, or her designee, will be conducting quality improvement audits (see attached) to verify that pharmacy recommendations are followed up	

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	or had signed and dated the document. Review of the historical physician orders indicated no lipid level or Vitamin D levels orders from 4/7/21 through 11/2/22, were observed. b. A pharmacy recommendation, dated 8/7/22, indicated the resident received gabapentin 300 milligrams (mg) three times a day. The resident's calculated Creatinine clearance (CrCl-the volume of blood plasma [fluid part of the blood that carries the blood cells] cleared of creatinine [a compound that is excreted from the body in urine]) was 11-15 milliliters (ml) per minute on ideal body weight. Patients on hemodialysis should receive by mouth maintenance doses based on CrCl as indicated for patients with renal impairment. A supplemental post-hemodialysis dose ranging from 125-300 mg PO should be given each 4 hours of hemodialysis. Recommendation to stop current order, and start gabapentin 100 mg, 2 at bedtime and 100 mg, 1 following each hemodialysis on Monday, Wednesday, and Friday. The recommendation lacked documentation that the physician had reviewed, signed or dated the document and lacked documentation of acceptance or declination, of the recommendation. c. A pharmacy recommendation, dated 8/7/22, indicated the resident had as needed (PRN) orders that had not been used in 3 months. The recommendation was to consider discontinuing the PRN medications of Benadryl (used to treat a variety of allergic disorders), cyclobenzaprine (skeletal muscle relaxant), Icy Hot patch (used to treat minor aches and pains of the muscles/joints), Preparation H cream (hemorrhoid treatment), Zofran (used to prevent nausea and vomiting), Ibuprofen (pain/fever relief), Biofreeze gel (soothes minor pain of the muscles or joints),		on timely with documented rationale for decisions, if necessary. Audits will be completed monthly for 3 months. Additional audits will be completed based upon the level of compliance. Results of all audits will be reported to the Quality Assurance and Performance Improvement committee for additional recommendations and for closure of the project in satisfactory standing.	

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	hydrocortisone cream (used to treat redness, swelling, itching, and discomfort of various skin conditions), Imodium A-D (over-the-counter drug used to treat diarrhea), and Tums (used to treat excess stomach acid). The recommendation lacked documentation that the physician had reviewed the recommendation, lacked documentation of acceptance or declination, signature and date. d. A second pharmacy recommendation, dated 9/6/22, of the original recommendation, dated 8/7/22, to stop the order of gabapentin 300 milligrams (mg) three times a day and start 100 mg at bedtime and 100 mg, 1 following each hemodialysis on Monday, Wednesday, and Friday, was re-submitted by the pharmacist. The recommendation was accepted by the physician and the document signed and dated on 9/19/22. The original order dated 5/2/22, for gabapentin 300 mg capsule was discontinued on 9/19/22, and a new order was written, for gabapentin 300 mg capsule, give a capsule, by mouth, 3 times daily. The concerns identified in the recommendation originally dated 8/7/22, had been addressed until 9/19/22, 43 days after the recommendation had been written. e. A second pharmacy recommendation, dated 9/6/22, of the original recommendation, dated 8/7/22, which recommended considering to discontinue PRN medications which not been used in 3 months, Benadryl, cyclobenzaprine, Icy Hot patch, Preparation H cream, Zofran, Ibuprofen, Biofreeze gel, hydrocortisone cream, Imodium A-D, and Tums, was re-submitted by the pharmacist. The recommendation was accepted by the physician and the document signed and dated on 9/19/22. used to treat ulcerative colitis in adults). The concerns identified in the recommendation originally dated 8/7/22, had been			

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	addressed until 9/19/22, 43 days after the recommendation had been written. f. A pharmacy recommendation, dated 12/8/22, indicated the resident had received Ibuprofen 600 milligrams (mg), 1 every 6 hours as needed for fever. Due to Ibuprofen being nephrotoxic (poisonous or damaging to the kidney), it should be avoided in resident's with GFR (a test used to check how well the kidneys are working) below 30 milliliters (ml) per minute. The resident's GFR was 15 ml/minute. Recommendation was to stop Ibuprofen. The recommendation lacked documentation that the physician had reviewed and lacked documentation of acceptance or declination, signature, and date. Historical review of the physician's orders indicated the order for Ibuprofen had not been discontinued and was still an active order. g. A pharmacy recommendation, dated 1/9/23, indicated Apriso extended release (ER) (used to treat ulcerative colitis in adults), 0.375 grams (gm), give 4 capsules daily. Recommendation was to stop current order and start Apriso ER 0.375 gm, 3 caps daily. The physician agreed and signed and dated the document on 1/17/23. Review of the current physician's orders indicated the order had not been changed from the original order written on 12/1/22. Current order was for Apriso ER 0.375 gm. Give 4 capsule by mouth one time a day. h. A second pharmacy recommendation, dated 1/9/23, of the original recommendation, dated 12/8/22, to stop Ibuprofen 600 milligrams (mg), 1 every 6 hours as needed for fever, was re-submitted by the pharmacist. The physician had agreed and signed and dated the document on 1/17/23. The concerns identified in the			

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	recommendation originally dated 12/8/22, had been addressed until 1/17/23, 41 days after the recommendation had been written. During an interview, on 1/26/23 at 9:50 a.m., the Director of Nursing (DON) indicated the she had not been able to find any additional information related to the recommendations she provided. The facility had changed to a new pharmacy in August 2022. For the recommendations prior to that date no documentaion of physican review, rationale, signature, or dates were found. 2. Resident 35's clinical record was reviewed on 1/27/23 at 1:16 p.m. The resident was admitted to the facility, on 4/20/21, with diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (a mini stroke caused by a temporary disruption in the blood supply to part of the brain), hypertension (high blood pressure), anxiety (feelings of fear, dread, and uneasiness that may occur as a reaction to stress), depression (mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily life), insomnia (difficulty sleeping or staying asleep), and heart failure. An annual Minimum Data Set (MDS) assessment, dated 12/29/22, indicated the resident had a moderate cognitive impairment, received an antidepressant (used to treat depression) and a hypnotic (sleeping pill) on a routine basis. An active physician's order, start dated 4/21/21, indicated sertraline hydrochloride (HCl) (brand name Zoloft) (medication used to treat anxiety and depression) oral tablet 25 milligrams (mg). Give 1 tablet, by mouth, at bedtime.			

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	An active physician's order, start dated 6/6/21, indicated Ambien (generic name Zolpidem Tartrate) oral tablet 5 mg. Give 1 tablet, by mouth, at bedtime, for difficulty sleeping. An active physician's order, start dated 3/3/22, indicated Zyrtec Allergy Tablet (generic name cetirizine HCl) oral tablet 10 mg. Give 1 tablet by mouth one time a day for allergies. On 1/26/23 at 9:50 a.m., the Director of Nursing (DON) provided pharmacy recommendations, for the resident, from January 2022 through January 25, 2023. Review of the pharmacy recommendations, indicated the following: a. A pharmacy recommendation, dated 4/7/22, indicated the resident was receiving Zoloft 25 mg daily since admission 4/2021 for anxiety and depression. The recommendation indicated, per federal regulations any medication when used to manage behavior, stabilize mood, or treat a psychiatric disorder is subject to GDR (gradual dose reduction) twice in two separate quarters with at least one month between attempts within the first year a resident is admitted on a psychopharmacological medication or after the facility has initiated a psychopharmacological medication. After the first year, it is subject to GDR once per year. A GDR is contraindicated if the continued use is in accordance with relevant current standards of practice, and physician has documented clinical rationale -or- Resident's target symptoms returned or worsened after most recent GDR attempt within facility and physician has documented clinical rationale and to review if a GDR may be attempted at this time. The recommendation lacked documentation that the physician had reviewed, signed, or dated the document and lacked documentation of			

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	acceptance or declination, of the recommendation. b. A pharmacy recommendation, dated 6/13/22, indicated the resident was receiving Ambien (Zolpidem) 5 mg daily at bedtime. The recommendation indicated, indicated, per federal regulations any medication when used to manage behavior, stabilize mood, or treat a psychiatric disorder is subject to GDR (gradual dose reduction) twice in two separate quarters with at least one month between attempts within the first year a resident is admitted on a psychopharmacological medication or after the facility has initiated a psychopharmacological medication. After the first year, it is subject to GDR once per year. A GDR is contraindicated if the continued use is in accordance with relevant current standards of practice, and physician has documented clinical rationale -or- Resident's target symptoms returned or worsened after most recent GDR attempt within facility and physician has documented clinical rationale and to review if a GDR may be attempted at this time. The physician checked "Other" on the recommendation form and wrote, "stable - as is," signed by the physician on 7/11/22. The document lacked documentation of a clinal rationale for not attempting a GDR. c. A pharmacy recommendation, dated 8/5/22, indicated the following PRN (as needed) orders had not been utilized in 3 months per nursing administration records. Please consider discontinuing the following: Colace (stool softener) 100 mg capsules, Donnatal (used to treat stomach problems), 16.2 mg tablet, Imodium A-D (diarrhea medication) 2 mg tablet [2 orders], Meclizine (used to prevent and treat nausea, vomiting, and dizziness) 12.5 mg tablet, Dextromethorphan HBr (cough medication) liquid,			

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	guaifenesin (used to relieve chest congestion) 100mg/5 milliliters (ml) syrup, Lidocaine (anesthetic causing loss of feeling in the skin and surrounding tissues) 4% cream, and Pyridium (used to relieve symptoms caused by irritation of the urinary tract) 100 mg tablet. The recommendation lacked documentation that the physician had reviewed, signed, or dated the document and lacked documentation of acceptance or declination, of the recommendation. d. A pharmacy recommendation, dated 8/6/22, indicated the resident was receiving Cetirizine (Zyrtec) 10 mg tablet my mouth daily. Recommended to stop current order, due to poor kidney function blood work, and start Cetirizine 10 mg tablet my mouth qod (every other day). The physician had agreed to the recommendation and signed the recommendation on 8/11/22. Resident 35's record lacked documentation the Cetirizine order was discontinued and changed to every other day administration. e. A repeated pharmacy recommendation, dated 8/9/22, indicated the resident was receiving Zolpidem (Ambien) 5 mg daily at bedtime. The recommendation indicated, the use of hypnotics should generally be limited to 7-10 days of treatment per labeling from the FDA (Food and Drug Administration). This is also the regulation in nursing facilities. Per behavior meeting on 8/9/22, patient and family are resistant to changes in this medication. They also report that she does not exhibit any morning "hangover effect" or other side effects. While technically this cannot be documented as a clinical contraindication to change because the order is not in accordance with relevant current standards of practice, please take a moment to write a clinical rationale for continued use and reasons preventing a GDR at			

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	this time. The recommendation lacked documentation that the physician had reviewed, signed, or dated the document and lacked documentation of acceptance or declination, of the recommendation. f. A repeated pharmacy recommendation, dated 9/6/22, indicated the resident was receiving Cetirizine (Zyrtec) 10 mg tablet my mouth daily. Recommended to stop current order, due to poor kidney function blood work, and start Cetirizine 10 mg tablet my mouth qod (every other day). The physician checked "Other" on the recommendation form and wrote, "Leave as is," signed by the physician on 9/14/22. The document lacked documentation of a clinal rationale for not attempting a GDR. g. A repeated pharmacy recommendation, dated 9/6/22, indicated the resident was receiving Zolpidem (Ambien) 5 mg daily at bedtime. The recommendation indicated, indicated, per federal regulations any medication when used to manage behavior, stabilize mood, or treat a psychiatric disorder is subject to GDR (gradual dose reduction) twice in two separate quarters with at least one month between attempts within the first year a resident is admitted on a psychopharmacological medication or after the facility has initiated a psychopharmacological medication. After the first year, it is subject to GDR once per year. A GDR is contraindicated if the continued use is in accordance with relevant current standards of practice, and physician has documented clinical rationale -or- Resident's target symptoms returned or worsened after most recent GDR attempt within facility and physician has documented clinical rationale and to review if a GDR may be attempted at this time. The physician checked "Other" on the			

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	recommendation form and wrote, "Leave as is," signed by the physician on 9/14/22. The document lacked documentation of a clinal rationale for not attempting a GDR. h. A repeated pharmacy recommendation, dated 9/6/22, indicated the following PRN (as needed) orders had not been utilized in 3 months per nursing administration records. Please consider discontinuing the following: Colace (stool softener) 100 mg capsules, Donnatal (used to treat stomach problems), 16.2 mg tablet, Imodium A-D (diarrhea medication) 2 mg tablet [2 orders], Meclizine (used to prevent and treat nausea, vomiting, and dizziness) 12.5 mg tablet, Dextromethorphan HBr (cough medication) liquid, guaifenesin (used to relieve chest congestion) 100mg/5 milliliters (ml) syrup, Lidocaine (anesthetic causing loss of feeling in the skin and surrounding tissues) 4% cream, and Pyridium (used to relieve symptoms caused by irritation of the urinary tract) 100 mg tablet. The physician agreed and signed the recommendation, on 9/14/22, to discontinue all the medications listed on the recommendation form. i. A pharmacy recommendation, dated 12/6/22, indicated the resident was receiving Cetirizine (Zyrtec) 10 mg tablet my mouth daily. Recommended to consider ordering a more current blood work of a BMP (basic metabolic panel is a blood test that gives doctors information about the body's fluid balance, levels of electrolytes like sodium and potassium, and how well the kidneys are working) or CMP (comprehensive metabolic panel is a blood test that gives doctors information about the body's fluid balance, levels of electrolytes like sodium and potassium, and how well the kidneys and liver are working) and recommended to start Cetirizine (Zyrtec) 10 mg			

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	qod at bedtime. The recommendation lacked documentation the physician had reviewed, signed, or dated the document and lacked documentation of acceptance or declination, of the recommendation. On 1/27/23 at 12:08 p.m., the Director of Nursing (DON) indicated the physician did not address the pharmacy recommendations in a timely manner and should have provided a clinical rationale when the recommendation was not accepted. The DON provided and identified a document as a current facility policy, titled "Consultant Pharmacist Policy," dated 12/7/22. The policy indicated, " ...Purpose: To define the role and responsibilities of the Consultant Pharmacist and support personnel involved in consultation duties. To establish guidelines for timely reviews of residents' medication regimen ...Responsibility: Director of Health Services, Consulting Pharmacist, Director of Nursing, Licensed Nurses, and attending Physicians ...Policy: It is the policy of Providence Health Care to have an agreement with a long term care experienced, licensed pharmacist to provide consultation on all aspects of the provision of pharmacy services and perform monthly medication regimen reviews for all residents ...Standards: 1. Responsibilities of the Consultant Pharmacist, or qualified designee, shall include but not limited to: ...a. Conduct monthly, and for new admissions, drug regimen reviews for each resident and report any irregularities to the Director of Health Care Services, Director of Nursing and attending physicians as appropriate ...11. In the event a problem or irregularity is noted during the review, the nurse in charge and/or Director of Nursing will be promptly notified. When necessary, the attending physician, Medical Director and Director of Heal Care Services will be notified. The pharmacist will			

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	notify the physician as appropriate ...12. The written report of the Drug Regimen Review shall be discussed and given to the Director of Nursing and Director of Health Care Services. The Director of Health Care Services and Director of Nursing shall review the report for significant problems and initiate action(s) as necessary. The Director of Nursing shall forward the report to the unit managers for follow-up, physician contact, and corrections and physician recommendation review as appropriate ...." 3.1-48(a)(1) 3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(5) 3.1-48(a)(6)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and			

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	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 for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure pharmacy recommendation were reviewed and addressed by the physician for 2 of 5 residents reviewed for unnecessary medications (Residents 2 and 21). Findings include: 1. Resident 2's record was reviewed on 1/25/23 at	F 0758	It is the policy of PHC to adequately show timely documentation of pharmacy to physician recommendations with rationale if declined. I. Corrective Action Taken Related to this Finding: A. On, 2/1/23, the DON reviewed all unresolved pharmacy recommendations made since Jan	02/10/2023

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	1:59 p.m. The profile indicated the resident's diagnoses included, but were not limited to, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (symptoms of intense anxiety or panic that are directly caused by a physical health problem), and mood disorder due to a known physiological condition (when various physical diseases or conditions create some form of mental health issue). An annual Minimum Data Set (MDS) assessment, dated 9/15/22, indicated the resident had severe cognitive deficit and received antispychotic, antidepressant and antianxiety medications. On 1/26/23 at 9:50 a.m., the Director of Nursing (DON) provided pharmacy recommendations, for the resident, from January 2022 through January 25, 2023. A pharmacy recommendation, dated 4/6/22. indicated to consider a GDR (gradual dose reduction) of risperdal (medication used to treat mood disorder), 1 milligram (mg) at bedtime for mood disorder, buspar (medication used to treat anxiety) 5 mg every morning and 15 mg at bedtime for anxiety, and cymbalta (medication used to treat depression) 60 mg daily and remeron (medication used to treat depression) 7.5 mg at bedtime for depression. The resident had been on the medications since her admission on 10/8/21. The form lacked documentation that the physician had revived or addressed the recommendation, and lacked a physician signature, and date. 2. Resident 21's record was reviewed on 1/26/23 at 11:45 a.m. The profile indicated the resident's diagnoses included, but were not limited to, major depressive disorder (a mood disorder that causes		2022 for Resident #21 and # 2 with the physician and physician documented response for each recommendation with signature and date. II. Other residents with the potential to be affected by this finding will be identified by: On 2/3/23, Don reviewed all pharmacy recommendations made in the past 30 days to identify any pharmacy recommendations that were not acted on timely or lacked a physician signature and date. Any unresolved pharmacy recommendations were reviewed with the physician for response and documentation of rationale. III. Measures and Systemic changes put into place to assure deficient practices do not recur are as follows: A. On 2/10/23, the Administrator and Director of Nursing provided education to all attending physicians on the facility policy and procedure for responding to pharmacy recommendations and the timeline for responding to recommendations and required them to sign and date all pharmacy recommendations reviewed. IV. Corrective Actions will be Monitored to Ensure Compliance by: The Director of Nursing, or her designee, will be conducting	

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	155802	A. BUILDING 00 B. WING	02/01/2023

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	a persistent feeling of sadness and loss of interest). An annual Minimum Data Set (MDS) assessment, dated 12/6/22, indicated the resident had no cognitive deficit and received antidepressant medications. On 1/26/23 at 9:50 a.m., the Director of Nursing (DON) provided pharmacy recommendations, for the resident, from January 2022 through January 25, 2023. A pharmacy recommendation, dated 6/13/22, indicated the resident received Paxil 10 mg daily for depression since June 2020 and was due for an annual evaluation for a possible GDR (gradual dose reduction). The recommendation lacked documentation that the physician had reviewed and lacked documentation of his acceptance or declination, signature, and date. Review of the historical physician's orders indicated there had been no change on the Paxil order from 6/10/20 until 11/30/22. During an interview, on 1/26/23 at 9:50 a.m., the Director of Nursing (DON) indicated the facility had started with a new pharmacy in August 2022. The pharmacy recommendations were from the previous pharmacy. She was unable to find any recommendations from the old pharmacy, which had any physician documentation, rationale, signatures, or dates on them. On 1/27/23 at 12:08 p.m., the DON provided a document, dated 12/7/22, titled, "Consultant Pharmacy Policy," and indicated it was the policy currently being used by the facility. The policy indicated, "...Standards...2. Each month the consulting pharmacist will review each resident's		quality improvement audits to verify that pharmacy recommendations are followed up on timely with signature and date of physician reviewing. Audits will be completed monthly for 3 months. Additional audits will be completed based upon the level of compliance. Results of all audits will be reported to the Quality Assurance and Performance Improvement committee for additional recommendations and for closure of the project in satisfactory standing.	

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	medication regimen to identify appropriate use, resident response, side effects and drug interactions, etc., in accordance with the stated purpose...11. In the event of a problem or irregularity is noted during the review, the nurse in charge, and/or the Director of Nursing...attending physician, Medical Director...will be notified...." 3.1-48(a)(3) 3.1-48(b)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing			

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	dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medications, biologicals, and feeding tube formulas were labeled, stored, and destroyed according to policy for 1 of 4 medication carts observed, and 1 of 2 medication rooms observed for medication and biological storage. Findings include: 1a. On 1/27/23 at 10:50 a.m., observation of the rehabilitation unit medication room with Registered Nurse (RN) 19, the following was observed, a. A plastic bin containing 32 cartons of Perative 1.5 cal (enteral formula) with an expiration date of 1/24/23. b. A plastic bin containing 10+ bags of Peptamen 1.5 (for tube feeding) with an expiration date of 12/2022. c. A plastic bin containing 20 + cartons of Peptide 1.5 (Kate's Farm plant based formula) with an expiration date of 1/24/23. A medication cart was also observed to have an opened and unlabeled tube of Lidocaine with Prilocaine (topical antiseptic) 2.5%-2.5% cream laying on top a roll of Acetaminophen 325 mg tablet packets for Resident 107. On 1/27/23 at 11:10 a.m., RN 19 indicated there were currently 4 residents receiving nutrition through feeding tubes to included Resident 4 who received Perative 1.5 cal boluses of 250 mg twice daily and a continuous feeding of Perative 70 ml/hr (milliliters per hour) at night. Resident 4's record was reviewed on 1/30/23 at 3:10 p.m.	F 0761	It is the policy of PHC to ensure all medications will be labeled and stored in accordance with state and federal regulations I. Corrective Action Taken Related to this Finding: On 1/31/23, the cartons/bags of expired tube feeding/enteral formulas were disposed of and the opened/unlabeled tube of lidocaine for resident 107 was discarded. The medications stored in resident 40's room were removed from resident's room and stored in the medication cart. II. Other residents with Potential to be Affected by this Finding will be Identified by: On 2/10/23, all medication rooms and medication carts were reviewed to ensure that no expired medication/biologicals were present and that all medications are properly labeled and dated. On 2/10/23, observations of each resident room were made to ensure that no medications were stored in resident rooms without proper assessment or storage. Any identified issues were immediately corrected. III. Measures and Systemic Changes put into place to assure deficient practices do not recur are as follows: All licensed nursing personnel and QMA's were re-educated on the medication storage and labeling policy and given a copy of	02/10/2023

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	Physician's orders for Resident 4 included, Perative TB (tube feed) bolus of 250 ml daily at noon and 4:00 p.m. Perative TF every night shift 8:00 p.m. - 7:00 a.m. at 75 ml/hr with 40 ml hr water flush. A Medication Administration Record (MAR) for Resident 4, dated January 2023, indicated documentation the resident had received Perative 1.5 cal tube feeding daily as ordered. On 1/30/23 at 2:11 p.m., supply aide 20 indicated she stocked supplies on Monday, Friday, and as needed. 1b. During a random observation of Resident 40's room on 1/30/23 at 2:32 p.m., the following was observed, a. 2 vials of Albuterol 3 mg/ml (bronchodilator nebulizer medication) on a table beside her recliner. b. 1 opened and 1 unopened tube of Mupirocin 2% ointment (Bactroban used for moderate to severe bacterial infections). Resident record lacked documentation of an order or instructions for this medication. c. A medication cup with an unidentified white pill on the bedside stand among personal items. Resident record lacked documentation of an order or care plan for the resident to self-administer medications. During an interview on 1/31/23 at 10:58 a.m., Supply Aide 20 indicated she and the nurses were responsible for monitoring the expiration dates on supplies to include supplements and tube feeding formulas. When the supplements and tube feeding formulas were expired, they were to be pulled from the medication room and thrown in the		the policy at mandatory in-service on 2/8/2023. IV. Corrective Actions will be Monitored to Ensure Compliance by: The Director of Nursing, or her designee, will be conducting audits (see attached) of the medication carts throughout the facility to ensure that no topical medications are stored with oral medications and audits of medication rooms to ensure no expired enteral feeds are present. This audit will be done 5x per week times 4 weeks, then 3 x per week x 4 weeks, then 2 x per week x 4 weeks, then 1 x per week x 3 months. The outcome of this audit tool will be reviewed at the Quality Assurance meetings to determine if any additional action is warranted. Providence Health Care, through the QAPI program, will review, update, and make changes to this plan of correction as needed for sustaining compliance for no less than six months.	

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	trash. The last time she had thrown away formula from the rehabilitation medication room was on Monday 1/30/23, and she had not seen Perative 1.5 with the expiration date of 1/24/23. Indicated on 1/30/23 she had pulled half a bin of Kates Farm supplement that was expired, and that morning she had pulled the 10+ bags of Peptamen that had expired on 12/22. During an interview on 1/31/23 at 11:18 a.m., the DON indicated, the nurse and consulting pharmacist were responsible for monitoring medication and supplement storage. Medications including pills and nebulizer treatments could not be left at the bedside without an assessment being done by the nurse managers. The supply person was responsible for checking expiration dates on the supplements and tube feed formulas. On 1/31/23 at 12:00 p.m., the Director of Nursing (DON) provided a Medication Storage Policy, dated 9/22/21, and indicated the policy was the one currently being used by the facility. The policy indicated, it was the policy of the facility that drugs and biologicals were be stored in a safe, sanitary, and orderly manner. "Drugs and biologicals, prescribed by a physician, shall be locked in a medication room[s] or locked in a medication cart ...External use drugs will be stored separately from drugs for internal use in the treatment cart ...Drugs which had been discontinued, are outdated or deteriorated shall not be stored in the facility longer than 7 days ...No drugs or biologicals shall be stored which are beyond manufacturer's expiration date or facility established expiration date ..." 3.1-25(m) 3.1-35(o)			

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F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on interview, observation, and record review, the facility failed to ensure the temperature and palatability of food served, for 1 of 1 test tray reviewed for temperature and palatability. This had the potential to effect 59 of 59 residents who received food from the kitchen. Findings include: During an interview, on 1/23/23 at 12:10 p.m., Resident 27 indicated she ate meals in her room and the food was often not hot enough. During an interview, on 1/24/23 at 10:50 a.m., Resident 111 indicated she ate meals in her room and the food was cold when she received the meal tray. During an interview, on 1/24/23 at 10:49 a.m., Resident 25 indicated he ate meals in his room and the food was not as warm as it could be. Resident Council minutes were provided by the Activity Director (AD) on 1/24/23 at 10:28 a.m. The minutes indicated the resident group had	F 0804	The Nursing Home Dietary Manager and Sous Chef implemented corrective actions potentially affecting the residents at Providence Healthcare: 1. On 1/27/23, a grievance report was completed for Residents 27, 111, 25, and the resident council group's unresolved concerns regarding food temperatures, with the final resolution of the grievance documented and entered on the grievance log. 2. On 2/2/23, the facility conducted temperature checks of test trays on all units and dining areas for each meal service to ensure holding temperatures of at least 140 F for hot food. 3. On 2/3/23, dietary staff were re-educated on the proper procedure for use of the warming pellets and facility policy on meal	02/03/2023

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	voiced multiple concerns of cold food temperatures of the residents' meals. During an interview with the Activities Director (AD), on 1/26/23 at 10:12 a.m., she indicated she took minutes for the Resident Council meetings and then spoke with the Administrator (ADM), who was the facility's grievance officer, the department heads, and staff about the Resident Council's concerns. The cold food temperature concerns had been brought up at several of the Resident Council meetings. There was not a written follow-up for the Resident Council's concerns. On 1/31/23 at 11:20 a.m., a lunch meal test tray was requested from the Dietary Manager (DM) in the kitchen. Dietary Aide (DA) 25 temped the food on the steam table, while the DM wrote onto a food temperature log the temperatures of: green beans at 153.3 Fahrenheit (F), salmon at 188.4 F, and rice at 173.4 F. DA 25 then began plating the food onto a plate with a warming pellet underneath the plate and a plastic cover on top of the plate. She placed the plate onto a tray and placed the tray into a tray cart. The last four plates did not have a warming pellet underneath, only the plastic cover on top of the plate. On 1/31/23 at 12:43 p.m., DM observed the four meal trays without warming pellets underneath the plates and indicated the kitchen was short on four warming pellets for the residents' lunches. When the staff do not bring back the warming pellets after a meal, the kitchen was short on the warming pellets for the next meal. The test tray food temperatures were green beans at 114.8 F, rice at 120.7 F, and salmon at 113.9 F. The DM indicated the test tray food temperatures were cold and should have been at least 125 F.		quality and temperature which included: · Ensuring there are enough pellets available for all trays at each meal. · Promptly picking up dirty trays and pellets immediately after meal service for ware washing. · Notify a supervisor if not enough pellets are available to complete the entire meal service. · When bulk food is transported to a dining serving location, temperatures must be taken and recorded in the kitchen before transport as well as at the final serving location. If temperatures are not optimal at the receiving location, corrective action must be taken Holding temperatures of hot entrees, vegetables, hot soup, sauces, gravies, and hot beverages must be at least 140 F. 4. A preliminary monitoring system will be put in place to randomly audit 5 test trays per week x 4 weeks, then 3 per week x4 weeks, then 2 per week x 4 weeks, and then 1 per week x4 weeks to ensure food is served at the appropriate temperature. The outcome of the audit tool will be reviewed at the Quality Assurance meetings to determine if any additional action is warranted. Providence Health Care will review, update and make changes to this plan of correction as needed for sustaining compliance for no less	

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	On 1/27/23 at 10:25 a.m., ADM indicated the dietary department had completed test trays and have requested the residents to notify the staff immediately if they had a concern with their meal being cold. We have told the Resident Council verbally resolutions to the concerns of the cold food, but the facility had not provided the Resident Council a written follow-up response to the residents' concerns. On 1/27/23 at 10:05 a.m., the Director of Dining Services (DD) provided and identified a document as a current facility policy, titled "Resident Food Services," dated 1/22. The policy indicated, "...Subject: Meal Quality and Temperature...Policies: ...Food and drinks are palatable, attractive, and served at a safe and appetizing temperature to ensure residents' satisfaction and to meet nutrition and hydration needs...Productive Kitchen: ...All menu items will be temped with an accurate thermometer and documented on the log...If hot or cold food temperatures do not meet standards, corrective actions are implemented and documented on log ...Dining Room Service: ...When bulk food is transported to a dining serving location, temperatures are taken and recorded in the kitchen before transport as well as at the final serving location...If temperatures are not optimal at the receiving location, corrective action is taken and documented in the notes section...." At the same time, DD provided and identified another document as a current facility policy, titled "MenuWorks Daily Service Patient/Resident Taste and Temperature Log," dated 7/12/21. DD indicated the holding temperatures on the policy were hot entrees, vegetables, hot soup, sauces, gravies, and hot beverages holding temperatures should be at least 140 F.		than six months. All results will be reported to the Quality Assurance and Process Improvement Committee quarterly until deemed no longer necessary.	

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R 0000 Bldg. 00	1.3-21 (a)(1)(2) This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00393738 completed November 10, 2022. Complaint IN00393738 - Corrected. Survey dates: January 23, 24, 25, 26, 27, 30, 31, and February 1, 2023 Facility number: 0003624 Residential Census: 35 Providence Health Care Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on February 14, 2023.	R 0000		