STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00419759. Complaint IN00419759- No deficiencies releated to the allegations are cited. Survey dates: October 23, 24, 25, 26, and 27, 2023. Facility number: 000095 Provider number: 155181 AIM number: 100290490 Census Bed Type: SNF: 15 SNF/NF: 117 Total: 132 Census Payor Type: Medicare: 11 Medicaid: 101 Other: 20 Total: 132 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 31, 2023	F 0000	The plan of correction is to serve as Carmel Health & Living's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Carmel Health & livings or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this provision constitute an agreement or admission of the survey allegations. **The facility respectfully requests desk review for the following citations**	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir Based on interview and record review the facility failed to ensure code status was clearly indicated for 1 of 26 residents reviewed. (Resident 81).	F 0578	F578 The facility failed to ensure code status was clearly indicated for 1 of 26 residents reviewed. (Resident 81)	11/10/2023

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

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	Findings include: Resident 81's record was reviewed on 10/24/23 at 3:02 PM. Diagnoses included cerebral infarction with cognitive, speech and language deficits, encephalopathy, disorientation, hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non-dominant side, and stage 3 chronic kidney disease, chronic diastolic (congestive) heart failure and malignant neoplasm of the female breast. . Resident 81's current quarterly Minimum Data Set (MDS) assessment, dated 8/21/23, indicated her Basic Interview for Mental Status (BIMS) score was 5 (moderately impaired). The MDS indicated the resident required physical assistance of 1 person for personal hygiene. She received chemotherapy while a resident. A physician order dated 5/17/23 indicated Resident 81 had a Full code status. The current medical record ribbon indicated Resident 81 had a Do Not Resuscitate (DNR) code status. Resident 81's Continuity of Care Document section Advance Directives indicated Resident 81's had a DNR code status. Resident 81's current care plan, dated 9/11/23, titled Psychological Well-Being indicated the resident had requested a DNR code status with an approach if no pulse to not attempt cardiopulmonary resuscitation. Resident 81's had an Out of Hospital DNR Declaration and Order signed on 11/26/22 by her daughter, Power of Attorney (POA). No POA		**1 What Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice.** i Resident 81's Advanced Directive updated to reflect current wishes for Code status. Resident 81 suffered no ill effects due to this alleged deficient practice. **2 The facility will identify other residents that may potentially be affected by the practice.** i All residents have to potential to be affected by this alleged deficient practice. Current residents charts were reviewed to ensure the Advance Directive is updated in the physician order, care plan and face sheet. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** i Administrator or designee will re-educate the Social Services team and licensed nursing staff on Advanced Directive Practices **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** i The Social Services Director/designee will audit 5 residents code status weekly for 4 weeks, then bi-weekly for 8	

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	papers were provided by the Resident 81's daughter. Resident 81's had an Indiana Physician Orders for Scope of Treatment (POST) signed by her daughter on 10/25/23. The form indicated the resident was a DNR. In an interview on 10/25/23 at 8:58 AM, the Director of Nursing (DON) indicated Resident 81's physician's order indicated she was a full code. The DON indicated the medical record ribbon, current care plan, Out of Hospital DNR Declaration and Order, and POST form indicated the resident had a DNR code status. She indicated Resident 81's code status should be the same, DNR. A current policy titled "Advanced Directives", undated, provided by the RN 10 on 10/26/23 at 11:05 AM indicated advanced directive documentation will be reviewed quarterly, at a minimum, by designated staff member to ensure consistency throughout the medical record. 3.1-4(l)(5)		weeks, then monthly for 9 months to ensure the advance directive is updated in the physician order, care plan and face sheet. ii The results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based upon the results of the audits. 5 **By what date the systemic changes for each deficiency will be completed.** i Completed by 11/10/23	
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records Based on observation, interview, and record review the facility failed to ensure privacy was maintained for 3 of 11 residents reviewed (Resident 8, Resident 43, and Resident 64). Findings include: 1) During an observation on 10/23/23 at 10:57 AM,	F 0583	**F583 The facility failed to ensure privacy was maintained for 3 of 11 residents reviewed. (Resident 8, Resident 43, Resident 64)** **1 What Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice.**	11/10/2023

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	Housekeeper 6 was observed in the hallway of the 200 hall. She spoke loudly to another employee who was near the nurses' station using Resident 8's name and indicating Resident 8 had a bowel movement and it smelled bad. She indicated she had used spray and it still smelled bad. The surveyor was able to hear the statement in the hallway several doors away from where Housekeeper 6 stood. Resident 8's record was reviewed on 10/25/23 at 1:58 PM. Diagnoses included end stage renal disease, adjustment disorder with mixed anxiety and depressed mood, and multiple sclerosis. A review of Resident 8's current quarterly Minimum Data Set (MDS) dated 8/11/23 indicated her Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact). The MDS indicated Resident 8 was always incontinent of bowel and utilized extensive staff assistance with toileting tasks. 2) During an observation on 10/24/23 at 10:17 AM, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) entered the room of Resident 43 and began discussing his plan of care with the door open. The surveyor was seated in a nearby lounge with another resident and was able to hear the conversation. Conversation topics included a new lotion that nursing staff would be applying to Resident 43's dry skin and procedure for use of a condom catheter at bedtime for management of bladder elimination needs. Resident 43's record was reviewed on 10/25/23 at 2:18 PM. Diagnoses included Parkinson's disease, depression, and polyneuropathy. A review of Resident 43's quarterly MDS dated 9/27/23 indicated his BIMS score was 13		i Resident 8, 43, 64 without ill effect. Mental Anguish screen was completed on Residents 8, 43, 64. Residents 8, 43, 64 did not show signs of mental anguish. **2 The facility will identify other residents that may potentially be affected by the practice.** **i** All residents have to potential to be affected by this alleged deficient practice. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** i Staff were in serviced on resident privacy, Not discussing resident information in the hallway, closing the door in a residents room when discussing resident care to them. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** i The DON/designee will be responsible for conducting audits daily for 5 days a week Mon-Fri for 4 weeks, biweekly for 4 weeks, monthly for 9 months. The results of the audit will be reviewed at the monthly quality assurance meeting until substantial compliance is achieved and	

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	(cognitively intact). The MDS indicated Resident 43 was frequently incontinent of bladder and utilized extensive staff assistance with toileting tasks. 3) During an observation on 10/24/23 at 10:24 AM, Certified Nurse Aide (CNA) 7 was standing in the hallway walking toward the 300-hall lounge area. CNA 7 called down the hall to another staff member beyond the view of the surveyor in the hall on the other side of the lounge. She used Resident 64's name and indicated Resident 64 had refused her shower because she had been up all night. Resident 64's record was reviewed on 10/25/23 at 2:26 PM. Diagnoses included vascular dementia without behavioral disturbance, Type 2 diabetes with unspecified complications, and major depressive disorder. A review of Resident 64's quarterly MDS dated 9/23/23 indicated her BIMS score was 15 (cognitively intact). The MDS indicated Resident 64 had trouble falling asleep, staying asleep, or sleeping too much half or more than half of the time. In an interview on 10/25/23 at 1:28 PM, Unit Manager 2 indicated all resident health information should be discussed in a private area and not in the hallway where others could hear. A current policy dated 6/6/2019 provided by the Administrator on 10/25/23 at 3:24 PM indicated residents have the right to privacy and confidentiality. 3.1-3(p)(4)		maintained. Changes may be established to the auditing process, based upon the results of the audit. **5 By what date the systemic changes for each deficiency will be completed.** i Completed by 11/10/23	

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F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances	F 0585	**F585 The facility failed to ensure the right to file a grievance without interference was maintained for 2 of 9 residents reviewed. (Resident 36, Resident 97)**	11/10/2023

Based on interview and record review the facility failed to ensure the right to file a grievance without interference was maintained for 2 of 9 residents reviewed (Resident 36 and Resident 97).

Findings include:

During an interview on 10/25/23 at 9:45 AM, Resident 97 indicated he approached three nursing staff members seated at the nurses' station and requested assistance with a grievance form during the previous evening shift. He indicated the staff gave him a hard time and did not provide him a grievance form or help with filling out a form. He indicated he became frustrated and discussed his concern with Resident 36. He indicated Resident 36 approached the desk and requested assistance from the same staff. He indicated Resident 36 asked several times and became angry and adamant before they gave her a form.

Resident 97's record was reviewed on 10/25/23 at 3:07 PM. Diagnoses included major depressive disorder, recurrent, unspecified, bipolar disorder, current episode, manic, severe with psychotic features, and chronic kidney disease.

A review of Resident 97's current quarterly Minimum Data Set (MDS) dated 9/28/23 indicated his Basic Interview for Mental Status (BIMS) score was 11 (mild cognitive impairment).

During an interview on 10/25/23 at 9:48 AM Resident 36 indicated Resident 97 approached her

1 What Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice.

i Resident 36, 97 without ill effect. Resident 97 and 36 filed their grievance and received resolution to their concern.

2 The facility will identify other residents that may potentially be affected by the practice.

i All residents have the potential to be affected by this alleged deficient practice. In-house completed with residents to ensure they are able to voice their grievances.

3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;

i Administrator or designee will re-educate staff on the grievance policy.

4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality

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	the previous evening and told her staff would not help him with a grievance form. She indicated she approached the nurse's desk where three members of the nursing staff were present. She indicated staff would not initially give her a grievance form when she asked for one. She indicated the staff did not give her a form until she had asked several times and became upset and insistent. Resident 36's record was reviewed on 10/25/23 at 3:08 PM. Diagnoses included chronic respiratory failure with hypoxia, Spinal stenosis, and chronic kidney disease. A review of Resident 36's current quarterly MDS dated 8/24/23 indicated her BIMS score was 14 (cognitively intact). In an interview on 10/25/23 at 10:03 AM the Administrator indicated a resident can go to any staff member and the staff member they speak to should assist them in filling out a grievance form. She indicated forms were available in nurse's stations, social services, resident council meetings and staff meetings. She indicated staff should readily provide forms when a grievance is voiced. In an interview on 10/25/23 at 2:51 PM, Social Services 4 indicated when a resident reported a concern, any staff member was able to assist the resident in completing a grievance form. In an interview on 10/26/23 08:28 AM the Administrator indicated she investigated the concern regarding grievances. She indicated it was unclear as to whether staff did not know how to proceed with assisting to fill out a grievance or if they were reluctant to assist with filling out a grievance. She indicated it could have been a		**assurance program will be put into place;** i.The DON/designee will be responsible for interviewing residents to ensure their grievances were handled correctly. Interviews will be conducted daily for 5 days a week Mon-Fri for 4 weeks, biweekly for 4 weeks, monthly for 9 months. The results of the audit will be reviewed at the monthly quality assurance meeting until substantial compliance is achieved and maintained. Changes may be established to the auditing process, based upon the results of the audit. **5 By what date the systemic changes for each deficiency will be completed.** i Completed by 11/10/23	

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	combination of both. She indicated she had begun education with the staff. A current policy, untitled and undated, provided by the Administrator on 10/26/23 at 8:30 AM indicated residents should report concerns to Social Services. The policy did not address instructions to floor staff hearing resident concerns during shifts when Social Service staff was not present in the building. 3.1-7(a)(1)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, interview, and record review the facility failed to follow physician orders for 2 of 6 residents reviewed. (Resident 4 and Resident 98) Findings include: 1)During an observation and interview, on 10/23/23 at 10:16AM, Resident 4 was in her room. An inhaler was observed in the bed with the resisdent. The inhaler had a pharmacy label with Resident 4's name and the drug name of fluticasone furoate-vilanterol. Resident 4 indicated she was not sure when she last administered the inhaler to herself. Resident 4 indicated nursing staff were aware the inhaler was on her bedside table. The inhaler was in open view from the door. Resident 4's record review began on 10/23/23 at 1:10PM. Resident 4 had an order for fluticasone furoate-vilanterol inhaler 1 puff daily. The order had the instructions Resident 4 was able to self-administer medication, but the medication was	F 0684	**F684 The facility failed to follow physicians orders for 2 of 6 residents reviewed. (Resident 4, Resident 98)** **1 What Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice.** i Resident 4, 98 without ill effect. Residents 4 and 98 meds that were observed at bedside were removed from the rooms. **2 The facility will identify other residents that may potentially be affected by the practice.** i All residents have the potential to be affected. If meds are observed at bedside medications will be removed and a comprehensive assessment will be conducted.	11/10/2023

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	to be kept at nursing station. The inhaler was ordered on 7/12/23. During an observation with the DON (Director of Nursing) on 10/23/23 at 3:03PM the inhaler continued to be present on Resident 4's bedside table. 2) Resident 98's record review began on ,10/24/23 at 2:53 PM. Resident 98 had a physician order for Humalog U-100 Insulin 100unit/ml solution; 8 units three times a day. The order included instructions to hold if blood sugar was less than 150. The order was started on 6/8/23. The insulin was ordered for Resident 98's diagnosis of Type 2 diabetes mellitus. Resident 98's September MAR (Medication Administration Record) was reviewed. The following times her blood sugar was documented below 150 without documentation the 8 units of insulin was held. 9/1/23 Lunch 125 9/2/23 Breakfast 145, dinner 129 9/4/23 Breakfast 132 9/8/23 Breakfast 144 9/9/23 Breakfast 148, dinner 142 9/12/23 Breakfast 148 9/13/23 Breakfast 139 9/14/23 Breakfast 130 9/15/23 Breakfast 136 9/16/23 Dinner 98 9/17/23 Dinner 108 9/18/23 Dinner 101 9/19/23 Lunch 116 9/22/23 Dinner 78 9/23/23 Lunch 137 9/29/23 Dinner 146 In the month of September there were 14 times the		**3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** i The DON/designee will provide education to all nursing staff on medication administration, to include assessment and orders for self-administration. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** i The DON/designee will be responsible to audit 5 resident rooms for meds at bedside. Audits will be conducted daily for 5 days a week Mon-Fri for 4 weeks, biweekly for 4 weeks, monthly for 9 months. The results of the audit will be reviewed at the monthly quality assurance meeting until substantial compliance is achieved and maintained. Changes may be established to the auditing process, based upon the results of the audit. **5 By what date the systemic changes for each deficiency will be completed.** i Completed 11/10/23	

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	insulin was held for blood sugars under 150. Those incidents were not listed above. Resident 98's October MAR (Medication Administration Record) was reviewed from October 1, 2023, to October 25, 2023. The following times her blood sugar was documented below 150 without documentation the 8 units of insulin was held. 10/6/23 Dinner 123 10/9/23 Dinner 149 10/11/23 Dinner 122 10/13/23 Breakfast 131 10/14/23 Breakfast 141, Dinner 135 10/16/23 Breakfast 141, Dinner 126 10/17/23 Breakfast 133 10/18/23 Breakfast 146, Dinner 129 10/20/23 Dinner 125 10/22/23 Lunch 99 10/24/23 Dinner 102 In the month of October from 1-25 there were 9 times the insulin was held for blood sugars under 150. Those incidents were not listed above. In an interview with the DON, on 10/26/23 at 2:51PM, she indicated the insulin should have been held during all the above incidents listed for September and October; per the physician order, but the MAR was not clear the insulin had been held. A policy and procedure titled, "Change in a Resident's Conditions or Status" was provided by ADON (Assistant Director of Nursing) on 10/27/23 at 9:59am, revised October 2010. The policy and procedure did not address following physician orders.			

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	No other policy and procedure were provided at time of exit. 3.1-37			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on record review, and interview, the facility failed to ensure weights weekly as ordered were obtained for 1 of 3 residents reviewed. (Resident 40). Findings include: Resident 40's record was reviewed on 10/24/23 at 2:54 PM. Diagnoses included osteomyelitis of vertebra, sacral and sacrococcygeal region with Proteus mirabilis and morganii infections, stage 4 pressure ulcer of sacral region, stage 3 pressure ulcer of right hip, right hand contracture, mixed receptive-expressive language disorder and nausea. Resident 40's current significant change Minimum Data Set (MDS) assessment, dated 10/6/23, indicated their Basic Interview for Mental Status (BIMS) score was 1 (severe impairment). The MDS indicated the resident had a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months and was on a mechanically altered diet. The MDS indicated 1 stage 4 pressure ulcer, moderate hearing difficulty and had hearing aid or other hearing appliance. The facility indicated on 9/5/23 at 2:55 PM Resident 40's weight was 137.6 pounds. The facility indicated on 10/5/23 at 5:01 PM Resident 40's weight was 130.4 pounds.	F 0692	**F692 The facility failed to ensure weights weekly as ordered were obtained for 1 of 3 residents reviewed. (Resident 40)** **1 What Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice.** i Resident 40 suffered no ill effects from the alleged deficient practice. Resident 40's weight was immediately obtained and no significant weight loss was noted. **2 The facility will identify other residents that may potentially be affected by the practice.** i Current residents receiving care have the potential to be affected. Current residents weights were audited to ensure all weights are being obtained per order. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** i IDT will meet weekly to review	11/10/2023

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	Resident 40's current Care plan, dated 1/30/22 and revised 10/12/23, titled nutritional status indicated the resident was at nutritional risk related to her diagnosis of dysphagia, mechanically altered diet, meal consumption, and wound infection. The care plan indicated on 10/6/23 the resident had a significant weight loss of 5.2% in 30 days related to a decrease in meal intake and wound infection. A progress note titled "IDT/NAR/Weight Review", dated 10/8/23 at 8:03 PM, indicated Resident 40 triggered for weight loss of 5.2% in 30 days from 137.6 pounds on 9/5/23 to 130.4 pounds on 10/5/23. The RD recommended weekly weights for 4 weeks. A physician's order, dated 10/9/23, indicated to complete weekly weight monitoring for 4 weeks to be discontinued 10/30/23. A nutritional assessment, dated 10/11/23 at 2:14 PM by the registered dietician, indicated Resident 40 weighed 130.4 pounds on 10/5/23. This showed significant weight loss of 7.2 pounds or 5.2% in 30 days. The registered dietician indicated she would follow weekly weights for 4 weeks, progress with intakes, skin condition and labs. A weight flow sheet indicated the following weights: On 10/12/23: No weight documented. On 10/19/23: No weight documented. On 10/26/23 9:32 AM: 129.8 pounds Progress notes indicated the following IDT/NAR/Weight Review meetings: Week of 10/16/23: No IDT/NAR/Weight Review meeting was documented.		residents with weight changes and ensure weights were obtained timely. ii Licensed nurses will be reeducated on weight management policy. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** i The DON/designee will be responsible for auditing ordered weights for completion. Audits will be conducted daily for 5 days a week Mon-Fri for 4 weeks, biweekly for 4 weeks, monthly for 9 months. The results of the audit will be reviewed at the monthly quality assurance meeting until substantial compliance is achieved and maintained. Changes may be established to the auditing process, based upon the results of the audit. **5 By what date the systemic changes for each deficiency will be completed.** i Completed by 11/10/23	

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	155181	A. BUILDING 00 B. WING	10/27/2023

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	Week of 10/23/23: No IDT/NAR/Weight Review meeting was documented. In an interview on 10/26/23 at 2:20 PM the ADON indicated Resident 40 should have been weighed weekly after 10/5/23. The ADON indicated the resident was not weighed on 10/12/23 and 10/19/23 and she should have been. In an interview on 10/27/23 at 9:15 AM the ADON indicated, per the facility policy, when a resident had a significant weight change the IDT should meet weekly to evaluate the current interventions and make changes as necessary to stabilize the resident and document the meeting in the medical record. On 10/8/2023 at 8:03 PM the IDT/NAR/WEIGHT REVIEW and documentation indicated Resident 40 triggered for weight loss of 5.2% x 30 days and was evaluated. No IDT/NAR/WEIGHT REVIEW or documentation had been completed since 10/8/23 and it should had been completed weekly. A current policy titled "CarDon Weight Management Policy", dated 3/2015, provided by the ADON on 10/26/23 at 2:25 PM indicated the IDT would meet weekly on residents with significant weight changes to evaluate the current interventions and make changes as necessary to stabilize the resident, document the meeting in the medical record and monitor weight weekly. 3.1-46			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids Based on Observation, interview, and record review the facility failed to ensure consistent	F 0694	**F694 The facility failed to ensure consistent midline**	11/10/2023

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	midline intravenous (IV) care for 1 of 1 resident reviewed with parenteral fluids. (Resident 40). Findings include: During an observation on 10/24/23 at 9:21 AM 5 milligram/milliliter (mg/ml) of metronidazole was infusing at 200 milliliter per hour (ml/hr) through Resident 40's upper left arm via a midline IV. The midline IV dressing was dated 10/7/23. During an observation on 10/25/23 at 9:50 AM 5 mg/ml of metronidazole was infusing at 200 milliliter ml/hr through Resident 40's upper left arm via a midline IV. The midline IV dressing was dated 10/7/23. Resident 40's record was reviewed on 10/24/23 at 2:54 PM. Diagnoses included osteomyelitis of vertebra, sacral and sacrococcygeal region with Proteus mirabilis and morganii infections, stage 4 pressure ulcer of sacral region, and stage 3 pressure ulcer of right hip. Resident 40's current significant change Minimum Data Set (MDS) assessment, dated 10/6/23, indicated their Basic Interview for Mental Status (BIMS) score was 1 (severe impairment). The MDS indicated the resident had a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months and was on a mechanically altered diet. The MDS indicated 1 stage 4 pressure ulcer, on antibiotics 7 day a week and had a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months. Resident 40's current Care plan, initiated 9/26/23 and revised 10/5/23, indicated the resident required IV antibiotics related to the potential of complication from her osteomyelitis. The goal		**intravenous (IV) care for 1 of 1 resident reviewed with parenteral fluids. (Resident 40)** **1 What Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice.** i Resident 40 without ill effect. Resident #40's midline dressing was changed immediately, and all appropriate IV orders were entered into the medical record. **2 The facility will identify other residents that may potentially be affected by the practice.** i Other resident's with a physician order for a midline have the potential to be affected by this alleged deficient practice. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** i Education has been provided to the nursing staff regarding entering the correct orders for the care of a midline IV to include dressing changes and IV flushes. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** i The DON/designee will be responsible for conducting audits	

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	included not experiencing complications related to the IV. Interventions included administer IV medication as ordered, change IV dressing as ordered, maintain/flush IV per orders, and report complications related to IV including localized infection, systemic infection, electrolyte imbalance, air embolus, dislodgment, infiltration, extravasation, phlebitis, fluid overload, dehydration, swelling, redness, tenderness, warmth, and infiltrate.) A progress notes dated 10/7/23 at 8:20 PM indicated Mobilex was at the facility to replace Resident 40's midline IV after previous midline IV was dislodged at 4:00 AM that morning. A progress notes dated 10/7/23 at 10:00 PM indicated Resident 40's midline IV was replaced and patent (one that was correctly placed, allowed the treatment to flow directly into the patient's vein). In an interview on 10/25/23 at 9:50 AM, the Director of Nursing (DON) indicated Resident 40 had no physician orders for the midline IV dressing change or the flushing of the midline IV and she should have had orders. In an interview on 10/25/23 at 1:50 PM, the DON indicated she observed the date on the midline IV dressing to be 10/7/23. In an interview on 10/26/23 at 10:05 AM, Registered Nurse (RN) 10 indicated Resident 40 had no physician orders for her midline IV dressing change or flushing of her midline IV and she should have had orders. A current skills validation titled "Changing IV PICC/Midline/Non-Tunneled/Tunneled Dressing		daily for 5 days a week Mon-Fri for 4 weeks, biweekly for 4 weeks, monthly for 9 months. The results of the audit will be reviewed at the monthly quality assurance meeting until substantial compliance is achieved and maintained. Changes may be established to the auditing process, based upon the results of the audit. **5 By what date the systemic changes for each deficiency will be completed.** i Completed by 11/10/23	

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	Skills", undated, provided by RN 10 on 10/25/23 at 2:10PM indicated to verify the physicians order before changing a midline IV dressing and the dressing should be changed every 7 days. A current skills validation titled "Flushing Intravenous Access Devices Skills", undated, provided by the RN 10 on 10/25/23 at 2:10 PM indicated to verify the physician order before flushing the midline IV with 5 milliliters of saline at least every 12 hours or before and after each use and document the type and amount of flush, any complications to the flush, notifications, interventions, and the resident's response to the procedure. 3.1-47(a)(2)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management Based on observation, interview, and record review the facility failed to ensure pain interventions were initiated consistently for 2 of 6 residents reviewed. (Resident 238 and Resident 4) Findings include: 1) In an interview with Resident 238, on 10/23/23 at 12:03PM, she indicated pain medication was slow to be delivered. Resident 238 indicated it has taken over an hour to receive as needed narcotic medications. Resident 238 indicated she was not offered any non-pharmacological interventions prior to receiving as needed narcotic medications. Resident 238 indicated she was trying very hard to not use as needed medication. During an observation, on 10/24/23 11:06 AM, Resident 238 was being pushed in a wheelchair by	F 0697	**F697 The facility failed to ensure pain interventions were initiated consistently for 2 of 6 residents reviewed. (Resident 238, Resident 4)** **1 What Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice.** i Resident 238, 4 without ill effect. Resident 4 was provided pain interventions immediately after notification of pain. Resident 238 was also provided pain intervention immediately after notification of pain. **2 The facility will identify other residents that may**	11/10/2023

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	a therapist and requested pain medication from RN 8. RN 8 explained to Resident 238 she already had her Tylenol. Resident 238 explained she was in severe pain from walking with therapy. RN 8 indicated she would check into it. Resident 238 again requested pain medication as soon as possible. RN 8 did not offer any non-med interventions at the time of observation. Resident 238's record was reviewed 10/24/23 at 1:38PM. Resident 238 received as needed oxycodone (an opioid pain medication) at 12:49PM from RN 8. The pain medication had been requested at 11:06AM. Resident 238 had an order dated 10/11/23 for oxycodone 5mg 1 tablet every 4 hours as needed for pain. Resident 238's diagnoses included pathological fracture, hypertension, and fracture around internal right hip joint. Resident 238's MAR (Medication Administration Record) indicated Oxycodone was administered as follows: 10/10/23 3:38PM with a "x" for non-med intervention; at 8:24PM with a "x" for non-med intervention 10/11/23 1:01AM with a "n" for non-med intervention; at 5:19AM with a "n" for non-med intervention; at10:12AM with rest for non-med intervention; at 3:53PM with a "n" for non-med intervention; at 8:46PM with a "n" for non-med intervention 10/12/23 2:07AM with a "n" for non-med intervention; at 6:49AM with a "n" for non-med intervention; at 10:57AM with a "n/a" non-med intervention. 10/13/23 5:53AM with a "n" for non-med intervention. 10/14/23 00:20AM with a rest/ice for non-med		**potentially be affected by the practice.** **i** Current residents receiving pain interventions have the potential to be affected. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** **i** All nursing staff will be in-serviced on the facilities pain policy and providing alternate interventions for pain outside of pharmacological interventions. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** i The DON/designee will be responsible for conducting audits daily for 5 days a week Mon-Fri for 4 weeks, biweekly for 4 weeks, monthly for 9 months. The results of the audit will be reviewed at the monthly quality assurance meeting until substantial compliance is achieved and maintained. Changes may be established to the auditing process, based upon the results of the audit. **5 By what date the systemic changes for each deficiency will be completed.**	

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	intervention. 10/15/23 12:46AM with a "0" (zero) for non-med intervention. 10/16/23 9:40AM with "pretherapy" as non-med intervention; at 5:48PM "n" as non-med intervention. 10/17/23 4:29 AM with "n" as non-med intervention. 10/23/23 12:49AM with "n" for non-med intervention. For 15 administrations of as needed opioid medication; no non-med interventions were attempted according to Resident 238's documentation. Resident 238's care plan indicated a goal of pain interventions to maintain pain at a manageable level that was identified by the resident. An approach was non-med interventions were attempted to ease patient pain such as ice, warm pack, repositioning, and controlled breathing. In an interview with the DON (Director of Nursing). on 10/25/23 at 10:16AM, she indicated Resident 238 should have been given the pain medication in a timely manner. The DON indicated an hour, and a half was not a reasonable amount of time to wait on pain medication while in pain. The DON indicated nonpharmacological (non med) interventions should be documented or a refusal of the intervention when giving as needed pain medications for every resident every time. In an interview with Resident 238 on 10/25/23 at 11:04AM she indicated she was unsure if ice, repositioning, or heat would help with her pain as it was not offered. Resident 238 indicated no non-pharmacy interventions were offered often		i Completed by 11/10/23	

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	prior to getting her medication. Resident 238 indicated she was frequently in too much pain for the medication to be completely effective by time she received it. 2) In an interview with Resident 4 in her room on 10/23/23 at 10:06AM she indicated the facility did not manage her pain. Resident 4 indicated they were late or slow with all medications and did not take requests or needs of residents seriously. Resident 4 indicated she was frequently in pain. Resident 4 denied being offered any non-pharmacological interventions such as ice, heat, repositioning, rest, relaxation, distraction etc. Resident 4's record review, began on 10/23/23 at 3:10PM, indicated her diagnoses included cervical cancer, anxiety, lung disease, and heart disease. Resident 4 had a routine order for gabapentin 100mg twice a day and 300 mg at night for restless leg syndrome (7/12/23-open ended). Oxycodone 5mg at bedtime for pain (10/6/23-open ended). Oxycodone 5mg (1/2 tablet) twice a day PRN upon rising, before bedtime; not to be given within 4 hours of bedtime dose (10/9/23-open ended). Oxycodone 5mg (1/2 tablet) every 6hours (9/21/23 to 10/6/23). Resident 4's care plan indicated a goal of pain interventions to maintain pain at a manageable identified by the resident. An approach was non pharmacy intervention were attempted to ease pain. Resident 4's October MAR (Medication Administration Record) from October 1st through October 24th was reviewed. The following 14 times the Oxycodone, an opioid, medication was documented as administered without a			

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	non-pharmacy intervention. 10/1/23 8:21 PM "na" was documented for non-med intervention. 10/3/23 8:52AM "na" was documented for non-med intervention. 10/4/23 7:53AM "na" was documented for non-med intervention. 10/6/23 12:42PM "n" was documented for non-med intervention. 10/7/23 1:13AM "na" was documented for non-med intervention. 10/8/23 1:42AM "n" was documented for non-med intervention. 10/9/23 3:19AM "n" was documented for non-med intervention. 10/12/23 1:24AM "n" was documented for non-med intervention. 10/15/23 12:31AM "0" was documented for non-med intervention. 10/16/23 1:05AM "n" was documented for non-med intervention. 10/17/23 2:20AM "n" was documented for non-med intervention. 10/20/23 3:16AM "n" was documented for non-med intervention. 10/22/23 12:07AM "n" was documented for non-med intervention. 10/23/23 12:07AM "n" was documented for non-med intervention. A policy titled, "Pain Policy" printed on May 15, 2015, and provided by the Administrator on 10/26/23 at 3:18PM indicated...the goal for managing pain should be to achieve a consistent level of comfort while maintaining as much function as possible. Alternative treatments should be sought after .... 3.1-37(a)			