STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155840	A. BUILDING 00 B. WING	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYMPHONY OF DYER	1532 CALUMET AVENUE DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00382587, IN00386616, IN00388244, and IN00388395. Complaint IN00382587 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00386616 - Substantiated. Federal/State deficiencies related to the allegations are cited at F656, F677, and F692. Complaint IN00388244 - Substantiated. Federal/State deficiencies related to the allegations are cited at F695 and F842. Complaint IN00388395 - Substantiated. Federal/State deficiencies related to the allegations are cited at F656 and F842. Unrelated deficiency is cited. Survey dates: August 30 & 31, 2022 Facility number: 013462 Provider number: 155840 AIM number: 201330210 Census Bed Type: SNF/NF: 10 SNF: 76 Residential: 28 Total: 114 Census Payor Type: Medicare: 42 Medicaid: 10 Other: 34	F 0000	Symphony of Dyer Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. This facility respectfully requests a desk review for the given citations in this survey. Please see all attached documentation for your consideration.	

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

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	Total: 86 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/6/22.			
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-			

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	(A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on record review and interview, the facility failed to ensure Care Plans were developed for residents related to discharge planning and Hospice services, for 2 of 7 residents reviewed for Care Plans. (Residents E and C) Findings include: 1. Resident E's record was reviewed on 8/30/22 at 10:56 a.m. The diagnoses included, but were not limited to, urinary tract infection, chronic kidney disease, and stroke. The Admission date to the facility was 6/30/22 and discharge from the facility occurred on 8/17/22. An Admission Minimum Data Set (MDS) assessment, dated 7/6/22, indicated an intact cognitive status and was receiving Speech Therapy, Physical Therapy, and Occupational Therapy. There was no Care Plan developed for discharge planning. A Physician's Progress Note, dated 7/1/22 at 1:54 p.m., indicated the resident was admitted into the	F 0656	p="" paraid="1829144561" paraeid="{c2a7681b-5773-4e8b-a42d-cb3459eedff8}{136}">POC for F656 – Develop/Implement Comprehensive Careplan What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? p="" paraid="1829144561" paraeid="{c2a7681b-5773-4e8b-a42d-cb3459eedff8}{136}">Resident E no longer resides in the facility p="" paraid="1829144561" paraeid="{c2a7681b-5773-4e8b-a42d-cb3459eedff8}{136}">Resident C careplan for hospice has been completed. p="" paraid="1628667720" paraeid="{c2a7681b-5773-4e8b-a42d-cb3459eedff8}{188}">How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by this alleged deficient	09/14/2022

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	facility for rehabilitation services. During an interview on 8/30/22 at 2:04 p.m., the Social Service Director indicated there was no Care Plan developed for discharge planning. A facility policy, dated 6/2022, received from the Director of Nursing as current, and titled, "Discharges", indicated a plan for the resident's discharge to home, another facility, or the hospital would be established by the facility. 2. Resident C's record was reviewed on 8/31/22 at 8:59 a.m. The diagnoses included, but were not limited to, dementia. A Physician's Order, dated 5/31/22, indicated an admission into a Hospice program. There was no facility Care Plan for Hospice. During an interview on 8/31/22 at 9:50 a.m., the Unit Manager indicated there was no Care Plan developed for Hospice Services. This Federal tag relates to Complaints IN00386616 and IN00388395. 3.1-35(a)		practice. House audit was completed to ensure all residents have a discharge careplan. ul="" role="list" Hospice residents EMRs were audited to ensure all residents have a hospice careplan. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? ¿ Social service department has been educated on creating a discharge careplan for every resident admitted. Nursing, social services, and MDS were educated on creating a careplan for each patient that is admitted to hospice. p="" paraid="781602986" paraeid="{5e296ae4-7a44-4ed2-8e3c-aec5c7a0b4a0}{23}"> How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ¿ Administrator/designee will monitor 10 residents weekly to ensure discharge careplans are created for each resident. Administrator/designee will monitor 10 residents weekly to ensure hospice careplans are created for each resident. The Administrator/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months.¿ Thereafter, if determined	

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			by the Quality Assurance committee that further monitoring is needed, audits will continue. Date of compliance: 9/14/2022	
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 a resident who required extensive to dependent care received incontinent care in a timely manner, for 1 of 3 residents reviewed for incontinent care. (Resident C) Finding includes: Resident C was observed in a Broda (reclining chair) chair at the Nurses' Station on 8/31/22 at 8:55 a.m., 9 a.m., and 9:10 a.m. The resident was then moved to the Unit Dining Room/Lounge at 9:17 a.m. At 9:30 a.m., CNA 1 assisted the resident to her room and LPN 1 entered the room and they assisted the resident from the chair to the bed, covered the resident, and ensured the call light was in reach and the bedside table was within reach and exited the room. The resident was not assessed for urinary or bowel incontinence. CNA 1 indicated at the time of the observation of the transfer, she had started her shift at 6 a.m. and assisted the resident out of bed to the chair approximately 7 a.m.- 7:30 a.m.	F 0677	p="" paraid="1829144561" paraeid="{30c92092-b7fd-416f-aa29-96e93c97bc2e}{44}">POC for F677 – ADL Care Provided for Dependent Residents ¿ What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ¿ Resident C was immediately provided with incontinent care. No harm came to resident. CNA 1 and LPN 1 have been provided with education related to timely ADL care and incontinence checks. p="" paraid="940356407" paraeid="{30c92092-b7fd-416f-aa29-96e93c97bc2e}{92}"> How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by this alleged deficient practice. All residents who require assistance for incontinent care were reviewed to ensure they were	09/14/2022

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	The resident's room was observed on 8/31/22 from 9:30 a.m. to 11:43 a.m. No staff entered the room. On 8/31/22 at 11:43 a.m., the Unit Manager and CNA 3 entered the room. The resident's brief was wet and she had been incontinent of bowel. CNA 3 indicated at the time of the observation, residents were to be checked for incontinence at least every two hours. Resident C's record was reviewed on 8/31/22 at 8:59 a.m. The diagnoses included, but were not limited to, dementia. A Quarterly Minimum Data Set assessment, dated 6/12/22, indicated the cognitive status was unable to be assessed, required extensive assistance of one with bed mobility, transfers, and toileting, and was always incontinent of bladder and frequently incontinent of bowel. A Care Plan, dated 11/17/21, indicated a risk for skin impairment. The interventions included good pericare was to be completed after each incontinence episode. A facility policy, titled, "Activities of Daily Living", dated 5/22/22, and received from the Director of Nursing as current, indicated residents would be monitored for incontinence episodes as needed when they were unable to communicate their toileting needs. This Federal tag relates to Complaint IN00386616. 3.1-38(a)(3)		not affected by this alleged deficient practice. p="" paraid="394180866" paraeid="{30c92092-b7fd-416f-aa29-96e93c97bc2e}{122}"> What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? ¿ Nursing staff was educated on the importance of timely ADL care and incontinence checks. How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ¿ ul="" role="list" DON/designee will monitor 10 dependent residents weekly on alternating shifts to ensure incontinence care is being completed timely during AM care, after meals, and throughout the midnight shifts and as needed. The DON/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months.¿ Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue. Date of compliance: 9/14/2022	
F 0692 SS=D	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance			

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Bldg. 00	§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to ensure residents who were assessed as a nutritional risk received meals and/or were monitored for dietary intake, and a Physician's Order for a dietary supplement for a resident at risk was complete with the amount of supplement to be administered, for 2 of 3 residents reviewed for nutritional risk. (Residents C and F) Findings include: 1. Resident C's record was reviewed on 8/31/22 at 8:59 a.m. The diagnoses included, but were not limited to, dementia. A Quarterly Minimum Data Set (MDS) assessment, dated 6/12/22, indicated the cognitive status was unable to be assessed and required	F 0692	p="" paraid="350485454" paraeid="{5d98bc42-360c-4a67-bae6-1c6ed5f6f9c1}{12}">POC for F692 – Nutrition/Hydration Status Maintenance ¿ What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ¿ Resident F suffered no ill effect from alleged deficient practice. ul="" role="list" Order was placed in Resident C's EMR to reflect amount of supplement to be administered. suffered no ill effects from alleged deficient practice. ¿How will you identify other	09/14/2022

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	assistance of one for meal consumption. A Care Plan, dated 3/12/22, indicated a concern with malnutrition. The interventions included, assistance with eating would be provided, signs of malnutrition would be monitored, and nutritional supplements would be provided as ordered by the Physician. A Physician's Order, dated 5/18/22, indicated 2-Cal (two calorie per milliliter) supplement was to be administered three times a day. There was no Physician's Order for the amount of the 2-Cal supplement to be given. A Physician's Order, dated 5/31/22, indicated an admission into a Hospice program. A Dietary Progress Note, dated 8/11/22 at 11:31 a.m., indicated a weight loss of 15% in 30 days, 19.5% in three and six months. The dietary intake was not adequate to maintain her weight. Hospice care continued and further weight loss may be expected and unavoidable due to poor oral intakes. The Dietary Intake Record, dated 8/2022, indicated no supper meal was received and/or documented on August 3, 4, 5, 8, 19, 24, and 28, 2022. No meals were received and/or documented on August 13, 2022, and Breakfast and Lunch were not received and/or documented on August 18, 2022. During an interview on 8/31/22 at 11:43 a.m., CNA 3 indicated all meal consumptions were to be documented in the record. During an interview with the Director of Nursing on 8/31/22 at 3:59 p.m. , he indicated the Hospice		residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by this alleged deficient practice. ul="" role="list" house audit of supplement orders was completed to ensure to be given is included in each order. Full house audit of all resident's intake documentation in POC completed. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? ¿ All clinical staff were educated POC documentation, the importance of tracking meal intakes for all residents, and notifying nurse supervisor/manager for any meal refusals. ul="" role="list" All nurses were educated that all supplement orders need an amount to be given designated within the order set. How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ¿ DON/designee will review POC documentation 5x a week to ensure food consumption is being documented for each meal. The DON/designee will audit all new supplement order 5x a week to ensure every supplement has an	

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	Aide also assisted the resident with meals and was not sure where the intake was documented from them. He acknowledged there was no amount for the 2-Cal supplement ordered by the Physician. 2. Resident F's record was reviewed on 8/31/22 at 2:13 p.m. The diagnoses included, but were not limited to, Alzheimer's disease. An Admission MDS assessment, dated 7/28/22, indicated the cognitive status was unable to be assessed, required extensive assistance with eating, and had no significant weight loss. A Care Plan, dated 7/27/22, indicated a risk for malnutrition. The interventions included, assistance would be given with meals as needed and signs of malnutrition would be monitored. The Dietary Intake Record, dated 8/2022, indicated no supper meal was received and/or documented on August 2, 3, 4, 6, 10, 12, 13, 14, 16, 17, 18, 19, 25, 27, and 30, 2022, and no meals were received and/or documented on August 7 and 8, 2022. The Director of Nursing and Administrator were informed of the concern of intakes not documented on 8/31/22 at 3 p.m. No further information was received at the time of the exit on 8/31/22 at 5:20 p.m. This Federal tag relates to Complaint IN00386616. 3.1-46(a)(2)		amount to be given designated in the order set. ul="" role="list" The DON/designee will present the summaries of the audits to the Quality Assurance Committee monthly for six months. Thereafter, if determined by the Quality Assurance Committee that further monitoring is needed, audit will continue. Date of compliance: 09/14/2022	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including			

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	tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on record review and interview, the facility failed to ensure a resident who required a CPAP(continuous positive airway pressure - oxygen treatment for sleep apnea) treatment, received the treatment as ordered for 1 of 3 residents reviewed for CPAP usage. (Resident D) Finding includes: Resident D's discharge record was reviewed on 8/31/22 at 10:34 a.m. The diagnoses included, but were not limited to, respiratory failure, heart failure, and morbid obesity. The admission date was 5/3/22 and the discharge date was 7/12/22. An Admission Minimum Data Set assessment, dated 5/9/22, indicated an intact cognitive status, no behaviors, required extensive assistance with bed mobility, transfers, locomotion, dressing, toilet use, and bathing and required oxygen usage. A Care Plan, dated 5/5/22, indicated a risk for complications related to obstructive sleep apnea. The interventions included, maintenance of the CPAP machine would be completed and the use of the CPAP machine would be encouraged. A Physician's Order, dated 5/3/22, indicated the CPAP was to be used with pressure setting at 40% when resting.	F 0695	p="" paraid="1829144561" paraeid="{8fa8446d-8a97-4be1-bdbe-b9d7ec0fe965}{224}">POC for F695 – Respiratory/Tracheostomy Care and Suctioning ¿ What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ¿ Resident D no longer resides in facility. p="" paraid="968882788" paraeid="{3836d92b-47af-4f23-8a91-85ed022dd9b2}{6}">How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents with CPAP/BIPAP orders have the potential to be affected by this alleged deficient practice. An audit was completed to ensure all residents who require a CPAP/BIPAP have an order to apply and remove CPAP/BIPAP p="" paraid="1326808853" paraeid="{3836d92b-47af-4f23-8a91-85ed022dd9b2}{53}">What measures will be put into place or what systemic changes you will	09/14/2022

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	The Medication and Treatment Administration Records, dated 5/2022, 6/2022, and 7/2022, indicated the CPAP order had not been placed on the records and the CPAP had not been used. During an interview on 8/31/22 at 4:05 p.m., the Director of Nursing indicated the resident refused to wear the CPAP, though there was no documentation of the refusals. A CPAP administration policy, dated 8/2022, and received as current from the Director of Nursing, indicated, CPAP administration would be completed by the Licensed Nurse or Respiratory Therapist as directed by the Physician's Orders and would be documented in the Resident's record. This Federal tag relates to Complaint IN00388244. 3.1-47(a)(6)		make to ensure that the deficient practice does not recur? Clinical staff was educated on ensuring that residents who require CPAP/BIPAP have orders to apply and remove in EMR. ¿ How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ¿ DON/designee will monitor residents with new CPAP/BIPAP orders to ensure orders are placed to apply and remove . ul="" role="list" DON/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months.¿ Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue. Date of compliance: 09/14/2022	
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			

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	155840	A. BUILDING 00 B. WING	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYMPHONY OF DYER	1532 CALUMET AVENUE DYER, IN 46311

(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
	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 dose can be readily detected. Based on observation, record review, and interview, the facility failed to ensure medications were stored in a locked medication storage area, related to an unlabeled medication, not ordered by the Physician, observed at a resident's bedside, for 1 random observation of medications not stored properly. (Resident C) Finding includes: Resident C's room was observed on 8/31/22 at 9:13 a.m., there was an unlabeled bottle of nasal spray, ipratropium bromide (treatment of nasal drainage) sitting on the over the bed table. There was a non-labeled bottle of vitamin B12, 2500 micrograms and vitamin C 500 milligrams sitting on the bedside dresser. During an observation on 8/31/22 at 9:30 a.m., LPN 2 and CNA 1 entered the room and assisted the resident from the chair to the bed. LPN 2, then moved the over the bed table, where the bottle of nose spray was sitting, closer to the bed.	F 0761	p="" paraid="1829144561" paraeid="{56434c05-d50c-4d50-b61f-0d60bc6f1852}{80}">POC for F761 – Label/Store Drugs and Biologicals ¿ What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ¿ Resident over the counter vitamins and nasal spray were immediately removed from resident room. ADON spoke with family same day who acknowledged they had just brought those medications the night prior and were encouraged to bring any medications to the station in the future. ul="" role="list" LPN 2 was educated on ensuring medications are not left at bedside unless there is a self-administration assessment	09/14/2022

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	During an observation on 8/31/22 at 11:43 a.m., the nasal spray and bottles of vitamins remained in the room. The Unit Manager indicated they were not to be left in the room and removed the nasal spray and the vitamin bottles. She indicated she would notify the family as they had brought the medication into the facility. Resident C's record was reviewed on 8/31/22 at 8:59 a.m. The diagnoses included, but were not limited to, dementia. There were no Physician's Orders for the ipratropium bromide, the vitamin B12, and the vitamin C. During an interview on 9/1/22 at 3:59 p.m., the Director of Nursing indicated the Nursing staff interviewed had not seen the medications in the room. An undated facility policy for medication storage, received as current by the Director of Nursing on 8/31/22 at 3:30 p.m., indicated all medications were to be stored in a locked cabinet, cart or Medication Room. 3.1-25(m)		and a physician order for the medications and for self-administration of medication. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by this alleged deficient practice. ul="" role="list" House sweep was completed with no further unlabeled/un-ordered medications left at residents' bedside. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? ¿ Nursing staff was educated on ensuring medications are not left at bedside unless there is a self-administration assessment and a physician order for the medications and for self-administration of medication. p="" paraid="62602943" paraeid="{56434c05-d50c-4d50-b61f-0d60bc6f1852}{228}">How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ¿ DON/designee will monitor 10 residents weekly on alternating shifts to ensure no medications are left at resident's bedside unless there is a	

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			self-administration assessment and a physician order for the medications and for self-administration of medication. The DON/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months.¿ Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue. Date of compliance: 09/14/2022	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records,			

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	regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and			

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	determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on record review and interview, the facility failed to ensure residents' records were accurate and completed, related to the appeal status after Notice of Medicare Non-Coverage was given, a late entry for bathing, and flow rate documentation for oxygen administration, for 2 of 7 residents' records reviewed. (Residents D and E) Findings include: 1. Resident D's record was reviewed on 8/31/22 at 10:34 a.m. The diagnoses included, but were not limited to, respiratory failure, morbid obesity, and heart failure. A Physician's Order, dated 5/5/22, indicated oxygen was to be administered continuously by a nasal cannula at three liters per minute. The Medication Administration Records, dated 5/2022, 6/2022, and 7/2022 indicated the oxygen had been administered continuously, every shift, at three liters per minute. The Nurses' Progress Notes, dated 5/24/22 at 9:40 p.m., 5/25/22 at 10:42 p.m., 6/11/22 at 9:13 p.m., 6/12/22 at 11:38 p.m., and 7/4/22 at 10:35 a.m., indicated the oxygen was administered at two liters per minute. During an interview on 8/31/22 at 4:05 p.m., the Assistant Director of Nursing indicated she had spoken to the nurses who charted the oxygen was administered at two liters and they indicated they had documented the flow rate incorrectly.	F 0842	p="" paraid="1829144561" paraeid="{86dc7c91-d8b9-4dd4-b6fa-0251df76f745}{102}">POC F842 Resident Records-Identifiable Information ¿ What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ¿ Resident D no longer resides in the facility. Resident E no longer resides in the facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. ul="" role="list" All residents have the potential to be affected by this alleged deficient practice. Audit of residents on oxygen was completed to ensure the clinical staff are charting the correct liters of oxygen accurately in the progress notes when indicated. of scheduled showers was reviewed for the past week to ensure completed showers/baths, and/or refusals have been documented timely. House audit of residents with appeals has been completed to ensure appropriate documentation of appeal results	09/14/2022

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	A Nurse's Progress Note, dated 7/12/22 at 1:44 p.m., indicated the resident had been discharged to home. A Nurse's Progress note, dated 8/30/22 at at 3:07 p.m. and documented as a late entry for 7/12/22 at 6:06 p.m., indicated the resident refused a shower three times and a bed bath was offered and refused. The Responsible Party was notified of the refusals. During an interview on 8/31/22 at 4:05 p.m., the Director of Nursing indicated he was unsure why the shower refusal was a late entry on 8/30/22 with the time of late entry documented after the resident had been discharged from the facility. 2. Resident E's record was reviewed on 8/30/22 at 10:56 a.m. The diagnoses included, but were not limited to, urinary tract infection, chronic kidney disease, and stroke. Review of a Notice of Medicare Non-Coverage letter, dated 7/21/22 and signed by the resident's Responsible Party, indicated the last day of coverage was 7/25/22, and a discharge date of 7/26/22 had been given by the Responsible Party. Review of a second Notice of Medicare Non-Coverage letter, dated 8/12/22 and signed by the Responsible Party indicated the last day of payment was 8/17/22. There was no documentation in the record that indicated an appeal was requested, was granted, and another non-coverage letter was given to the Responsible Party. During an interview on 8/30/22 at 2:04 p.m., the		after a NOMNC was issued is in the medical record. p="" paraid="1061614573" paraeid="{a4a63b6e-4f6c-4086-9be2-8e4227e4344b}{1}">What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? ¿ Nursing staff educated on accurate documentation including documenting accurate liters of oxygen when completing progress notes and timely documentation of showers being given/offered. Social service staff educated on appropriate EMR documentation related to appeal results after a NOMNC was issued. How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ¿ ul="" role="list" DON/designee will monitor 10 residents weekly to ensure scheduled showers are documented timely and accurately.¿ DON/designee will audit 5 residents with oxygen weekly to ensure nurses are charting correct liters of oxygen when competing progress notes. ¿ Administrator/Designee will audit 5 discharges a week to ensure appropriate EMR	

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	Social Service Director indicated the Responsible Party had appealed the non-coverage. The resident had won the appeal. There was no documentation in the record that indicated an appeal was requested and granted. This Federal tag relates to Complaints IN00388244 and IN00388395. 3.1-50(a)(1) 3.1-50(a)(2)		documentation is in place related to appeal results after a NOMNC has been issued. ¿ ul="" role="list" The DON/Designee will present the summaries of the audits to the Quality Assurance committee monthly for three months.¿ Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, will continue.¿ The Administrator/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, will continue.¿ Date of compliance: 09/14/2022	