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	02/03/2023

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 a Recertification and State Licensure Survey and the Investigation of Complaints IN00398131 and IN00399166. This visit included a State Residential Licensure Survey. Complaint IN00398131 - Substantiated. Federal/state deficiencies related to the allegations are cited at F677 and F692. Complaint IN00399166 - Substantiated. Federal/state deficiencies related to the allegations are cited at F684 and F697. Survey dates: January 29, 30, and 31 2023, and February 1, 2, and 3, 2023. Facility number: 013462 Provider number: 155840 AIM number: 201330210 Census Bed Type: SNF/NF: 10 SNF: 74 Residential: 22 Total: 106 Census Payor Type: Medicare: 37 Medicaid: 8 Other: 39 Total: 84 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/9/23.	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
Megan Matula	Administrator	02/27/2023

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F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders and an assessment to self-administer their own medications for 2 of 2 residents reviewed for self-administration of medication. (Residents 125 and 19) Findings include: 1. On 1/30/23 at 10:54 a.m., Resident 125 was observed in his room seated in his wheelchair. A tube of Diclofenac (a topical pain reliever) gel was in the resident's room and he was observed applying some of the gel to his left knee. The record for Resident 125 was reviewed on 2/1/23 at 10:21 a.m. Diagnoses included, but were not limited to, fall and arthritis. The 2/1/23 Admission Minimum Data Set (MDS) assessment was in progress. A Physician's Order, dated 1/26/23, indicated the resident was to receive Diclofenac Sodium External Gel 1 %, apply 4 grams to the left medial knee topically every 6 hours as needed for pain. There was no Physician's Order indicating the medication could be left at the bedside and the resident could apply the gel himself. There was also no self-administration of medication assessment available for review.	F 0554	**POC for F544 – Resident Self – Admin Meds – Clinically Appropriate** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · R125 no longer resides in facility. · R19's inhaler was immediately removed from room by floor nurse. · LPN 4 was educated on ensuring medications are not left at bedside unless there is a self-administration assessment, a physician order, and an updated careplan for self-administration of medications. · Residents suffered no ill effects from alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**	02/24/2023

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	The January 2023 Medication Administration Record (MAR), indicated the Diclofenac had not been signed out as being administered. Interview with the Assistant Director of Nursing (ADON) on 2/1/23 at 3:15 p.m., indicated the medication should not have been left at the bedside. Interview with the ADON on 2/2/23 at 2:15 p.m., indicated the resident had brought the medication from the hospital with him and he didn't tell anyone. He had another tube of the Diclofenac that was secured in the medication cart. 2. During a random observation on 1/30/23 at 10:07 a.m., Resident 19 was observed sitting in his wheelchair by his bed. At that time there was an Albuterol Sulfate hand held inhaler in the window sill. The resident indicated he already used it today. At 11:30 a.m., the inhaler was still observed in the window sill. The record for Resident 19 was reviewed on 1/31/23 at 9:31 a.m. Diagnoses included, but were not limited, emphysema, asthma, COPD, weakness, high blood pressure, and respiratory failure. The 1/12/23 Admission Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for cognition. There was no self-administration of medication assessment or a Care Plan for the resident to self-administer his medications. Interview with LPN 4 on 1/31/23 at 10:11 a.m., indicated she administered the resident's medications to him yesterday, however, she did not realize she left his Albuterol inhaler in the		· All residents have the potential to be affected by this alleged deficient practice. · Full house audit was completed with no further medications left in resident rooms without an assessment, orders, and careplans updated to reflect self-administration. **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, a physician order, and an updated careplan for self-administration of medications. · DCE was educated to notify nursing staff if any medications accompany guest while completing inventory of belongings upon admission to the facility. **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**	

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	room. The resident does not self-administer his own medications. Interview with the Director of Nursing on 2/1/23 at 2:15 p.m., indicated the Albuterol inhaler was not to be left in the resident's room. The resident did not have an order or an assessment to self-administer his own medications. The current and updated 2/5/21 "Self-Administration of Medication and Treatment" policy, provided by the Director of Nursing on 2/3/23 at 10:47 a.m., indicated self-administration of medications and treatments was determined by an order after determining the resident was able to self administer. The decision for self administration was done by the interdisciplinary team. 3.1-11(a)		**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 self administration assessment, a physician order, and updated care plan for the self administration of medications. · DON/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. **Date of compliance: 02/24/2023**	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;			

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

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	under §483.15(c)(9). Based on record review and interview, the facility failed to ensure the resident was notified of a new medication for 1 of 2 residents reviewed for notification of change. (Resident F) Finding includes: During an interview on 1/29/23 at 10:47 a.m., Resident F indicated she had refused a Vitamin B12 injection yesterday. No one had explained what it was for and why she had to take it. She indicated the nurse on duty last night indicated it was for pain in her shoulder, but the resident stated she had no pain in her shoulder. The resident was adamant she was not taking the B12 injection without an explanation of why she had to receive it. During an interview on 1/30/23 at 2:29 p.m., the resident indicated the Nurse Practitioner (NP) came in earlier and explained why the Vitamin B12 injection was ordered. She indicated she was going to contact her primary Physician and if he said it was okay, then she would take the injection. The record for the resident was reviewed on 1/31/23 at 1:53 p.m. The resident was admitted on 1/20/23 to the facility. Diagnoses included, but were not limited to, right knee replacement, and weakness. The Admission Minimum Data Set (MDS) assessment, dated 1/27/23, indicated the resident was cognitively intact and needed extensive assist with 1 person physical assist with transfers and toilet use. Physician's Orders, dated 1/24/23, indicated	F 0580	**POC for F580 – Notify of Changes (Injury/Decline/Room, etc.)** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident F no longer resides in facility. · Resident F suffered no ill effect from this alleged deficient practice. **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. · Nursing managers met with each resident residing in house to ensure residents had no questions pertaining to current orders and treatment plan. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	02/24/2023

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	Vitamin B12 lab draw for admission. The lab results for the Vitamin B12, dated 1/24/23, indicated the level was 285 (a normal range 211 - 911). Physician's Orders, dated 1/24/23 Cyanocobalamin Solution (Vitamin B12) 1000 micrograms (mcg)/ milliliters (ml), inject 1 ml intramuscularly one time a day for nutritional supplement for 7 days. Cyanocobalamin Solution 1000 mcg/ml inject 1 ml intramuscularly one time a day every Wednesday for nutritional supplement for 4 Weeks start date 2/8/23. NP Progress Notes, dated 1/24, 1/25, and 1/26/23, indicated there was no information explained to the resident regarding the rationale for the Vitamin B12 injections. A NP Progress Note, dated 1/30/23 at 2:07 p.m. indicated the resident was seen and examined with her son present. The resident had many questions about her B12 injection. A NP Progress Note, dated 1/30/23 at 2:43 p.m., indicated the resident was questioning prescription written for the B12 injections. The resident was informed it was a nutritional supplement and she may decline to take them if she wanted. The 1/2023 Medication Administration Record (MAR) indicated the vitamin B12 was signed out as being administered on 1/25, 1/26, 1/27, refused on 1/28, and signed out as being administered again on 1/29, 1/30 and 1/31/23. The medication cart was observed on 2/1/23 at 2:00 p.m. There was a bag of 6 single dose vials of		· Nursing staff was educated on notifying residents/families of any changes pertaining to resident care (i.e. medications, treatments, plan of care). **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 resident charts weekly to ensure there is documented notification of any changes. · DON/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. **Date of compliance: 02/24/2023**	

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	Vitamin B12. The label on the bag indicated on 1/25/23 a total of 7 vials were sent to the facility. Interview with the Director of Nursing (DON) on 2/1/23 at 2:15 p.m., indicated there was no documentation the NP explained to the resident why she needed the vitamin B12 injections. Interview with the DON on 2/2/23 at 9:30 a.m., indicated he had spoken to the nurses who took care of the resident and they all told him they had administered the vitamin B12 injections to the resident. Another interview at 11:50 a.m., indicated he had called the pharmacy and they only sent 7 vials of the Vitamin B12 injections and there were 6 left in the bag. 3.1-5(a)(3)			
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. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to insulin and anticoagulant medication use for 1 of 21 MDS assessments reviewed. (Resident 42) Finding includes: The record for Resident 42 was reviewed on 1/31/23 at 11:16 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and atrial fibrillation (irregular heartbeat). The 12/30/22 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately	F 0641	Education was completed for accuracy of MDS.	02/24/2023

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	impaired for daily decision making. Section N - Medications, indicated the resident had not received insulin injections or an anticoagulant within the last 7 days. A Physician's Order, dated 9/26/22, indicated the resident was to receive Lovenox (a blood thinner) prefilled syringe 30 milligrams (mg)/0.3 milliliters (ml), inject 0.3 ml subcutaneously one time a day for DVT (deep vein thrombosis) prophylaxis. The medication was discontinued 1/4/23. A Physician's Order, dated 11/30/22, indicated the resident was to receive 24 units of Glargine insulin every evening. Interview with the Director of Nursing on 2/1/22 at 3:15 p.m., indicated the insulin and anticoagulant use should have been coded on the MDS. 3.1-31(i)			
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the			

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	participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, record review and interview, the facility failed to ensure residents were invited to attend and participate in care planning conferences for 3 of 6 residents reviewed for participation in care planning. The facility also failed to ensure Care Plans were reviewed and revised related to behaviors for 1 of 21 Care Plans reviewed. (Residents E, 16, 31, and 26) Findings include: 1. Interview with Resident E on 1/29/23 at 10:07 a.m., indicated he was not aware of being invited to his care conference. The record for Resident E was reviewed on 1/31/23 at 10:03 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), cellulitis of the left lower limb, and Parkinson's. The resident was his own Responsible Party. The Admission Minimum Data Set (MDS) assessment, dated 1/15/23, indicated the resident was cognitively intact.	F 0657	**POC for F657 – Care Plan Timing and Revision** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Residents suffered no ill effects from alleged deficient practice. · Residents E and 31 no longer reside in facility. · Care plan conference was held with R16 and family. · R26's Care Plan was updated immediately to reflect appropriate interventions. **How will you identify other residents having the potential to be affected by the same deficient practice and what**	02/24/2023

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	The resident's Care Plan was dated 1/13/23. There was no documentation indicating the resident had been invited and/or participated in his care conference. Interview with the Social Service Director on 2/2/23 at 1:25 p.m., indicated he told the residents and/or their families about the care conferences, he also indicated he didn't have anything in writing related to those invites. 2. Interview with Resident 16 on 1/29/23 at 1:43 p.m., indicated she had not participated in her care conference. The record for Resident 16 was reviewed on 1/30/23 at 2:32 p.m. Diagnoses included, but were not limited to, bipolar disorder, anxiety, depression, and dementia with behavior disturbance. The resident was her own Responsible Party. The Quarterly Minimum Data Set (MDS) assessment, dated 11/6/22, indicated the resident was cognitively intact. The resident's last Care Plan review was 11/9/22. There was no documentation indicating the resident had been invited and/or participated in her care conference. Interview with the Social Service Director on 2/2/23 at 1:25 p.m., indicated he told the residents and/or their families about the care conferences, he also indicated he didn't have anything in writing related to those invites.		**corrective action will be taken.** · All residents have the potential to be affected by this alleged deficient practice. · Full house audit completed to ensure all residents and/or families have been invited to their Care Plan conferences. · Full house audit completed to ensure all Care Plan interventions are current and appropriate. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Social Services department was educated on ensuring residents and/or families are invited to participate in their Care Plan conference. · All currently scheduled Care Plan conference meeting invitations have been sent to residents and/or families. · Invitation form implemented to include resident and/or families acknowledgement of invitation to Care Plan conference. · Social Services department educated on reviewing and revising	

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	3. Interview with Resident 31 on 1/30/23 at 10:07 a.m., indicated he was not aware of being invited to his care conference. The record for Resident 31 was reviewed on 1/30/23 at 2:53 p.m. Diagnoses included, but were not limited to, unspecified fall, weakness, and COVID-19. The resident was his own Responsible Party. The Admission Minimum Data Set (MDS) assessment, dated 1/7/23, indicated the resident was cognitively intact. The resident's Care Plan was dated 1/4/23. There was no documentation indicating the resident had been invited and/or participated in his care conference. Interview with the Social Service Director on 2/2/23 at 1:25 p.m., indicated he told the residents and/or their families about the care conferences, he also indicated he didn't have anything in writing related to those invites. 4. During a random observation on 1/29/23 at 8:45 a.m., Resident 26 was laying flat in a broda chair staring at the ceiling in his room. He was unable to view the television in his room. On 1/29/23 at 11:14 a.m., Resident 26 was still laying flat in the broda chair staring at the ceiling in his room. The record for Resident 26 was reviewed on 2/2/23 at 10:04 a.m. Diagnoses included, but were not limited to, bipolar disorder, intellectual disabilities, chronic obstructive pulmonary disease, and		Care Plans when necessary, including updating current or new interventions related to behaviors. **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 all new admissions weekly to ensure residents and/or families were invited to their Care Plan conference. · Administrator/Designee will monitor 10 resident charts weekly to ensure any documented behaviors have current interventions included in the Care Plans. · The Administrator/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. **Date of compliance: 02/24/2023**	

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	155840	A. BUILDING 00 B. WING	02/03/2023

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

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	intermittent explosive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 11/24/22, indicated the resident was severely impaired for daily decision making. A Care Plan, dated 8/11/22, indicated the resident displayed maladaptive behavioral symptoms related to impaired insight, judgement, and decision making skills. Interventions included, but were not limited to, control the environment to the degree possible to moderate stress and reduce noise, over-stimulation, commotion, movement, crowds, and close contact. Interview with the Assistant Director of Nursing on 2/2/23 at 3:05 p.m., indicated the resident would have behaviors of yelling out and preferred to lay flat in his broda chair with a neck pillow which helped to calm him down. The intervention should have been included in the resident's Care Plan. 3.1-35(b)(1) 3.1-35(d)(2)(B)			
F 0677 SS=E 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 dependent residents received help with Activities of Daily Living (ADLs) related to dirty fingernails, transfers to the bathroom, shaves, and showers, for 4 of 7 residents reviewed for ADLs. (Residents B, F, H and G)	F 0677	**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?** · Residents	02/24/2023

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	Findings include: 1. On 1/29/23 at 8:43 a.m., and 11:30 a.m., Resident B was observed in bed. At those times, his fingernails were long and dirty. On 1/30/23 at 2:27 p.m., the resident was observed in bed and his fingernails were long and dirty. On 1/31/23 at 9:25 a.m., the resident was observed sitting up in the broda chair. At that time, the resident's fingernails were long and dirty. On 01/31/23 at 1:48 p.m., and 2:59 p.m., the resident was observed in bed. At those times, the resident's fingernails were long and dirty. The record for Resident B was reviewed on 1/31/23 at 3:10 p.m. Diagnoses included, but were not limited to, dependence on renal dialysis, legal blindness, type 2 diabetes, anorexia, metabolic encephalopathy, high blood pressure, stroke, and end stage renal disease. The Quarterly minimum Data Set (MDS) assessment, dated 11/28/22, indicated the resident was cognitively intact. The resident needed extensive assist with 1 person physical assist for personal hygiene and eating. A Care Plan, revised on 6/8/22, indicated the resident required extensive assistance with ADLs. The approaches were to assist with ADLs each shift as needed. A Nurses' Note, dated 1/11/23 at 3:15 p.m., indicated the resident's fingernails were trimmed and filed. There were no further entries related to nail care.		suffered no ill effects from alleged deficient practice.· Residents B was immediately provided with nail care.· Resident F was interviewed, and concern form completed regarding allegation with resolution completed and education provided to staff.· Resident H was immediately offered to have facial hair shaved but refused. · Resident G shower preferences reviewed with resident and ADL care/shower was offered and provided.**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. · Full house audit of facial hair was completed to ensure shaves were completed as needed/requested.· Full house audit was completed to ensure showers/baths are being provided as scheduled.· Full house audit was completed to ensure residents are being toileted timely when requested.· Full house audit of nails was completed to ensure residents nails are clean. **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 providing timely ADL	

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	Interview with the Director of Nursing on 2/1/23 at 2:15 p.m., indicated the resident's nails should have been cleaned. 2. During an interview on 1/29/23 at 10:30 a.m., Resident F indicated staff do not answer her call light timely. She has had to call down to the receptionist to use the bathroom and then again to get off of the toilet. She has waited long periods of time at different times of the day for her call light to be answered. The record for the resident was reviewed on 1/31/23 at 1:53 p.m. The resident was admitted on 1/20/23 to the facility. Diagnoses included, but were not limited to, right knee replacement, and weakness. The Admission Minimum Data Set (MDS) assessment, dated 1/27/23, indicated the resident was cognitively intact and needed extensive assist with 1 person physical assist with transfers and toilet use A Care Plan, dated 1/24/23, indicated the resident had an ADL self care deficit. A call light log provided by the Director of Nursing indicated the resident had her call light on and it was not answered as follows: 1/21/23 at 8:07 a.m., for 36 minutes 1/21/23 at 10:19 a.m., for 27 minutes 1/22/23 at 1:07 a.m., for 26 minutes 1/22/23 at 9:21 a.m., for 24 minutes 1/23/23 at 7:35 a.m., for 26 minutes 1/23/23 at 8:41 a.m. for 31 minutes, 1/23/23 at 7:22 p.m., for 41 minutes 1/27/23 at 7:01 a.m., for 24 minutes 1/28/23 at 8:26 a.m., for 31 minutes 1/29/23 at 5:21 a.m., for 27 minutes		care to all residents who require assistance, including, but not limited to, nail care, shaving, showers, and bathroom transfers. · Shower record updated to include documentation for nail care and shaving. **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 dependent residents weekly on alternating shifts to ensure ADL care has been provided. · DON /Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. **Date of compliance: 02/24/2023**	

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	1/30/23 at 4:12 a.m., for 43 minutes 2/1/23 at 6:16 a.m., for 28 minutes Interview with the Director of Nursing on 2/1/23 at 10:20 a.m., indicated the resident's call light should have been answered more timely for her ADL needs and assistance to the bathroom and off of the toilet.3. During a random observation on 1/29/23 at 12:48 p.m., Resident H was observed in his room with facial hair. He indicated he wanted to be clean shaven. On 1/30/23 at 11:44 a.m., Resident H was observed in his room with facial hair. Resident H's record was reviewed on 1/30/23 at 2:42 p.m. Diagnoses included, but were not limited to, diabetes mellitus, heart disease, and high blood pressure. The Admission Minimum Data Set (MDS) assessment, dated 1/24/23, indicated the resident was moderately cognitively impaired for daily decision making. He required extensive assistance with one person physical assist for bed mobility, transfers, dressing, toilet use, and personal hygiene. The Shower Record indicated the resident received sponge baths on 1/21/23, 1/25/23, and 1/28/23. The record lacked documentation related to shaving. Interview with the Director of Nursing on 2/2/23 at 10:20 a.m., indicated he had no further information to provide. 4. Interview with Resident G on 1/30/23 at 10:17			

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	a.m., indicated she had not received twice a week bed baths or showers since arrival to the facility. The record for Resident G was reviewed on 2/2/23 at 10:05 a.m. Diagnoses included, but were not limited to, acute respiratory failure, fibromyalgia, anxiety disorder, and heart failure. The resident was re-admitted to the facility on 1/24/23. The Admission Minimum Data Set (MDS) assessment, dated 1/31/23, indicated the resident was cognitively intact for daily decision making. The resident required extensive assistance with one person physical assist for bed mobility, dressing, personal hygiene, and toilet use. She required physical help with one person physical assist for bathing. The Shower Record indicated the resident received a sponge bath on 1/30/23. There were no further bed baths/showers documented. Interview with the Director of Nursing on 2/2/23 at 10:20 a.m., indicated he had no further information to provide. This Federal tag relates to Complaint IN00398131. 3.1-38(a)(2)(C) 3.1-38(a)(3)(D) 3.1-38(a)(3)(E) 3.1-38(b)(2)			
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the			

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	facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure signs and symptoms of constipation were monitored for 1 of 3 residents reviewed for constipation. The facility also failed to ensure areas of discoloration were assessed and monitored for 1 of 1 residents reviewed for anticoagulant medication side effects and 1 of 2 residents reviewed for skin conditions non-pressure related. The facility also failed to ensure fall follow-up was completed for a resident with a potential injury and documentation for a discharge was completed for 2 of 2 residents reviewed for hospitalization. (Residents E, C, D, and F) Findings include: 1. Interview with Resident E on 1/29/23 at 10:13 a.m., indicated he was having issues with constipation. The resident indicated he took Miralax (a laxative) at home but had not received it since he had been admitted to the facility. During the interview, the resident was observed with reddish/purple discoloration to the top of his left hand and in between the fingers. There was also discoloration noted to the top of his right hand. The record for Resident E was reviewed on 1/31/23 at 10:03 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), cellulitis of the left lower limb, and Parkinson's. The Admission Minimum Data Set (MDS) assessment, dated 1/15/23, indicated the resident	F 0684	**POC for F684 – Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · No harm came to Resident E related to alleged deficient practice. Resident E resumed normal bowel movements while in facility prior to discharge. Resident E no longer resides in facility. · Resident C was discharged prior to survey. No harm came to Resident C related to alleged deficient practice. · Resident D was discharged prior to survey. No harm came to Resident D related to alleged deficient practice. · No harm came to Resident F related to lack of documentation of bruise post identification. Resident F no longer resides in this facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what**	02/24/2023

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	was cognitively intact and he needed extensive assistance with bed mobility and transfers. He also had received an anticoagulant and opioid medication during the assessment reference period. A Physician's Order, dated 1/8/23, indicated the resident was to receive Norco (a narcotic pain medication) 5-325 milligrams (mg), one tablet every 6 hours as needed (prn) for pain. The January 2023 bowel movement flow sheet, indicated the resident had no bowel movements documented for 1/11, 1/12, 1/13, and 1/14/23. The January 2023 Medication Administration Record (MAR), indicated the resident had received the prn Norco on 1/10 at 4:30 a.m. and 9:00 p.m., and on 1/13/23 at 8:31 a.m. The resident had no orders for a laxative or stool softener during the above time frame. A Physician's Order, dated 1/31/23, indicated the resident was to receive a Miralax packet 17 grams, 1 packet by mouth every morning for constipation. A Physician's Order, dated 1/12/23, indicated the resident was to receive Lovenox (a blood thinner) prefilled syringe 30 milligrams (mg)/0.3 milliliters (ml), inject 0.3 ml subcutaneously one time a day for DVT (deep vein thrombosis) prophylaxis. A Care Plan, dated 1/13/23, indicated the resident was on anticoagulant therapy. Interventions included, but were not limited to, monitor, document, and report to the Physician prn signs and symptoms of anticoagulant complications such as bruising.		**corrective action will be taken.** · All residents have the potential to be affected by this alleged deficient practice. · Full house audit completed to ensure all guests have documented bowel movements or treatment in place to prevent constipation. · Full house skin sweep completed to ensure all areas of discoloration and non-pressure skin conditions are documented and monitoring/treatment orders are in place. · Full house audit of residents who are on anticoagulation medications was completed to ensure each resident on anticoagulation therapy have orders to monitor for side effects. · Full house audit of falls was completed to ensure fall follow-up assessment and documentation is completed. · Last 30 days of discharges have been audited to ensure discharge progress notes with location is documented appropriately. **What measures will be put**	

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	A Physician's Order, dated 1/31/23, indicated the resident's right and left hand was to be monitored for discoloration to the area one time a day every Tuesday for preventable wound care. The Physician or Nurse Practitioner were to be notified of any changes. Interview with the Director of Nursing (DON) on 2/2/23 at 1:20 p.m., indicated the discoloration to the resident's hands should have been assessed and monitored prior to 1/31/23. At 2:35 p.m., the DON indicated an order for a stool softener or laxative should have been obtained after the resident had signs and symptoms of constipation. 2. The closed record for Resident C was reviewed on 1/30/23 at 11:35 a.m. The resident was admitted on 12/29/22. Diagnoses included, but were not limited to, fall, fracture of medial orbital wall, high blood pressure, traumatic subdural hemorrhage with loss of consciousness. There was no Minimum Data Set (MDS) available for review. A Care Plan, dated 12/29/22, indicated the resident had a history of frequent falls and was at risk for injury from falls. The approaches were to ensure the resident was wearing appropriate footwear when ambulating or mobilizing in the wheelchair, provide adequate lighting, and toilet the resident in a timely manner. A Nurses' Note, dated 12/29/22 at 4:51 p.m., indicated the resident was alert and oriented times 4 and had a bruised eye from a previous fall. The resident had dizzy spells and was an assist times one. The resident was not to be left alone while on the toilet. The resident was resting in bed which was in the lowest position and the call light was in		**into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Nursing staff educated to monitor for signs and symptoms of constipation. · Nursing staff educated on documenting, monitoring, and notification of wound care team for any new areas of discoloration or non-pressure related skin conditions. · Nursing staff was educated on monitoring for side effects of anticoagulation medication such as bruising/bleeding. · Nursing staff educated on proper fall follow-up assessment and documentation. · Nursing staff educated to complete discharge progress notes including documenting discharge location. **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	

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	reach. A Nurses Note, dated 12/30/22 at 4:01 a.m., indicated the writer found the resident lying on the left side on floor near the bed. The resident indicated she was trying to go to the toilet by herself. The resident was asked why she did not call for help and stated that she had forgotten how to use the call light. The resident was assessed and transferred with two plus assist back to bed. The Physician and family were made aware of the fall. A Physician Progress Note, dated 12/30/2022 at 11:31 a.m., indicated an assessment was completed for the resident after the fall (the first assessment post fall by any staff member). The resident stated she "feels terrible." A stat X-ray was being ordered at that time due to the fall earlier that morning. Upon examination, the resident "does manifest some tenderness over the left hip." A Physical exam indicated the resident looked uncomfortable. Examination of the extremities revealed no cyanosis and no clubbing. The extremities were symmetric bilaterally and there was tenderness over the left hip. The Impression/Plan indicated the resident had a fall from the bed with an onset of new left hip pain. The next documented entry was a Follow Up/Monitoring Assessment, dated 12/30/22 at 12:09 p.m., recorded as a late entry, which indicated the resident reported no changes in pain, the ability to perform ADL tasks, or cognition. A SBAR Assessment, dated 12/30/22 at 3:24 p.m., indicated the resident had an acute left femoral neck fracture.		10 residents weekly to ensure bowel movements documented and/or treatment for constipation in place. · DON/Designee will monitor 10 random residents weekly to assess for any undocumented skin conditions. · DON/Designee will monitor 10 residents on anticoagulants weekly to ensure assessments of anticoagulant side effects is being completed. · DON/Designee will monitor all falls to ensure proper assessment and follow-up documentation is completed. · DON/Designee will monitor 10 discharges weekly to ensure discharge progress notes and locations are included in EMR. · The DON/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. **Date of compliance: 02/24/2023**	

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	There was no documentation of an assessment of the resident's left hip after 4:01 a.m., until 11:31 a.m. (7.5 hours) when the Physician visited. The resident was sent to the hospital for the fractured hip. Interview with the Director of Nursing on 2/2/23 at 9:30 a.m., indicated he personally went into the resident's room during the morning hours and asked her about the use of the call light. He was unsure if the resident did not know how to use the call light or just did not use the call light to get up from the bed. There was no documentation of an assessment of the resident's hip after the fall. The stat X-ray was not ordered until after the Physician had seen the resident. 3. The closed record for Resident D was reviewed on 1/30/23 at 1:53 p.m. The resident was admitted on 12/28/22 from the hospital. Diagnoses included, but were not limited to, falls, type 2 diabetes, weakness, stroke, hemiplegia, heart disease, high blood pressure, dementia without behaviors, anxiety, and wedge compression fracture of the second lumbar vertebrae. The 5 day Minimum Data Set (MDS) assessment, dated 12/29/22, indicated the resident was moderately impaired for decision making. The resident had a fall with a fracture in the last 6 months and had a history of falls in the last month prior to the nursing home admission. A Skilled Look Back Progress Note, dated 12/28/22 at 3:31 p.m., indicated the resident arrived to the facility at 2:00 p.m. The resident speaks Korean but does understand and was able to use hand gestures. The resident was pending a procedure on 12/30/22.			

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A Nurses' Note, dated 12/29/22 at 10:24 p.m., indicated the Physician was made aware of pre-surgical instructions with orders noted. The resident and family were made aware.

A Physician's Progress Note, dated 12/30/22 at 9:20 a.m., indicated the resident was unable to ambulate without excessive pain. An Orthopedic consult initially recommended a brace, however due to disabling back pain, surgical intervention was recommended with a tentative date of 12/30/22.

There was no documentation or an assessment of the resident after 12/28/22 when she first arrived. There was no documentation when the resident was discharged to the hospital and the condition she was in at the time of discharge.

Interview with the Director of Nursing (DON) on 2/2/23 at 9:30 a.m., indicated there was no documentation or an assessment of when the resident left for surgery on 12/30/22.

The current and revised 5/2021 "Appointments and Transportation" policy, provided by the DON on 2/2/23 at 11:46 a.m., indicated prior to the appointment, the staff nurse will gather the necessary paperwork to send with the resident to the appointment. This includes, but was not limited to, a face sheet, and required documentation form the EMR system.

4. On 1/29/23 at 10:52 a.m., Resident F was observed with a bruise to her right hand by her thumb. The bruise was purple in color.

The record for the resident was reviewed on 1/31/23 at 1:53 p.m. The resident was admitted on

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	1/20/23 to the facility. Diagnoses included, but were not limited to, right knee replacement, and weakness. The Admission Minimum Data Set (MDS) assessment, dated 1/27/23, indicated the resident was cognitively intact and needed extensive assist with 1 person physical assist with transfers and toilet use A Care Plan, dated 1/24/23, indicated the resident received Aspirin related to post surgery. The approaches were to monitor/document any complications such as bruising. A Care Plan, dated 1/31/23, indicated the resident had actual impairment to skin integrity related to anticoagulant therapy, a right hand bruise. A Wound Care Note, dated 1/29/23 at 3:17 p.m., indicated the resident had staples intact with no drainage present. A Wound Care Note, dated 1/31/23 at 12:08 p.m., indicated the resident was observed with a bruise to the right hand that measured 10 by 10. The resident received Aspirin daily. The Physician and family were made aware. Physician's Orders, dated 1/20/23, indicated Aspirin tablet 325 milligrams (mg). Give 1 tablet by mouth every 12 hours for prophylaxis status post surgery for 26 days. Physician's Orders, dated 1/31/23, indicated to monitor bruise to right hand until resolved every shift. There was no documentation in nursing progress notes on 1/29 and 1/30/23 regarding the bruise to			

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	her right hand near the thumb. Interview with the Director of Nursing (DON) on 2/1/23 at 2:15 p.m., indicated nursing staff were to assess and document any type of bruises when first noted. The 5/8/21 "Bruise Identifying/Monitoring" policy, provided by the DON on 2/2/23 at 11:46 a.m., indicated when a resident was identified with a bruise, the nurse will notify the Physician and resident representative. The staff nurse will complete the appropriate documentation in the electronic medical record. This Federal tag relates to Complaint IN00399166. 3.1-37(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives			

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	one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on record review and interview, the facility failed to monitor and assess a resident after antibiotic therapy had been started for a urinary tract infection (UTI) for 1 of 2 residents reviewed for UTI. (Resident 35) Finding includes: During an interview on 1/29/23 at 2:20 p.m., Resident 35's spouse indicated the nurse collected a urine sample and told him his wife had a UTI, but he did not know if she was on an antibiotic. The record for Resident 35 was reviewed on 1/31/23 at 10:32 a.m. Diagnoses included, but were not limited to, peg tube, weakness, mild protein malnutrition, UTI, and Parkinson's disease. The Quarterly Minimum Data Set (MDS) assessment, dated 11/11/22, indicated the resident was severely impaired for decision making. The resident was frequently incontinent of urine and bowel.	F 0690	**POC for F690 – Bowel/Bladder Incontinence, Catheter, UTI** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · R35 suffered no ill effect from alleged deficient practice. · R35 is no longer on anti-biotics. **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 on antibiotic therapy have the potential to be affected by this alleged deficient practice.	02/24/2023

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	A Care Plan, dated 1/30/23, indicated the resident was on an antibiotic for a UTI. The approaches were to observe for possible side effects every shift. A Urinalysis collected on 1/11/23, indicated the resident had some bacteria. A culture, dated 1/16/23, indicated Escherichia Coli 10-50,000 colonies and Proteus mirabilis 10-50,000 colonies. Physician's Orders, dated 1/16/23, indicated Cephalexin Oral Tablet (an antibiotic medication) 500 milligrams (mg). Give 500 mg via PEG-Tube every 12 hours for UTI for 7 days. The 1/2023 Medication Administration Record (MAR) indicated the Cephalexin was initiated on 1/17/23 at 9:00 a.m. Follow Up Antibiotic Charting forms were completed on 1/19, 1/22, and 1/23/23. There was no documentation in nursing notes regarding the antibiotic therapy or symptoms the resident had for the UTI on 1/17-1/21/23. A Skilled Look Back Assessment, dated 1/23/23 at 3:38 p.m., indicated the resident continued on the antibiotics for the UTI. Nurses' Notes, dated 1/27/23 at 5:12 p.m., indicated the resident had a light yellow thick discharge in her brief during peri care. The Physician was made aware and a new order was received to obtain a vaginal culture and urinalysis and culture. Both cultures were obtained and waiting for lab to pick up. A urinalysis lab result, dated 1/27/23, indicated the resident had bacteria and white blood cells in		· House audit completed of residents on antibiotic therapy to ensure proper follow -up monitoring and assessments have been completed. **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 educated on proper assessment and monitoring documentation to be completed for guests receiving antibiotic therapy. **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 resident charts weekly to ensure appropriate assessments and monitoring is documented for residents receiving antibiotic therapy. · DON/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months.	

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	the urine. A final culture, dated 1/31/23, indicated Escherichia Coli greater than 100,000 colonies and Morganella morganii greater than 100,000 colonies. Physician's Orders, dated 1/29/23, indicated Cipro (an antibiotic) 500 mg. Give 1 tablet via PEG-Tube every 12 hours for UTI for 5 days. The 1/2023 MAR indicated the Cipro was initiated on 1/29/23 at 9 p.m. There were no Follow Up Antibiotic Forms completed on 1/29, 1/30, 1/31, 2/1, or 2/2/23. There was no documentation regarding the Cipro antibiotic after it had been initiated. Interview with the Infection Preventionist on 2/2/23 at 1:15 p.m., indicated nursing staff were to complete the Follow Up Antibiotic Forms while the resident received the antibiotic. Interview with the Assistant Director of Nursing on 2/2/23 at 1:40 p.m., indicated antibiotic charting was to be done every shift for 72 hours. The revised and current 8/2021 "Antibiotic Stewardship" policy provided by the Administrator on 1/29/23 at 2:00 p.m., indicated when a new antibiotic was prescribed a Follow Up Antibiotic Monitoring will be completed at least daily for the duration of the antibiotic therapy. 3.1-41(a)(2)		Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. **Date of compliance: 02/24/2023**	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic			

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	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 observation, record review, and interview, the facility failed to ensure the intake amounts of nutritional supplements were documented and food consumption logs were completed for residents with a history of weight loss for 2 of 4 residents reviewed for nutrition. (Residents B and G) Findings include: 1. During an interview on 1/29/23 at 11:30 a.m., Resident B indicated he did not always get his Nepro supplement and he had lost weight. The record for Resident B was reviewed on 1/31/23 at 3:10 p.m. Diagnoses included, but were not limited to, dependence on renal dialysis, legal blindness, type 2 diabetes, anorexia, metabolic encephalopathy, high blood pressure, stroke, and end stage renal disease.	F 0692	**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?** · Residents B's supplement order changed immediately to include documentation for percentage of supplement consumed. · Resident G no longer resides in facility. · No Residents suffered ill effects from alleged deficient practice.	02/24/2023

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	The Quarterly minimum Data Set (MDS) assessment, dated 11/28/22, indicated the resident was cognitively intact. The resident needed extensive assist with 1 person physical assist for personal hygiene and eating. The resident had no oral problems, weighed 151 pounds and had a significant weight loss during the assessment period. A Care Plan, revised on 8/17/22, indicated the resident had a nutritional problem. The approaches were to provide and serve diet as ordered and observe intake and record. An Interdisciplinary Note, dated 11/10/22 at 10:35 a.m., indicated the resident has been trending weight loss for some time now, despite interventions in place. A Registered Dietitian's Note, dated 1/19/23 at 11:32 a.m., indicated supplements already in place however, by mouth intake was varied. Physician's Orders, dated 4/15/22, indicated Renal supplement (ex. Nepro) two times a day 1 can/carton. The 1/2023 Medication Administration Record (MAR) indicated the supplement was signed out as being administered to the resident at 9:00 a.m. and 5:00 p.m., however, there was no documentation of how much the resident consumed. Interview with the Director of Nursing on 2/1/23 at 2:15 p.m., indicated there was no documentation on how much of the renal supplement the resident had consumed.2. Interview with Resident G on 1/30/23 at 10:16 a.m., indicated she had previous weight loss but was unsure of the severity.		**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. · Full house audit of supplements was completed to ensure percentage consumed is properly documented in order set. · Full house audit of all resident's intake documentation was completed to help identify nutritional concerns to address as needed, and/or address further documentation trends for correction. **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 on POC documentation, the importance of tracking meal intakes for all residents, and notifying nurse supervisor/manager for any meal refusals. · Nurses were educated that supplement orders must contain a percentage consumed within the	

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	The record for Resident G was reviewed on 2/2/23 at 10:05 a.m. Diagnoses included, but were not limited to, acute respiratory failure fibromyalgia, high blood pressure, hypothyroidism, and heart failure. The resident was hospitalized on 12/26/22 and returned on 1/24/23. The Admission Minimum Data Set (MDS) assessment, dated 1/31/23, indicated the resident was cognitively intact for daily decision making. The resident weighed 242.6 pounds on 12/23/22 and 198 pounds on 1/24/23. The Meal Consumption Log for December 2022 lacked documentation of the following meals: - Breakfast on 12/18/22 - Lunch on 12/18/22 and 12/21/22 - Dinner on 12/17/22, 12/18/22, 12/19/22, 12/20/22, 12/23/22, 12/24/22, 12/25/22, and 12/26/22 The Meal Consumption Log for January 2023 lacked documentation of the following meals: - Breakfast on 1/25/23, 1/26/23, 1/27/23, and 1/29/23 - Lunch on 1/26/23 and 1/29/23 - Dinner on 1/25/23, 1/26/23, 1/27/23, 1/28/23, and 1/29/23 Interview with the Director of Nursing on 2/2/23 at 12:15 p.m., indicated he had no further information to provide. This Federal tag relates to Complaint IN00398131. 3.1-46(a)(1) 3.1-46(a)(2)		order set in order to monitor nutritional intake. **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 accurate food consumption. · DON/Designee will audit all new supplement orders 5x a week to ensure every supplement has a percentage consumed designated in the order set. · The DON/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. **Date of compliance: 02/24/2023**	

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure oxygen was set at the correct flow rate and the nasal cannula was properly placed for 2 of 4 residents reviewed for respiratory services. (Residents 4 and H) Findings include: 1. On 1/29/23 at 1:45 p.m., Resident 4 was observed sitting in a wheelchair in her room. At that time, she was wearing oxygen by the way of a nasal cannula. The flow rate was set above 2.5 but not at 3 liters per minute. On 1/30/23 at 10:48 a.m., and 2:25 p.m., the resident was observed in her wheelchair. At those times, she was wearing oxygen by the way of a nasal cannula. The flow rate was set above 2.5 but not at 3 liters per minute. On 1/31/23 at 9:23 a.m., and 10:45 a.m., and on 2/1/23 at 9:18 a.m., the resident was observed in her wheelchair. At those times, she was wearing oxygen by the way of a nasal cannula. The flow rate was set above 2.5 but not at 3 liters per minute.	F 0695	**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?** · No harm came to either resident related to alleged deficient practice. · Residents 4's oxygen was immediately adjusted to correct flow rate. · Resident H's nasal cannula was immediately adjusted to fit as designed. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**	02/24/2023

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	The record for Resident 4 was reviewed on 1/30/23 at 3:00 p.m. Diagnoses included, but were not limited to, COPD, chronic pulmonary edema, heart failure, chronic kidney disease, and high blood pressure. The Admission Minimum Data Set (MDS) assessment, dated 1/9/23, indicated the resident was moderately impaired for cognition. The resident used oxygen at the facility. A Care Plan, revised on 11/17/22, indicated the resident had prn oxygen therapy. The approaches were to administer oxygen per Physician's Orders. Physician's Orders, dated 1/11/23 and discontinued on 1/29/23, indicated oxygen at 2 liters per nasal cannula continuous. Physician's Orders, dated 1/29/23 at 11:45 a.m., indicated Oxygen at 2 Liters/Minute per nasal cannula continuous. Interview with the Assistant Director of Nursing (ADON) on 2/1/23 10:38 a.m., indicated her oxygen was not at 2 liters per minute.2. On 1/29/23 at 12:48 p.m., Resident H was observed in his room with his nasal cannula not properly placed in his nares. On 1/30/23 at 11:44 a.m., Resident H was observed in his room with his nasal cannula not properly placed in his nares. On 1/31/23 at 9:58 a.m., Resident H was observed in his room with his nasal cannula not properly placed in his nares. Resident H's record was reviewed on 1/30/23 at 2:42 p.m. Diagnoses included, but were not limited		· All residents with oxygen orders have the potential to be affected by this alleged deficient practice. · Full house audit of all guests on oxygen therapy was completed to ensure oxygen is set to proper flow rate and nasal canula is properly placed. **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 that residents on oxygen therapy are receiving oxygen at the ordered flow rate, and that residents with oxygen therapy have device for administration such as nasal cannulas properly placed. **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 20 residents receiving oxygen therapy a week on all shifts to ensure proper flow rate and nasal canula placement. · The DON/Designee will	

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	to, pneumonia, heart disease, anemia, high blood pressure, and atrial fibrillation (irregular heart rhythm). The Admission Minimum Data Set (MDS) assessment, dated 1/24/23, indicated the resident was moderately cognitively impaired for daily decision making. He used oxygen therapy while a resident. A Physician's Order, dated 1/19/23, indicated oxygen at 4 liters/minute per nasal cannula continuously. There was no Care Plan related to oxygen use. Interview with the Director of Nursing on 2/2/23 at 10:20 a.m., indicated he had no further information to provide. 3.1-47(a)(6)		present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. **Date of compliance: 02/24/2023**	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure a resident with complaints of pain received the appropriate scheduled medication to relieve the pain based on the resident's pain level for 1 of 3 residents reviewed for pain. (Resident C) Finding includes:	F 0697	**POC for F697 – Pain Management** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Pain medication given was	02/24/2023

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	The closed record for Resident C was reviewed on 1/30/23 at 11:35 a.m. The resident was admitted on 12/29/23. Diagnoses included, but were not limited to, fall, fracture of medial orbital wall, high blood pressure, traumatic subdural hemorrhage with loss of consciousness. There was no Minimum Data Set (MDS) available for review. A Care Plan, dated 12/29/22, indicated the resident was at risk for alteration in comfort related to generalized aches and pains. A Nurses' Note, dated 12/29/22 at 4:51 p.m., indicated the resident was alert and oriented times 4 and had a bruised eye from a previous fall. The resident had dizzy spells and was an assist times one. The resident was not to be left alone while on the toilet. The resident was resting in bed which was in the lowest position and the call light was in reach. A Nurses Note, dated 12/30/22 at 4:01 a.m., indicated the writer found the resident lying on the left side on floor near the bed. The resident indicated she was trying to go to the toilet by herself. The resident was asked why she did not call for help and stated that she had forgotten how to use the call light. The resident was assessed transferred with two plus assist back to bed. The Physician and family were made aware of the fall. A Physician Progress Note, dated 12/30/2022 at 11:31 a.m., indicated an assessment was completed for the resident after the fall (the first assessment post fall by any staff member). The resident stated she "feels terrible." A stat X-ray was being ordered at that time due to the fall		effective. · No ill effects related to alleged deficient practice. · Resident C no longer resides in 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?** · All residents receiving pain medication have the potential to be affected by this alleged deficient practice. · Full house audit was completed to ensure residents received appropriate PRN pain medication based on pain level. **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 that residents with complaints of pain receive the proper PRN pain medication based on the resident's pain level.	

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	155840	A. BUILDING 00 B. WING	02/03/2023

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	earlier that morning. Upon examination, the resident "does manifest some tenderness over the left hip." A Physical exam indicated the resident looked uncomfortable. Examination of the extremities revealed no cyanosis and no clubbing. The extremities were symmetric bilaterally and there was tenderness over the left hip. The Impression/Plan indicated the resident had a fall from the bed with an onset of new left hip pain. The next documented entry was a Follow Up/Monitoring assessment, dated 12/30/22 at 12:09 p.m., recorded as a late entry, which indicated the resident reported no changes in pain, the ability to perform ADL tasks, or cognition. A SBAR Assessment, dated 12/30/22 at 3:24 p.m., indicated the resident had an acute left femoral neck fracture. Physician's Orders, dated 12/29/22, indicated a pain assessment every shift. Another order dated 12/29/22 and discontinued on 12/30/22, indicated Tramadol HCl Oral Tablet 50 milligrams (mg). Give 50 mg by mouth every 12 hours as needed for mild pain. Physician's Orders, dated 12/30/22 at 10:56 a.m., indicated stat left hip X-ray due to fall. Physician's Orders, dated 12/30/22, indicated Tramadol HCl Oral Tablet 50 milligrams (mg). Give 50 mg by mouth every 12 hours as needed for pain rated 5-10. Tylenol Oral Tablet 325 mg, give 650 mg by mouth every 6 hours as needed for pain rated 1-4. A pain assessment in the vital signs section of the record indicated the resident had complaints of		**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 15 PRN pain medication administrations a week to ensure appropriate medication administered based on resident's pain level. · The DON/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. **Date of compliance: 02/24/2023**	

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	pain on 12/30/22 at 2:33 p.m. and had rated her pain a 9 out 10. The Medication Administration Record (MAR) dated 12/2022, indicated the Tramadol had not been signed out as being administered on 12/30/22. On 12/30/22 at 2:33 p.m., Tylenol was signed out as being administered for the resident's pain. Interview with the Director of Nursing on 2/2/23 at 9:30 a.m., indicated he personally went into the resident's room during the morning hours and asked her about the use of the call light, he was unsure if the resident did not know how to use the call light or just did not use the call light to get up from the bed. He indicated the resident had no complaints of pain during his assessment. A pain assessment was completed on 12/30/22 at 2:33 p.m., of which the resident indicated her pain was 9 out of 10 and Tylenol was administered rather than the Tramadol. This Federal tag relates to Complaint IN00399166. 3.1-37(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or			

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	§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 medications were not used for excessive duration and monitored adequately related to medicated wipes and giving medications outside of blood pressure parameters for 2 of 5 residents reviewed for unnecessary medications. (Residents 42 and 4) Findings include: 1. The record for Resident 42 was reviewed on 1/31/23 at 11:16 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and atrial fibrillation (irregular heartbeat). The 12/30/22 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for daily decision making. A Physician's Order, dated 10/11/22, indicated the resident was to receive a Chlorhexidine Gluconate Cloth External Pad (a topical antiseptic that helps reduce the chances of infection prior to surgery), apply to body topically one time a day for MRSA decolonization. There was no stop date for the order.	F 0757	**POC for F757 – Drug Regimen is Free from Unnecessary Drugs** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 4 no longer resides in this facility. · Resident 42's order was discontinued immediately. · No harm came to either resident regarding this alleged deficient practice. **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	02/24/2023

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	Interview with the Director of Nursing on 2/2/23 at 2:15 p.m., indicated the Chlorhexidine pads needed to be discontinued. 2. The record for Resident 4 was reviewed on 1/30/23 at 3:00 p.m. Diagnoses included, but were not limited to, COPD, chronic pulmonary edema, heart failure, chronic kidney disease, and high blood pressure. The Admission Minimum Data Set (MDS) assessment, dated 1/9/23, indicated the resident was moderately impaired for cognition. Physician's Orders, dated 1/10/23, indicated Midodrine (a medication to increase blood pressure) HCl Oral Tablet 10 milligrams (mg). Give 1 tablet by mouth three times a day for hypotension. Hold for Systolic Blood Pressure (SBP) greater than 100. 1/2023 Medication Administration Record (MAR) indicated the Midodrine was administered three times a day on the following days when the resident's systolic blood pressure was greater than 100: 9:00 a.m.: 1/12-157/91 1/13-128/82 1/15-130/76 1/16-143/89 1/17-124/76 1/18-116/68 1/20-137/69 1/23-123/68 1/26-133/77 1/27-136/72 1/28-129/67 1/29-111/59 1:00 p.m.:		alleged deficient practice. · Full house audit was completed to ensure blood pressure medications were administered appropriately based on blood pressure parameters. · Full house audit completed for guests with orders for CHG wipes to ensure all orders have a stop date. · Full House audit was completed to ensure there were stop dates for all appropriate orders. **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 educated on ensuring that medications are administered appropriately as it relates to order parameters. · Nursing staff educated on ensuring all CHG wipes have an appropriate stop date within order set. · Nursing staff was educated on placing stop date in every appropriate order when initially obtaining order, or if receiving upon admission.	

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	1/10-141/77 1/12-152/86 1/13-128/82 1/15-129/75 1/16-136/69 1/17-124/76 1/18-116/68 1/20-137/69 1/22-126/79 1/24-120/68 1/25-130/74 1/26-133/77 1/27-136/72 1/28-129/67 1/29-111/59 5:00 p.m.: 1/10-144/66 1/13-128/82 1/16-138/78 1/17-116/69 1/18-118/66 1/20-137/69 1/23-112/60 1/24-120/68 1/25-110/55 1/26-124/72 1/27-136/72 1/28-124/68 1/29-111/59 1/30-130/72 Interview with the Unit Manager on 1/31/23 at 12:25 a.m., indicated the medication was to be held for a systolic blood pressure over 100. 3.1-48(a)(2) 3.1-48(a)(3)		**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 15 blood pressure medication administrations a week to ensure medications are being administered appropriately as it relates to parameters. · DON/Designee will monitor all new orders for CHG and any other order requiring a stop date to ensure stop date is in order set. · DON/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. **Date of compliance: 02/24/2023**	

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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 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			

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	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 residents did not receive unnecessary psychotropic medications without adequate indications for use for 1 of 5 residents reviewed for unnecessary medications. (Resident G) Finding includes: The record for Resident G was reviewed on 2/2/23 at 10:05 a.m. Diagnoses included, but were not limited to, acute respiratory failure, insomnia, fibromyalgia, anxiety disorder, and heart failure. The Admission Minimum Data Set (MDS) assessment, dated 1/31/23, indicated the resident was cognitively intact for daily decision making. The resident received anti-anxiety medication, antidepressant medication, and opioids in the last seven days. A Care Plan, dated 1/25/23, indicated the resident used anti-anxiety medications related to an anxiety disorder. Interventions included, but were not limited to, administer medications as ordered and monitor for side effects. A Physician's Order, dated 1/25/23, indicated lorazepam 1 milligram tablet every 12 hours as needed (PRN) for anxiety.	F 0758	**POC for F758 – Free from Unnecessary Psychotropics** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident G no longer resides in facility. · No harm came to Resident G regarding alleged deficient practice. **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 orders for PRN psychotropic medications have the potential to be affected by this alleged deficient practice. · Full house audit of residents with orders for PRN psychotropics completed to ensure appropriate	02/24/2023

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	The lorazepam medication was administered on 1/25/23 at 9:30 a.m., 1/27/23 at 8:24 a.m., 1/29/23 at 12:38 p.m., and 1/30/23 at 5:12 p.m. with no indication for use. Interview with the Director of Nursing on 2/2/23 at 10:20 a.m., indicated he had no further information to provide. The policy titled, "Medication Administration" and noted as current, indicated "...Guideline...21. Document reason and response for any PRN Medication." 3.1-48(a)(4)		documentation in place. **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 that any PRN psychotropic medication administrations have a documented indication in the 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 15 PRN psychotropic medication administrations a week to ensure indication is documented in the EMR. · The DON/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue.	

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F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on observation, record review, and interview, the facility failed to ensure a resident was free from significant medication errors related to administering the wrong insulin for 1 of 6 residents observed during medication pass. (Resident 42) Finding includes: On 2/1/23 at 4:07 p.m., LPN 3 checked Resident 42's blood sugar by the way of a glucometer. The resident's blood sugar was 417 and the LPN indicated she was going to have to notify the Physician to see if additional insulin coverage would be needed. The Physician ordered an additional 5 units of insulin to be given. The LPN indicated the resident would receive a total of 15 units. At 4:22 p.m., the LPN removed a Glargine insulin pen from the medication cart. The pen was primed and the LPN proceeded to dial up 15 units. She then entered the resident's room and administered the insulin in the abdomen. The record for Resident 42 was reviewed on 2/2/23	F 0760	**POC for F760 – Residents are Free of Significant Med Errors** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 42 suffered no ill effects from this alleged deficient practice. · Medical Director/PCP notified of medication error with no new orders. · Family/resident notified of medication error. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Immediate investigation of	02/24/2023

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	at 10:00 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and atrial fibrillation (irregular heartbeat). The 12/30/22 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for daily decision making. A Physician's Order, dated 2/1/23, indicated the resident was to receive 5 units of Novolog insulin one time only for hyperglycemia (high blood sugar). A Physician's Order, dated 10/19/22, indicated the resident was to receive Novolog insulin per sliding scale three times a day for diabetes mellitus. Inject per sliding scale: if 201-250=2 units, 251-300=4 units, 301-350=8 units, 351-400=10 units. For blood sugar greater than 400, give 10 units and notify the Physician. A Physician's Order, dated 11/30/22, indicated the resident was to receive 24 units of Glargine insulin every evening. Interview with the Director of Nursing on 2/2/23 at 2:15 p.m., indicated the resident should have received the Novolog insulin rather than the Glargine. 3.1-48(c)(2)		medication error was completed and there were more than one insulin pens stored together in a storage bag on the medication cart for Resident 42 increasing potential for error. · All residents who are being administered insulin or any other medication have the potential to be affected by this alleged deficient practice. · Each medication cart has been audited to ensure no more than one insulin pen is in storage bag at a time while being used, and the storage bag/box and insulin pen/bottle are both separately labeled identifying name of drug for each resident. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · LPN 3 was educated on proper medication administration technique with competency and verifying that the correct medication is being administered. · Nursing staff educated on rights of medication pass. · Nursing staff educated on triple checking all medications prior to administration of any drug	

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			or treatment. · Nursing staff educated specifically on insulin administration with a focus on verification that correct medication is being administered based on orders. · Nursing staff educated on ensuring insulins are stored separately on cart with identifying information on each administration vessel and on each corresponding bag or box. **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 5 medication administrations, including insulin administration, on each of the 4 designated halls weekly for a total of at least 20 to ensure rights of medication are followed and correct insulin is administered based on orders. · DON/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue.	

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F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on record review and interview, the facility failed to promote antibiotic stewardship by ensuring the appropriate use of antibiotic therapy and a system of monitoring to improve resident outcomes and reduce antibiotic resistance related to a practitioner prescribing antibiotics for not true infections based on the McGeer Criteria for 1 of 2 residents reviewed for urinary tract infections (UTI). (Resident 35) Finding includes: During an interview on 1/29/23 at 2:20 p.m., Resident 35's spouse indicated the nurse collected a urine sample and told him his wife had a UTI, but he did not know if she was on an antibiotic. The record for Resident 35 was reviewed on 1/31/23 at 10:32 a.m. Diagnoses included, but were not limited to, peg tube, weakness, mild protein malnutrition, UTI, and Parkinson's disease. The Quarterly Minimum Data Set (MDS)	F 0881	**POC for F881 – Antibiotic Stewardship Program** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 35 suffered no ill effects from this alleged deficient practice. · R35 is no longer on antibiotics. **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	02/24/2023

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	assessment, dated 11/11/22, indicated the resident was severely impaired for decision making. The resident was frequently incontinent of urine and bowel. A Care Plan, dated 1/30/23, indicated the resident was on an antibiotic for a UTI. The approaches were to observe for possible side effects every shift. A Nurse Practitioner's (NP) Progress note, dated 1/12/23 at 9:22 p.m., recorded as a late entry, indicated the resident's husband expressed concern that she appeared to have increased fatigue for the last 2 days. He indicated in the past the when the resident presented similarly before being diagnosed with a UTI. The resident had no fever, chills or apparent distress. The assessment and plan was to collect an urinalysis. A Urinalysis collected on 1/11/23, indicated the resident had some bacteria. A culture, dated 1/16/23, indicated Escherichia Coli 10-50,000 colonies and Proteus mirabilis 10-50,000 colonies. Physician's Orders, dated 1/16/23, indicated Cephalexin Oral Tablet (an antibiotic medication) 500 milligrams (mg). Give 500 mg via PEG-Tube every 12 hours for UTI for 7 days. The 1/2023 Medication Administration Record (MAR) indicated the Cephalexin was initiated on 1/17/23 at 9:00 a.m. and continued until 1/23/23. A NP Progress Note, dated 1/19/23 at 9:20 p.m., recorded as a late entry, indicated the resident was currently taking oral antibiotics for acute cystitis. An Infection Surveillance Form was completed on		alleged deficient practice. · All residents on antibiotics were reviewed for appropriateness of antibiotic therapy. **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 educated on ensuring that all new antibiotic orders meet McGeer criteria. · NPS and Physicians educated on McGeer criteria and appropriate use of antibiotic therapy. **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 all new antibiotic orders weekly to ensure McGeer criteria is met. · DON/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months.	

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	1/17/23. The documentation indicated the UTI met the criteria and an antibiotic was ordered. Interview with the Infection Preventionist on 2/2/23 at 1:15 p.m., indicated the NP had ordered the antibiotic based on the husband's comments about wanting to send his wife to the hospital for increased fatigue. She had checked the UTI met the criteria and it was a mistake because it was not a true UTI. 3.1-18(b)(1)		Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. **Date of compliance: 02/24/2023**	
F 9999 Bldg. 00	3.1-14 PERSONNEL (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (6) Care of cognitively impaired residents. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure annual dementia training was	F 9999	Education completed for dementia training for all staff.	02/24/2023

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	completed for 5 of 10 employee records reviewed. (LPN 2, Maintenance 1, CNA 4, QMA 2, Laundry 1) Finding includes: The employee records were reviewed on 2/2/23 at 11:45 a.m. LPN 2, Maintenance 1, CNA 4, QMA 2, and Laundry 1 had not completed any dementia training for 2022. Interview with HR 1 on 2/2/23 at 1:25 p.m., indicated staff were given an initial test and if they passed, then they were not required to complete any further dementia training. The annual dementia training had not been completed.			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Complaints IN00398131 and IN00399166. Complaint IN00398131 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677 and F692. Complaint IN00399166 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684 and F697. Survey dates: January 29, 30, and 31 2023, and February 1, 2, and 3, 2023. Facility number: 013462 Residential Census: 22	R 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.	

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	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 2/9/23.			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure there was one staff member with a current first aid certificate scheduled for 13 of 21 shifts reviewed. Finding includes: Facility staffing schedules for 1/28/23 through	R 0117	**R117 Personnel** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · No residents suffered ill	02/24/2023

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	2/3/23 were reviewed on 2/3/23 at 8:45 a.m. The schedules indicated there were no staff members who were first aid certified on the following dates and shifts: Day shift on 2/2/23 and 2/3/23. Evening shift on 1/30/23, 1/31/23, 2/1/23, and 2/2/23. Midnight shift on 1/28/23, 1/29/23, 1/30/23, 1/31/23, 2/1/23, 2/2/23, and 2/3/23. Interview with HR 1 on 2/3/23 at 9:23 a.m., indicated she had no further first aid certificates to provide for review. Interview with the Assisted Living Director on 2/3/23 at 10:05 a.m., indicated she had a CPR/first aid certification class set up for March.		effects from this alleged deficient practice. **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. · Staff missing First Aid/CPR certification are scheduled for upcoming trainings. · First Aid Certified staff work in the skilled area of the building attached to our AL so staff were available at all times to provide first aid. · House audit completed of all employee files to identify staff members still in need of first aid training. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · First Aid/CPR training is currently scheduled for every Wednesday in the month of March.	

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			· First Aid/CPR certification documentation will be added to processing checklist to ensure documents are on file prior to employee start date. **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?** · HR/Designee will audit all new clinical hires weekly to ensure proper certifications are in place. · HR/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. **Date of compliance: 2/24/23**	
R 0120	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance			

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Bldg. 00	(e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure annual dementia training was completed for 3 of 5 employee records reviewed.	R 0120	**R120 Personnel – Non Compliance** **What corrective action(s) will**	02/24/2023

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	(CNA 1, LPN 1, CNA 2) Finding includes: The employee records were reviewed on 2/2/23 at 11:45 a.m. CNA 1, LPN 1, and CNA 2 had not completed any dementia training for 2022. Interview with HR 1 on 2/2/23 at 1:25 p.m., indicated staff were given an initial test and if they passed, then they were not required to complete any further dementia training. The annual dementia training had not been completed.		**be accomplished for those residents found to have been affected by the deficient practice?** · No residents suffered ill effects from this alleged deficient practice. **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. · CNA 1, LPN 1, and CNA 2 have all completed their required dementia training. · House audit completed of all employee files to identify staff members still in need of dementia training. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Monthly dementia training will occur the 3rd Tuesday of every month. · Dementia training is included in every orientation	

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			schedule for all new hires. **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?** · HR/Designee will ensure all new hires receive dementia training during orientation. · HR/Designee will audit employees monthly to ensure annual dementia training is completed based off of hire date. · HR/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. **Date of compliance: 2/24/23**	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs			

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	assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to complete Semi-Annual evaluations as well as a recorded weight twice a year for 4 of 7 residents reviewed. (Residents 4, 2, 5, and 3) Findings include: 1. Resident 4's record was reviewed on 2/2/23 at 2:00 p.m. Diagnoses included, but were not limited to, dementia and anxiety. The most recent Semi-Annual Evaluation was completed on 2/14/21. Interview with the Assisted Living Director on 2/3/23 at 10:31 a.m., indicated she was unable to provide any documentation of an updated Semi-Annual Evaluation. 2. Record review for Resident 2 was completed on 2/2/23 at 9:53 a.m. Diagnoses included, but were not limited to, congestive heart failure and type 1 diabetes mellitus. A Senior Living Level of Care Evaluation was completed on 8/9/21. There were no further Semi-Annual Evaluations completed. A weight was recorded for the resident on	R 0216	**R216 – Evaluation – Non compliance** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Residents 4, 5, and 3 all have updated semi-annual evaluations and current weight in place. R2 no longer resides in facility. · No residents suffered ill effects from this alleged deficient practice. **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.	02/24/2023

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	12/13/21. There were no further weights documented. Interview with the Assisted Living Director on 2/3/23 at 10:05 a.m., indicated she had recently taken the Director position and was unable to provide any further documentation. She had now obtained the resident's weight and completed an evaluation. 3. Record review for Resident 5 was completed on 2/2/23 at 1:53 p.m. Diagnoses included, but were not limited to, hypertension and asthma. The resident was admitted to the facility on 3/11/22. There was a lack of documentation any Senior Living Level of Care Evaluations had been completed. Interview with the Assisted Living Director on 2/3/23 at 10:05 a.m., indicated she had recently taken the Director position and was unable to provide any further documentation. She had now completed an evaluation.4. Resident 3's record was reviewed on 2/2/23 at 10:52 a.m. Diagnoses included, but were not limited to, Parkinson's disease, major depressive disorder, and high blood pressure. The resident was admitted to the facility on 1/15/15. The most recent Semi-Annual Evaluation was completed on 11/3/15. Interview with the Assisted Living Director on 2/3/23 at 10:31 a.m., indicated she was unable to provide any documentation of an updated Semi-Annual Evaluation.		· House audit completed to ensure all semi annual evaluations are completed and current weight is up to date. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · AL Director educated on ensuring weights are documented 2xs a year on all residents and semi annual evaluations are completed. **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 audit all new admissions to ensure evaluation and weight is in place upon admission. · Administrator/Designee will audit 3 charts a week to ensure semi evaluation and weights are up to date. · Administrator/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that	

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			further monitoring is needed, audits will continue. **Date of compliance: 02/24/23**	
R 0275 Bldg. 00	410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires. Based on record review and interview, the facility failed to ensure a Physician's Order was obtained for a resident's diet for 2 of 7 sampled residents. (Residents 2 and 5) Findings include: 1. Record review for Resident 2 was completed on 2/2/23 at 9:53 a.m. Diagnoses included, but were not limited to, congestive heart failure and type 1 diabetes mellitus. There was lack of documentation of any Physician's Orders for a diet. Interview with the Assisted Living Director on 2/3/23 at 10:05 a.m., indicated she had recently taken the Director position and was unable to provide any further documentation. She had now obtained the resident's diet order. 2. Record review for Resident 5 was completed on 2/2/23 at 1:53 p.m. Diagnoses included, but were not limited to, hypertension and asthma.	R 0275	**R275 – Food and Nutritional Services** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · R2 no longer resides in facility. · Physician order was obtained for R5 diet immediately. · No residents suffered ill effects from this alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**	02/24/2023

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	There was lack of documentation of any Physician's Orders for a diet. Interview with the Assisted Living Director on 2/3/23 at 10:05 a.m., indicated she had recently taken the Director position and was unable to provide any further documentation. She had now obtained the resident's diet order.		· All residents have the potential to be affected by this alleged deficient practice. · House audit completed to ensure residents have physician order for diet in place. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · AL Director educated on ensuring all residents have accurate diet order in place upon admission and updated as needed. **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 audit all new admissions weekly to ensure physician order for diet is in place. · Administrator/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue.	

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	02/03/2023

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			Date of compliance: 2/24/23	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to discharge documentation for 1 of 2 closed records reviewed. (Resident 7) Finding includes: The record for Resident 7 was reviewed on 2/2/23 at 1:52 p.m. Diagnoses included, but were not limited to, aftercare following joint replacement surgery, type 2 diabetes, stage 3 pressure ulcer, and depression. Discharge instructions were dated 1/25/23, however, there was no documentation of where the resident went. There was no documentation in the Nurses' Notes	R 0349	**R349 – Clinical Records** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · R7 no longer resides in facility. · Residents suffered no ill effects from alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**	02/24/2023

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	related to the resident's discharge. Interview with the Assisted Living Director on 2/3/23 at 10:05 a.m., indicated the resident was transferred to another assisted living facility and documentation should have been completed.		· All residents have the potential to be affected by this alleged deficient practice. · All discharges from the last 30 days were audited to ensure discharge location was documented. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · AL Nursing staff educated on ensuring discharge location is documented in residents 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?** · Administrator/Designee will audit all AL discharges weekly to ensure discharge location is documented in EMR. · Administrator/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue.	

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			Date of compliance: 2/24/23	