STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 00 B. WING	08/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 27, 28, 29, August 1, and 2, 2022 Facility number: 000537 Provider number: 155409 AIM number: 100267270 Census Bed Type: SNF/NF: 71 Total: 71 Census Payor Type: Medicare: 13 Medicaid: 50 Other: 8 Total: 71 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 4, 2022.	F 0000	August 17, 2022 Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by Federal and State law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during the Recertification and Licensure Survey on August 2, 2022. Please accept this plan of correction as the provider's credible allegation of compliance. We respectfully request a desk review.	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care			

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

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	plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. Based on interview and record review, the facility failed to ensure a pneumonia baseline care plan was developed and implemented, within 48 hours	F 0655	**F655 (D)** **What corrective action(s) will be accomplished for those**	09/21/2022

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	of diagnosis, for 1 of 5 residents reviewed for baseline care plan development and implementation. (Resident 43) Findings include: Resident 43's clinical record was reviewed on 8/1/22 at 9:08 a.m. Resident 43 was admitted to the facility on 11/29/21. The diagnosis included, but was not limited to, viral pneumonia. The viral pneumonia diagnosis had a start date of 11/26/21. A Physician's note, dated 12/3/21 at 11:57 a.m., indicated Resident 43 was prescribed Levaquin (antibiotic) tablet 500 mg (milligram) daily for 5 days for pneumonia. The Medication Administration Record indicated Resident 43 received one Levaquin 500 mg tablet on December 4, 5, 6, 7, and 8, 2021 for the treatment of pneumonia. The modification of the Admission MDS (Minimum Data Set) assessment, dated 12/3/21, indicated Resident 43 had an active diagnosis of pneumonia. Resident 43's nursing progress note, dated 12/3/21 at 11:00 a.m., indicated "...Resident had chest x-ray completed with results stating right mid lung atelectasis [complete or partial collapse of a lung]...n.o. [new order] for Levaquin 500 mg PO [administer orally] daily x5 days [for 5 days]..." Resident 43's care plan, date initiated on 12/8/21, revised on 3/1/22, and date canceled 3/1/22, indicated "...Resident [43] has pneumonia..." Resident 43's care plan, date initiated 12/8/21, revised on 3/1/22, and date canceled 3/1/22,		**residents found to have been affected by the deficient practice?** The care plan for resident 43 has been reviewed and updated to include a baseline care plan for pneumonia. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The MDS Coordinator will review admitting diagnoses and coordinate a baseline care plan with the IDT that reflects the resident's current needs and meets professional standards of quality. This will be an ongoing practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The DON or designee will reeducate the Interdisciplinary Team (IDT) and the nurses on the policy and procedure for development and completion and development of baseline care plans within 48 hours of admission. **(Attachment A)** The Minimum Data Set	

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	indicated "...Resident [43] is on antibiotic therapy r/t [due to] infection pna [pneumonia]..." During an interview on 8/2/22 at 8:40 a.m., the Director of Nursing Services (DNS) indicated Resident 43 was admitted with a diagnosis of pneumonia; however she was unsure if it was an active diagnosis at the time of admission. The DNS indicated chest X-rays were taken on 12/2/21 and again on 12/3/21 which indicated Resident 43 had pneumonia. Resident 43 was started on Levaquin for the treatment of pneumonia. Resident 43's pneumonia baseline care plan should have been started within 48 hours of the pneumonia diagnosis. Resident 43's clinical record lacked supporting documentation that a pneumonia baseline care plan was developed and implemented within 48 hours of being diagnosed with and treatment of pneumonia. On 8/2/22 at 9:10 a.m., the Administrator provided a copy of the Baseline Care Plan Assessment/Comprehensive Care Plans policy, dated 9/18/18, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...it is the policy of the facility to ensure that every resident has a baseline care plan completed and implemented within 48 hours of admission...the baseline care plan will be updated with changes in risk factors, goals and interventions until the comprehensive care plan is completed...at a minimum, it will address initial goals based on admission orders, physician orders...observations, interviews with the resident...information obtained from the physician as well as review of the available medical records on admission will be reference points for development of the baseline care plan		Coordinator (MDS)/nurse manager will review admitting diagnosis and coordinate a baseline care plan with the interdisciplinary team that reflects the resident's current needs and meets professional standards of quality. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Baseline care plan audits will be conducted by the MDS Coordinator/designee weekly times 8 weeks, then monthly times 4 months to validate compliance with federal and state law. The results of the audit will be reviewed, reported and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter until substantial compliance is achieved. (Attachment A-1)	

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	assessment." 3.1-30(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to implement new interventions to prevent falls for 2 of 5 resident reviewed for falls. (Resident 7, Resident 22) Findings include: 1. On 7/29/22 at 10:42 A.M., Resident 7 was observed in bed. The bed was not in the lowest position and the call light was observed to be out of reach at the foot of the bed hanging off the footboard by about 2 feet. On 7/29/22 at 12:50 P.M., Resident 7 was observed sitting in a wheelchair with a meal tray on the bedside table. The call light was out of resident's reach on his bed approximately 5 feet away, the bedside floor mat was between the resident and the call light. On 8/1/22 at 10:05 A.M., Resident 7 was observed resting in bed. The bed was not in lowest position.	F 0689	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The care plans for residents 7 and 22 have been reviewed and updated to include new interventions to prevent falls. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken**? Residents who are “at risk” to fall have the potential to be affected by this deficient practice. The MDS Coordinator and/or designee will audit current resident records noted to be “at risk” for falls to ensure the clinical record are	09/21/2022

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	On 7/28/22 at 9:00 A.M., Resident 7's clinical record was reviewed. The Significant Change MDS (Minimal Data Set) assessment, dated 4/23/22, indicated Resident 7 had moderate cognitive impairment. The MDS assessment further indicated that the resident was a fall risk with a history of falls. A current care plan for falls, revised 12/23/21, included the following interventions: Attempt to keep areas clutter free, initiated 12/9/19. Keep call light in reach when in room, initiated 12/9/19. Encourage resident to use call light to seek assistance, initiated 12/9/19. Offer toileting as needed, initiated 12/9/19. Refer to therapies as needed, initiated 12/9/19. Therapy evaluation for enabler bar, initiated 6/8/20. Offer to assist to bed before and after meals prn (as needed), initiated 8/8/21. Nursing to order labs, initiated 11/23/21. Therapy to evaluate for safe transfers, initiated 11/23/21. Educate staff to remind resident to wear non slip socks while out of bed or self propelling in the wheelchair, initiated 12/6/21. Keep bed in lowest position, initiated 12/23/21. Staff to safely assist resident to sleep safely in preferred place bed or floor, initiated 12/23/21. Fall matt to side of bed, initiated 2/14/22. Staff to encourage resident not to self transfer, initiated 2/14/22. Therapy to screen, initiated 2/14/22. Apply larger mattress to bed, initiated 2/24/22. A progress note, dated 9/26/21 at 10:13 A.M., indicated Resident 7 had an unwitnessed fall in the room and demonstrated facial grimacing when		accurate and current for fall prevention. Any deficiencies noted will be corrected. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The DON or designee will reeducate the Interdisciplinary Team (IDT) and nursing staff on the policy and procedure for Falls Prevention including safety observations and implementation of new interventions to prevent falls. **(Attachment B)** As an ongoing measure, the IDT will continue to review falls in the morning meeting and at stand down to ensure implementation and documentation of fall intervention and communication to line staff. Communication may be relayed via care plan updates, Point Click Care (PCC) task or CNA assignment sheets. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Fall care plan audits will be conducted by the DON/designee weekly times 8 weeks, then	

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	moving extremities. Resident 7 denied pain. Resident 7 was sent out to the hospital for evaluation as a result of this fall. No new interventions were implemented after this fall. A progress note, dated 9/26/21 at 8:50 P.M., indicated Resident 7 had an unwitnessed fall without injury. The bed was noted to be in high position. No new interventions were implemented after this fall. A progress note, dated 11/3/21 at 5:52 A.M., indicated Resident 7 had an unwitnessed fall without injury and was found lying next to the bed. No new interventions were implemented after this fall. A progress note, dated 3/25/22 at 11:30 A.M., indicated Resident 7 had an unwitnessed fall and was lying on the floor under wheelchair. Resident 7 was sent out to the hospital for evaluation as a result of this fall. No new interventions were implemented after this fall. A progress note, dated 4/13/22 at 8:16 A.M., indicated Resident 7 fell out of the chair. Resident 7 said his head was hurting badly. Resident 7 was sent out to the hospital for evaluation as a result of this fall. No new interventions implemented after this fall. A progress noted, dated 5/27/22 at 2:59 A.M., indicated Resident 7 had an unwitnessed fall and was found next to the bed with a small area to bottom lip. No new interventions were implemented after this fall. During an interview on 8/2/22 at 11:40 A.M., the Administrator indicated that IDT (Interdisciplinary Team) meetings occurred the day after the fall and		monthly times 4 months to validate compliance with federal and state law. The results of the audit will be reviewed, reported and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter until substantial compliance is achieved. (Attachment B-1) Fall Intervention observations will be conducted by the DON/designee weekly times 8 weeks, then monthly times 4 months to validate compliance with federal and state law. The results of the audit will be reviewed, reported and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter until substantial compliance is achieved. (Attachment B-2)	

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	that interventions discussed at the IDT meetings were then placed on care plans after a fall, she stated care plans were typically updated the next day after a fall occurs. 2. On 7/27/22 at 1:15 P.M., Resident 22's clinical record was reviewed. The Quarterly MDS assessment, dated 5/28/22, indicated Resident 22 had moderate cognitive impairment. The MDS assessment further indicated that resident was a fall risk with a history of falls with injury. A current care plan for falls, revised 3/15/19, included the following interventions: Fall mat at bedside, initiated 3/15/19. Attempt to keep areas free of clutter, initiated 3/15/19. Keep call light in reach when in room, initiated 3/15/19. Encourage resident to use call light to seek assistance, initiated 3/15/19. Offer toileting as needed, initiated 3/15/19. Refer to therapies as needed, initiated 3/15/19. Notify and update physician and family as needed, initiated 3/15/19. Evaluate possible causes of falls and address issues to the extent possible, initiated 3/15/19. Staff to keep frequently used items in reach, initiated 5/31/22. Bed in lowest position, initiated 6/9/22. Reacher at bedside to assist resident to reach for commonly used items, initiated 6/9/22. A current care plan for resident scooting out of bed per resident preferences, initiated 3/8/22, included the following interventions: Assess for potential hazard and rearrange as needed, initiated 3/8/22. Provide comfort for resident while in preferred position, initiated 3/8/22.			

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	Staff to assist resident as needed safely to preferred position, initiated 3/8/22. Weekly skin checks by nurse, initiated 3/8/22. A progress note, dated 3/5/22 at 6:30 P.M., indicated Resident 22 had an unwitnessed fall in the dining room and was on the floor with blood on head and the floor and an injury to right eyebrow (care plan was updated for resident scooting out of bed per resident preferences on 3/8/22). A progress note, dated 5/22/22 at 10:25 P.M., indicated Resident 22 had a witnessed fall in the room when staff member entered and saw resident fall out of the chair and resulted in an abrasion to right forearm. An intervention was added to fall care plan on 5/31/22, resident fell again on 5/30/22. The new intervention was not initiated for 9 days after the fall. A progress noted, dated 5/30/22 at 1:42 P.M., indicated Resident 22 had an unwitnessed fall in room; Resident 22 was found lying on stomach with wheelchair on their back and resulted in a skin tear to right and left forearm, bruising to right eye, and an abrasion to forehead. Resident 22 was also sent out to hospital for evaluation as a result of this fall. An intervention was added to fall care plan on 6/9/22. The new intervention was not initiated for 10 days after the fall. During an interview on 8/2/22 at 11:40 A.M., the Administrator indicated that IDT (Interdisciplinary Team) meetings occurred the day after the fall and that interventions discussed at the IDT meetings are then placed on care plans after a fall, she stated care plans are typically updated the next day after a fall occurs.			

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	On 8/1/22 at 1:25 PM, the Administrator provided an undated policy titled "Incidents/Accidents/Falls" and indicated it was the policy currently in use by the facility. The policy included, but was not limited to, "11....Each fall needs a new intervention rolled out." 3.1-45(a)(2)			
F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on record review and interview, the facility failed to provide 8 continuous hours of Registered Nursing services seven days a week, for 30 of 31 days reviewed. Findings include: On 8/1/22 at 3:00 p.m., the Administrator provided a copy of the July 2022 Report of Nursing Staff Directly Responsible for Resident Care document. A review of the report indicated the following data	F 0727	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The facility is engaged in continual efforts to recruit and retain licensed nurses in order to comply with RN coverage dictated by CMS. These efforts are documented and available for review. No resident has been negatively impacted by this	09/21/2022

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	for each calendar day: facility census; shift hours: day (6:00 a.m. to 2:00 p.m.); evening (2:00 p.m. to 10:00 p.m.); and night (10:00 p.m. to 6:00 a.m.); number of Registered Nurses (RN) who worked that shift; and the number of hours worked. The July report indicated the following: On 7/1/22, during the night shift, one RN worked 2 of the required 8 continuous hours (10:00 p.m. to 12:00 a.m.) for that day. The facility census was 71. On 7/2/22, the report indicated one RN worked 6 of the required continuous hours (12:00 a.m. to 6:00 a.m.) for that day. The facility census was 71. On 7/4/22, the report lacked documentation to indicate any RN coverage was provided. The facility census was 70. On 7/5/22, the report lacked documentation to indicate any RN coverage was provided. The facility census was 71. On 7/6/22, during the night shift, one RN worked 2 of the required 8 continuous hours (10:00 p.m. to 12:00 a.m.) for that day. The facility census was 71. On 7/7/22, the report indicated one RN worked 6 of the required 8 continuous hours (from 12:00 a.m. to 6:00 a.m.) for that day. The report also indicated during the night shift one RN worked 2 of the 8 required continuous hours (10:00 p.m. to 12:00 a.m.) for that day. The facility census was 71. On 7/8/22, the report indicated one RN worked 6 of the required 8 continuous hours (from 12:00 a.m. to 6:00 a.m.) for that day. The report also		finding. **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 deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The facility will provide 8 continuous hours of Registered Nursing services 7 days per week. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** RN labor audits will be conducted by the ADON/designee weekly times 8 weeks, then monthly times 4 months to validate compliance with federal and state law. The results of the audit will be reviewed, reported and trended for compliance through the facility Quality Assurance Committee for	

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	indicated during the night shift one RN worked 2 of the 8 required continuous hours (10:00 p.m. to 12:00 a.m.) for that day. The facility census was 71. On 7/9/22, the report indicated one RN worked 6 of the required 8 continuous hours (from 12:00 a.m. to 6:00 a.m.) for that day. The report also indicated during the night shift one RN worked 2 of the 8 required continuous hours (10:00 p.m. to 12:00 a.m.) for that day. The facility census was 71. On 7/10/22, the report indicated one RN worked 6 of the required 8 continuous hours (from 12:00 a.m. to 6:00 a.m.) for that day. The report also indicated during the night shift one RN worked 2 of the 8 required continuous hours (10:00 p.m. to 12:00 a.m.) for that day. The facility census was 71. On 7/11/22, the report indicated one RN worked 6 of the required 8 continuous hours (from 12:00 a.m. to 6:00 a.m.) for that day. The facility census was 69. On 7/12/22, the report lacked documentation to indicate any RN coverage was provided. The facility census was 69. On 7/13/22, during the night shift, one RN worked 2 of the required 8 continuous hours (10:00 p.m. to 12:00 a.m.) for that day. The facility census was 69. On 7/14/22, the report indicated one RN worked 6 of the required 8 continuous hours (from 12:00 a.m. to 6:00 a.m.) for that day. The facility census was 69.		a minimum of 6 months then randomly thereafter until substantial compliance is achieved. (Attachment C)	

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	155409	A. BUILDING 00 B. WING	08/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

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	On 7/15/22, during the night shift, one RN worked 2 of the required 8 continuous hours (10:00 p.m. to 12:00 a.m.) for that day. The facility census was 69. On 7/16/22, report indicated one RN worked 6 of the required 8 continuous hours (from 12:00 a.m. to 6:00 a.m.) for that day. The report also indicated during the night shift one RN worked 2 of the 8 required continuous hours (10:00 p.m. to 12:00 a.m.) for that day. The facility census was 69. On 7/17/22, report indicated one RN worked 6 of the required 8 continuous hours (from 12:00 a.m. to 6:00 a.m.) for that day. The report also indicated during the night shift one RN worked 2 of the 8 required continuous hours (10:00 p.m. to 12:00 a.m.) for that day. The facility census was 69. On 7/18/22, the report indicated one RN worked 6 of the required 8 continuous hours (from 12:00 a.m. to 6:00 a.m.) for that day. The facility census was 69. On 7/19/22, the report lacked documentation to indicate any RN coverage was provided. The facility census was 71. On 7/20/22, during the night shift, one RN worked 2 of the required 8 continuous hours (10:00 p.m. to 12:00 a.m.) for that day. The facility census was 71. On 7/21/22, report indicated one RN worked 6 of the required 8 continuous hours (from 12:00 a.m. to 6:00 a.m.) for that day. The report also indicated during the night shift one RN worked 2 of the 8 required continuous hours (10:00 p.m. to 12:00 a.m.) for that day. The facility census was 70.			

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	On 7/22/22, report indicated one RN worked 6 of the required 8 continuous hours (from 12:00 a.m. to 6:00 a.m.) for that day. The report also indicated during the night shift one RN worked 2 of the 8 required continuous hours (10:00 p.m. to 12:00 a.m.) for that day. The facility census was 70. On 7/23/22, report indicated one RN worked 6 of the required 8 continuous hours (from 12:00 a.m. to 6:00 a.m.) for that day. The report also indicated during the night shift one RN worked 2 of the 8 required continuous hours (10:00 p.m. to 12:00 a.m.) for that day. The facility census was 71. On 7/24/22, report indicated one RN worked 6 of the required 8 continuous hours (from 12:00 a.m. to 6:00 a.m.) for that day. The report also indicated during the night shift one RN worked 2 of the 8 required continuous hours (10:00 p.m. to 12:00 a.m.) for that day. The facility census was 70. On 7/25/22, the report indicated one RN worked 6 of the required 8 continuous hours (from 12:00 a.m. to 6:00 a.m.) for that day. The facility census was 71. On 7/26/22, the report lacked documentation to indicate any RN coverage was provided. The facility census was 71. On 7/27/22, during the night shift, one RN worked 2 of the required 8 continuous hours (10:00 p.m. to 12:00 a.m.) for that day. The facility census was 71. On 7/28/22, the report indicated one RN worked 6 of the required 8 continuous hours (from 12:00 a.m. to 6:00 a.m.) for that day. The facility census was 71.			

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	On 7/29/22, during the night shift, one RN worked 2 of the required 8 continuous hours (10:00 p.m. to 12:00 a.m.) for that day. The facility census was 72. On 7/30/22, the report indicated one RN worked 6 of the required 8 continuous hours (from 12:00 a.m. to 6:00 a.m.) for that day. The facility census was 72. On 7/31/22, the report lacked documentation to indicate any RN coverage was provided. The facility census was 72. During an interview on 7/27/22 at 10:00 a.m., the Administrator indicated the facility census was 71. During an interview on 8/1/22 at 3:45 p.m., the Administrator indicated the Report of Nursing Staff Directly Responsible for Resident Care documents accurately reflected the RN's work hours. The Administrator indicated that not all of the days met the required 8 hours of continuous RN coverage. During an interview, on 8/2/22 at 8:40 a.m., the Director of Nursing Services (DNS) indicated as a RN, her hours worked were included in the daily 8 hours of continuous RN coverage. During an interview on 8/2/22 at 8:50 a.m., DNS indicated the Report of Nursing Staff Directly Responsible for Resident Care document indicated the number of hours the RN staff had worked each day and the facility's daily census. The DNS indicated the shift hours were from 6:00 a.m. to 2:00 p.m.; 2:00 p.m. to 10:00 p.m.; and 10:00 p.m. to the 6:00 a.m. When a RN staff member worked a 10:00 p.m. to 6:00 a.m. shift, 2 hours were logged as worked at the start of the shift and the			

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	remaining 6 hours were logged for the following morning to account for the RN's 8 hour shift. During an interview on 8/2/22 at 12:45 p.m., the Administrator indicated the facility lacked a specific policy that addressed the 8 hours of continuous RN coverage 7 days a week requirement. During the exit conference on 8/2/22 at 2:50 p.m., the Administrator and DNS indicated they had no additional documentation to present regarding the requirement of the 8 continuous hours of RN services to be provided seven days a week. On 8/2/22 at 12:42 p.m., the Administrator provided a copy of the Standard Supervision and Monitoring policy, dated 11/25/11, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...staff assignments are based on the resident "needs" as far as their acuity and their assessment results and their person-centered care planning. Therefore the requirements of meeting those needs to include physical, emotional, psychosocial, social and spiritual, will be accomplished by provision of as much "hands on" care as necessary,.." 3.1-17(b)(3)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer			

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	drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to document the drug disposition for 1 of 3 residents reviewed for discharge. (Resident 70) Finding includes: On 8/2/22 at 10:33 a.m., the clinical record of Resident 70 was reviewed. Resident 70 was admitted to the facility on 5/5/22 and was discharged from the facility on 5/8/22. A Physicians Order Summary Report, dated May 2022, indicated the following physician's orders:	F 0755	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 70 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**	09/21/2022

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	Atorvastin (a medication used to treat high cholesterol) 80 mg (milligram). Cyanocobalamin (Vitamin B) 1000 mcg (microgram). Famotidine (a medication used to treat indigestion) 20 mg. Folic acid (Vitamin B9) 1 mg. Lisinopril (a medication used to treat high blood pressure) 10 mg. Metformin (a medication used to treat Diabetes Mellitus) 500 mg. Nitroglycerin (a medication used to treat chest pain) 0.4 mg. Tamsulosin (a medication used to treat urinary retention) 0.4 mg. Thiamine (Vitamin B1) 100 mg. The clinical record lacked a completed drug disposition record. On 8/2/22 at 11:00 a.m., a policy for drug disposition was requested from the Director of Nursing. During an interview on 8/2/22 at 1:45 p.m., the Director of Nursing indicated Resident 70's drug disposition record was not available for review. and the facility did not have a process for the disposition of medications for discharged residents. The facility failed to provide a policy for drug disposition by the end of the survey. 3.1-25(s)		**corrective action will be taken?** Residents who discharge have the potential to be affected by this deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The DON or designee will reeducate the nurses on the policy and procedure for Documentation of Drug Disposition at the time discharge. **(Attachment D)** **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Audits of Drug Disposition Records will be conducted by the DON/designee weekly times 8 weeks, then monthly times 4 months to validate compliance with federal and state law. The results of the audit will be reviewed, reported and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter until substantial compliance is achieved. (Attachment D-	