STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155041	A. BUILDING 00 B. WING	01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHWEST MANOR HEALTH CARE CENTER	6440 W 34TH ST INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00398309. Complaint IN00398309 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: January 17, 18, 19 and 20, 2023. Facility number: 000015 Provider number: 155041 AIM number: 100273750 Census Bed Type: SNF/NF: 88 SNF: 7 Total: 95 Census Payor Type: Medicare: 9 Medicaid: 66 Other: 20 Total: 95 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 31, 2023.	F 0000	*Preparation and 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/or executed because it is required by the provisions of federal and state law.*	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.			

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

Bryce Reagan HFA | Administrator | 02/16/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on observation, interview, and record review, the facility failed ensure advanced	F 0578	**F-578** **SS- D** **It is the intention of Northwest**	02/20/2023

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	directives were legally signed and available on the resident record for 2 of 3 residents reviewed for advanced directives (Residents 198 and 202). Findings include: 1. On 1/17/23 at 11:03 a.m., Resident 198 was observed and interviewed as she rested in bed watching television. On 1/18/23 at 9:54 a.m., Resident 198's medical record was reviewed. The diagnoses included, but were not limited to chronic kidney disease, hypertension (high blood pressure) and hyperlipidemia (high cholesterol). A physician's order, dated 12/29/22, indicated Do Not Resuscitate (DNR). Resident 198 did not have an advanced directive document in the medical record. Documentation was requested. On 1/19/23 the Executive Director (ED) provided an out of hospital do not resuscitate order and declaration form for Resident 198. The form was dated 1/19/23 and signed by the resident, 2 witnesses and the physician on 1/19/23. 2. On 1/17/23 at 11:29 a.m., Resident 202 was observed and interviewed as he was seated in a wheelchair in his room watching television. The resident was somewhat confused. He did not know how long he had been at the facility and kept asking what he was supposed to do next. On 1/17/23 at 1:55 p.m., Resident 202's medical record was reviewed. The diagnoses included, but were not limited to, urinary tract infection, sepsis (infection in the blood stream), encephalopathy		**Manor Health Care Center to ensure advance directives are completed legally and present on a resident's record.** **1. What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** *Advance directives were verified by the resident and/or resident representative for both residents identified during the survey. The facility verified the appropriate Physician orders, Advance Directive forms and care plans are in place according to the resident's choice.* **2. How other resident having the potential to be affected by the same deficient practice will be identified and that corrective action(s) will be taken:** *An audit was completed to ensure physician orders, Advance Directive forms and care plans were in place and in compliance.* **3. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur:** *The facility will provide education to staff completing Advance Directive forms to ensure compliance with proper execution of required forms. Social Service Director or designee will complete an admission audit to ensure the*	

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	(deterioration of the brain), kidney failure and malignant neoplasm of the prostate (cancer). Resident 202 had an out of hospital do not resuscitate declaration order, dated 1/5/23. The document indicated it had been obtained over the telephone with Resident 202's court appointed guardian. The document had a place for 2 witness signatures, but only had one witness signature. The physician signature was dated 1/5/23. On 1/20/23 at 10:16 a.m., during an interview, the Director of Nursing (DON) indicated Residents 198 and 202 should have had all DNR documents and care plans in the medical record. She did not know if an out of hospital do not resuscitate order taken over the phone required 2 witness signatures, she would have to check the policy. On 1/20/23 at 9:00 a.m., the ED provided a current, undated policy, titled "Do not Resuscitate Orders." This policy indicated "...The facility will document in the resident's record whether or not he or she has an executed DNR. When the resident has executed a DNR, a copy of that document will be made part of the resident's record....." 3.1-4(d) 3.1-4(l)(4) 3.1-38(f)		*resident's right to formulate an advance directive was upheld. The audit will ensure if the resident chooses to formulate an advance directive, it is executed and documented in accordance with federal and state regulations. Director of Nursing or designee will complete an audit to ensure appropriate Physician's orders are obtained and care plans are developed to uphold the resident's choices. Whenever a resident wishes to implement new advance directives or change advance directives already in place, an advance directive audit will be completed by the interdisciplinary clinical team to ensure advance directives are documented in accordance with federal and state regulations and facility policy. The audit process will begin 2/17/2023.* **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** *The admission advance directive audit will be ongoing by the Social Service Director and interdisciplinary clinical team. The audit results will be reviewed during the clinical portion of the department head meeting. Any documentation identifying residents with new advance directives or a change in advance directives will be identified in the*	

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			facility clinical meeting. Then an audit will be completed to ensure the advance directive form of choice was completed legally, physician's orders were obtained, and choices were added to the resident's care plan. The weekly audit log, maintained by the Social Service Director or designee, will be reviewed with the Administrator weekly for one month, then twice a month for 2 months and then monthly for 3 months. The weekly audit log will be presented in monthly QAPI meetings with an expected compliance of 100%. Social Service Director or designee will complete a monthly advance directive audit involving at least 10% of the facility residents and results will be reported in monthly QAPI meetings for 6 months with an expected compliance of 100%. The expect compliance rate established by the QAPI team is 100%. If the threshold falls below the target, the monitoring will continue until a pattern of compliance is established with 3 consecutive months of 100%. This monitoring process will begin 2/20/2023. 5. **By what date the systemic changes will be completed:** 2/20/2023	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments.			

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	The assessment must accurately reflect the resident's status. Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set (MDS) assessments were accurately coded for 3 of 19 residents reviewed for MDS accuracy (Residents 59, 45 and 79). Findings include: 1. Resident 59's medical record was reviewed on 1/19/23 at 8:00 a.m. His diagnoses included, but were not limited to retention of urine, urinary tract infection, cerebral infarction (stroke), vision deficit, and sepsis (a serious condition resulting from the presence of harmful microorganism in the blood or other tissue). Resident 59 had a Notice of PASRR level II outcome dated 1/17/2020. The PASSR indicated Resident 59 required a level II due to diagnoses of bipolar disorder, anxiety disorder, depressive disorder, and history of alcohol abuse. His comprehensive MDS, dated 7/20/22, indicated he was not currently considered by the State level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. 2. Resident 45's medical record was reviewed on 1/19/23 at 10:04 a.m. His diagnoses included but were not limited to cerebral infarction (stroke), protein-calorie malnutrition, major depressive disorder, heart disease, vascular dementia, spinal stenosis (this happens when the space inside the backbone spine is too small, placing pressure on the spinal cord and nerves) and flexion deformity of the left hip (the hip cannot be straightened actively or passively.	F 0641	**F 641** **SS- D** **It is the intention of Northwest Manor Health Care Center to complete an assessment to accurately reflect the resident status.** **1. What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** *A MDS correction was made and submitted upon finding the identified inaccuracies on each resident identified during the survey.* **2. How other resident having the potential to be affected by the same deficient practice will be identified and that corrective action(s) will be taken:** *A MDS audit was completed with an MDS auditor to ensure MDS accuracy for sections related to the inaccuracies found. No other inaccuracies were found.* **3. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur:** *MDS auditor or designee will proof MDS assessment sections during their routine visit. Substantial*	02/20/2023

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	Resident 45 was receiving hospice services through a local hospice company. He was admitted to hospice on 1/22/22. His MDS, dated 11/2/22, did not indicate that he was receiving hospices services. His care plan, dated 1/3/22, indicated he was receiving hospice services related to severe protein calorie malnutrition and vascular dementia. During an interview with the MDS Coordinator, on 1//19/23 at 10:24 a.m., she indicated she was not aware that Resident 59 had a level II. She indicated she would provide a corrected MDS for Resident 59 to reflect he had a level II. During the interview regarding the lack of coding for a fall for Resident 47 and lack of coding hospice for Resident 45; the MDS Coordinator indicated "It is what it is, I guess." The MDS Coordinator indicated she would follow up if she had any additional documentation. 3. During an interview, on 1/17/23 at 10:59 a.m., Licensed Practical Nurse (LPN) 4 indicated Resident 79's Foley catheter was out, and had been out for a while. On 1/18/23 at 9:08 a.m., during an observation of Resident 79 while up in her Broda chair, no Foley catheter bag was observed. An unidentified staff member who was on the medication cart, indicated her Foley catheter was out. During a conversation, on 1/18/23 at 3:00 p.m., the MDS Coordinator (MDSC) indicated the most recent MDS (Minimum Data Set) sent indicated Resident 70 had an indwelling catheter with treatment. She reviewed Resident 79's chart and indicated the indwelling Foley catheter was removed on 11/1/22, and it should not have been on the 1/6/23 MDS.		*compliance is defined as 95% accurate for 3 months. The audit process was started on 1/31/2023.* **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** *MDS coordinator or designee will present results of MDS audits in the Quality Assurance Performance Improvement committee meetings monthly. The expected accuracy rate will be 100% for 3 months or 3 MDS auditor visits. The acceptable compliance rate established by the QAPI team is 95%. If the 95% -100% threshold is met, the monitoring will end after 3 months of substantial compliance. If the threshold falls below the target, monitoring will continue until substantial compliance is establish for 3 consecutive months or 3 MDS auditor visits.* 5. **By what date the systemic changes will be completed:** 2/20/2023	

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	On 1/20/23 at 1:46 p.m., the Director of Nursing (DON) indicated the process used by the facility was to have all physician's orders reviewed, the original was saved for the physician to sign, and the yellow copy was to update the care plans and then all orders go to MDS for them to do updates. On 1/19/23 at 12:41 p.m., the MDSC provided Section Z from the MDS. It indicated, " ...I certify that the accompanying information accurately reflects resident assessment information for this resident ...As a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information ...." On 1/19/23 at 12:41 p.m., the MDSC provided a page from, "CMS's RAI Version 2.0 Manual." A review indicated, "Federal requirements ...required that facilities use an RAI that has been specified by the State. The assessment system provides a comprehensive, accurate, standardized, reproducible assessment of each long-term care facility resident ...." 3.1-31(i)			
F 0656 SS=E Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and			

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	psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.			

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	Based on observation, interview, and record review, the facility failed to ensure comprhensive care plans were initiated and implement for 6 of 19 residents reviewed for comprehensive care planning (Residents 1, 46, 45, 198, 202, and 5). Findings include: 1. Resident 1's medical record was reviewed on 1/9/23 at 2:49 p.m. She was admitted on 9/21/22. Her diagnoses included, but were not limited to fracture of right femur, chronic kidney disease, major depressive disorder, chronic heart failure, hypothyroidism, and protein-calorie malnutrition. Resident 1's Minimum Data Set (MDS), dated, 10/2/22 indicated she received extensive assistance with bed mobility. Her side rail assessment, dated 9/21/22, indicated she used her side rails as an enabler (the rail is used to promote independence with bed mobility). During an observation on 1/18/23 at 10:25 a.m., Resident 1 was observed lying on her right side in bed with her eyes closed. She had a half side rail on both sides of her bed. During an observation on 1/19/23 at 9:10 a.m., Resident 1 was observed lying on her right side with her eyes closed. She had a half side on both sides of her bed. Resident 1's care plan lacked a problem, goal, and interventions to address the use of side rails. 2. Resident 46's medical record was reviewed on 1/19/23 at 11:59 a.m. She was admitted on 12/9/22. Her diagnoses included, but were not limited to epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures),	F 0656	**F 656** **SS- E** **It is the intention of Northwest Manor Health Care Center to ensure comprehensive care plans are initiated and implemented in a timely manner.** **(1) What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** The Facility completed a review of the comprehensive care plan for each of the residents identified with deficient care plans. Care plans were updated and amended to ensure compliance with the current plan of care. **(2) How other resident having the potential to be affected by the same deficient practice will be identified and that corrective action(s) will be taken:** The facility will complete a review of the comprehensive care plans for each resident in the facility. **(3) What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur:** Director of Nursing or designee will review physician orders in the clinical department meeting. Care plans are reviewed and amended in the meeting as needed according to physician orders or	02/20/2023

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	pneumonia (an infection of the lungs), acute embolism of deep veins of the lower extremities, anorexia (an eating disorder), autistic disorder (a broad range of conditions characterized by challenges with social skills, repetitive behaviors, speech and non-verbal communication), contracture of muscle, multiple sites (permanent tightening of the muscles, tendon, skin and nearby tissues that causes the joints to shorten and become very stiff) and pressure ulcer of sacral region. Resident 46's MDS, dated 10/2/22, indicated she was dependent on two persons with bed mobility. Her side rail assessment, dated 12/13/22, indicated she used her side rails as an enabler. During an observation on 1/16/23 at 9:30 a.m., Resident 46 was observed lying in bed, facing her window. She was holding a stuffed animal. She has a low air loss mattress. She had her eyes opened, but she was non-verbal. She had one half side rails on both sides of her bed. During an observation on 1/19/23 at 10:16 a.m., Resident 46 was non-verbal. She was observed lying on her left side, holding a small stuffed animal in her right hand. She was able to make eye contact. She had one half side rails on both sides of her bed. Resident 46's care plan lacked a problem, goal, and interventions to address the use of side rails. 3. Resident 45's medical record was reviewed on 1/19/23 at 10:04 a.m. He was admitted on 5/9/21. His diagnoses included, but were not limited to cerebral infarction (stroke), protein-calorie malnutrition, major depressive disorder, heart disease, vascular dementia, spinal stenosis (this		care issues identified during the clinical review. Comprehensive care plans will be updated weekly according to the MDS assessments by Unit Managers, other Nursing management, or designee. The list of completed care plan updates will be returned to the Administrator weekly. **(4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** The weekly care plan update lists will be reviewed weekly by the Administrator or designee for a period of three months. A comprehensive care plan audit will be completed monthly on ten percent of the facility residents for a period of three months. The audit process will start on 2/20/23. The compliance rate is expected to be 100%. The acceptable compliance rate, established by the QAPI team is 90%. If the 90% -100% threshold is met, the monitoring will end after 3 months of substantial compliance. If the threshold falls below the target, the monitoring will continue without a stop date. A pattern of compliance will be established with 3 consecutive months of 90% -100%. **By what date the systemic changes will be completed:**	

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	happens when the space inside the backbone is too small, placing pressure on the spinal cord and nerves) and flexion deformity of the left hip. His MDS dated 11/2/22 indicated he was dependent on two persons for bed mobility. His side rail assessment, dated 11/15/22, indicated he was able to use the grab bars as an enabler. Resident 45 was observed on 1/17/23 at 9:38 a.m., lying in bed with his head pushing against a pad attached to his grab bar on the right side of his bed. He had an unpadded grab bar on the left side of the bed. He was unable to reposition himself in bed. Resident 45 was observed on 1/19/23 at 2:15 p.m. He was sitting up in his reclining chair. His head was leaning into the padded frame of the chair. He was unable to reposition in the chair. Resident 45's care plan lacked a problem, goal, and interventions to address the use of grab bars. During an interview on 1/20/23 at 9:40 a.m., with the Owner, Administrator and Director of Nursing, the DON indicated that Residents 1, 45 and 46 could use their rails as an enabler. The DON indicated the resident's medical record lacked a care plan to address the side rails on resident's bed. During an interview on 1/20/23 at 11:05 a.m., the DON indicated she would have Resident 46's one half rails changed to a grab bar. The DON demonstrated that Resident 46 could hold onto her bed rail. The DON demonstrated that Resident 45 could hold a blanket and shake her hand to indicate he could hold his grab bars, because he was able to grasp with his hand4. On		2/20/2023	

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	1/17/23 at 11:03 a.m., Resident 198 was observed and interviewed as she rested in bed watching television. On 1/18/23 at 9:54 a.m., Resident 198's medical record was reviewed. The diagnoses included, but were not limited to chronic kidney disease, hypertension (high blood pressure) and hyperlipidemia (high cholesterol). A physician's order, dated 12/29/22, indicated DNR, do not resuscitate. Resident 198 did not have an advanced directive care plan. On 1/19/23 the Executive Director provided an out of hospital do not resuscitate order and declaration form for Resident 198. The form was dated 1/19/23. 5. On 1/17/23 at 11:29 a.m., Resident 202 was observed and interviewed as he was seated in a wheel chair in his room watching television. The resident was somewhat confused. He did not know how long he had been at the facility and kept asking what he was suppose to do next. On 1/17/23 at 1:55 p.m., Resident 202's medical record was reviewed. The diagnoses included, but were not limited to, urinary tract infection, sepsis (infection in the blood stream), encephalopathy (deterioration of the brain), kidney failure and malignant neoplasm of the prostate (cancer). Resident 202 had a out of hospital do not resuscitate declaration order, dated 1/5/23. Resident 202 did not have an advanced directive care plan.			

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	On 1/20/23 at 10:16 a.m., during an interview, the Director of Nursing (DON) indicated Residents 198 and 202 should have had all DNR documents and care plans in the medical record. 6. On 1/19/23 at 2:16 p.m., Resident 5's record was reviewed. She was admitted on 5/5/22. Her diagnoses included, but were not limited to, chronic respiratory failure (failure of the lungs to bring in enough oxygen and eliminate carbon dioxide), and cerebral infarction (stroke). Her physician's orders included, but were not limited to, administer 4 L oxygen via NC every shift, dated 7/22/22 and change oxygen tubing weekly, dated 7/24/22. Resident 5 did not have an oxygen care plan. On 1/19/23, the facility provided one, it indicated to administer oxygen, change the oxygen tubing per protocol and provide humidification. During an interview, on 1/20/23 at 1:52 p.m., the Director of Nursing (DON) indicated when a physician's order comes through, she reviewed it and it was mentioned in clinical morning meeting. The orders were distributed, reviewed, and an assessment would be completed. Recently, the facility added more assistance with physician orders with the DON writing further notes on the orders as PRN (as needed) reminders. All management staff wrote care plans. It was human error that Resident 5's oxygen care plan was missed.			
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			

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	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 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, interview, and record review, the facility failed to ensure comprehensive care plans were revised and/or updated for 4 of 19 residents reviewed for comprehensive care planning (Residents 23, 45, 59 and 83). Finding include: 1. Resident 23's medical record was reviewed on 1/19/23 at 2:10 p.m. Her diagnoses included, but were not limited to, hyperlipidemia (high cholesterol), hypothyroidism	F 0657	**F 657** **SS= E** **It is the intention of Northwest Manor Health Care Center to ensure comprehensive care plans are revised and updated in a timely manner.** **1. What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** The Facility completed a review of	02/20/2023

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	(abnormally low activity of the thyroid gland), osteoarthritis, anxiety, anemia, depression, and acute embolism of the deep veins of the upper extremity. Resident 23 had a care plan, dated 5/21/21, addressing an acute UTI (Urinary Tract Infection). Her medical record lacked evidence of a UTI. Her care plan, dated 5/21/21, indicated she received two diuretics. Her physician orders lack orders for diuretic medications. Her Minimum Data Set (MDS), dated 10/19/22, indicated she did not receive any diuretics during the assessment period. Her care plan, dated 5/21/21, indicated she had difficulty with sleep due to insomnia. An intervention included to monitor the effectiveness of medication therapy. Her medication orders lacked an order for a medication to treat insomnia. Her MDS dated 1/19/22 did not indicate she received medication to treat insomnia during the assessment period. Her care plan, dated 5/21/21, indicated she received an anticoagulant medication. Her physician's orders lacked an order for an anticoagulant medication. Her MDS dated 10/19/22 did not indicate she received an anticoagulant during the assessment period. 2. Resident 45's medical record was reviewed on 1/19/23 at 10:04 a.m. His diagnoses included but were not limited to cerebral infarction (stroke), protein-calorie malnutrition, major depressive disorder, heart disease, vascular dementia, spinal stenosis (this happens when the space inside the backbone is too small, placing pressure on the spinal cord and nerves), and flexion deformity of		the comprehensive care plan for each of the residents identified with deficient care plans. Care plans were updated and amended to ensure compliance with the current plan of care. **2. How other resident having the potential to be affected by the same deficient practice will be identified and that corrective action(s) will be taken:** The facility will complete a review of the comprehensive care plans for each resident in the facility. **3. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur:** Physician orders are reviewed in the clinical department meeting. Care plans are reviewed and amended in the meeting as needed according to physician orders or care issues identified during the clinical review. Whiteboard has been initiated to monitor changes in physician orders, facility events, or new specialized services or equipment to guide the creation or revision of a resident care plan. Whiteboard will be updated during the clinical department meeting and as needed. Comprehensive care plans will be updated weekly according to the MDS	

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	the left hip (the hip cannot be straightened actively or passively). His care plan, dated 4/22/21, indicated he had a pressure ulcer to his sacrum. The medical record lacked orders or documentation to treat or address a pressure ulcer. His MDS, dated 11/2/22, indicated he does not have a pressure ulcer. His care plan, dated 4/22/21, indicated he used an antidepressant medication. His current physician orders lacked an antidepressant medication. His MDS, dated 11/2/22, did not indicate he received an antidepressant during the assessment period. 3. Resident 59's medical record was reviewed on 1/19/23 at 8:00 a.m. His diagnoses included, but were not limited to retention of urine, urinary tract infection, cerebral infarction (stroke), vision deficit, and sepsis (a serious condition resulting from the presence of harmful microorganism in the blood or other tissue). Resident 59's indwelling catheter was discontinued on 1/9/23. His care plan indicated he had a urinary catheter, indwelling, related to urinary retention. During an interview with the Owner, Administrator and Director of Nursing (DON) on 1/20/23 at 9:20 a.m., the DON indicated the UM (Unit Managers) are responsible for initiating and revising residents care plans with changes. The DON indicated herself and the Transitional Care Nurse will revise care plans also. The DON indicated "they" do a great job at initiating care plans, but need to do better at updating them. 4. On 1/17/23 at 9:56 a.m., Resident 83 was initially observed. He laid in bed on his back, his eyes were open, and he answered questions		assessments by Unit Managers, other Nursing management, or designee. The list of completed care plan updates will be returned to the Administrator weekly. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** The weekly care plan update lists will be reviewed weekly by the Administrator or designee for a period of three months. A comprehensive care plan audit will be completed monthly on ten percent of the facility residents for a period of three months. The audit process will start on 2/20/23. The compliance rate is expected to be 100%. The acceptable compliance rate, established by the QAPI team is 90%. If the 90% -100% threshold is met, the monitoring will end after 3 months of substantial compliance. If the threshold falls below the target, the monitoring will continue without a stop date. A pattern of compliance will be established with 3 consecutive months of 90% -100%. 5. **By what date the systemic changes will be completed:** 2/20/23	

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	appropriately. He was observed to be covered with three layers, a sheet, a fleece blanket, and a third top blanket. He indicated he was often cold and liked the weight of the blankets. He had pressure reliving boots to both of his feet but wore no socks so that his toes were in direct contact with the weight of the blankets. On 1/18/23 at 2:06 p.m., Resident 83 was observed. He remained in bed, covered with layers of blankets. His toes remained in contact with the weight of the blankets as they stuck out past his pressure reliving boots. He indicated his feet did not hurt, but sometimes his toes tingled. On 1/19/23 at 9:14 a.m., Resident 83 was observed. He remained in bed, covered with layers of blankets that laid across the top of his toes. On 1/19/23 at 11:42 a.m., CNA 15 entered Resident 83's room. She indicated Resident 83 liked to keep a lot of blankets over him because he got cold and when she removed his blankets so that his feet were uncovered, the following was observed: a. redness at the corner of his left big toe, approximately the size of dime. b. a red blister-like area to the knuckle of his left big toe, approximately the size of a pencil eraser. c. a smaller, red blister area to the knuckle of his right big toe. During an interview on 1/19/23 at 12:03 p.m., the Wound Nurse (WN) indicated Resident 83 was at a greater risk for pressure ulcers since he had a history of wounds and was on hospice. She reviewed his comprehensive care plans at that time and indicated the care plan for an open area on his coccyx should not still be active as that wound had been healed months ago. She indicated there did not appear to be any revisions			

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	in place to address the Resident's preference for additional blankets and how to prevent new areas from developing as a result of the blankets. During an interview on 1/19/23 at 12:30 p.m., the WN indicated she was not aware of any new areas to Resident 83's toes and was available to go observe them at this time. When she pulled his blankets back, the WN indicated it appeared there were three new areas, two to his left big toe, and one on his right big toe. Upon her initial assessment, she indicated all three areas were blanchable so they were not pressure ulcers at that time, but if left untreated could turn into pressure ulcers. It appeared the areas had developed from the weight of the sheets and from the sheets being tucked in, under his feet which pulled and put pressure to the areas. The WN indicated she would get new orders for skin prep to the areas, possibly order new pressure boots that would go higher over his toes to prevent the sheets from touching, and she would educate the aids not to tuck the sheets too tight. On 1/18/23 at 2:25 p.m., Resident 83's medical record was reviewed. He was a long-term care resident who received hospice care and diagnoses which included, but not limited to, Parkinson's disease. His comprehensive care plans were reviewed. He had a care plan which was initiated 7/31/22 for an open area to his coccyx which had not been revised to indicate the area was healed. He had a care plan which was initiated on 3/18/22 for being at risk of developing pressure ulcers related to incontinence, impaired mobility and			

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	medications, but had not been revised to address the Resident's preferences for his use of additional blankets. On 1/20/23 at 9:15 a.m., the ADM provided a copy of current, but undated facility policy titled, "Updating Care Plans." The policy indicated, " ...actual or potential problems may be addressed ... care plans will be continually reviewed and revised as needed ...." 3.1-35(c)(2)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observations, interviews and record review, the facility failed to identify the potential for the development of pressure ulcers for a resident, (Resident 83) who preferred to use thick layers of blankets which caused weight and friction to his toes for 1 of 2 residents reviewed for pressure ulcers. Findings include:	F 0686	**It is the intention of Northwest Manor Health Care Center to identify the potential for development of pressure ulcers with appropriate interventions to prevent pressure ulcers.** **1. What corrective action(s) will be accomplished to those residents found to have been**	02/20/2023

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	On 1/17/23 at 9:56 a.m., Resident 83 was initially observed. He laid in bed on his back, his eyes were open, and he answered questions appropriately. He was observed to be covered with three layers, a sheet, a fleece blanket, and a third top blanket. He indicated he was often cold and liked the weight of the blankets. He had pressure reliving boots to both of his feet but wore no socks so that his toes were in direct contact with the weight of the blankets. On 1/18/23 at 2:06 p.m., Resident 83 was observed. He remained in bed, covered with layers of blankets. His toes remained in contact with the weight of the blankets as they stuck out past his pressure reliving boots. He indicated his feet did not hurt, but sometimes his toes tingled. On 1/19/23 at 9:14 a.m., Resident 83 was observed. He remained in bed, covered with layers of blankets that laid across the top of his toes. During an interview, on 1/19/23 at 11:37 a.m., Unit Manager (UM) 9, indicated Resident 83 was on hospice and needed extra close attention in all aspects of his care because he as very fragile. He had a history of pressure ulcers, so the staff took care to keep his pressure boots on at all times, and he needed to be turned and repositioned at least every two hours. At this time, Certified Nursing Assistant (CNA) 15 approached the nurse's station an indicated she was going to Resident 83's room to reposition him before lunch. On 1/19/23 at 11:42 a.m., CNA 15 entered Resident 83's room. She indicated, Resident 83 liked to keep a lot of blankets over him because he got cold and when she removed his blankets so that his feet were uncovered, the following was observed:		**affected by the deficient practice:** *A skin assessment was completed on the resident identified during the survey by the facility wound nurse on 1/19/2023. Physician orders were obtained for treatment to the areas identified at risk for skin breakdown. Interventions were implemented to reduce pressure or friction to the areas caused by blankets. On 1/20/23, a skin assessment was completed on the identified resident, the areas of concern were no longer present and did not develop into pressure areas.* **2. How other resident having the potential to be affected by the same deficient practice will be identified and that corrective action(s) will be taken:** *A skin assessment was performed on each resident in the facility to identify any area of concerns.* **3. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur:** *Education will be provided to clinical staff on identifying and reporting areas of potential pressure ulcers. Educated will be provided on the utilization of the INTERACT Stop and Watch*	

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	a. redness at the corner of his left big toe, approximately the size of dime. b. a red blister-like area to the knuckle of his left big toe, approximately the size of a pencil eraser. c. a smaller, red blister area to the knuckle of his right big toe. During an interview on 1/19/23 at 12:03 p.m., the Wound Nurse (WN) indicated Resident 83 was at a greater risk for pressure ulcers since he had a history of wounds and was on hospice. She reviewed his comprehensive care plans at that time and indicated the care plan for an open area on his coccyx should not still be active as that wound had been healed months ago. She indicated there did not appear to be any revisions in place to address the Resident's preference for additional blankets and how to prevent new areas from developing as a result of the blankets. During an interview on 1/19/23 at 12:30 p.m., the WN indicated she was not aware of any new areas to Resident 83's toes and was available to go observe them at this time. When she pulled his blankets back, the WN indicated it appeared there were three new areas, two to his left big toe, and one on his right big toe. Upon her initial assessment, she indicated all three areas were blanchable so they were not pressure ulcers at that time, but if left untreated could turn into pressure ulcers. It appeared the areas had developed from the weight of the sheets and from the sheets being tucked in, under his feet which pulled and put pressure to the areas. The WN indicated she would get new orders for skin prep to the areas, possibly order new pressure boots that would go higher over his toes to prevent the sheets from touching, and she would educate the aids not to tuck the sheets too tight.		*monitoring tool to report areas of concern for potential development of pressure areas and implement interventions to prevent pressure ulcers. Director of Nursing or designee will collect completed Stop and Watch forms during daily clinical rounds. Clinical rounds performed by the clinical Interdisciplinary team will be ongoing. Weekly skin assessments completed by nurses will be ongoing.* **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** *Director of Nursing or designee will monitor the utilization of the INTERACT Stop and Watch tool to ensure it is used to identify potential development of pressure ulcers and implement preventative interventions. The Director of Nursing or designee will complete an audit weekly for one month, twice a month for 2 months then monthly for three months. The expected compliance rate of utilizing the INTERACT Stop and Watch tool and implementing interventions for pressure ulcer prevention will be 100%. The audit process will start on 2/20/23. The compliance rate is expected to be 100%. The acceptable compliance rate, established by the QAPI team is 90-100%. If the*	

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	On 1/18/23 at 2:25 p.m., Resident 83's medical record was reviewed. He was a long-term care resident who received hospice care and diagnoses which included, but not limited to, Parkinson's disease. A nursing progress note dated 1/19/23 at 4:17 p.m., indicated, "noted slightly red area to left great to, this area measures 0.5 cm (centimeters) x 0.6cm x 0.0 cm and is blanchable. Denies pain or discomfort upon assessment. Resident noted to have several blankets on bed per preference as resident is often cold. MD (Medical Doctor) family, and wound nurse made aware of new area. New orders received and noted for skin prep to bilateral great toes every shift and to not tuck linens under feet or bed and check placement and skin every shift. Foot cradle placed at foot of bed to keep blankets off feet ...." An initial wound assessment report dated 1/19/23 indicated new redness to left great toe, and some pain with wound treatment noted by facial grimacing. His comprehensive care plans were reviewed. He had a care plan, initiated 7/31/22, for an open area to his coccyx which had not been revised to indicate the area was healed. He had a care plan which was initiated on 3/18/22 for being at risk of developing pressure ulcers related to incontinence, impaired mobility and medications, but had not been revised to address the Resident's preferences for his use of additional blankets. On 1/20/23 at 9:15 a.m., the Administrator		*threshold falls below the target, the monitoring will continue until a pattern of compliance is established for 3 consecutive months of 90-100% compliance rate.* 5. **By what date the systemic changes will be completed:** 2/20/2023	

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	provided a copy of current, but undated, facility policy titled, "Treatment/Services to Prevent/Heal Pressure Ulcers." The policy indicated, "It is the policy of the facility to ensure it identifies and provides needed care and services that are resident centers, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs ... a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable ... interventions will be implemented in the resident's plan of care to prevent pressure sore development when the resident has no areas of concern ...." On 1/20/23 at 9:15 a.m., the Administrator provided a copy of current, but undated facility policy titled, "Updating Care Plans." The policy indicated, " ...actual or potential problems may be addressed ... care plans will be continually reviewed and revised as needed ...." 3.1-40(a)(2)			
F 0688 SS=E Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and			

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	services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview, and record review, the facility failed to provide range of motion for 4 of 4 residents reviewed for limitations in range of motion of joints (Residents 23, 1, 45, and 46). Findings include 1. Resident 23's medical record was reviewed on 1/19/23 at 2:10 p.m. Her diagnoses included, but were not limited to, hyperlipidemia (high cholesterol), hypothyroidism (abnormally low activity of the thyroid gland), osteoarthritis, anxiety, anemia, depression, and acute embolism (blood clot) of the deep veins of the upper extremity. Resident 23's Minimum Data Set (MDS) assessment, dated 10/19/22, indicated she required extensive assistance of 1 person to complete her personal hygiene (combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands). The MDS indicated that she was not receiving restorative nursing services. Resident 23's care plan indicated she required assistance with all activities of daily living (ADLs) due to weakness and debility. An active goal indicated to refer the resident to occupational therapy to work on ADL retraining, dated 5/21/21.	F 0688	F 688 SS=E It is the intention of Northwest Manor Health Care Center to ensure range of motion services are provided. **1. What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** *Range of motion program documentation was added to daily documentation for each resident identified in the survey. Nursing caregiver education was provided for the completion and documentation of range of motion services each day.* **2. How other resident having the potential to be affected by the same deficient practice will be identified and that corrective action(s) will be taken:** *Range of motion documentation was added to resident's plan of care and daily documentation. Nursing caregiver education was provided for the completion and*	02/20/2023

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	On 1/17/23 at 2:25 p.m., Resident 23 was observed in her room sitting in a chair. She indicated she just finished brushing her hair. She had arthritis in upper arms and shoulders making it difficult for her to brush her hair, but she pushed through and brushed her hair independently. Resident 23 indicated she had therapy, but since they stopped seeing her she had not had anyone help her with range of motion of her upper arms and shoulders. 2. Resident 46's medical record was reviewed on 1/19/23 at 11:59 a.m. Her diagnoses included, but were not limited to epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), pneumonia (an infection of the lungs), acute embolism (blood clot) of deep veins of the lower extremities, anorexia (an eating disorder), autistic disorder (a broad range of conditions characterized by challenges with social skills, repetitive behaviors, speech and non-verbal communication), contracture of muscle, multiple sites (permanent tightening of the muscles, tendon, skin and nearby tissues that causes the joints to shorten and become very stiff), and pressure ulcer (bed sore) of sacral region. Her medication orders were reviewed. Resident 46's MDS, dated 11/24/22, indicated that she was totally dependent on staff to provide ADLs for her. The MDS indicated that she was not receiving restorative nursing and she was not receiving therapy services. Resident 46's care plan, dated 3/21/22, indicated she had an alteration in comfort/pain related to contractures. She had a care plan indicating she required assistance for all ADL's (bed mobility, transfers, toileting, and eating) related to intellectually disabled, contractures and		*documentation of range of motion services each day.* **3. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur:** *Interventions for range of motion services will be implemented upon admission to the facility. The interventions will be automatically implemented for all new admissions to the facility. EMR components will be changed to implement range of motion services for each resident admitted or readmitted to the facility. A medical records audit will be completed upon admission to verify interventions have been implemented by the EMR program. Range of motion documentation monitoring will be added to nursing management's daily documentation monitoring for ADL care.* **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** *The medical records audit will occur ongoing as part of the admission audit process. Nursing management will complete a documentation audit weekly for 1 month, then twice monthly for 2 months and then monthly for 3*	

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	dependent for all care. During an observation on 1/16/23 at 9:30 a.m., Resident 46 was observed lying in bed, facing her window. She was holding a stuffed animal. She had a low air loss mattress. She had her eyes opened, but she was non-verbal. During an observation on 1/19/23 at 10:16 a.m., Resident 46 was non-verbal. She was observed lying on her left side, holding a small stuffed animal in her right hand. She was able to make eye contact. 3. Resident 1's medical record was reviewed on 1/9/23 at 2:49 p.m. Her diagnoses included, but were not limited to fracture of right femur, chronic kidney disease, major depressive disorder, chronic heart failure, hypothyroidism, and protein-calorie malnutrition. Resident 1's MDS, dated, 10/2/22, indicated she received extensive assistance with her ADLs. Her MDS indicated she was not receiving a restorative nursing program. Her care plan, dated 9/22/22, indicated she required assistance for all ADLs bed mobility, transfers, toileting, and eating related to visual impairment and chronic pain. During an observation on 1/18/23 at 10:25 a.m., Resident 1 was observed lying on her right side in bed with her eyes closed. During an observation on 1/19/23 at 9:10 a.m., Resident 1 was observed lying on her right side with her eyes closed. 4. Resident 45's medical record was reviewed on		*months. Audit results will be accumulated and reported in the facility QAPI meeting monthly. The audit process will start on 2/20/23. The compliance rate is expected to be 100%. The acceptable compliance rate, established by the QAPI team is 90-100%. If the threshold falls below the target, the monitoring will continue until a pattern of compliance is established for 3 consecutive months of 90- 100% compliance rate.* 5. **By what date the systemic changes will be completed:** 2/20/2023	

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	1/19/23 at 10:04 a.m. His diagnoses included but were not limited to cerebral infarction (stroke), protein-calorie malnutrition, major depressive disorder, heart disease, vascular dementia, spinal stenosis (this happens when the space inside the backbone is too small, placing pressure on the spinal cord and nerves), and flexion deformity of the left hip. His MDS, dated 11/2/22, indicated he was dependent of staff to complete his ADLs. The MDS indicated he was not receiving a restorative nursing program. His care plan dated 10/19/20 indicated he required assistance with all ADLs, bed mobility, transfers, toileting and eating related to dementia, CVA (cerebral vascular accident (stroke) with left sided weakness and impaired mobility. Resident 45 was observed on 1/17/23 at 9:38 a.m., lying in bed with his head pushing against a pad attached to his grab bar. He was unable to reposition himself in bed. Resident 45 was observed on 1/19/23 at 2:15 p.m. He was sitting up in his reclining chair. His head was leaning into the padded frame of the chair. He was unable to reposition in the chair. During an interview with the Owner, Administrator (ADM), Director of Nursing (DON) on 1/20/23 at 9:20 a.m., the DON indicated that range of motion was supposed be done during resident's ADL care. The staff did this to prevent further limitations and contractures for their residents. The DON indicated she could not provide any documentation indicating range of motion was completed. The Owner indicated the staff were to document range of motion on the			

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	electronic medical record. On 1/20/23 at 9:1454 a.m., the ADM provided a copy of current, but undated facility policy titled, "Increase/Prevent Decrease in ROM/Mobility." The policy indicated, "It is the policy of the facility to ensure it identifies and proves needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each residents physical, mental and psychosocial needs...." 3.1-47(a)(1)			
F 0695 SS=E 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, interview, and record review, the facility failed to ensure resident respiratory durable medical equipment (DME) was stored according to policy, oxygen tubing was dated correctly, and oxygen was humidified according to facility policy for 4 of 4 residents reviewed for respiratory equipment use (Resident 5, 60, 26 and 29). Findings include: 1. On 1/17/23 at 11:38 a.m., Resident 5 was	F 0695	**F 695** **SS= E** **It in the intention of Northwest Manor Health Care Center to provide respiratory services and equipment with professional standards of practice.** **1. What corrective action(s) will be accomplished to those residents found to have been affected by the deficient**	02/20/2023

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	observed in bed with a nasal cannula (NC), eyes closed. Her oxygen was set at 4 liters (L), it was not humidified. Her oxygen tubing was dated 12/29/22. On 1/18/23 at 9:27 a.m., Resident 5 was observed in bed with a NC, eyes closed. Her oxygen was set at 4 liters (L), it was not humidified. Her oxygen tubing was dated 12/29/22. On 1/18/23 at 2:20 p.m., Resident 5 was observed in bed with a NC, eyes closed. Her oxygen was set at 4 liters (L), it was not humidified. Her oxygen tubing was dated 12/29/22. On 1/19/23 at 2:16 p.m., Resident 5's record was reviewed. She was admitted on 5/5/22. Her diagnoses included, but were not limited to, chronic respiratory failure (failure of the lungs to bring in enough oxygen and eliminate carbon dioxide), and cerebral infarction (stroke). Her physician's orders included, but were not limited to, administer 4 L oxygen via NC every shift, dated 7/22/22, and change oxygen tubing weekly, dated 7/24/22. Resident 5 did not have an oxygen care plan. On 1/19/23, the facility provided one, it indicated to change oxygen tubing per protocol and provide humidification. 2. On 1/17/23 at 11:21 a.m., Resident 60's unbagged NC was observed rolled up and laid on top of his oxygen concentrator. He was in his room utilizing a portable canister for oxygen. On 1/18/23 at 2:16 p.m., Resident 60's unbagged NC was observed rolled up and laid on top of his oxygen concentrator. He was in his room utilizing		**practice:** The deficiencies identified for the delivery of oxygen and oxygen equipment were corrected at the time of discovery for each resident identified. **2. How other resident having the potential to be affected by the same deficient practice will be identified and that corrective action(s) will be taken:** Nursing management completed an audit of all oxygen and oxygen equipment to ensure oxygen was being delivered appropriately and oxygen equipment was dated and stored appropriately. Any problems identified were corrected immediately. **3. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur:** Consistent staff members will be assigned to complete weekly rounds to change oxygen equipment. Director of Nursing or designee will provide a weekly report of residents utilizing oxygen or respiratory equipment and place it in an Oxygen binder. The Oxygen binder will be used by the assigned staff members while issuing or changing out equipment. The worksheets in the Oxygen binder will be used during	

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	a portable canister for oxygen. On 1/19/23 at 12:07 p.m., his record was reviewed. His diagnoses included, but were not limited to, chronic respiratory failure and chronic cough, His physician orders included, but were not limited to, oxygen 2 L via nasal cannula, dated 12/23/22, and change oxygen tubing and humidifier weekly, dated 12/26/22. His oxygen care plan, dated 12/25/22, indicated he was at risk for respiratory complications and administer oxygen therapy as ordered. 3. In 1/18/23 at 2:30 p.m., Resident 26's NC was observed unbagged and undated. hanging on the oxygen concentrator. On 1/19/23 at 11:02 a.m., Resident 26's record was reviewed. Her diagnoses included, but were not limited to, chronic respiratory failure and diabetes mellitus. Her physician orders included, but were not limited to, administer 2 L oxygen via NC, dated 12/28/20, and change oxygen tubing weekly, dated 6/23/22. Her oxygen care plan, dated 2/5/21, indicated she received oxygen therapy due to respiratory failure and to administer oxygen therapy as ordered and change tubing per protocol. During an interview, on 1/18/23 at 2:33 p.m., Unit Manager (UM) 9 indicated NC and oxygen tubing should have been changed weekly and dated, NC when not in use should have been bagged, and if a resident was over 2 L of oxygen, then it should have been humidified.		weekly rounds to ensure oxygen equipment is changed and dated according to facility policies. Resident education on oxygen equipment storage will be provided for residents that independently remove nasal cannulas when changing from devices that provide oxygen, (ex. concentrator to portable tank). **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** The Director of nursing or designee will audit the Oxygen binder weekly to ensure proper completion of the weekly rounds. The Director of Nursing or designee will perform rounds weekly to verify oxygen and supplies are provided according to facility policy. An audit to ensure the completion of the Oxygen binder and rounds will be completed weekly for one month, twice a month for 2 months and monthly for 3 months. The audit process will begin 2/22/2023. The compliance rate is expected to be 100%. The acceptable compliance rate, established by the QAPI team is 90-100%. If the threshold falls below the target during the last three months of monitoring, the monitoring will continue until a pattern of	

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	On 1/18/23 at 2:41 p.m., UM 9 was observed preparing and dating bags for Residents 26 and 60 oxygen tubing/NC. Licensed Practical Nurse (LPN) 4 was observed dating tubing for Resident's 26, 60, and 5, and dating a humidifier bottle for Resident 5. On 1/18/23 at 2:57 p.m., LPN 4 was observed to change the oxygen concentrator for one that would humidify the oxygen for Resident 5. On 1/18/23 at 1:48 p.m., the Director of Nurses (DON) indicated the nurses should have checked the oxygen tubing and changed and dated it as needed. The nurse should have been aware, if a resident was on 4 L of oxygen, the oxygen should have been humidified. 4. On 1/18/23 at 10:45 a.m., during an observation and interview, Resident 29 was in his room wearing oxygen per nasal cannula (tube). The tubing and humidifier bottle, which was on the oxygen concentrator, were not dated. On 1/18/23 at 2:22 p.m., Resident 29 was observed as he sat on the side of his bed. He wore oxygen per nasal cannula, connected to a concentrator with humidification. He indicated sometimes they put a date on them but the last time they changed it it had not been marked. On 1/18/23 at 2:29 p.m., the medical record for Resident 29 was reviewed. The diagnoses included, but were not limited to, chronic respiratory failure, COPD (chronic obstructive pulmonary disease, diabetes and obstructive sleep apnea. A physician order, dated 6/23/22, indicated 5 liters of oxygen per nasal cannula. change oxygen tubing and humidifier weekly.		compliance is established for three consecutive months of 90-100% compliance rate. 5. **By what date the systemic changes will be completed:** 2/20/2023	

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	On 1/19/23 at 12:15 p.m., during an interview, Licensed Practical Nurse (LPN) 9, Unit Manager, indicated oxygen tubing and humidifier bottles should have had a date marked on them when they were changed. She did not know when Resident 29's tubing or humidifier bottle was changed. On 1/19/23 at 12:05 p.m., the Executive Director (ED) provided a current, undated policy, titled "Departmental (Respiratory Therapy)- Prevention of Infection." This policy indicated " The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff...Distilled water used in respiratory therapy must be dated and initialed when opened, and discarded after 14 days or as needed...Mark bottle with date and initials upon opening and discard after 14 days, or as needed...Change the oxygen cannulae and tubing every seven (7) days, or as needed...Keep oxygen cannulae and tubing used PRN [as needed] in a plastic bag when not in use...." 3.1-47(a)(6)			
F 0757 SS=E 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 interview, and record review, the facility failed to ensure each resident medication order had a diagnosis included for 7 of 19 residents reviewed for medication orders with diagnoses (Resident 1, 16, 23, 37, 45, 46, and 59). Findings include: 1. Resident 23's medical record was reviewed on 1/19/23 at 2:10 p.m. She was admitted on 5/20/21. Her diagnoses included, but were not limited to, hyperlipidemia (high cholesterol), hypothyroidism (abnormally low activity of the thyroid gland), osteoarthritis, anxiety, anemia, depression, and acute embolism (blood clot) of the deep veins of the upper extremity. Her medication orders were reviewed. a. Her sertraline75mg (used to treat depression) lacked an indication for use. b. Her I-vite tablet (used as a vitamin supplement) lacked an indication for use. c. Her acetaminophen 325mg (used to treat pain)	F 0757	**It is the intention of Northwest Manor Health Care Center to ensure each resident is free from unnecessary drugs.** **1. What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** Diagnoses found in the resident's health record were added to the appropriate medication orders for each of the residents identified with medication orders without a diagnosis indicated. **2. How other resident having the potential to be affected by the same deficient practice will be identified and that corrective action(s) will be taken:** The facility completed and audit for all residents to identify other medication orders without a diagnosis indicated in the	02/20/2023

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	two tablets two times daily lacked an indication for use. d. Her buspirone HCL 5mg (used to treat anxiety) lacked an indication for use. e. Her acidophilus X-STR captab (used as a supplement for the stomach) lacked an indication for use. 2. Resident 1's medical record was reviewed on 1/9/23 at 2:49 p.m. She was admitted on 9/21/22. Her diagnoses included, but were not limited to fracture of right femur, chronic kidney disease, major depressive disorder, chronic heart failure, hypothyroidism, and protein-calorie malnutrition. Her medication orders were reviewed. a. Her levothyroxine 25mcg (used to treat hypothyroidism) lacked an indication for use. b. Her acetaminophen 500mg (used to treat pain) lacked an indication for use. c. Her amlodipine besylate (used to treat high blood pressure) lacked an indication for use. d. Her aspirin 81mg (used to prevent heart attacks) lacked an indication for use. e. Her latanoprost 0.005% eye drops (used to treat glaucoma) lacked an indication for use. f. Her dorzolamide 2% eye drops (used to treat glaucoma) lacked an indication for use. g. Her stimulant laxative plus (used to treat constipation) lacked an indication for use. 3. Resident 46's medical record was reviewed on 1/19/23 at 11:59 a.m. She was admitted on 12/9/22. Her diagnoses included, but were not limited to epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), pneumonia (an infection of the lungs), acute		medication order. Any other medication orders found without a diagnosis indicating its use were corrected. **3. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur:** Education was provided to nurses on ensuring a proper diagnosis is provided in a medication order. Physician orders are collected from the nursing units and brought to the clinical department meetings. The Director of Nursing or designee will review the physician medication orders in the clinical department meeting to ensure an indication is provided in the written order and EHR system. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** The Director of Nursing or designee will audit medication orders for diagnosis or indications using a EHR report. The Director of nursing or designee will audit the report to verify each medication has a diagnosis or indication weekly for one month, then twice a month for 2 months, then monthly for 3 months. The audit will begin 2/17/23. The	

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	embolism (blood clot) of deep veins of the lower extremities, anorexia (an eating disorder), autistic disorder (a broad range of conditions characterized by challenges with social skills, repetitive behaviors, speech and non-verbal communication), contracture of muscle, multiple sites (permanent tightening of the muscles, tendon, skin and nearby tissues that causes the joints to shorten and become very stiff) and pressure ulcer (bed sore) of sacral region. Her medication orders were reviewed. a. Her valproic acid 250mg (used to treat seizures) lacked an indication for use. b. Her lacosamide 250mg (used to treat seizures) lacked an indication for use. c. Her as needed Tylenol 120mg (used to treat pain or fever) lacked an indication for use. d. Her amatadine 100mg (used to treat shakiness) lacked an indication for use. e. Her multivitamin (used as a vitamin supplement) lacked an indication for use. f. Her baclofen 10mg (used to treat muscle spasms) lacked an indication for use. g. Her Eliquis 5mg (used as a blood thinner, to treat blood clots) lacked an indication for use. 4. Resident 45's medical record was reviewed on 1/19/23 at 10:04 a.m. He was admitted on 5/9/21. His diagnoses included, but were not limited to cerebral infarction (stroke), protein-calorie malnutrition, major depressive disorder, heart disease, vascular dementia, spinal stenosis (this happens when the space inside the backbone is too small, placing pressure on the spinal cord and nerves) and flexion deformity of the left hip. His medication orders were reviewed.		compliance rate is expected to be 100%. The acceptable compliance rate, established by the QAPI team is 90-100%. If the threshold falls below the target, the monitoring will continue until a pattern of compliance is established for 3 consecutive months of 90%-100% compliance rate. 5. **By what date the systemic changes will be completed:** 2/20/2023	

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	a. His losartan potassium 100mg (used to treat high blood pressure) lacked an indication for use. 5. Resident 59's medical record was reviewed on 1/19/23 at 8:00 a.m. He was admitted on 1/10/23. His diagnoses included, but were not limited to retention of urine, urinary tract infection, cerebral infarction (stroke), vision deficit, and sepsis (a serious condition resulting from the presence of harmful microorganism in the blood or other tissue). His medication orders were reviewed. a. His atrorvastain 80mg (used to treat high cholesterol) lacked an indication for use. b. His mirtazapine 30mg lacked an indication for use c. His olanzepiine 5mg (used to treat psychiatric disorders) lacked an indication for use. d. His tamsulosin 0.4mg (used to treat urine flow problems) lacked an indication for use. e. His lactulose 10gm/15ml (used to treat constipation) lacked an indication for use. f. His aspirin 81mg (used to prevent heart attacks) lacked an indication for use. g. His azathioprine (used to lower the body's natural immunity) lacked an indication for use. h. His metoprolol succinate ER 50mg (used to treat high blood pressure) lacked an indication for use. i. His tradjenta 5mg (used to treat diabetes) lacked an indication for use. j. His venlafaxine HCL 262.5mg (used to treat depression) lacked an indication for use. k. His vitamin B-1 100mg (used as a vitamin supplement) lacked an indication for use.6. Resident 16's record was reviewed on 1/19/23 at 11:24 a.m. He was admitted on 12/20/22.			

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	His diagnoses included, but were not limited to, epilepsy (seizure disorder), coronary heart disease, and diabetes mellitus (blood sugar disorder). His Medication Administration Record (MAR) was reviewed. a. His fluticasone (treats allergies) 50 mcg spray order had no physician's indication for use. b. His laxative stimulant (treats constipation) had no physician's indication for use. c. His Levemir FlexTouch injection (treats diabetes) had no physician's indication for use. d. His pantoprazole sodium (treats heartburn) 40 mg had no physician's indication for use. e. His ferrous gluconate (supplement) 324 mg had no physician's indication for use. f. His clopidogrel (reduce the risk of blood clots) 75 mg had no physician's indication for use. g. His metoprolol ER (extended release) (treats high blood pressure) 25 mg had no physician's indication for use. h. His levothyroxine (treats low thyroid function) 125 mcg had no physician's indication for use. i. His atorvastatin (treats high cholesterol) 40 mg had no physician's indication for use. j. His tamsulosin (treats symptoms of enlarged prostate) 0.4 mg had no physician's indication for use. k. His lamotrigine (treats epilepsy) 150 mg had no physician's indication for use. l. His melatonin (assists with sleep) 1 mg had no physician's indication for use. m. His Novolog Flex Pen (treats diabetes) had no physician's indication for use. n. His Gabapentin (treats epilepsy) 100 mg had no physician's indication for use. o. His acetaminophen (treats pain)500 mg had no physician's indication for use. p. His albuterol (treats bronchospasms) via			

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	nebulizer had no physician's indication for use. q. His levetiracetam (treats seizures) 750 mg had no physician's indication for use. s. His Novolin R Flex Pen (treats diabetes) 10 units for injection had no physician's indication for use. t. His Tramadol (treats pain) 50 mg had no physician's indication for use. u. His Eliquis (blood thinner) 2.5 mg had no physician's indication for use. 7. On 1/18/23 at 2:39 p.m., the medical record for Resident 37 was reviewed. The admission date was listed as 7/16/21. The diagnoses included but were not limited to, Covid -19, diabetes, intracardiac thrombus (a blood clot in the heart),and malignant neoplasm (a cancer) , lower lobe, left bronchus or lung. A review of Resident 37's physican orders listed the following medications, and their order dates, without a diagnosis listed for use: a. "APLISOL 5T UNIT/0.1 ML VIAL, ADMINISTER 0.1 CC INTRADERMALLY EVERY YEAR, 5/4/23, 12:30 AM [used for tuberculin testing]" b. "MORPHINE SULF ER 15 MG TABLET GIVE ONE TABLET BY MOUTH EVERY 8 HOURS, 1/20/23, 12:00 AM [narcotic pain medication]" c. "ATORVASTATIN 40 MG TABLET TAKE ONE TABLET BY MOUTH DAILY AT 8PM, 12/26/22, 8:00 PM [treats high cholesterol]" d. "MELATONIN 3 MG TABLET TAKE ONE TABLET BY MOUTH ONCE A DAY AT BEDTIME, 12/23/22, 8:00 PM [enhances sleep]" e. "TRAZODONE 50 MG TABLET TAKE ONE			

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	TABLET BY MOUTH DAILY AT BEDTIME, 11/22/22, 9:00 PM [antidepressant]" f. "BUSPIRONE HCL 15 MG TABLET GIVE ONE TABLET BY MOUTH THREE TIMES A DAY, 11/17/22, 2:30 PM [anti-anxiety]" g. "DULOXETINE HCL DR 30 MG CAP GIVE ONE CAP BY MOUTH ONCE A DAY, 11/10/22, 9:00 AM [antibiotic]" h. "INJ INSULIN GLARGINE-YFGN U100 PEN INJECT 17 UNITS SUBCUTANEOUSLY TWICE A DAY, 11/7/22, 11:26 AM [(treats elevated blood sugars]" i. "GABAPENTIN 100 MG CAPSULE GIVE 2 CAPSULES BY MOUTH AT BEDTIME, 10/22/22, 9:00 PM [treats nerve pain]" j. "INSULIN LISPRO 100 UNIT/ML PEN INJECT 12 UNITS SUBCUTANEOULSY WITH MEALS 10/22/22, 12:00 PM [treats elevated blood sugars]" k. "POLYETHYLENE GLYCOL 3350 POWD MIX 17 GRAMS IN 8OZ FLUID, TAKE BY MOUTH TWICE A DAY 10/22/22, 10:00 AM [treats/prevents constipation]" l. "SENNA PLUS 8.6-50 MG TABLET 50MG/8.6MG 2 TABS AT BEDTIME 10/21/22, 9:00 PM [treats/prevents constipation]" m. "LOSARTAN POTASSIUM 25 MG TAB GIVE ONE TABLET BY MOUTH ONCE A DAY 10/21/22, 12:00 PM [treats elevated blood pressure]" n. "ZOFRAN 4 MG TABLET GIVE ONE TABLET EVERY 4 HOURS AS NEEDED FOR			

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	NAUSEA/VOMITING 10/21/22, 12:00 PM" o. "NALOXONE HCL 4 MG NASAL SPRAY ONE SPRAY IN EACH NOSTRIL AS NEEDED FOR DROWZINESS. MAY REPEAT TIMES ONE AFTER 4 MINUTES 10/21/22, 12:00 PM [narcotic blocker used in overdose]" p. "GLUCAGON 1 MG EMERGENCY KIT GIVE 1MG SUBCUTANEOULSY TIMES ONE IF GLUCOSE LESS THAN 70 AND REPEAT AS NEEDED TIME ONE IN 15 MINUTES 10/21/22, 12:00 PM [increases sugar level in blood, treats low blood sugar]" q. "ACETAMINOPHEN 325 MG TABLET GIVE 2 TABLETS TO EQUAL 650MG BY MOUTH EVERY 4 HOURS AS NEEDED FOR PAIN 10/21/22, 12:00 PM [treats pain and/or fever]" r. "HYOSCYAMINE 0.125 MG ODT GIVE ONE TABLET BY MOUTH EVERY 6 HOURS AS NEEDED FOR ABDOMINAL CRAMPING 10/21/22, 12:00 PM [antispasmotic]" s. "NITROGLYCERIN 0.4 MG TABLET SL GIVE SUBLINGUALY EVERY 5 MINUTES AS NEEDED FOR CHEST PAIN, NOT TO EXCEED 3 DOSES IN 15 MINUTES, IF CHEST PAIN PERSISTS, CALL MD 10/21/22, 12:00 PM" t."FOLIC ACID 1 MG TABLET 1 TAB BY MOUTH ONCE A DAY 10/21/22, 10:00 AM [nutritional supplement]" u." INSULIN LISPRO 100 UNIT/ML PEN INSULIN LISPRO PER SLIDIMG SCALE BEFORE MEALS 150-200=1 UNIT 201-250=2 UNITS 251-300=3 UNITS 301-350=4 UNITS 351-400=5 UNITS >400=6 UNITS AND NOTIFY MD, 10/21/22, 9:45			

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	AM [use to treat high blood sugars]" v. "ELIQUIS 5 MG TABLET GIVE ONE TABLET BY MOUTH TWICE A DAY, 10/21/22, 9:11 AM [thins the blood]" w. "METOPROLOL SUCC ER 25 MG TAB 1 TAB BY MOUTH ONCE A DAY, 10/21/22, 8:00 AM [treats high blood pressure]" x. "ALLERGY (LORATADINE) 10 MG TAB 10MG BY MOUTH ONCE A DAY, 10/21/22, 8:00 AM [prevents or treats allergy symptoms]" On 1/20/23 at 1:25 p.m., during an interview, the Director of Nursing (DON) indicated the physician's orders should have all had an indication for use on each of the entered medication orders. A current policy, titled, "Medication Orders," with no date, was provided by the Director of Nursing (DON), dated 1/20/23 at 3:30 p.m. A review of the policy indicated, " ...Elements of the Medication Order ...Name of medication ...Strength of medication ...Dosage and dosage form ...Time of Frequency of Administration ...Route of Administration ....Duration of therapy ...Diagnosis or indication for use ...." 3.1-48(a)(4)			
F 0758 SS=E 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			

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	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 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			

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	prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure appropriate indications for use were documented with antipsychotic medications for 2 of 5 residents reviewed for unnecessary medications (Residents 36 and 80). Findings include: 1. On 1/19/23 at 9:05 a.m., Resident 36's medical record was reviewed. He was a long-term care resident with diagnoses which included but were not limited to, unspecified dementia, psychotic disorder with hallucinations and major depressive disorder. His most recent current physician's orders included an order for Risperidone (an antipsychotic medication) 0.5 mg (milligrams). Although the order included instructions to take one tablet by mouth at bedtime, the order lacked documentation of its indication for use. 2. On 1/19/23 at 9:52 a.m., Resident 80's medical record was reviewed. He was a long-term care resident with diagnoses which included but were not limited to undifferentiated schizophrenia. His most recent current physician's orders included an order for Olanzapine (an antipsychotic medication) 5mg. Although the order included instructions to give one tablet a day through his G/J tube, the order lacked documentation of its indication for use. During an interview on 1/20/23 at 9:20 a.m., the Director or Nursing (DON) indicated, she was unaware that the orders did not have diagnoses nor was she aware the indication for the	F 0758	**F 758** **SS= E** **It is the intention of Northwest Manor Health Care Center to ensure appropriate indications for use of antipsychotic medications are documented.** 1. **What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** Diagnoses found in each of the identified resident's health record were added to the physician medication orders for antipsychotic medications. 2. **How other resident having the potential to be affected by the same deficient practice will be identified and that corrective action(s) will be taken:** The facility completed and audit for all residents to identify other medication orders without a diagnosis indicated in the medication order. Any other medication orders found without a diagnosis indicating its use were corrected. 3. **What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur:**	02/20/2023

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	medications use was required. On 1/20/23 at 9:15 a.m., the Administrator (ADM) provided a copy of current, but undated facility policy titled, "Behavior and Psychoactive Management." The policy indicated, " ...The Behavior Management team will meet monthly to review those residents receiving psychoactive medications ... The Behavior Management Committee will ensure the prescriber's order for the Dose of medication is based on the following: a. Resident's diagnosis ...." 3.1-48(a)(4)		Education was provided to nurses on ensuring a proper diagnosis is provided in a medication order. Physician orders are collected from the nursing units and brought to the clinical department meetings. The Director of Nursing or designee will review the physician medication orders in the clinical department meeting to ensure an indication is provided in the written order and EHR system. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** The Director of Nursing or designee will audit medication orders for diagnosis or indications using a EHR report. The Director of nursing or designee will audit the report to verify each medication has a diagnosis or indication weekly for one month, then twice a month for 2 months, then monthly for 3 months. The audit will begin 2/17/23. The compliance rate is expected to be 100%. The acceptable compliance rate, established by the QAPI team is 90%-100%. If the threshold falls below the target, the monitoring will continue until a pattern of compliance is established for 3 consecutive months of 90%-100% compliance	

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(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
			rate. 5. **By what date the systemic changes will be completed:** 2/20/2023	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to date and remove expired multi-dose vials of Tubersol (a liquid medication that is injected under the skin to test	F 0761	**F 761** **SS= D** **It is the intension of Northwest Manor Health Care Center to**	02/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155041	A. BUILDING 00 B. WING	01/20/2023

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	for tuberculosis) from 2 of 2 medication room refrigerators and failed to remove an expired insulin pen and date eye drops that were opened for 1 of 3 medication carts reviewed (Resident 38 and 41). Findings include: During an observation of 100 hall medication room on 1/19/23 at 11:33 a.m. a multi-dose vial of Tubersol was observed inside the refrigerator. The vial lacked a date to indicate when it was opened. During an observation of 200 hall medication room on 1/19/23 at 11:46 a.m., a multi-dose vial of Tubersol was observed in the refrigerator with a date opened of 12/2/22. The vial expired 30 days after opening. During an observation of 200 hall medication cart (cart 4) on 1/19/23 at 12:00 p.m., a transparent bag with Resident 41's name contained a medication, artificial tears 0.2-0.2-1% drops lacked a date the bottle was opened. An insulin pen was observed in a side drawer of the medication cart. The pen was labeled with Resident 38's name and contained insulin glargine 100unit/ml with a date opened 11/28/22. The insulin had expired. A policy was provided by the Administrator on 1/19/23 at 9:15 a.m. It was titled, "Control of Medications," indicated " ...labeling requirements for medications and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, manufacturer's expiration date, and opened dated, when applicable ...."		**label drugs and biologicals used in the facility with currently accepted professional principles and the expiration date when** applicable. **1. What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** Undated and expired medications identified during the surveyor's audit were destroyed according to facility policy. **2. How other resident having the potential to be affected by the same deficient practice will be identified and that corrective action(s) will be taken:** The facility conducted an audit to identify any other undated or expired medications in medication carts and medication refrigerators to ensure no other residents were affected by the deficient practice. **3. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur:** Nursing education was provided on the proper labelling and storage of medications. A monthly audit will be done by a pharmacist on at least two medication carts and refrigerators. A pharmacy reference for recommended	

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	3.1-25(j) 3.1-25(m) 3.1-25(n)		expiration dates for medications will be available in the medication storage rooms and a binder available for the medication cart. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** Director of Nursing or designee will complete audits of medication carts and medication refrigerators to ensure medication storage and labelling is compliant. The audits will be completed weekly for one month, then twice a month for two months and then monthly for three months. The audit process will start 2/20/2023. The compliance rate is expected to be 100%. The acceptable compliance rate, established by the QAPI team is 90%-100%. If the threshold falls below the target, the monitoring will continue until a pattern of compliance is established for 3 consecutive months of 90%-100% compliance rate. 5. **By what date the systemic changes will be completed:** 2/20/2023	