STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN 47150

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00443610 and IN00443867. Complaint IN00443610 - No deficiencies related to the allegations are cited. Complaint IN00443867 - No deficiencies related to the allegations are cited. Survey dates: September 23, 24, 25, 26, 27 and 30, 2024 Facility number: 000321 Provider number: 155614 AIM number: 100286130 Census Bed Type: SNF: 5 SNF/NF: 104 Total: 109 Census Payor Type: Medicare: 4 Medicaid: 85 Other: 20 Total: 109 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 7, 2024.	F 0000	**October 21, 2024** **Brenda Buroker, Director** **Long-Term Care Division** **Indiana State Department of Health** **2 North Meridian Street** **Indianapolis, IN 46204** **Re: Allegation of Compliance** **Event ID: 2UHHII** **Dear Mrs. Buroker:** **Please find enclosed the Plan of Correction for the Complaint Survey conducted on September 30, 2024. This letter is to inform you that the plan of correction attached is to serve**	

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

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			as Lincoln Hills of New Albany credible allegation of compliance. We allege substantial compliance on October 07, 2024. We are requesting paper compliance for this plan of correction. **If you have any further questions, please do not hesitate to contact me at 317-512-4655.** **Sincerely,** **Kim Povinelli, HFA** **Lincoln Hills of New Albany** **Submission of this plan of correction in no way constitutes an admission by Lincoln Hills of New Albany or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction**	

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			is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response Based on record review and interview, the facility failed to promptly resolve the grievances made by the Resident Council and discussed the resolutions/responses at the next Resident Council meeting during 3 of 9 Resident Council meetings. (February, April, and August 2024) Findings include: During the Resident Council meeting on 9/24/24 at 9:55 a.m., with 13 residents whom the Activities Director indicated were alert and oriented. The residents voiced that they had the meetings and voiced their concerns, and then that was the last they heard. They never knew what the outcome was to their concerns. They indicated it was not discussed in the next month's meeting. 1. The Resident Council meeting, held on 2/2/24, indicated the following concerns were not addressed by the responsible department or resolved:	F 0565	**F-0565** **Resident/Family Group and Response** The resident has the right to organize and meet as a group in the facility. The facility must consider the views of a resident or family group and act promptly upon the grievances… **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Old business from February, April, and August 2024 was reviewed at Resident Council and added to the minutes.	10/07/2024

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	- Resident 34 was missing clothes. - Residents were tired of the same menu. The kitchen needed to cut back on the salt in the food. No response to these concerns could be located. During the meeting, the residents voiced concerns about not getting their clothes back. The Director of Laundry responded on 2/2/24, that she would speak with the laundry staff and that as long as things were labeled, they would try to make sure they got to the correct residents. The residents voiced concerns that the third shift CNA (Certified Nursing Aide) on B hall needed to do a better job. On 2/2/24, the Director of Nursing (DON) responded that she would educate and discipline the staff. These concern responses were not signed by the Resident Council President. Documentation was lacking of the departments' responses being discussed in the next month's meeting. 2. The Resident Council meeting, held on 4/5/24, indicated the following concerns were not addressed by the responsible department or resolved: - Resident 34 was missing clothes. - Tired of the same menu. Needed to cut back on the salt in the food. No response to these concerns could be located. 3. The Resident Council meeting, held on 8/2/24, indicated the following concerns were not addressed by the responsible department or resolved:		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Old business will be reviewed at each Resident Council meeting and added to the minutes. All residents have the potential to be affected by this alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Staff have been re-educated regarding resident rights and resident council. The form utilized to record Resident Council Minutes has been updated to reflect a section for Old Business which will be reviewed during each meeting. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The DON or Designee will review Resident Council Meeting Minutes monthly to ensure that old business is being discussed at each meeting for 4 months and every other month for 4 months.	

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	- Resident 62 was missing pants. - Although the food tasted good, residents would like more choices. No response to these concerns could be located. During the meeting, the residents voiced they would like the shower times and days to be the same every time and call lights needed to be answered faster. On 8/2/24, the DON responded that she would educate the staff. Documentation was lacking of the Nursing department's responses being discussed in the next month's meeting. During an interview with the Activities Director on 9/24/24 at 11:20 a.m., he indicated there was no place on the Resident Council Minutes form to write what the old business was, but that he did go over last month's concerns and resolutions with the residents at the next meeting. During an interview with RN 1 on 9/30/24 at 9:40 a.m., she indicated the facility did not have a policy on Resident Council. They followed the State and Federal rules on Resident Rights. During an interview with the Social Services Director on 9/30/24 at 9:45 a.m., she indicated the facility did not have a grievance policy. They followed the Resident Rights. During an interview with the ED (Executive Director) on 9/30/24 at 3:00 p.m., she indicated any issues raised in Resident Council meetings were written on a concern form for the responsible department to address. It was then gone over with the Resident Council President as he signed the concern forms. She was not aware the resolutions		The results of the audits will be reviewed at the monthly quality assurance meetings. Changes may be made to the auditing process, based upon the results of the audits.	

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	(old business) were not being brought to the Resident Council at the next meeting. The old Resident Council forms did have a place to write about old business and if there were resolutions to their concerns or it was still being worked on. She did not know why the new forms did not have this section. 3.1-3(k) 3.1-3(l) 3.1-7(a)(2)			
F 0576 SS=E Bldg. 00	483.10(g)(6)-(9) Right to Forms of Communication w/ Privacy Based on record review and interview, the facility failed to ensure the residents received their mail on Saturdays when it was delivered to the facility. This deficient practice had the potential to affect 109 residents currently residing in the facility. Findings include: During the Resident Council meeting on 9/24/24 at 9:55 a.m., with 13 residents whom the Activities Director indicated were alert and oriented. The residents voiced that they were not receiving any mail on Saturdays. They indicated they knew it was being delivered to the facility as they had seen the mailman come in. During an interview with the Activities Director on 9/30/24 at 9:15 a.m., he indicated the mail during the week was passed by him. If the Friday mail came in late in the afternoon, he would go ahead and pass it before he left for the day. The mail was being delivered to the facility on Saturdays, but someone had to sort through it and remove the mail the residents were not supposed to receive such as bills. He did not	F 0576	**F-0576** **Right to Forms of Communication w/Privacy** The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service. The facility failed to ensure that residents received mail on Saturdays when it was delivered to the facility. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All residents have received their mail and will continue to receive their mail the day it is delivered to the facility. Residents were	10/07/2024

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	know who did the sorting on Saturday, but any mail that came in on Saturday was not delivered until Monday when he came in. During an interview with RN 1 on 9/30/24 at 9:40 a.m., she indicated the facility did not have a policy on the mail delivery. The facility followed the State and Federal rules on Resident Rights. During an interview with the Executive Director (ED) on 9/30/24 at 3:00 p.m., she indicated that usually the residents did receive their mail on Saturdays, but they had been short a weekend receptionist on duty for a couple of weeks. The weekend receptionist was responsible for sorting the mail for Activities to then pass to the residents. During this time, the residents did not receive mail on Saturdays. 3.1-3(s)(1)		advised of saturday mail process during resident council. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Mail will be delivered on Saturdays by an assigned staff member. The receptionist and activity staff will ensure that mail is delivered on Saturdays. If neither are present, the charge nurse will distribute Saturday mail. All residents currently residing at Lincoln Hills have the potential to be affected by the deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Staff have been provided education regarding Resident Rights and mail delivery. Activity Staff or receptionist will distribute Saturday mail and document compliance by signing log indicating that it was passed. If the receptionist or activity staff aren't available, the weekend nursing supervisor will distribute and sign log. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place: The DON or Designee will check the mail log weekly for 4 weeks, then bi-weekly for 8 weeks, then monthly for 9 months. Compliance will be discussed at Resident Council meetings monthly and added to the minutes. The results of the audits will be reviewed at the monthly quality assurance meetings. Changes may be made to the auditing process, based upon the results of the audits.	
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on observation, record review and interview, the facility failed to ensure a resident was provided the care and services to prevent the development of skin breakdown for four areas, to ensure the skin assessments identified a pressure ulcer prior to it becoming a Stage 3 wound, and the worsening of the Stage 3 pressure ulcer. This resulted in the wound worsening to a Stage 4 pressure ulcer. (Resident 18) Findings include: The record for Resident 18 was reviewed on 9/26/24 at 10:27 a.m. The resident's diagnoses included, but were not limited to, dementia, skin changes, Stage 4 pressure ulcer (full thickness ulcer with the involvement of the muscle or bone) of the left heel, limitation of activities due to disability, abnormalities of gait and mobilities, lack of coordination, Parkinsonism, hallucinations, left	F 0686	F 686 Treatment/Services to prevent/heal pressure ulcer **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Licensed nurses that work at Lincoln Hills Health Center were educated by 10/07/2024 regarding implementation of interventions to prevent the development of pressure ulcers and the worsening of pressure ulcers. Certified Nurse Aids (CNA) that work at Lincoln Hills Health Center were educated by 10/07/2024 regarding implementation of	10/07/2024

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	foot drop, neuralgia (nerve pain) and neuritis (inflammation of one or more nerves), and type 2 diabetes mellitus with diabetic nephropathy (kidney disease). The nurse's note, dated 10/16/23 at 12:15 p.m., indicated the resident arrived at the facility for admission. The physician's order, dated 10/16/23, indicated to elevate or offload the resident's heels while in bed, as tolerated. The resident was to be turned and repositioned per the plan of care. The care plan, dated 10/17/23, indicated the resident was at risk for skin breakdown related to decreased mobility, incontinence and a diagnosis of diabetes. The interventions, dated 10/26/23, included, but were not limited to, assist the resident with bed mobility as indicated, elevate heels as the resident would allow, monitor skin for signs of skin breakdown, apply a pressure reduction cushion in the wheelchair (if applicable), apply a pressure reduction mattress, turn and reposition for bed mobility, and per the resident's individual needs, and perform weekly skin assessments. The nurse's note, dated 10/18/23 at 8:00 a.m., indicated the resident's skin was assessed with scars to the bilateral knees and lower back, faded bruises on the bilateral shins, and the buttock, peri area, and heels were clean, dry and intact with dry flaky heels and feet. The Admission MDS (Minimum Data Set) assessment, dated 10/25/23, indicated the resident was cognitively intact. The resident required substantial to maximal assistance of two staff members for rolling left and right, sitting to a lying		interventions to prevent the development of pressure ulcers and the worsening of pressure ulcers to include turning and repositioning, incontinent care, placing devices per plan of care for pressure reduction, off-loading pressure points, and reporting refusals of care to the nurse. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents with potential to be affected by the alleged deficient practice were reviewed and a skin sweep was performed on 10/07/2024 all current residents and interventions were in place as appropriate All current residents had a skin risk assessment updated on 10/07/2024. All current residents in the facility with pressure ulcers were assessed by the wound physician, Dr. Hutchinson on 10/07/2024. All current residents in the facility with pressure ulcers had a care plan review completed on 10/07/2024. Ad Hoc PI meeting with Director was held on 10/07/2024. **What measures will be put into place and what systemic changes will be made to**	

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	position, and lying to a sitting position. The resident had no skin breakdown upon admission or refusal of care. The resident had bilateral lower extremity impairment. The resident was at risk for skin breakdown. The physician's orders, dated 11/29/23, indicated to place a low loss air mattress on the resident's bed and the licensed nurse was to perform weekly head to toe skin inspections. If any new areas were observed, the nurse was to complete a Skin Integrity Event once a day on Wednesdays. The physician's order, dated 11/30/23, indicated staff were to off-load the resident's heels every shift. The resident's clinical record indicated on the following dates the resident acquired four areas of skin breakdown. Three of the four areas had healed, and one area had worsened. a. The Events tab report, dated 11/30/24, indicated the resident had an unstageable wound to the right heel. The wound measured 2 cm (centimeters) long by 3 cm wide by an unmeasurable depth. The wound had healed on 12/21/23. b. The Events tab report, dated 12/26/23, indicated the resident had a Stage 3 (full thickness ulcer that extends to the subcutaneous tissue) open wound to the coccyx. The wound measured 1 cm long by 0.6 cm wide by 0.1 cm deep on 11/20/23. The wound had healed on 12/20/23. c. The Events tab report, dated 11/26/23, indicated the resident had an open area to the left side of the outer ankle. No documentation of a wound or size could be found. Upon observation on 9/26/24		**ensure that the deficient practice does not recur:** All licensed nurses that work at Lincoln Hills Health Center were educated regarding implementation of interventions to prevent the development of pressure ulcers and the worsening of pressure ulcers. Newly hired licensed staff nurses will receive the above education upon hire. All Certified Nurse Aids (CNA) that work at Lincoln Hills Health Center were educated regarding implementation of interventions to prevent the development of pressure ulcers and the worsening of pressure ulcers to include turning and repositioning, incontinent care, placing devices per plan of care for pressure reduction, off-loading pressure points, and reporting refusals of care to the nurse. Newly hired CNAs will receive the above education upon hire. Collaboration with wound physician regarding assessment of wounds, recommendations of treatment weekly and staff education on prevention and care of residents with pressure ulcers as necessary. Monitoring of resident care for repositioning, off-loading, and skin moisture care will be conducted through walking rounds by the licensed nurse every shift.	

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	the wound had healed. d. The Events tab report, dated 11/26/23, indicated the resident had an open area to the left heel. The wound management note, dated 11/30/23, indicated a Stage 3 facility acquired pressure ulcer to the resident's left heel was observed, and measured 3 cm long by 3 cm wide by 0.1 cm deep. The surface area measured 9 cm square. There was a moderate amount of serous exudate (clear or pale yellow, watery, thin plasma that leaks from a wound) with granulation tissue (new connective tissue that forms in a healing wound). The dressing order indicated to apply alginate calcium daily for 30 days, cover with an ABD pad, and apply a gauze roll over the dressing. The 12/7/23 Wound Company note indicated the wound to the left heel was improving. The wound management note, dated 12/14/23, indicated the Stage 3 facility acquired pressure ulcer to the resident's left heel measured 2 cm long by 2 cm wide by 0.1 cm deep. There was a light amount of serous exudate with 50% granulation tissue and 50% necrotic tissue. The wound had improved. The care plan, dated 12/14/23, indicated the resident had a Stage 3 pressure ulcer to the left heel. The interventions, dated 12/14/23, included, but were not limited to, provide treatment and monitoring per the physician's orders in the MAR (Medication Administration Record). The nurse's note, dated 12/15/23 at 12:41 p.m., indicated the treatment to the left heel were completed as ordered with no signs or symptoms of infection.		Caring Heart Rounds will be conducted by department team members to assist residents in meeting their needs, checking that devices are in place to aid in off-loading per plan of care and communicating with the clinical team any immediate needs to address. DON or will review current residents with pressure ulcers weekly in IDT to validate interventions are appropriate and in place to monitor for deterioration of pressure ulcers. Regional clinical team oversight to assess need for continued education of wound management weekly through review of wound reports to include the PUSH Tool to monitor for worsening wounds and interventions per plan of care. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** DON or will audit five residents at risk for skin breakdown daily for 1 week, then weekly for implementation of interventions and prevention of worsening pressure ulcers. CNA and licensed nurse's skills competency validation of care for the resident at risk for pressure	

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	The wound management note, dated 12/21/23, indicated the facility-acquired stage three pressure injury deteriorated to an unstageable facility acquired pressure ulcer to the left heel and measured 3 cm long by 3 cm wide by 0.1 cm deep. There was a moderate amount of serous exudate with 100% eschar (dead tissue that eventually sloughs off healthy skin) tissue. The wound physician assessed the wound and indicated the wound was stable, but not at the goal of healing. She would continue to follow weekly. The Wound Company note, dated 1/11/24, indicated a wound evaluation was completed. The wound had improved with a measurement of 1.5 cm long by 1.5 cm wide by 0.1 cm deep. There was 100% thick adherent devitalized necrotic tissue and a moderate amount of serous exudate. The wound management note, dated 1/11/24, indicated the Stage 3 facility acquired pressure ulcer to the resident's left heel had improved and measured 2 cm long by 1.5 cm wide by 0.1 cm deep. There was moderate serous exudate with 80% granulation tissue and 20% necrotic tissue. The physician's order, dated 1/18/24, indicated lift boots were to be placed while the resident was in bed and to check every shift. The wound management note, dated 2/1/24, indicated the Stage 3 facility acquired pressure ulcer to the resident's left heel measured 1.2 cm long by 1 cm wide by 0.1 cm deep. There was a moderate amount of serous exudate with 50% granulation tissue and 50% necrotic tissue and had deteriorated. The wound management note, dated 3/7/24, indicated the Stage 3 facility acquired pressure		ulcers and prevention will be completed every quarter for 1 year. The DON or designee will validate resident care of turning & repositioning to achieve off-loading for residents at risk for skin breakdown daily 4 times per day for 2 weeks, then 2 times per day for 4 weeks, then random shift audits 3 days per week. The results of these reviews will be discussed at the monthly facility Quality Assurance Performance Improvement Committee meeting. Frequency and duration of reviews will be adjusted as needed, if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance/Performance Improvement Committee. **We respectfully request an IDR for this deficiency based on documentation from the wound care physician that this residents wounds were unavoidable.**	

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	ulcer to the resident's left heel measured 1.5 cm long by 1 cm wide by 0.1 cm deep. There was light serous exudate with 30% slough, 70% subcutaneous tissue and 30% slough (cast off dead tissue). The wound was improving. The IDT (Interdisciplinary Team) note, dated 3/22/24 at 1:43 p.m., indicated the resident's left heel wound remained. The nurse's note, dated 3/4/24 at 2:56 p.m., indicated wound care was completed to the bilateral heels per the treatment orders. The area was very tender during the dressing change. A small amount of bleeding was observed to the left heel. The area was cleansed as ordered and the dressing was applied as ordered. The resident denied pain when the dressing change was completed. The wound management note, dated 4/4/24, indicated the Stage 3 facility acquired pressure ulcer to the resident's left heel measured 1.5 cm long by 1.5 cm wide. There was a moderate amount of serous exudate with 60% granulation tissue, 20% slough, and 20% necrotic tissue. The wound was declining. The physician's order, dated 4/17/24, indicated to administer 30 mL (milliliters) of Active Critical Care Liquid Protein three times daily and to place the resident in enhanced barrier precautions. The wound management note, dated 5/9/24, indicated the Stage 3 facility acquired pressure ulcer to the resident's left heel measured 1.5 cm long by 1.5 cm wide by 0.1 cm deep. There was a moderate amount of serous exudate with 100% necrotic tissue and was declining.			

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	The nurse's note, dated 5/27/24 at 11:44 a.m., indicated the left heel dressing was removed with a moderate amount of yellow drainage, indicating infection. The center of the wound had a small black center surrounded by white tissue. The wound management note, dated 5/30/24, indicated the Stage 3 facility acquired pressure ulcer to the resident's left heel was documented as a deep tissue injury and measured 4 cm long by 4 cm wide by 0.1 cm deep with a moderate amount of serous exudate. There was 100% granulation tissue, and the wound was declining. The nurse's note, dated 6/4/24 at 3:52 p.m., indicated the wound care was completed to the resident's left heel. The old dressing was removed, and a large amount of thin foul smelling yellow drainage was present indicating a wound infection. The wound bed had a small amount of pink and yellow slough. The wound was tender to the touch during the wound care. The nurse's note, dated 6/8/24 at 2:40 p.m., indicated when the resident's wound care was completed to the left heel, the old dressing had a large amount of serous drainage and a slight odor. The wound management note, dated 6/12/24, indicated the unstageable facility acquired pressure ulcer to the resident's left heel measured 5 cm long by 5 cm wide by 0.1 cm deep. There was a moderate amount of serous exudate with 50% granulation tissue and necrotic tissue. The wound was declining. The nurse's note, dated 6/14/24 at 5:56 p.m., indicated when wound care was completed, the old dressing had yellow/greenish drainage, and some odor. There was no change from the			

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	assessment on the previous day. The nurse's note, dated 6/17/24 at 4:00 p.m., indicated the dressing change was completed to the resident's left heel, with decreased yellow drainage. The nurse's note, dated 6/20/24 at 11:45 a.m., indicated the resident was seen by the wound physician for the left heel ulcer. The resident indicated she had increased pain due to the procedure being done at bedside. The PRN (as needed) hydrocodone was given for the left heel pain. The dressing change was done to the left heel per the wound nurse and physician. The Wound Company evaluation, dated 6/20/24, indicated the wound to the left heel was staged as unstageable, due to the necrotic tissue. The wound measured 2 cm long by 2 cm wide by 0.1 cm deep. There was 50% thick adherent devitalized necrotic at and 50% granulation tissue. The wound was documented as improved due to the decreased surface area. The dressing was to apply Santyl daily for 9 days and to apply a Mesalt sheet daily for 22 days. Apply a gauze island with border daily for 30 days. Offload the wound and reposition per facility protocol. The wound management note, dated 6/27/24, indicated the resident's wound was now a Stage 4 facility acquired pressure ulcer to the left heel measured 2 cm long by 2 cm wide by 0.1 cm deep with moderate serous exudate. There was 50% granulation tissue and 50% necrotic tissue and was improving. The wound management note, dated 7/18/24, indicated the Stage 4 facility acquired pressure ulcer to the resident's left heel measured 2 cm long			

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	by 2.3 cm wide by 0.4 cm deep with a moderate amount of serous exudate. There was 80% granulation tissue and 20% necrotic tissue. The wound was improving. The Wound Company evaluation, dated 7/24/24, indicated the risks and benefits of using human tissue-based skin substitute graft treatment was discussed with the resident's family member. The family member and physician agreed to proceed with the placement during the subsequent wound care visit. The wound nurse's note, dated 8/5/24 at 1:16 p.m., indicated the pressure ulcer to the resident's left heel measured 2 cm long by 2 cm wide by 1 cm deep with 100% granulation and moderate serous drainage. The wound was stable with the skin substitute not intact. The physician's order, dated 8/26/24, indicated to cleanse the left heel wound with normal saline or wound cleanser and pat dry. Apply Mesalt (dressing used to help manage wounds that are discharging heavily or are infected) and cover with an ABD (abdominal pad). Wrap the dressing with rolled gauze and apply tape. Wrap the rolled gauze with an ACE wrap. Provide dressing changes as needed for soiled or dislodged dressing per physician's orders. Do not disturb the wound bed more than 6 times per day as needed. The wound nurse's note, dated 8/27/24 at 1:12 p.m., indicated during a follow-up of the left foot dressing, the dressing had been replaced. The dressing was removed over the weekend and the skin substitute was absent. The wound measured 2 cm long by 2 cm wide and had improved.			

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	The Quarterly MDS assessment, dated 7/17/24, indicated the resident had bilateral lower extremity impairment. She used a wheelchair for mobility. She required substantial or maximal assistance for putting on or taking off footwear. The wound management note, dated 8/29/24, indicated the Stage 4 facility acquired pressure ulcer to the left heel, measured 1.9 cm long by 1.5 cm wide by 0.3 cm deep with a moderate amount of serous exudate. There was 100% granulation tissue, and the wound was improving. The physician's order, dated 8/29/24, indicated the left heel wound dressing was to be left intact with the skin substitute left in place. The skin substitute was to only be replaced if soiled or dislodged as needed. Do not disturb the wound bed. The skin substitute was to be changed per the wound physician or wound nurse on Thursdays during wound rounds unless soiled or dislodged. The physician's order, dated 8/29/24, indicated to apply Mesalt to the left heel wound and cover with an ABD, wrap with rolled gauze, and apply tape. Wrap the dressing with ACE wrap. The dressing may be replaced if it became soiled or dislodged as needed. This was to be completed by the wound physician or wound nurse manager on Thursdays with the new skin substitute. The wound management note, dated 9/19/24, indicated the Stage 4 facility acquired pressure ulcer to the resident's left heel, measured 0.9 cm long by 1.2 cm wide by 0.3 cm deep with a moderate amount of serous exudate. There was 100% granulation tissue, and the wound was improving.			

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	The wound nurse's note, dated 9/24/24 at 1:35 p.m., indicated a follow-up visit by the wound physician was performed on the left heel pressure ulcer. The dressing was to be kept clean, dry and intact per the physician's orders with a skin substitute in place. The wound management note, dated 9/26/24, indicated the Stage 4 facility acquired pressure ulcer to the resident's left heel, measured 0.8 cm long by 1.2 cm wide by 0.2 cm deep with a moderate amount of serous exudate. There was 100% granulation tissue and was improving. During an interview on 9/26/24 at 8:54 a.m., the wound physician indicated the resident's wound to the left heel wasn't responding well, so a placenta membrane graft was used. After the placenta membrane graft there was a 50% reduction in the wounds size. The wound had been stagnant forever. Pressure was the cause of the wound. The resident had multiple comorbidities of dementia, obesity, and diabetes mellitus. Positioning was a big issue. Even with the boots on the resident, it was hard to get her heels offloaded. She was compliant with turning and repositioning and keeping the boots on. The wound physician had changed treatments over the last year. The skin grafts helped with hormonal stimulation. During an observation and interview on 9/26/24 at 11:00 a.m., the wound physician indicated the resident's left heel wound, measured 1.2 cm x 0.9 cm wide. The resident's oxygen saturations were acceptable now. The wound nurse indicated the resident had her pain medications and she asked the resident if she was experiencing pain. The resident indicated she still had some pain. The wound physician indicated the skin substitute			

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	had just been removed, but it would dissolve over time. The wound bed was a beefy red. The skin substitute was ordered weekly for ten weeks. The wound had improved over the last four weeks. The start date of the left heel wound was on 11/23/23. The resident's heels were offloaded, and the preventative measures were in place on 10/26/23. The resident was independent enough and could remove the preventative measures if she wanted to. The wound physician indicated the resident's left heel wound was not unavoidable, since there needed to be more indicators for that diagnosis. The Skin Assessment policy, dated 2/1/19, included, but was not limited to, " ... Procedure: Residents within a [corporate company] will have a head-to-toe skin assessment completed by a licensed nurse upon admission and weekly thereafter ... committed to providing quality care to our residents by implementing clinical guidance and best practices for management of wounds and other skin conditions throughout a resident's stay ..." 3.1-40(a)(1)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, record review, and interview, the facility failed to ensure a hot liquid assessment was completed for a resident with a decline in function for 1 of 4 residents reviewed for accidents. (Resident 80) Findings include: During an observation on 9/23/24 at 12:30 p.m., Resident 80's lunch tray was sitting on the table	F 0689	**F-0689** **Free of Accident, Hazards/Supervision/Devices** The facility ensures that each resident receives adequate supervision and assistance devices to prevent accidents. The facility failed to ensure a hot liquid	10/07/2024

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	within the resident's reach. No staff were in the resident's room. The resident was able to pull the tray close to him and pick up his spoon. He attempted to pick up his peaches. Due to the resident's bilateral hand contractures, he was unable to pick up the small bowl of peaches. He attempted to pick up a peach with his spoon and was unable to do so. The record for Resident 80 was reviewed on 9/24/24 at 11:00 a.m. The resident's diagnoses included, but were not limited to, moderate intellectual disabilities, limitation of activities due to his disability, contracture of the right hand, contracture of the left hand, contracture of muscle on the right hand, contracture of the muscle on the left hand, and abnormal posture. The Quarterly Minimum Data Set (MDS) assessment, dated 7/4/24, indicated the resident was severely cognitively impaired. The resident had functional limitations in range of motion and required moderate assistance with eating. The nurse's note, dated 1/17/24 at 3:49 p.m., indicated Resident 80 was observed to have spilled soup in his lap during lunch. The resident was brought back to his room after lunch for an assessment. The resident had a red and pink area to his right inner thigh. A therapy and nursing interdisciplinary communication form was completed, related to self-feeding difficulties. The physician order, dated 1/17/24, indicated staff were to apply skin prep to the resident's burn area on the right inner thigh every shift twice a day upon rising and before bedtime. The nurse's note, dated 1/18/24 at 9:54 a.m., indicated the resident's skin was assessed by the		assessment was completed for a resident with a decline in function for 1 of 4 residents reviewed for accidents. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 80 was observed to have spilled soup in his lap during lunch causing reddened area on thigh. Resident is being followed by OT and will be provided a cup with a lid for hot liquids. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Current residents were observed during meal service to ensure safety with drinking cups/hot liquids. Residents will have hot liquids poured for them and not have access to pour their own. All residents have the potential to be affected by this alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Staff will observe residents during the meal service to identify any problems with managing drinking	

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	nurse for a post event follow-up. Redness was observed to the right inner thigh measuring 4.5 cm(centimeters) long by 2.5 cm wide. The nurse's note, dated 1/21/24 at 5:59 p.m., indicated the burn area to the resident's inner thigh had healed at that time. During an interview on 9/30/24 at 9:38 a.m., the DON (Director of Nursing) indicated the resident could feed himself at times. He could pick up finger foods such as sandwiches. Staff encouraged him to eat and if he needed assistance, they would assist him. His hot liquids should be put in a cup with a lid on it. The facility did not do a hot liquid evaluation on the residents and there was no policy for hot liquids. During an interview on 9/30/24, at 10:00 a.m., OT (Occupational Therapy) 2 indicated the resident could handle finger foods. He would use two to three fingers to pick the food up due to his contractures. He had to be positioned straight up in his chair due to the potential for choking. Soups would be difficult for him to handle. The staff should put hot liquids in a cup with a lid. The resident could be impulsive at times and grabbed for his food. She was not aware he received a burn from soup, but she would have concerns giving him anything hot that was not in a cup with a lid on it. 3.1-45(a)		cups. Residents will have hot liquids poured for them and not have access to pour their own. Residents identified to have difficulty with drinking cups will be referred to OT for evaluation/treatment. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The DON or Designee will do 5 random observations during meal service to determine ability to manage drinking cups weekly for 4 weeks, then bi-weekly for 8 weeks, then monthly for 9 months. Any identified residents will be referred for an OT evaluation/treatment. The results of the audits will be reviewed at the monthly quality assurance meetings. Changes may be made to the auditing process, based upon the results of the audits.	
F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on observation, record review and interview, the facility failed to ensure narcotics were documented on the Controlled Drug	F 0755	**F-0755** **Pharmacy**	10/07/2024

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	Record of the administered narcotics for 6 of 68 residents observed for medication storage on the C and E Hall medication carts. (Residents 104, 21, 60, 26, 3, and 54) Findings include: 1. During an observation on 9/25/24 at 1:53 p.m., of the C Hall medication cart, the following were identified: a. Resident 104's oxycodone 10 mg (milligrams) Controlled Drug Record had a count of 7 tablets left. The resident's medication card contained 6 tablets of the oxycodone. The last dose signed out on the Controlled Drug Record was on 9/25/24 at 2:44 a.m. The clinical record was reviewed on 9/29/24 at 1:20 p.m., the physician's order, dated 9/20/24, indicated the resident received the oxycodone 10 mg every 4 hours as needed for pain. The resident's September MAR (Medication Administration Record) indicated the resident's last dose of oxycodone 10 mg was administered on 9/25/24 at 12:38 p.m., by LPN (Licensed Practical Nurse) 3. b. Resident 21's hydrocodone/APAP (acetaminophen) 5-325 mg Controlled Drug Record had a count of 8 tablets left. The resident's medication card contained 7 tablets of the hydrocodone/APAP. The last dose signed out on the Controlled Drug Record was on 9/24/24 at 9:00 p.m. The clincial record was reviewed on 9/29/24 at 1:24 p.m., the physician's order, dated 9/19/24, indicated the resident received the		**Srvcs/Procedures/Pharmacist/Records** The facility must establish a system that determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. The facility failed to ensure narcotics were documented on the Controlled Drug Record of the administered narcotics for 6 of 68 residents observed for medication storage on the C and E Hall medication carts. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents 104, 21,60,26, 3, and 54 received medications as ordered and suffered no ill effects. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All narcotic sheets have been reviewed for correct documentation. All residents have the potential to be affected by this alleged deficient practice. **What measures will be put into place and what systemic changes will be made to**	

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	hydrocodone/APAP 5-325 mg twice a day for pain. The resident's September MAR indicated the resident's last dose of hydrocodone 5-325 mg was administered on 9/25/24 between 7:00 a.m. and 11:00 a.m., by LPN 3. c. Resident 60's Tramadol 50 mg Controlled Drug Record had a count of 18 tablets left. The resident's medication card contained 17 tablets of the Tramadol. The last dose signed out on the Controlled Drug Record was on 9/24/24 at 8:00 p.m. The clinical record was reviewed on 9/29/24 at 1:27 p.m., the physician's order, dated 9/13/24, indicated the resident received the Tramadol 50 mg twice a day for pain. The resident's September MAR indicated the resident's last dose of Tramadol 50 mg was administered on 9/25/24 between 7:00 a.m. and 11:00 a.m., by LPN 3. d. Resident 26's Clonazepam 0.5 mg Controlled Drug Record had a count of 14 tablets left. The resident's medication card contained 13 tablets of the Clonazepam. The last dose signed out on the Controlled Drug Record was on 9/24/24 at 8:00 p.m. The clinical record was reviewed on 9/29/24 at 1:29 p.m., the physician's order, dated 9/18/24, indicated the resident received the Clonazepam 0.5 mg twice a day for anxiety disorder. The resident's September MAR indicated the resident's last dose of Clonazepam 0.5 mg was administered on 9/25/24 between 7:00 a.m. and		**ensure that the deficient practice does not recur:** Nursing staff have been provided re-education regarding narcotic medication needing to be signed out on the MAR immediately upon administration and signed out in the narcotic book on the count sheet immediately upon administration. Nursing supervisors will check documentation at the beginning and end of each shift to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The DON or Designee will do 5 random audits of residents narcotic sheets to ensure that they are documented correctly weekly for 4 weeks, then bi-weekly for 8 weeks, then monthly for 9 months. The results of the audits will be reviewed at the monthly quality assurance meetings. Changes may be made to the auditing process, based upon the results of the audits	

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	155614	A. BUILDING 00 B. WING	09/30/2024

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	11:00 a.m., by LPN 3.. e. Resident 3's Clonazepam one half tablet of 0.5 mg (0.25 mg) Controlled Drug Record had a count of 17 tablets left. The resident's medication card contained 16 tablets of the Clonazepam. The last dose signed out on the Controlled Drug Record was on 9/24/24 at 8:00 p.m. The clincial record was reviewed on 9/29/24 at 1:32 p.m., the physician's order, dated 6/6/24, indicated the resident received the Clonazepam one half tablet of 0.5 mg (0.25 mg) three times daily for anxiety disorder. The resident's September MAR indicated the resident's last dose of Clonazepam one half tablet of 0.5 mg (0.25 mg) was administered on 9/25/24 between 7:00 a.m. and 11:00 a.m., by LPN 3. f. Resident 3's Tramadol 50 mg Controlled Drug Record had a count of 14 tablets left. The resident's medication card contained 13 tablets of the Tramadol. The last dose signed out on the Controlled Drug Record was on 9/24/24 at 8:00 p.m. The clincial record was reviewed on 9/29/24 at 1:35 p.m., the physician's order, dated 6/30/23, indicated the resident received the Tramadol 50 mg three times daily for chronic pain. The resident's September MAR indicated the resident's last dose of Tramadol 50 mg was administered on 9/25/24 between 7:00 a.m. and 11:00 a.m., by LPN 3. During an interview on 9/25/24 at 1:58 p.m., LPN 3 indicated she should have signed out each narcotic as she pulled it.			

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	2. During an observation on 9/25/24 at 2:21 p.m., E Hall medication cart, the following was observed: Resident 54's hydrocodone/APAP 5-325 mg Controlled Drug Record had a count of 11 tablets left. The resident's medication card contained 10 tablets of the hydrocodone/APAP. The last dose signed out on the Controlled Drug Record was on 9/24/24 at 8:30 p.m. The clinical record was reviewed on 9/29/24 at 1:40 p.m., the physician's order, dated 8/28/24, indicated the resident received the hydrocodone/APAP 5-325 mg every 6 hours as needed for pain. The resident's September MAR indicated the resident's last dose of hydrocodone 5-325 mg was administered on 9/25/24 at 9:13 a.m., by LPN 4. During an interview on 9/25/24 at 2:25 p.m., LPN 4 indicated she should have signed the narcotic out after it was given. During an interview on 9/26/24 at 8:39 a.m., the DON (Director of Nursing) indicated nurses should sign narcotics out once it was given. Neither of the nurses did that. They needed to show that the count was correct and that there were no narcotic discrepancies. The current Clinical Policy and Procedure for Scheduled Drugs, included but was not limited to, " ... Step 2: Passing of Scheduled Drugs. Immediately after a dose of a scheduled drug is administered, the licensed nurse administering the schedule drug is to enter all of the following information on the green sheet attached hereto as Exhibit 1: Date and time of administration. Dose			

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	administered. Signature of nurse administering the dose. Remaining Doses ..." 3.1-25(b)(1)(c)			