STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155738	A. BUILDING 00 B. WING	08/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILTON HOME, THE	206 E MARION ST SOUTH BEND, IN 46601

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: July 26, 27, 28, 29, and August 1, 2022 Facility number: 001141 Provider number: 155738 AIM number: 200905640 Census Bed Type: SNF/NF: 24 Residential: 14 Total: 38 Census Payor Type: Medicare: 3 Medicaid: 17 Other: 4 Total: 24 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/4/22.	F 0000		
F 0622 SS=A Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's			

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

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	needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that			

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	the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.			
	Based on record review, and interview, the facility failed to ensure each resident had a	F 0622	**F622- Transfer and Discharge Requirements**	08/26/2022

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	transfer/discharge summary completed and was given a written notice of the bed bold policy and the appeal of rights information after the facility initiated transfer of the resident to the hospital for 2 of 2 residents reviewed for hospitalization. (Residents 21 and 24) Findings include: 1. Record review for Resident 21 was completed on 7/27/22 at 2:12 p.m. Diagnoses included, but were not limited to, dementia, and Parkinson's disease. The Admission Minimum Data Set (MDS) assessment, dated 6/30/22, indicated the resident was moderately cognitively impaired. A Progress Note, dated 7/24/22 at 6:11 a.m., indicated the resident's condition declined. The doctor was notified and an order was received to send the resident to the Emergency Room (ER). The paper work was done. The record lacked documentation that a transfer/discharge summary for the resident was completed, and the resident or the resident's representative received a written notice of the bed hold policy and the appeal of rights information after the facility initiated transfer of the resident to the hospital. Interview with Nurse Consultant on 7/29/22 at 11:11 a.m., indicated she was unable to locate the transfer paperwork that was completed for the resident when they were sent to the hospital. 2. Record review for Resident 24 was completed on 7/28/22 at 11:25 a.m. Diagnoses included, but were not limited to, hypertension, diabetes		**1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident # 21 and resident # 24 did not have a negative outcome related to the alleged deficient practice. **2.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents in the facility have the potential to be affected by the same alleged deficient practice. ·Audit of residents that have been transferred or discharged in last 60 days completed to ensure that discharge summary/ bed hold policy was provided or completed. IDT will follow up and correct any irregularities noted if applicable **3.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Licensed nursing staff educated on Bed Hold Policy, process and procedures and requirements for discharge summary to be sent with residents at time of transfer/discharge · IDT has been educated on the process for sending a copy of the discharge papers with residents who discharged when	

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	mellitus, and psychotic disorder. The Annual MDS assessment, dated 6/23/22, indicated the resident was cognitively intact. A Progress Note, dated 1/11/22 at 3:35 p.m., indicated the resident had been complaining of stomach pain. The doctor was notified with an order received to sent the resident to the ER. The record lacked documentation that a transfer/discharge summary for the resident was completed, and the resident or the resident's representative received a written notice of the bed hold policy and the appeal of rights information after the facility initiated transfer of the resident to the hospital. Interview with Nurse Consultant on 7/29/22 at 11:11 a.m., indicated she was unable to locate the transfer paperwork that was completed for the resident when they were sent to the hospital. 3.1-12(a)(6)(A) 3.1-12 (a)(9)(A)		they are alert and orientated and to provide a copy to the responsible party for residents who are not alert or oriented at the time of discharge via the mail. · IDT educated on use of Clinical meeting process with emphasis on IDT discharge review process · IDT team educated on discharge process including Bed Hold Policy and discharge summary requirements · Social services/designee will maintain a log for all discharges and log who was provided copies of discharge paperwork. **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 into place?** ·SSD/ designee will complete the Discharge/ Transfer Audit to ensure that Bed Hold policy was followed and discharge summary was completed ·Audit will be completed weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is	

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			maintained for 2 consecutive quarters. ·The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission.			

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	(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.			
	Based on observation, record review, and interview, the facility failed to develop a baseline care plan within 48 hours of admission related to oxygen use for 1 of 17 residents whose care plans were reviewed. (Resident 23) Finding includes: On 7/26/22 at 11:39 a.m., Resident 23 was observed with oxygen on via a nasal cannula with a flow rate of 4 liters. The resident indicated she always wore her oxygen. Record review for Resident 23 was completed on 7/26/22 at 1:42 p.m. The resident was admitted to the facility on 6/8/22. A Care Plan indicated the resident had chronic obstructive pulmonary disease (COPD) and respiratory failure. The care plan did not reflect oxygen use. The record lacked any documentation a base line	F 0655	**F655 Baseline Care Plan** **1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 23's baseline care plan was completed, and her comprehensive care plan is up to date and reflects the use of oxygen. **2) 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 that have been admitted to the facility at risk for same alleged deficient practice. · An Audit of the new	08/26/2022

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	care plan related to oxygen use was completed. Interview with Nurse Consultant on 7/29/22 at 11:11 a.m., indicated she could not provide any documentation to indicate a baseline care plan for oxygen had been completed. 3.1-30(a)		admissions from the last 60 days completed. Residents with missing or incomplete baseline care plans will be reviewed, audited with comprehensive care plan to ensure accuracy and completion. **3) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** · DON/Designee will provide education to nursing and IDT team related to baseline care plans. Education to include: o A review of the 48 Hour Baseline Care Plan Policy & Procedure. o Special emphasis will be placed on the admitting/readmitting charge nurse responsibility to initiate the 48-hour Baseline Care Plan UDA in PCC o Further emphasis will be placed on detailing any service and treatment to be administered by the facility according to physician orders such as oxygen use · Nurse Consultant will provide education to IDT Team on IDT Admission Review Process Education to include: o The DNS and/or designee will review all new admissions within 48 hours of admission to ensure	

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			that a Baseline Care Plan or Comprehensive Care Plan has been created and meet the requirements of483.21. DNS and/or designee will complete the Baseline Care Plan at that time in the event of noncompliance. **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 into place.** · The Clinical Management Team will be responsible to identify new admissions or readmissions daily, including weekends and holidays alerting the IDT. · The Clinical Manager will assure the 48 Hour Baseline Care Plan UDA was initiated and completed within 48 hours of admission. The Clinical Manager will review the completed Baseline Care Plan to assure services and treatments necessary to properly care for a resident. · Baseline care plan audit will be completed including each admission/readmission to validate Implementation and completion of accurate baseline care plan · The DON/designee will be responsible for the completion of the Baseline Care Plan Audit Tool o Audit will be completed weekly times 4 weeks, monthly	

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			times 5 months, and quarterly until continued compliance is maintained for 2 consecutive quarters. · The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will			

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	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.			
	Based on record review and interview, the facility failed to ensure an individualized care plan was developed related to diabetes management for 1 of 17 resident care plans reviewed. (Resident 11) Finding includes: Record review for Resident 11 was completed on 7/27/22 at 3:31 p.m. Diagnoses included, but were not limited to, diabetes management and anemia. The Admission Minimum Data Set (MDS) assessment, dated 5/30/22, indicated the resident was cognitively intact. The resident had received insulin (diabetes medication). The record lacked any documentation a care plan had been completed related to diabetes management. Interview on 7/28/22 at 10:23 a.m. with Regional MDS indicated the resident should have had a	F 0656	**656- Developing comprehensive Assessments** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·IDT team reviewed resident 11 and compressive care plan was reviewed including care plan for Diabetes Mellitus **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** **All residents in the facility have the potential to be affected by alleged deficient practice** ·Facility to complete audit of all resident's care plans conducted to ensure accuracy, facility will audit	08/26/2022

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	care plan for the management of diabetes. 3.1-35(a)		5 Resident Care plans weekly until 100% of Resident care plans reviewed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·IDT in-serviced on the MDS assessment process and their role including use of CARE PLAN Review sheet to ensure all areas are addressed ·Audits Tool "Comprehensive Care Plan Audit Tool" will be completed for all new admissions to ensure completion within 21 days of the date of admission or 7 days after the ARD to ensure accuracy of assessments, Care plans, and Coding. ·Audit Tool "Comprehensive Care Plan Audit Tool" will be completed as part of all resident Quarterly and annual assessments or upon change of condition to ensure accuracy of MDS and Care Plans within 7 days of the ARD. **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?** ·MDS/ Designee will complete "Comprehensive Care Plan Audit Tool" will be completed for all new admissions to ensure completion within 21 days of the date of	

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			admission or 7 days after the ARD to ensure accuracy of assessments, Care plans, and Coding. ·Audit Tool "Comprehensive Care Plan Audit Tool" will be completed as part of all resident Quarterly and annual assessments or upon change of condition to ensure accuracy of MDS and Care Plans within 7 days of the ARD. o Audit will be completed weekly times 4 weeks, monthly times 5 months, and quarterly until continued compliance is maintained for 2 consecutive quarters. · The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review and interview, the facility failed to ensure dependent residents received ADL (activities of daily living) assistance related to scheduled showers and shaving for 2 of 2 residents reviewed for ADL care. (Residents 15 and 19)	F 0677	**677- ADL Care for Dependent Residents** **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	08/26/2022

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	Findings include: 1. On 7/26/22 at 10:16 a.m., Resident 15 was observed in bed. He was wearing tubigrips (elastic coverings) on both arms. Both were soiled with dried blood. He indicated he was only getting a shower or bath once every two weeks. The resident's record was reviewed on 7/27/22 at 1:39 p.m. The resident was admitted on 12/10/21. Diagnoses included, but were not limited to, Diabetes Mellitus, weakness and low back pain. The Quarterly Minimum Data Set (MDS) assessment, dated 5/3/22, indicated the resident was cognitively intact, and required one person assistance for transfers, bed mobility and toileting. The June and July 2022 shower sheets indicated the resident was showered on the following days: 6/16/22, 7/7/22 and 7/16/22. He was scheduled to receive showers every Monday and Thursday. There was no documentation he had refused any scheduled showers. 2. On 7/27/22 at 9:41 a.m., Resident 19 was observed in bed. He was unshaven. The resident's record was reviewed on 7/27/22 at 9:33 a.m. The resident was admitted on 2/26/19. Diagnoses included, but were not limited to, Alzheimer's disease and heart disease. The Quarterly MDS, dated 6/24/22, indicated the resident had severe cognitive deficits, and required limited assistance with bed mobility, transfers and toileting.		**practice?** ·Residents 15 and 19 were provided with ADL care related to showers and shaving did not have a negative outcome related to the alleged deficient practice **1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents in the facility have the potential to be affected by alleged deficient practice** · Audit completed of showers to ensure that each resident has schedule and agreed upon shower days, shower schedule to be updated as necessary · Audit completed of residents in the facility and all with facial hair offered ADL care. **1.What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·Nursing Staff in serviced related to ADL care for dependent resident, with emphasis on showers, documentation, and shaving **1.How will the corrective action (s) be monitored to ensure the deficient practice**	

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	155738	A. BUILDING 00 B. WING	08/01/2022

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	The June and July 2022 shower sheets indicated the resident was showered and shaved on 7/6/22, showered on 6/8/22, and refused on 7/16/22. He was scheduled to receive showers every Wednesday and Saturday evening. A telephone interview with a family member on 7/26/22 at 1:32 p.m., indicated the resident had always been clean shaven, but had not been shaved in a while. Interview with CNA 2 on 7/27/22 at 1:57 p.m., indicated residents should get two showers a week and a shower sheet should be completed with each shower. If refused, that should be documented also. 3.1-38(a)(3)		**will not recur, i.e., what quality assurance program will be put into place?** ·DON/ designee will complete ADL care Audits to monitor residents ADL status including showers and nailcare o Audit will be completed weekly times 4 weeks, monthly times 5 months, and quarterly until continued compliance is maintained for 2 consecutive quarters. · The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure residents received the necessary treatment and services related to not obtaining a Physician's order for	F 0684	**684- Quality of Care** **1.What corrective action(s) will be accomplished for those residents found to have been**	08/26/2022

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	wound treatment for 1 of 4 residents reviewed for non-pressure related skin conditions, not ordering or following up on a Physician's order for a chest x-ray for 1 of 3 residents reviewed for respiratory care, and not following up on a urinalysis for 1 of 2 closed records reviewed. (Residents 15, 20 and 21) Findings include: 1. On 7/26/22 at 10:16 a.m., Resident 15 was observed in bed. He was wearing tubigrips (elastic coverings) on both arms. Both were soiled with dried blood. He indicated he fell a few days ago and had skin tears on both arms, and staff had applied the tubigrips. The resident attempted to pull the tubigrip down to observe the skin tear, but the dried blood stuck the wound to the tubigrip. The resident's record was reviewed on 7/27/22 at 1:39 p.m. The resident was admitted on 12/10/21. Diagnoses included, but were not limited to, Diabetes Mellitus, weakness and low back pain. The Quarterly Minimum Data Set (MDS) assessment, dated 5/3/22, indicated the resident was cognitively intact, and required one person assistance for transfers, bed mobility and toileting. There was no documentation in the progress notes related to the resident falling or obtaining skin tears. There was no Physician's order for treatment of the skin tears. Interview with CNA 1 on 7/27/22 at 2:07 p.m., indicted the resident had fallen in the bathroom		**affected by the deficient practice?** · MD was notified and treatment orders obtained for Resident #15, skin tears have now resolved · MD notified of Resident # 20s CXR results orders were received and followed. · MD was notified that UA results of Resident # 21 were finalized on 7/15, results with less than 10,000 CGU/ml **2.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** **All residents in the facility have the potential to be affected by alleged deficient practice** · Full house skin sweep completed · Audit of lab and radiology orders and reports reviewed for last 30 days and any MD notifications or follow- up completed as necessary **3.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · All Licensed nursing staff in-serviced Quality of Care and treatment with emphasis on obtaining treatment orders for new skin impairment, obtaining labs/ UAs, and radiology follow up and documentation	

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	Saturday evening. CNA 1 and another CNA assisted him off the floor, and he had obtained the skin tears at that time. Interview with LPN 1 on 7/27/22 at 2:11 p.m., indicated the resident had picked at his skin so the weekend nurse had placed tubigrips on him. He indicated he was not aware of the resident falling or having skin tears. 2. Resident 20's record was reviewed on 7/28/22 at 9:44 a.m. The resident was admitted on 6/19/22. Diagnoses included, but were not limited to, Diabetes Mellitus and lymphedema. A Progress Note, dated 7/12/22, indicated the resident was complaining of shortness of breath. The Physician was notified, and he ordered a chest X-ray and labs. There was not a chest X-ray completed until 7/21/22. Interview with the Unit Manager on on 7/29/22 at 9:40 a.m., indicated the night nurse had notified the Physician and received the orders. The Unit Manager indicated she had placed the order stat that morning on 7/12/22. She was unable to locate a chest x-ray prior to the one dated 7/21/22. 3. Record review for Resident 21 was completed on 7/27/22 at 2:12 p.m. Diagnoses included, but were not limited to, dementia, and Parkinson's disease. The Admission Minimum Data Set (MDS) assessment, dated 6/30/22, indicated the resident was moderately cognitively impaired. A Progress Note, dated 6/28/2022 at 6:37 a.m., indicated the resident was noted with blood in the urine in his brief. The doctor was notified with		· IDT education on daily clinical meeting and 24-hour report review to ensure IDT is capturing and following up with outstanding clinical follow up such as labs and radiology orders · IDT education on Lab and Radiology Tracking process **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 into place?** · DNS/designee will complete Quality of Care related to change of condition Audit to ensure all change of conditions have been identified and followed up appropriately · DNS/designee to complete Lab/Radiology audit to ensure all labs and radiology have been obtained and followed up on appropriately · Audits will be completed **daily x 5**, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	new order to send a urinalysis. A Progress Note, dated 6/29/22 at 7:32 a.m., indicated urine was collected by clean catch for urinalysis and picked up for testing. A Progress Note, dated 7/24/22 at 6:11 a.m., indicated the resident had been sent to the Emergency Room related to a decline. The record lacked any documentation of results for the urinalysis completed on 6/29/22, nor had any follow up been completed. Interview on 7/28/22 at 10:57 a.m. with the Interim Director of Nursing indicated they should have followed up sooner on the urine collection. Interview on 7/29/22 at 11:11 a.m., with Nurse Consultant indicated she could not provide any further information related to the delay in the follow up regarding the urinalysis. 3.1-37(a)			
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			

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	with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure pressure offloading boots were in place as ordered for 1 of 2 residents reviewed for pressure ulcers. (Resident 22) Finding includes: On 7/26/22 at 3:39 p.m., Resident 22 was observed lying in bed. No pressure offloading boots were observed on her feet. On 7/27/22 at 2:08 p.m., Resident 22 was observed lying in bed. No pressure offloading boots were observed on her feet. On 7/28/22 at 10:45 a.m., Resident 22 was observed lying in bed. No pressure offloading boots were observed on her feet. Record Review for Resident 22 was completed on 7/28/22 at 11:17 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, hypertension, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 6/30/22, indicated the resident was severely cognitively impaired. The resident required an extensive 1 person assist for bed mobility and a total 1 person assist with dressing. The resident had impairment on both upper and lower extremities for a limitation in functional range of motion. The resident had 2 unstageable pressure ulcers and was on hospice care. A Care Plan, dated 6/23/21 and revised on 7/26/22, indicated the resident was at risk for skin	F 0686	**686- Pressure Ulcers** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident #22 had boots placed to BLE, resident with no negative outcome related to alleged deficiency. Resident # 22 will continue to be evaluated for healing and appropriate treatment modality weekly by the wound care physician. **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 in the facility have the potential to be affected by alleged deficient practice** ·Full house skin sweep completed with any new or abnormal assessments reported to the Physician. ·Audit completed of all residents to ensure all who are at risk for skin breakdown have preventative interventions in place and that interventions are listed in Care plan and Kardex ·Nursing staff educated on Nursing staff in-serviced on preventative wound care with emphasis importance of placing skin preventative interventions	08/26/2022

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	breakdown due to decreased mobility. An intervention included to float heels when in bed. A Care Plan, dated 7/26/22, indicated the resident had a pressure ulcer to the right medial foot. An intervention included to float heels. A Wound Assessment, dated 7/20/22, indicated the resident had an unstageable pressure ulcer to the right medial foot. The July 2022 Physician's Order Summary indicated an order for pressure relieving boots to be worn at all times while in bed and up in the chair. Interview with QMA 1 on 7/28/22 at 10:48 a.m., indicated the resident should have the pressure relieving boots on. She was unable to find them to apply them. 3.1-40(a)(2)		such as floating heels and pressure relieving boots. ·Nursing staff educated on use of Kardex / pocket care plan and what interventions are listed and in place for each resident **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·Nursing staff in-serviced on preventative wound care per policy with emphasis importance of placing skin preventative interventions such as floating heels and pressure relieving boots ·Nursing staff educated on use of Kardex and what interventions are listed and in place for each resident ·DON /designee will validate treatments continue to be completed as ordered and pressure relieving devices are in place. ·Wound team to make weekly rounds on residents identified with skin impairment to ensure treatments continue to be completed per order and devices are in place for prevention of skin breakdown, notify Physicians as changes are needed and that the plan of care is current/up-dated as needed. ·DON/designee will conduct rounds each shift to ensure preventative pressure relieving devices are in place per plan of	

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			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/designee will conduct rounds each shift to ensure preventative pressure relieving devices are in place per plan of care. ·Wound team to make weekly rounds on residents identified with skin impairment to ensure treatments continue to be completed per order and devices are in place for prevention of skin breakdown, notify Physicians as changes are needed and that the plan of care is current/up-dated as needed. ·The DON/Designee is responsible for the completion of the Skin/ Wound Audit weekly for 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. · The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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F 0688 SS=D 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 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, record review, and interview, the facility failed to ensure a splint was in place as ordered and Physician Orders included specific directions for use for 1 of 2 residents reviewed for limited range of motion. (Resident 17) Finding includes: On 7/26/22 at 3:52 p.m., Resident 17 was observed lying in bed. No splints were observed on the residents arms. An arm splint was observed on the nightstand next to the bed. On 7/27/22 at 11:34 a.m., Resident 17 was observed sitting in a reclining highback wheelchair in a dining area. The resident's arms were observed laying on his chest and no splints	F 0688	**688 Increase/Prevent Decrease in ROM/Mobility** **1.What corrective actions will be accomplished for those residents found to be affected by the alleged deficient practice.** ·Orders for splints clarified and entered for resident # 17 **2.How will you identify other residents having the potential to be affected by deficient practice and what corrective action will be taken?** ·All residents with splints ordered have the potential to be affected by the alleged deficient	08/26/2022

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	were observed on his arms. Record review for Resident 17 was completed on 7/27/22 at 12:12 p.m. Diagnoses included, but were not limited to, anoxic brain damage, contractures, cerebral palsy and stroke. The Admission Minimum Data Set (MDS) assessment, dated 6/23/22, indicated the resident was severely cognitively impaired. The resident required and extensive 2+ person assist for bed mobility and a total 2+ assist for dressing. The resident had an impairment of both upper and lower extremities for a functional limitation in range of motion. The July 2022 Physician's Order Summary indicated an order for bilateral hand and right elbow splints for contracture management. No directions were specified for the order. Interview with the Interim Director of Nursing on 7/27/22 at 11:41 a.m.., indicated therapy was responsible for applying and removing the residents splints. Therapy had ordered new splints and the splint on the nightstand was not to be used. Interview with the Director of Therapy on 7/27/22 at 11:47 a.m., indicated the resident was no longer in therapy and that the nursing staff was responsible for applying and removing the resident's splints. She had ordered another elbow splint because the one they had was broken. The staff had been educated to place a washcloth in his elbow crease until the new splint arrived. The resident should have still been wearing the wrist splints and the staff had been educated on how to apply and remove them.		practice. ·Audit of all residents with splints completed to ensure that orders are in place and clarified **3.What measures will be put in place or what systemic changes you will make to ensure that the alleged deficient does not recur** ·Nursing staff to be educated on splinting, orders, and application. ·Therapy educated on process to notify nursing staff of splints and orders required ·Nursing to therapy communication will be discussed in daily clinical meeting **4.How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place?** ·DON/Designee to complete “ROM/Mobility” audit to ensure that all residents with splints have orders in correctly and to ensure that splints are being applied per order ·DON/Designee will audit weekly for 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be	

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	A policy titled, "Splints" and received as current from the Administrator on 7/27/22, indicated, "...5. Nursing staff will: ... f. follow the device schedule as determined...." 3.1-42(a)(2)		developed to ensure compliance	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure a fall was investigated, post-fall monitoring was completed and interventions were in place for a resident with a history of falls for 2 of 2 residents reviewed for accidents. (Residents 15 and 19) Findings include: 1. On 7/26/22 at 10:16 a.m., Resident 15 was observed in bed. He was wearing tubigrips (elastic coverings) on both arms. Both were soiled with dried blood. He indicated he fell a few days ago and had skin tears on both arms, and staff had applied the tubigrips. The resident's record was reviewed on 7/27/22 at 1:39 p.m. The resident was admitted on 12/10/21. Diagnoses included, but were not limited to, Diabetes Mellitus, weakness and low back pain.	F 0689	**689- Accidents** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #15 was assessed, had IDT fall review completed, all resident interventions were reviewed, and care plan was updated. MD was notified of fall event. · Resident # 19 had fall interventions reviewed by IDT team and care plan updated, appropriate interventions in place in residents room per plan of care. **How will you identify other residents having the potential to be affected by the same deficient practice and what**	08/26/2022

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	The Quarterly Minimum Data Set (MDS) assessment, dated 5/3/22, indicated the resident was cognitively intact, and required one person assistance for transfers, bed mobility and toileting. There was no documentation in the progress notes related to the resident falling or obtaining skin tears. There was no post fall assessment completed. Interview with CNA 1 on 7/27/22 at 2:07 p.m., indicted the resident had fallen in the bathroom Saturday evening. CNA 1 and another CNA assisted him off the floor, and he had obtained the skin tears at that time. Interview with LPN 1 on 7/27/22 at 2:11 p.m., indicated the resident had picked at his skin so the weekend nurse had placed tubigrips on him. He indicated he was not aware of the resident falling or having skin tears. Interview with the Interim Director of Nursing (DON) on 7/27/22 at 2:14 p.m., indicated she had not been notified the resident fell. If a resident had fallen, she was to be notified and an incident report was to be completed, and the resident should be monitored. 2. On 7/27/22 at 9:41 a.m. and 7/28/22 at 8:49 a.m., Resident 19 was observed in bed. There were no non-skid strips on the floor next to his bed, and a floor mat was leaning against the wall. The resident's record was reviewed on 7/27/22 at 9:33 a.m. The resident was admitted on 2/26/19. Diagnoses included, but were not limited to, Alzheimer's disease and heart disease.		**corrective action will be taken?** **All residents in the facility have the potential to be affected by alleged deficient practice** ·An Audit of resident falls completed for last 60 days and all fall events reviewed to ensure that IDT note was written, and care plan was updated with intervention and that interventions were in place ·Resident interviews completed to identify any potential falls that did not have accurate assessment or documentation ·Skin Sweep completed to identity any skin impairment that may be related to fall event. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·Nursing staff educated on fall policy and procedures with emphasis on post fall assessment and documentation. Nursing staff educated on fall follow up procedures and documentation. ·IDT was educated on facility Fall policy with emphasis on IDT review and Care Plan Updates and interventions. ·All falls will be reviewed by the IDT team the following business day as part of the daily clinical meeting to determine root cause and other possible interventions to prevent future falls. Care plans will be updated as appropriate.	

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	155738	A. BUILDING 00 B. WING	08/01/2022

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	The Quarterly Minimum Data Set (MDS) assessment, dated 6/24/22, indicated the resident had severe cognitive deficits, and required limited assistance with bed mobility, transfers and toileting. A Care Plan, updated 6/30/21, indicated the resident was at risk for falls and had a history of falls with serious injury. Interventions included to have a floor mat on bedside, and non-skid strips at bedside. Interview with the Interim DON on 7/28/22 at 8:54 a.m., indicated when the resident was in bed, the floor mat should be in place. Interview with the MDS nurse on 7/28/22 at 9:00 a.m., indicated she spoke to staff and they indicated the mat was slipping and that was why it was not in use. She indicated staff should have notified them of the concern, and new interventions would need to be put into place. 3.1-45(a)		·DON/Designee will conduct rounds weekly to ensure fall interventions are implemented 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/ designee will complete the Fall Management audit tool to ensure fall procedures are followed and interventions are in place. ·Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. ·The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's			

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	comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on interview and record review, the facility failed to ensure a resident with a urinary catheter received the necessary treatment and services related to not changing the catheter, completing catheter care daily and not assessing urinary output as ordered for 1 of 1 residents reviewed for urinary catheters. (Resident 9) Finding includes: Interview with Resident 9 was completed on 7/26/22 at 11:46 a.m. The resident indicated he has had multiple issues with his urinary catheter. On one occasion, it took the facility an entire day to change out his catheter which was very	F 0690	**F 690 Bowel. Bladder, Incontinence, Catheter, UTI** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #9 was provided with catheter care and suprapubic catheter changed per MD orders. Resident did not have a negative outcome related to the alleged deficient practice **2.How will you identify other**	08/26/2022

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	uncomfortable. The facility told him they didn't have supplies available because they were locked up and they could not get to them. Record review for Resident 9 was completed on 7/27/22 at 10:54 a.m. Diagnoses included, but were not limited to, stroke, obstructive uropathy, renal insufficiency and hypertension. The Quarterly Minimum Data Set (MDS) assessment, dated 5/19/22, indicated the resident was cognitively intact. The resident required an extensive 1 person assist for toilet use and the resident had an indwelling catheter. A Care Plan, revised on 11/9/21, indicated the resident had an indwelling suprapubic urinary catheter. Interventions included to complete catheter changes per the physician's orders and to provide catheter care as ordered. The July 2022 Physician's Order Summary indicated orders for the following: - cleanse the suprapubic catheter site and tubing with soap and water, pat dry, apply drain sponge and anchor daily and when necessary - Urinary Output Every shift. Record output. - Catheter orders: catheter care every shift every shift - Change suprapubic catheter every 14 days and when necessary for blockage. The June 2022 Medication Administration Record (MAR) and Treatment Administration Record (TAR) indicated the following: - change suprapubic catheter every 14 days: was not completed on 6/4/22 and refused on 6/18/22 - cleanse suprapubic daily: was not completed at bedtime on 6/12/22, 6/27/22, and 6/29/22 - catheter orders: catheter care every shift: was		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents in the facility with Catheters have the potential to be affected by alleged deficient practice** · An Audit of residents with catheters to ensure that all residents have all appropriate catheter care and maintenance orders. **3.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Nursing staff educated on Catheter care, emphasis on daily catheter care, daily output monitoring and following MD orders related to changing suprapubic catheters. · Nursing staff educated on documentation with emphasis of signing out EMAR/ETAR after treatment has been complete · Audit completed to ensure that all appropriate catheter supplies are present and nursing staff education on location of supplies. · IDT to review EMAR/ETAR compliance reports and follow up with any missing documentation as necessary **4.How the corrective action (s) will be monitored to ensure the**	

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	not completed on days: 6/14/22 and 6/29, and evenings: 6/27/22 and 6/29/22 - urinary output: was not completed on days: 6/2/22, 6/5/22, 6/9/22, 6/13/22, 6/14/22, 6/29/22; evenings: 6/5/22, 6/14/22, 6/27/22, and 6/29/22; nights: 6/9/22 The July 2022 MAR and TAR indicated the following: - change suprapubic catheter every 14 days: was not completed on 7/16/22 - cleanse suprapubic catheter site and tubing one time a day at bedtime: was not completed on 7/1/22, 7/3/22, and 7/5/22 - catheter orders: catheter care every shift: was not completed on days 7/1/22; evenings: 7/1/22, 7/3/22, and 7/5/22 -urinary output every shift: was not recorded on days: 7/1/22, 7/5/22, 7/12/22, 7/14/22, 7/20/22, 7/21/22; evenings: 7/1/22, 7/3/22, 7/5/22, 7/12/22, 7/18/22 Interview with the Interim Director Of Nursing on 7/27/22 at 3:08 p.m., indicated she could not find any further documentation the catheter care had been completed as ordered on the above dates and times. Interview with Nurse Consultant on 7/29/22 at 11:11 a.m., indicated she could not provide any further information the urinary catheters care had been completed as ordered on the above dates and times. 3.1-41(a)(2)		**deficient practice will not recur, i.e., what quality assurance program will be put into place?** · DON/ designee will complete the Catheter audit tool to ensure that all residents have necessary catheter orders, documentation and treatments are in place and have been completed. · Audit will be completed **daily** x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. · The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including			

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	tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure a Physician's Order was in place for a resident who received oxygen for 1 of 2 residents reviewed for oxygen. (Resident 23) Finding includes: On 7/26/22 at 11:39 a.m., Resident 23 was observed wearing oxygen via a nasal cannula with a flow rate of 4 liters. The resident indicated she always wore her oxygen. On 7/28/22 at 2:27 p.m., Resident 23 was still observed wearing oxygen with a flow rate at 4 liters. Record review for Resident 23 was completed on 7/26/22 at 1:42 p.m. The resident was admitted to the facility on 6/8/22. A Care Plan indicated the resident had chronic obstructive pulmonary disease (COPD) and respiratory failure. The care plan did not reflect oxygen use. The record lacked any documentation of a Physician's Order for the use of oxygen. Interview with Nurse Consultant on 7/29/22 at 11:11 a.m., indicated the resident did not have a	F 0695	**F695 Resp Care** **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · MD was notified and Resident # 23 received appropriate oxygen orders, residents care plan was updated. Resident # 23 did not have a negative outcome related to the alleged deficient practice **2.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents in the facility with oxygen have the potential to be affected by alleged deficient practice** ·An Audit of residents in the facility completed to ensure that all residents with oxygen have appropriate physician orders in place. order. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient**	08/26/2022

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	Physician's Order for oxygen in place when she was observed wearing the oxygen, but should have had an order. They have since put in an order for oxygen use of 4 liters every shift. 3.1-47(a)(6)		**practice does not recur?** ·Licensed Nursing Staff were educated on appropriate necessary respiratory orders, following MD Orders related to o2 use, oxygen and nebulizer maintenance with emphasis on changing, labeling, and dating the equipment ·IDT team educated on IDT admission/ Readmission review and Clinical Meeting Agenda with emphasis on daily Huddle for observation and order review and verifications. **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 into place?** ·DON/ designee will complete the Respirator audit tool to ensure that all residents have necessary respiratory orders are in place and followed per MD Order ·Audit will be completed weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. ·The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure residents were free from unnecessary medications related to not monitoring a resident on an anticoagulant medication and not giving insulin and checking blood sugars as ordered for 2 of 5 residents reviewed for unnecessary medications. (Residents 15 and 11) Findings include: 1. On 7/26/22 at 10:16 a.m., Resident 15 was observed in his bed. He had tubigrips on his forearms and elbows, and there were numerous	F 0757	**F757- Free of Unnecessary Drugs** **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident # 11 and resident # 15 did not have a negative outcome related to the alleged deficient practice. **2.How will you identify other residents having the potential to be affected by the same**	08/26/2022

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	red discolorations visible on his upper arms. He indicated he was taking an anticoagulant medication and thought that was what caused the discolorations. The resident's record was reviewed on 7/27/22 at 1:39 p.m. The resident was admitted on 12/10/21. Diagnoses included, but were not limited to, Diabetes Mellitus and chronic deep vein thrombosis of the lower extremities. The Quarterly Minimum Data Set (MDS) assessment, dated 5/3/22, indicated the resident was on anticoagulant medication daily. The July 2022 Medication Administration Record indicated monitoring for side effects of an anticoagulant started on July 26, 2022. There was no previous monitoring documented. Interview with the MDS nurse on 7/27/22 at 2:14 p.m., indicated that monitoring for anticoagulant side effects had not began until the previous day. 2. Record review for Resident 11 was completed on 7/27/22 at 3:31 p.m. Diagnoses included, but were not limited to, diabetes management and anemia. The Admission Minimum Data Set (MDS) assessment, dated 5/30/22, indicated the resident was cognitively intact. The resident had received insulin (diabetes medication). The July 2022 Physician's Order Summary indicated an order for the following: - Humalog (insulin) to inject per the sliding scale before meals and at bedtime. The July 2022 Medication Administration Record (MAR) had blanks on the following dates and		**deficient practice and what corrective action will be taken?** All residents in the facility that are on anticoagulants and that are receiving insulin have the potential to be affected by alleged deficient practice ·Audit of residents that are receiving an anticoagulant completed to ensure that side effect monitoring is in place ·Diabetic residents that are receiving insulin will be reviewed and audited to ensure accu check orders are in place ·IDT team will review EMAR compliance report in daily clinical meeting to identify any late or missed medication administrations including insulin and accu check orders. **3.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·Licensed Nursing Staff will be educated on Medication Administration policy with emphasis MD orders, insulin administration, correct time and completing documentation on the MARs ·Clinical IDT team educated on clinical morning meeting and reviewing EMAR / ETAR reports daily ·IDT team will review EMAR compliance report in daily clinical meeting to identify any late or	

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	times for the administration of the Humalog. - 7/1, 7/2, 7/8/22 at 8:30 p.m. - 7/17/22 at 7:30 a.m., and 11:30 a.m. - 7/22/22 at 8:30 a.m. Interview with the Nurse Consultant on 7/28/22 at 10:49 a.m., indicated she could not find any documentation the resident's blood sugar was checked and if she had received any Humalog on the above dates and times. A policy titled, "Diabetes - Clinical Protocol", and received as current from the Administrator on 7/28/22, indicated, "...Monitoring and Follow - Up..." "...3...monitor 3 to 4 times a day if on intensive insulin therapy or sliding scale insulin...." 3.1-48(a)(6)		missed medication administrations. **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 into place?** ·DON/ designee will complete the Medication Administration audit tool to ensure that residents are receiving medication appropriately ·Audit will be completed weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. ·The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.			

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	The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or			

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	their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to not placing newly admitted residents who were unvaccinated for COVID-19 on transmission based precautions (TBP) as recommended for 2 of 2 new admissions reviewed for infection control. (Residents 125 and 126) Findings include: On 7/26/22 at 3:48 p.m., Room 111 was observed. The name plate on the outside wall had Resident 125 and Resident 126's names. There was no signage on the room door related to any TBP or a Personal Protection Equipment (PPE) bin located anywhere outside the door. On 7/29/22 at 1:41 p.m., Resident 125 was	F 0880	F 880 The Remedy of a Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424 effective September 5th, 2022. The DPOC and any supporting documentation should be submitted to ltcproviderservices@isdh.in.gov. The Milton Home must include the following as part of the submitted POC for the deficient practice cited at F880: **Specific/Immediate: Immediately implement specific plan for resident/residents/area/others identified in the deficiency to correct.**	08/26/2022

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	observed in Room 111 with TBP signage on the doorway and a PPE bin outside of room. Resident 126 was observed in Room 110 with TBP signage on the doorway and a PPE bin outside of room. 1. Record review for Resident 125 was completed on 7/28/22 at 4:00 p.m. The resident was admitted to the facility on 7/19/22 and was not vaccinated for COVID-19. A Physician's Order, dated 7/26/22, indicated: - Contact/droplet isolation as per CDC and Department of Health Guidelines for COVID 19 exposure/observation or new admission to the facility. All meals and services provided in room. Every shift for Covid-19 Isolation Color Yellow for 10 Days 2. Record review for Resident 126 was completed on 7/28/22 at 4:05 p.m. The resident was not vaccinated for COVID-19. A Physician's Order, dated 7/25/22, indicated: - Contact/droplet isolation as per CDC and Department of Health Guidelines for COVID 19 exposure/observation or new admission to the facility. All meals and services provided in room. Every shift for Covid-19 Isolation Color Yellow for 10 Days Interview with the Administrator and Interim Director of Nursing during the entrance conference on 7/26/22 at 9:45 a.m., indicated they did not have any residents who were on TBP. Interview with the Administrator and Regional MDS (Minimum Data Set) Coordinator on 7/28/22 at 4:30 p.m., indicated the nurse who admitted the residents read the vaccination record incorrectly and thought they were both vaccinated. The		1. Residents #125 and resident # 126 completed isolation per CDC guidance. Facility is not currently in outbreak status. 2. All residents that admitted in last 30 days were reviewed to ensure all isolation requirements were met and follow up completed as necessary. 3. The Director of Nursing (DON), Infection Preventionist (IP) or Designee will educate the admissions director on how to correctly read CHIRP vaccinations and CDC guidance related to up-to-date vaccination status and isolation requirements a. Educational Resources for this education: CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes 4. Facility staff will be educated on Transmission Based Precautions according to CDC and IP recommendations and ensure care giving staff are educated on isolation procedures. Education will ensure all staff are aware of who is on isolation and appropriate signage implemented. a. Educational Resources for this education: CDC Interim Infection Prevention and Control	

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	residents were not vaccinated prior to admission and should have been put in TBP immediately upon arrival to the facility and were not put on TBP until later. The CDC Interim Infection Prevention and Control Recommendation to Prevent SARS - CoV-2 Spread in Nursing Homes and Long-Term Care Facilities, and updated February 2, 2022, indicated, "...Empiric use of Transmission-Based Precautions (quarantine) is recommended for residents who are newly admitted to the facility and for residents who have had close contact with someone with SARS-CoV-2 infection if they are not up to date with all recommended COVID-19 vaccine doses..." 3.1-18(b)		Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes 5. The DON, IP, or designated facility leadership will conduct facility rounds at a minimum of daily to ensure Infection Control practices are being followed related to PPE use, Isolation signage and equipment availability. The DON, IP or designated facility leadership will enforce corrective measures and education if deficiencies are observed. **A. Systemic** 1). A root cause analysis (RCA) was conducted by the Infection Preventionist (IP), with input and review from the Medical Director, Executive Director, Director of Nursing/IP , MDS, and VP of Clinical Operations to determine the root cause resulting in the facilities Infection Control citation. · Through staff interviews it was determined that Admission director was reviewing COVID vaccine documentation in CHIRP	

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			to confirm status prior to admission, however admission director was incorrectly reading the information on CHIRP. The dates that are entered were under the past due section. · Admission Director is new to the organization and appropriate training on CHIRP did not occur · IDT team failed to complete IDT admission reviews to confirm Vaccination status and documentation · Increased Staffing challenges have made the clinical IDT participation challenging resulting in IDT failing to follow facility process b). The solutions and systemic changes developed by the DON, ADON and facility IP include: · The Director of Nursing (DON), Infection Preventionist (IP) or Designee will educate the admissions director on how to correctly read CHIRP vaccinations and CDC guidance related to up-to-date vaccination status and isolation requirements o Educational Resources for this education: CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes · Facility staff will be educated on Transmission Based	

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			Precautions according to CDC and IP recommendations and ensure care giving staff are educated on isolation procedures. Education will ensure all staff are aware of who is on isolation and appropriate signage implemented. o Educational Resources for this education: CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes · The DON, IP, or designated facility leadership will conduct facility rounds at a minimum of daily to ensure Infection Control practices are being followed related to PPE use, Isolation signage and equipment availability. The DON, IP or designated facility leadership will enforce corrective measures and education if deficiencies are observed. 2). The DON/ IP Nurse, and VP of Clinical Operations reviewed the LTC Infection Control Self-Assessment. Changes were made to so the assessment would now be an accurate reflection of the facility. This assessment will be submitted with the DPOC documentation. **B. Training:**	

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			1).Per the LTC infection control assessment review and Root Cause Analysis ,VP of Clinical, ED, Medical Director , MDS, and DON/IP. The following training needs were identified and implemented by facility IP and DON with training resources and polices provided and submitted as part of the DPOC documentation. · The Director of Nursing (DON), Infection Preventionist (IP) or Designee will educate the facility staff facility staff related to but not limited to, PPE use, Isolation requirements as it relates to New/ Readmissions, isolation signage and equipment use. · The Director of Nursing (DON), Infection Preventionist (IP) or Designee will educate the admissions director on how to correctly read CHIRP vaccinations and CDC guidance related to up-to-date vaccination status and isolation requirements · The Nurse consultant/ designee will educate the IDT team on IDT admission review with emphasis on verification of COVID vaccination status and documentation	

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			C. Monitoring: Monitoring of approaches to ensure Infection Control Practices are maintained. The DON, IP, or designated facility leadership will conduct visual facility rounds at a minimum of daily to ensure Infection Control practices are being followed related to PPE use, Isolation signage and equipment availability. The DON, IP or designated facility leadership will enforce corrective measures and education if deficiencies are observed. Rounds will be conducted daily for a minimum of six weeks and will continue until compliance is maintained. **E. Quality Assurance and Performance Improvement (QAPI):** The IP Nurse/Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 6 months. The facility through the QAPI program will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if	

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			ongoing monitoring is required. Elizabeth Kegg, VP of Clinical Frank Bensema, Executive Director Lisa Cook , Director of Nursing/ IP Jody Braun , MDS Shaya Mokfi , Medical Director Milissa Scully, Admissions Director · Resident 125 admitted to the facility on 7/19/2022 and was not placed in droplet precautions until 7/26/2022 · Resident 125 was admitted to the facility on 7/25/2022 and was not placed in droplet precautions until 7/26/2022 · Isolation signage and equipment was not placed appropriately for resident 125 or 126 until 7/26/2022 Lack of understanding from admissions team on reading COVID vaccine documentation Lack of IDT admission review to	

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			confirm COVID vaccine documentation after admission A root cause analysis (RCA) was conducted by the Infection Preventionist (IP), with input and review from the Medical Director, Executive Director, Director of Nursing, Unit Manager and Regional Director of Clinical Operations to determine the root cause resulting in the facilities Infection Control citation. · Through staff interviews it was determined that Admission director was reviewing COVID vaccine documentation in CHIRP to confirm status prior to admission, however admission director was incorrectly reading the information on CHIRP. The dates that are entered were under the past due section. · Admission Director is new to the organization and appropriate training on CHIRP did not occur · IDT team failed to complete IDT admission reviews to confirm Vaccination status and documentation · Increased Staffing challenges have made the clinical IDT participation challenging resulting in IDT failing to follow facility process	

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			The solutions and systemic changes developed by the, DON, and facility IP include: 1.) The Director of Nursing (DON), Infection Preventionist (IP) or Designee will educate the admissions director on how to correctly read CHIRP vaccinations and CDC guidance related to up-to-date vaccination status and isolation requirements Educational Resources for this education: CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes 2.) Facility staff will be educated on Transmission Based Precautions according to CDC and IP recommendations and ensure care giving staff are educated on isolation procedures. Education will ensure all staff are aware of who is on isolation and appropriate signage implemented. Educational Resources for this education: CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes	

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			2.) The DON, IP, or designated facility leadership will conduct facility rounds at a minimum of daily to ensure Infection Control practices are being followed related to PPE use, Isolation signage and equipment availability. The DON, IP or designated facility leadership will enforce corrective measures and education if deficiencies are observed. The DON, IP, or designated facility leadership will conduct rounds at a minimum of daily for 6 weeks and until compliance is maintained: to ensure staff are following proper infection control practices related to PPE use, Isolation signage and equipment availability The IP Nurse/Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 6 months. The facility through the QAPI program will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing	

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			monitoring is required. **Root Cause Analysis Worksheet for Planning a Performance Improvement Project** Date of meeting: 8/12/2022 The Milton Home Center F880 Citation ***Steps:*** **1. Identify the event to be investigated and gather preliminary information**. Events and issues can come from many sources (i.e. incident reports, risk management referrals, resident or family concerns, health department citations) The Remedy of a Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424 effective September 5th, 2022 . The Milton home must include the following in their POC for the deficient practice cited at F880: Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and	

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			implemented, including those to prevent and/or contain COVID-19, related to not placing newly admitted residents who were unvaccinated for COVID-19 on transmission-based precautions (TBP) as recommended for 2 of 2 new admissions reviewed for infection control **2. Charter Team Members involved in planning: (Appointed by Leadership due to personal knowledge of systems involved.) List names and title below** **3.Describe what happened** *Collect and organize the facts surrounding the event to understand what happened.* **4.Identify contributing factors** *The situations, circumstances or conditions that increased the likelihood if the events are identified.* **5. Identify root cause** *A thorough analysis of contributing factors leads to identification of the underlying process of system issues (root causes).* **6. Design and implement changes to eliminate the root causes** *The team determines how best to change processes and systems to reduce the likelihood of another similar event.* **7. Measure the success of changes**	

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			Like all improvement projects, the success of improvement actions is evaluated.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: July 26, 27, 28, 29, and August 1, 2022 Facility number: 001141 Residential Census: 14 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 8/4/22.	R 0000		
R 0026 Bldg. 00	410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents '			

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	rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands. Based on record review and interview, the facility failed to ensure there were signed copies of the Resident Rights in the records for 4 of 4 residents reviewed for resident rights. (Residents 2, 4, 6 and 8) Findings include: 1. Resident 2's record was reviewed on 7/29/22 at 12:27 p.m. The resident was admitted on 8/18/21. The record lacked documentation of a signed copy of the Resident Rights. 2. Resident 4's record was reviewed on 8/1/22 at 10:00 a.m. The resident was admitted on 5/14/22. The record lacked documentation of a signed copy of the Resident Rights. 3. Record review for Resident 6 was completed on 8/1/22 at 1:40 p.m. The resident was admitted to the facility on 1/12/22. The record lacked any documentation to indicate the resident received a copy of the Resident Rights on admission to the facility. 4. Record review for Resident 8 was completed on 8/1/22 at 12:16 p.m. The resident was admitted to the facility on 11/17/21. The record lacked any documentation to indicate the resident received a copy of the Resident Rights on admission to the facility.	R 0026	**R 026- Residents Rights** **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Residents #2,#4,#8 and # 8 have been provided with a copy of residents rights and they have been signed and placed in the medical record. **1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** **All residents in the facility have the potential to be affected by alleged deficient practice** All residents in the ALF facility were provided with a copy of residents rights and they have been signed and placed in the medical record. **1.What measures will be put into place or what systemic changes will you make to ensure that the deficient**	08/26/2022

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	Interview with the Nurse Consultant on 8/1/22 at 12:38 p.m., indicated she could not find any documentation the residents had received a copy of the Resident Rights when they were admitted to the facility.		**practice does not recur?** ·IDT team provided education on requirement with emphasis on ensuring that that the residents has signed a copy of resident rights upon admission. **1.How will the corrective action (s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·SS/ designee will complete Resident Right audit to ensure that all new admissions have resident rights signed and placed in medical record upon admission o Audit will be completed weekly times 4 weeks, monthly times 5 months, and quarterly until continued compliance is maintained for 2 consecutive quarters. · Executive Director or Designee will audit log after each completed admission provided by the Director of Nursing or Designee.	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request.			

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	A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to ensure there was pre-admission screening completed for 1 of 4 resident records reviewed for pre-admission screenings. (Resident 4) Finding includes: The record for Resident 4 was reviewed on 8/1/22 at 10:00 a.m. The resident was admitted on 5/14/22. There was no indication a pre-admission screening had been completed prior to admission. Interview with the Interim Director of Nursing on 8/1/22 at 2:06 p.m., indicated there was no additional information available for the resident.	R 0214	**R 0214- Evaluation** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 4 was provided a copy of service plan. A signed copy of the service plan was placed in residents medical record **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** **All residents in the facility have the potential to be affected by alleged deficient practice** All residents have the potential to be affected by this alleged deficient practice. All Nursing Staff in-serviced on Admission protocol which includes Admission Service Plan. A copy was provided to all Nursing Staff. An audit of all admissions/ readmissions in last 60 days completed to ensure admission service plan completed and signed by resident **What measures will be put into place or what systemic**	08/26/2022

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			changes will you make to ensure that the deficient practice does not recur? Director of Nursing will complete the Service Plan or will assign a Licensed Nurse to complete upon admission. Nursing Admission Checklist will be completed by Nursing Staff with signature and submitted to the Director of Nursing for audit within 24 hours of admission **How will the corrective action (s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** IDT/DON to log and monitor compliance for all new admissions to the facility. Audit will be completed weekly x 4, monthly x 5 Executive Director or Designee will audit log after each completed admission provided by the Director of Nursing or Designee.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual			

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	resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure there was a signed service plan for 1 of 7 resident records reviewed for signed service plans. (Resident 4) Finding includes: The record for Resident 4 was reviewed on 8/1/22 at 10:00 a.m. The resident was admitted on 5/14/22. There was no signed service plan in the resident's record. Interview with the Nurse Consultant on 8/1/22 at 11:38 a.m., indicated she was unable to locate a signed service plan for the resident.	R 0217	**R 0217- Evaluation** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 4 was provided a copy of service plan. A signed copy of the service plan was placed in residents medical record **How will you identify other residents having the potential to be affected by the same deficient practice and what**	08/26/2022

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			corrective action will be taken? **All residents in the facility have the potential to be affected by alleged deficient practice** All residents have the potential to be affected by this alleged deficient practice. All Nursing Staff in-serviced on Admission protocol which includes Admission Service Plan. A copy was provided to all Nursing Staff. An audit of all admissions/ readmissions in last 60 days completed to ensure admission service plan completed and signed by resident **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Director of Nursing will complete the Service Plan or will assign a Licensed Nurse to complete upon admission. Nursing Admission Checklist will be completed by Nursing Staff with signature and submitted to the Director of Nursing for audit within 24 hours of admission **How will the corrective action (s) 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? IDT/DON to log and monitor compliance for all new admissions to the facility. Audit will be completed weekly x 4, monthly x 5 Executive Director or Designee will audit log after each completed admission provided by the Director of Nursing or Designee.	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, record review and interview, the facility failed to ensure a Physician's Order was in place for a resident receiving oxygen for 1 of 1 residents reviewed for oxygen and failed to monitor a nephrostomy tube and change the dressing as ordered for 1 of 1 residents reviewed with a nephrostomy tube. (Residents 2 and 4) Findings include: 1. On 7/29/22 at 1:05 p.m., Resident 2 was observed in her room. She was wearing a nasal cannula and oxygen was flowing at 3 liters per minute. She indicated she wore oxygen at all times. The resident's record was reviewed on 7/29/22 at 12:27 p.m. The resident was admitted on 8/18/21. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease.	R 0240	**R240- Health Services** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** MD was notified and orders obtained for oxygen for Resident # 2 MD was notified related to Resident # 8's nephrostomy tubes, appropriate follow up initiated. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	08/26/2022

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	The record lacked a Physician's Order for the oxygen use. Interview with the Interim Director of Nursing on 8/1/22 at 8:55 a.m., indicated she was not aware there was not an order for the oxygen. 2. On 8/1/22 at 10:35 a.m., Resident 4 was observed in her room laying on her bed. She had bilateral nephrostomy tubes (a tube inserted into the kidney to drain urine) that attached to urine collection bags. Both urine collection bags were empty. The right side tube dressing was dated 7/28/22. The resident indicated the right tube had not been working for some time, and the left tube stopped draining a couple days ago. The resident's record was reviewed on 8/1/22 at 10:00 a.m. The resident had been admitted on 5/14/22. Diagnoses included, but was not limited to, kidney failure and obstructive uropathy. A Nursing Note, dated 6/1/22, indicated to call [company] RN at [phone number] if nephrostomy tube stops draining or resident is having flank pain. Dressings should be changed every other day. The July 2022 Treatment Administration Record (TAR) indicated the dressing had been changed on 7/30/22, although the dressing on the resident was dated 7/28/22. The TAR also indicated the sites were being monitored every shift for signs of infection and that the nephrostomy tubes were draining. Interview with LPN 1 on 8/1/22 at 10:42 a.m., indicated he wasn't aware the tubes weren't draining, that was the first he had heard of it. He did not know about the dressing not being		**All residents in the facility have the potential to be affected by alleged deficient practice** All residents have the potential to be affected by this alleged deficient practice. Audit completed of all ALF residents to ensure that any residents with oxygen had appropriate oxygen orders. Audit completed on all ALF residents to ensure that any resident with nephrostomy tubes have physician orders and that they are carried out as necessary **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** All Nursing Staff in-serviced on Oxygen use with emphasis on requirement of physician order All Nursing Staff in-services on Following Physician orders with emphasis on monitoring nephrostomy tube and completing treatment orders **How will the corrective action (s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	changed because he didn't work over the weekend.		**into place?** DON/Designee will complete Oxygen audit to ensure that all residents have appropriate oxygen orders in place. DON/ Designee will complete nephrostomy audit to ensure that physicians orders have been followed, including notification if sites are not draining and ensuring that treatments have been completed per order o Audits will be completed weekly times 4 weeks, monthly times 5 months, and quarterly until continued compliance is maintained for 2 consecutive quarters. · Executive Director or Designee will audit log after each completed admission provided by the Director of Nursing or Designee.	
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical			

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	limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on record review and interview, the facility failed to ensure a transfer/discharge form was completed for 1 of 2 closed records reviewed. (Resident 7) Finding includes: Record review for Resident 7 was completed on 8/1/22 at 11:28 a.m. The resident was admitted to the facility on 4/14/21. The facility census indicated the resident discharged from the facility on 5/6/22. The last Progress Note completed was dated 4/13/2022 at 11:50 a.m. The note was about the resident's Care Plan Meeting. The family indicated they were trying to move the resident to a new facility. The Social Service Director offered assistance with family's desire to move the resident to a facility closer to family. The family indicated they would be in touch if they had any questions. There was no documentation in the record to indicate where or when the resident discharged from the facility or where they had discharged to. Their was no transfer/discharge assessment or instructions completed for the resident. Interview with the Interim Director of Nursing on 8/1/22 at 12:30 a.m., indicated she could not find	R 0354	**F354 Clinical Records** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 7 no longer resides at the facility **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** **All residents in the facility have the potential to be affected by alleged deficient practice** All residents have the potential to be affected by this alleged deficient practice. ·Audit of residents that have been transferred or discharged in last 60 days completed to ensure that discharge summary/ assessment was provided or completed. IDT will follow up and correct any irregularities noted if	08/26/2022

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	any documentation related to the resident's transfer/discharge from the facility.		applicable **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** · Licensed nursing staff educated on Discharge, process and procedures and requirements for documentation, discharge assessment to be sent with residents at time of transfer/discharge · IDT educated on use of Clinical meeting process with emphasis on IDT discharge review process · IDT team educated on discharge process including discharge assessment and documentation requirements **How will the corrective action (s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·SSD/ designee will complete the Discharge/ Transfer Audit to ensure that discharge documentation was completed ·Audit will be completed weekly x 4 weeks, bi-monthly for 2	

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			months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. · Executive Director or Designee will audit log after each completed admission provided by the Director of Nursing or Designee.	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure the was a Physician's annual health statement in place for 7 of 7 records reviewed for Physician's annual health statements. (Residents 2, 3, 4, 5, 6, 7 and 8) Findings include: 1. Resident 2's record was reviewed on 7/29/22 at 12:27 p.m. The resident was admitted on 8/18/21. The record lacked a Physician's annual health statement. 2. Resident 3's record was reviewed on 7/29/22 at 1:41 p.m. The resident was admitted on 10/31/18. The record lacked a Physician's annual health statement.	R 0409	**R409 Infection Control** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** MD was notified that resident #2, #3,#4,#5,#6,7 and # 8 are in need of annual health assessment. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** **All residents in the facility have the potential to be affected by alleged deficient practice** All residents have the potential to	08/26/2022

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	3. Resident 4's record was reviewed on 8/1/22 at 10:00 a.m. The resident was admitted on 5/14/22. The record lacked a Physician's annual health statement. 4. Resident 5's record was reviewed on 8/1/22 at 12:49 p.m. The resident was admitted on 12/20/19. The record lacked a Physician's annual health statement. 5. Record review for Resident 6 was completed on 8/1/22 at 1:40 p.m. The resident was admitted to the facility on 1/12/22. The record lacked any documentation of an annual Health Statement. 6. Record review for Resident 7 was completed on 8/1/22 at 11:28 a.m. The resident was admitted to the facility on 4/14/21. The record lacked any documentation of an annual Health Statement. 7. Record review for Resident 8 was completed on 8/1/22 at 12:16 p.m. The resident was admitted to the facility on 11/17/21. The record lacked any documentation of an annual Health Statement. Interview with the Nurse Consultant on 8/1/22 at 12:38 p.m., indicated she could not find any documentation an annual Health Statement was completed for the above residents.		be affected by this alleged deficient practice. Audit completed of all ALF residents and annual health assessment schedule implemented MD notified of requirements and need for annual health assessment **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**IDT team educated on requirement of Health assessment being required prior to admission and then yearly thereafter. MD educated on requirement of Health assessment being required yearly with emphasis on statement that resident shows no evidence of tuberculosis in an infectious state**How will the corrective action (s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**DON/Designee to complete Health assessment Audit to ensure that schedule is being followed. ·Audit will be completed weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. · Executive Director or	

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			Designee will audit log after each completed admission provided by the Director of Nursing or Designee.	