STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 00 B. WING	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00433844, IN00434622, IN00435118, IN00436685, IN00438403, IN00438523, and IN00439030. Complaint IN00433844 - Federal/State deficiencies related to the allegations are cited at F684 and F695. Complaint IN00434622 - No deficiencies related to the allegations are cited. Complaint IN00435118 - Federal/State deficiencies related to the allegations are cited at F812. Complaint IN00436685 - Federal/State deficiencies related to the allegations are cited at F580. Complaint IN00438403 - No deficiencies related to the allegations are cited. Complaint IN00438523 - No deficiencies related to the allegations are cited. Complaint IN00439030 - Federal/State deficiencies related to the allegations are cited at F580, F676, F684 and F695. Survey dates: July 18, 19, 22, 23 and 24, 2024 Facility number: 000369 Provider number: 155530 AIM number: 100275190 Census Bed Type: SNF/NF: 74	F 0000	**This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. We kindly request consideration for Paper Compliance.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rick Walworth	administrator	08/29/2024

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

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	Total: 74 Census Payor Type: Medicare: 3 Medicaid: 66 Other: 5 Total: 74 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 7/29/24.			
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.			

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	§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on observation, record review, and interview, the facility failed to ensure a resident's preferences were honored related to turning up the volume on the television set for 1 of 1 resident reviewed for activities. (Resident 43) Finding includes: During random observations on 7/18/24 at 9:55 a.m. and 1:10 p.m., on 7/19/24 at 7:55 a.m. and 9:00 a.m., and on 7/22/24 at 9:00 a.m., Resident 43 was observed in his room in bed. At those times, the television was turned on and observed on top of a tall wardrobe closet and the volume was turned off. There was an air return vent observed by the television set making a very loud noise. During an interview on 7/19/24 at 9:00 a.m., the resident indicated he could not hear the television. The record for Resident 43 was reviewed on 7/19/24 at 2:48 p.m. Diagnoses included but were not limited to, stroke, type 2 dm, epilepsy, vascular dementia, anemia, major depressive disorder, and high blood pressure The Significant Change Minimum Data Set (MDS) assessment, dated 5/19/24, indicated the resident was not cognitively intact for daily decision making. The resident was interviewed for his daily preferences and activities and indicated it was somewhat important to read books, listen to music, keep up with the news, and do things with other people.	F 0561	**F561 Self- Determination** We respectfully request paper compliance for this citation. **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 43 had no negative outcome from this alleged deficient practice and TV was immediately moved for resident able to hear TV with resident given TV remote for resident to be able to hear the TV. Resident also will be referred to audiologist for evaluation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** All other resident's rooms were assessed for residents to be able to hear their TV and have remotes to be to control the volume of TV, per resident request. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Staff was in-serviced on making sure while rounding to check with	08/21/2024

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	An Activity Assessment, dated 3/27/24, indicated the resident enjoyed movies, television, and going outside when the weather permitted. An Activity Assessment, dated 5/30/24, indicated the resident enjoyed music, parties, and television. During an interview on 7/24/24 at 8:55 a.m., the Director of Nursing indicated she moved the television and gave the resident the remote control and ensured the volume was turned up so he could hear. 3.1-3(u)(1)		residents to make sure they can hear TV and if not to ensure TV is moved for resident to hear and have remote for them to able to control volume. **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:** UM and designee will ensure to monitor compliance and ensure residents TV are able to be heard and have access to remote to adjust volume. Audits will be completed daily x5, weekly x4, bi-monthly for 2 months, monthly x6 and then quarterly, until continue compliance is maintained for 2 consecutive months. Results of audits will be reviewed by the QA committee overseen by the ED. If there non-compliance not achieved at 95% and action plan will be taken to ensure compliance. **By what date the systemic changes will be completed: 8-21-24**	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or			

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

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	admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to ensure the resident's Responsible Party was notified of the onset of a new bruise and medication changes for 2 of 2 residents reviewed for notification of change. (Residents C and B) Findings include: 1. During a phone interview on 7/19/24 at 11:20 a.m., Resident C's Power of Attorney (POA) indicated she was notified on 7/17/24 the resident had a large purple bruise across her chest. The record for Resident C was reviewed on 7/22/24 at 10:50 a.m. Diagnoses included but were not limited to, respiratory failure, joint stiffness, COPD (chronic obstructive pulmonary disease), Parkinson's disease, heart disease, atrial fibrillation, anemia, and dementia. The 6/24/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and wore oxygen while a resident. A Nurses' Note, dated 7/14/24 at 6:39 p.m., indicated the resident was found sitting next to the bed Indian style. The resident indicated she was praying and the indwelling catheter was in the bed. The resident's POA, and physician were notified. Nurses' Notes, dated 7/15 and 7/16/24, indicated there was no documentation of any injury related	F 0580	**F 580 Notification of Changes** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B no longer resides in the facility. Resident C resides in the facility and has displayed no adverse effects from alleged deficient practice. All events such as a fall/change of condition in which resident skin may be affected will require a skin assessment to be performed. Resident/responsible party will be notified of any changes from resident baseline. **How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action(s) be taken?** All residents have the potential to be affected by this alleged deficiency. All changes in conditions with potential to affect skin integrity/appearance/texture or falls for all current residents will be reviewed to ensure skin assessments have been	08/21/2024

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	to the previous fall. Nurses' Notes, dated 7/17/24 at 2:51 p.m., indicated upon assessment, the resident was noted with a dark purple discoloration measuring 23 centimeters (cm) by 15 cm and extending down and under the left breast. The resident denied any pain or discomfort and was not able to recall when the discoloration first appeared. The resident's POA and physician were notified. During an interview on 7/24/24 at 8:55 a.m., the Director of Nursing indicated the bruise was more than likely from the fall she had on 7/14/24. During an interview on 7/24/24 at 11:00 a.m., the Unit 4 Manager indicated she did her own investigation into the bruise on the resident's left breast area. She interviewed CNA 3 who worked on 7/14/24 when the fall happened. CNA 3 indicated she noticed the bruise hours after the fall and told LPN 2 while CNA 2 was standing there and witnessed the conversation. The Unit Manager interviewed LPN 4 who worked on 7/13/24 on the 3-11 shift. He told the Unit Manager the bruise was not there on 7/13/24 because the resident removed her blouse and he could see her chest. The Unit Manager indicated she spoke with LPN 2 about the fall and LPN 2 told her nothing about the bruise. LPN 3 was interviewed as well and she informed the Unit Manager that she had seen the bruise on 7/15/24 but just assumed everyone knew about it and it was from the fall. During an interview on 7/24/24 at 2:00 p.m., the Unit 4 Manager indicated the resident's POA was notified on 7/17/24 (3 days after the bruise was first observed).		performed and resident/responsible party is aware of any changes effective 8-21-24 forward. All new medication orders, from 8-21- 24, will be reviewed to ensure that the resident/guardian has been notified of the order and is in agreement with the order. **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur?** MD NP will provide DNS/designee with all medication order changes in writing. UM/designee will be educated to review new order listings daily in the morning clinical meeting to ensure all medication orders have been received and resident/family notified. UM/designee will be educated to review all events (COC/falls) daily in the morning clinical meeting to ensure the resident/guardian has been notified of any changes to skin integrity/appearance/texture. **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 audit all COC/falls to ensure that	

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	2. The closed record for Resident B was reviewed on 7/19/24 at 10:59 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, depressive disorder with psychotic symptoms, schizophrenia, dementia, and intellectual disabilities. The 5/31/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and received antipsychotic and antidepressant medication while at the facility. A Nurse Practitioner (NP) Behavior Progress Note, dated 9/29/23, indicated the Social Service Director (SSD) reported the resident had been increasingly more agitated and physically aggressive with staff. She was taken to an outside psychiatrist by her brother and new medications were started. The resident had a history of auditory/visual hallucinations and today she reported having both, seeing black figures float across the room and hearing a voice in her head. Staff reported she was not sleeping well at night as well and was currently on 1 to 1 supervision for aggressive behavior. The plan was to discontinue Haloperidol (an antipsychotic medication) 10 milligrams (mg) three times a day and Perphenazine (an antipsychotic medication) 8 mg twice a day. The patient was to start on Zyprexa (an antipsychotic medication) 15 mg at bed time and Klonopin (a medication used to treat panic disorder and anxiety) 1 mg twice a day. Physician's Orders, dated 9/29/23, indicated Klonopin 1 mg two times a day and Zyprexa 15 mg at bed time. There was no documentation in the clinical record the resident's brother (her guardian) was notified		residents/responsible parties are aware of any changes from resident baseline and changes if any have been communicated with nursing staff for appropriate monitoring. DON/designee will audit 5 random residents' new medication orders to ensure that the resident/guardian has been notified and agrees with the new medication order. Audits will be completed daily x5, weekly x4 weeks, bi-monthly for 2 months, monthly x6, 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 the threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **By what date the systemic changes for each deficiency will be completed?** 8-21-2024	

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	of the change in medication. During an interview on 7/24/24 at 8:55 a.m., the Nurse Consultant indicated the NP from the behavioral company did not come to the facility any more. She indicated there was no documentation the resident's brother was notified of the new medication changes. The 7/1/21 "Notification of Changes" policy, provided by the Nurse Consultant on 7/24/24 at 2:05 p.m., indicated the nurse will immediately notify the resident, resident's physician, and the resident representative for the following: a significant change in the resident's physical status. This citation relates to Complaints IN00436685 and IN00439030. 3.1-5(a)(2)			
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this			

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	section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. Based on record review and interview, the facility failed to ensure a Functional Maintenance Program (FMP) was in place for continued ambulation and range of motion after a resident was discharged from physical therapy for 1 of 2 residents reviewed for rehabilitation services. (Resident C) Finding includes: During a phone interview on 7/19/24 at 11:20 a.m., Resident C's Power of Attorney (POA) indicated the resident used to walk with a walker before she entered the nursing home and now she could not walk. The record for Resident C was reviewed on 7/22/24 at 10:50 a.m. Diagnoses included but were	F 0676	**F-676 Activities Daily Living (ADLs)/Maintain Abilities** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident C resides in the facility. ·Residents will have restorative evaluation performed after completion of therapy services for restorative programming appropriateness. Residents will be added to restorative caseload pending therapy recommendation.	08/21/2024

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	not limited to, respiratory failure, joint stiffness, COPD (chronic obstructive pulmonary disease), Parkinson's disease, chronic bronchitis, and dementia. The 4/5/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident used a walker in the last 7 days and walking 10 feet was not attempted due to her medical condition. The resident needed substantial to maximum assist for transfers. The 6/24/24 Significant Change MDS assessment indicated the resident was moderately impaired for daily decision making. The resident had no limitation in range of motion to her upper and lower extremities and walking was not attempted due to her medical condition. The resident needed substantial to maximum assist for transfers. A Physical Therapy Discharge Note, dated 3/1/24, indicated at the time of discharge the resident met the goal of being able to walk 50 feet with stand by assist using the rolling walker. The discharge recommendation from therapy was 24 hour nursing care and a restorative nursing program (RNP). A RNP/FMP was recommended to facilitate the patient maintaining the current level of performance, and in order to prevent decline, the development of and instruction in the RNP had been completed with the IDT (interdisciplinary team) for passive range of motion and ambulation. There was no documentation from 3/1-7/18/24 the resident received passive range of motion or ambulation exercises. A Restorative Nursing Review, dated 4/26/24, indicated no restorative nursing program was indicated at that time. The resident did not need		**How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action(s) be taken?** All residents have the potential to be affected by this alleged deficiency. All referrals for restorative services must have an order input into PCC by therapy for accurate tracking of program requests. All referrals must have the signature of the Restorative nurse acknowledging receipt of programming request. Restorative services/Therapy department both will keep logs of referrals. **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur?** ·Therapy Dept/restorative nurse/designee will be educated to review new restorative referrals in the morning clinical meeting to ensure all referrals have been received, documented and resident/family notified. ·Therapy Dept will be educated to input all recommendations for restorative services as an order so nursing may be aware of referrals by reviewing new order listings daily in the morning clinical meeting. **How the corrective action(s) will be monitored to ensure the**	

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	passive or active range of motion and the section for how the resident walked in the room and the corridor with and without support indicated the activity did not occur during the assessment. During an interview on 7/24/24 at 10:15 a.m., the Restorative Nurse indicated the RNP did not start back up until 4/1/24. She did an assessment of the resident's physical limitations on 4/26/24 but did not have the information from therapy regarding needing a program for ambulation at that time. During an interview on 7/24/24 at 11:00 a.m., the Unit 4 Manger indicated she had never seen the resident walk with therapy. The therapy department did not relay the information regarding the RNP or the FMP for ambulation and passive range of motion for the resident after her therapy had been discontinued. During an interview on 7/24/24 at 11:15 a.m., the Director of Nursing indicated nursing staff do not have access to therapy progress notes. This citation relates to Complaint IN00439030. 3.1-38(a)(1)(B)		**deficient practice will not recur, i.e., what quality assurance program will be put into place?** Restorative nurse/designee will audit all new orders to ensure that restorative programming referrals have been received and reviewed by nursing clinical team. Audits will be completed daily x5, weekly x4 weeks, bi-monthly for 2 months, monthly x6, 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 the threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **By what date the systemic changes for each deficiency will be completed?** 8-21-2024	
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 a dependent resident received assistance with activities of daily living (ADL's) related to the removal of facial	F 0677	**F677- ADL Care Provided for Dependent Residents** **What corrective action(s) will**	08/21/2024

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	hair for 1 of 2 residents reviewed for ADL's. (Resident 282) Finding includes: On 7/18/24 at 11:47 a.m., on 7/19/24 at 9:40 a.m. and 11:36 a.m., and on 7/22/24 at 2:17 p.m., Resident 282 was observed in bed. At those times, the resident had long black facial hair above her top lip. During an interview at the time of observation on 7/19/24, the resident indicated she did not want facial hair. The record for Resident 282 was reviewed on 7/19/24 at 11:02 a.m. The diagnoses included, but were not limited to, epilepsy (seizure disorder), diabetes, depression, anemia, hypokalemia (low potassium), and psychotic disorder. The Quarterly Minimum Data Set (MDS) Assessment, dated 5/14/24. Indicated the resident was cognitively intact for daily decision making. The resident had impairment on both sides of the upper and lower extremities and used a wheelchair. The resident required dependent assistance with toileting hygiene and lower body dressing. Bathing required substantial/maximum assistance. Personal hygiene required partial/moderate assistance. A Care Plan, dated 7/18/24, indicated the resident had an ADL self-care performance deficit related to impaired mobility. The resident required extensive assistance by 1-2 staff members for personal hygiene and oral care. During an interview on 7/22/24 at 2:38 p.m., the Activity Aide 1 indicated the resident liked the		**be accomplished for those residents found to have been affected by the deficient practice?** ·Resident currently resides in the facility. Resident received nail care and shaving on 7-19-24 and has been routinely offered care thereafter. ·DON/Designee will review all dependent residents currently residing in facility for completion of adl tasks including facial hair removal and nail care. ·DON/Designee will educate nursing staff on adl care and performance for dependent residents. **How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action(s) be taken?** All residents have the potential to be affected by this alleged deficiency. All dependent residents will have skin assessments reviewed by UM/Designee for acceptance of adl care. UM/Designee will perform routine rounding with audit tool to ensure upkeep of care for dependent residents. DON/designee will audit care plans of all dependent residents for preferences regarding adl care. **What measures will be put into place, and what systemic changes will be made to ensure that the deficient**	

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	nursing staff to "stay on top" of her facial hair. During an interview on 7/23/24 at 9:20 a.m., the Director of Nursing (DON) indicated she understood the concern and the resident was shaved on 7/22/24. 3.1-38(a)(3)(D)		**practice does not recur?** ·DON/designee will be educated to review skin assessments for dependent residents in the morning clinical meeting to ensure resident has been provided with options for adl care such as facial hair removal and nail care per resident preference. DON/Designee will educate nursing staff on adl care and performance for dependent residents. **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?** UM/designee will audit 5 dependent skin assessments acceptance of adl care. UM/Designee will perform routine rounding with audit tool to ensure upkeep of care for dependent residents. Audits will be completed daily x5, weekly x4 weeks, bi-monthly for 2 months, monthly x6, 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 the threshold of 95% is not achieved, an action plan will be	

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			developed to ensure compliance. **By what date the systemic changes for each deficiency will be completed?** 8-21-2024	
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the 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 administer medications according to physician's orders related to not following parameters for 2 of 6 residents reviewed for unnecessary medications (Residents H and J), failed to ensure areas of bruising and rashes were assessed and monitored for 2 of 2 residents reviewed for non-pressure related skin conditions (Residents C and G), failed to ensure new onset edema (swelling) was assessed and monitored for 1 of 1 resident reviewed for edema (Resident K), and failed to provide transportation to physician's appointments for 3 of 4 residents reviewed for transportation to outside appointments (Residents D, E, and F). Findings include: 1. The record for Resident H was reviewed on 7/22/24 at 3:59 p.m. Diagnoses included, but were	F 0684	**F684- Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Residents currently reside in the facility and have displayed no adverse effects, continues with normal daily routine. Education to nursing DON/IDT/Nursing staff regarding recognition of changes of condition and documentation. Education to DON/IDT/Nursing regarding performing and documenting assessment under changes of condition. Resident H and J were	08/21/2024

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	not limited to, hypertension, type 2 diabetes, and vascular dementia with behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 6/17/24, indicated the resident was cognitively impaired for daily decision making. A Physician's Order, dated 6/25/24, indicated the resident was to receive Metoprolol Succinate (a blood pressure medication) 50 milligrams (mg) daily. The medication was to be held if the resident's systolic blood pressure (top number) was less than 110 or her pulse was less than 60. The July 2024 Medication Administration Record (MAR), indicated the resident's blood pressure was documented at the time of administration, however, the resident's pulse was not documented from 7/1-7/23/24. The June 2024 MAR, indicated the resident's pulse was not documented from 6/25-6/30/24 at the time of administration. During an interview on 7/23/24 at 4:10 p.m., the Director of Nursing indicated she would have to clarify with the physician to see if he wanted the systolic blood pressure and pulse both monitored prior to giving the medication. 2. The record for Resident J was reviewed on 7/22/24 at 1:10 p.m. Diagnoses included, but were not limited to, end stage renal disease, dependent on renal dialysis, hypertension, and hypotension (low blood pressure). The Annual Minimum Data Set (MDS) assessment, dated 6/5/24, indicated the resident was cognitively intact.		assessed for adverse reaction related to not following parameters of medication – no adverse reaction noted – MD / NP notified Change of condition, related to new onset of edema for resident K, was assessed and addressed by MD/NP Skin assessments were performed for affected residents. Non-pressure related skin conditions were assessed, documented and addressed with MD and orders carried out for residents C and G Missed appointments were rescheduled. Audit of upcoming appointments to ensure transportation is scheduled and secured for residents D, E, F **How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action(s) be taken?** All residents have the potential to be affected by this alleged deficiency. Skin assessments performed for all residents. Any abnormalities found will be assessed, documented and addressed with MD/NP. Audit of all upcoming appointments completed to ensure transportation is scheduled and secured UM/Nursing staff will be educated on the policy and procedure for transportation to	

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	A Care Plan, dated 11/2/23 and reviewed on 7/19/24, indicated the resident had hypotension with episodes of syncope (fainting) related to dialysis. Interventions included, but were not limited to, administer medications per physician's order. A Physician's Order, dated 5/3/24, indicated the resident was to receive Midodrine HCl (a medication used to treat low blood pressure) give 5 milligrams (mg) every 8 hours as needed (PRN) related to hypotension. Administer if the resident's systolic (top number) blood pressure was lower than 110 and diastolic (bottom number) blood pressure was lower than 80. The June 2024 Medication Administration Record (MAR), indicated the resident's systolic blood pressure was below 110 and/or his diastolic blood pressure was below 80 on the following dates and times and the PRN Midodrine was not administered: 9:00 a.m.: - 6/5 94/69 - 6/7 109/63 - 6/8 104/76 - 6/15 103/71 - 6/22 108/78 Evening: - 6/1 109/73 - 6/7 91/62 - 6/10 105/74 - 6/15 101/68 - 6/16 106/64 The July 2024 MAR, indicated the resident's systolic blood pressure was below 110 and/or his diastolic blood pressure was below 80 on the		appointments Education to nursing DON/IDT/Nursing staff regarding recognition of changes of condition and documentation, including but not limited to, new onset of edema and non-pressure related skin conditions Education to DON/IDT/Nursing regarding performing and documenting assessment under changes of condition, including but not limited to, new onset of edema and non-pressure related skin conditions DON/UM/Nursing staff will receive education regarding blood pressure medications and following parameters. **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur?** DON/UM/ designee will review all scheduled appointments to ensure that transportation has been scheduled prior to the appointment date. This review will occur daily in the morning clinical meeting. ED / designee will review all scheduled appointments in the daily morning IDT meeting. Transportation will be confirmed at that time. Daily review of upcoming appointments will be reviewed in am/clinical meeting to ensure	

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	following dates and times and the PRN Midodrine was not administered: 9:00 a.m. - 7/6 94/70 - 7/7 108/75 - 7/10 92/62 - 7/14 105/77 - 7/19 90/52 - 7/20 101/75 Evening: - 7/11 101/71 - 7/13 89/56 - 7/18 108/62 - 7/22 100/78 A Physician's Order, dated 5/14/24, indicated the resident was to receive Irbesartan (a medication used to treat high blood pressure) 300 mg at bedtime. The medication was to be held if the systolic blood pressure was less than 110. The July 2024 MAR, indicated the resident's blood pressure on 7/11 was 101/71 and on 7/22 his blood pressure was 100/78. The medication was not held and was administered on both days. During an interview on 7/23/24 at 4:10 p.m., the Director of Nursing indicated the medications weren't held or administered per parameters.3. The record for Resident C was reviewed on 7/22/24 at 10:50 a.m. Diagnoses included but were not limited to, respiratory failure, joint stiffness, COPD (chronic obstructive pulmonary disease), Parkinson's disease, heart disease, atrial fibrillation, anemia, and dementia. The 6/24/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and		transportation is scheduled/secured for residents. DON/UM will review all nursing documentation from the previous 24-72 hours in morning clinical meeting daily to ensure that all change of conditions, including but not limited to new onset of edema and non-pressure skin conditions, have been assessed, documented and addressed correctly. DON / UM/designee will monitor shower sheets daily to ensure that any skin conditions, including but not limited to non-pressure skin conditions, have been assessed, documented and addressed correctly. ·Nursing / UM staff will be educated on performing and documenting change of condition assessments including but not limited to, new onset of edema and non-pressure related skin conditions ·DON/Unit Managers/Nursing staff will receive education on proper notification to responsible parties for all changes of condition for residents including but not limited to, new onset of edema and non-pressure related skin conditions ·DON/UM/Nursing staff will receive education regarding blood pressure medications and following parameters. **·How the corrective action(s) will be monitored to ensure the**	

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	wore oxygen while a resident. A Nurses' Note, dated 7/14/24 at 6:39 p.m., indicated the resident was found sitting next to the bed Indian style. The resident indicated she was praying and the indwelling catheter was in the bed. The resident's POA and physician were notified. Nurses' Notes, dated 7/15 and 7/16/24, indicated there was no documentation of any injury related to the previous fall. Nurses' Notes, dated 7/17/24 at 2:51 p.m., indicated upon assessment, the resident was noted with a dark purple discoloration measuring 23 centimeters (cm) by 15 cm and extending down and under the left breast. The resident denied any pain or discomfort and was not able to recall when the discoloration first appeared. The resident's POA and physician were notified. An IDT (interdisciplinary team) Review Note, dated 7/18/24 at 8:28 a.m., indicated the resident's skin discoloration to the left breast was believed to be from the most recent fall. During an interview on 7/24/24 at 8:55 a.m., the Director of Nursing indicated the bruise was more than likely from the fall she had on 7/14/24. During an interview on 7/24/24 at 11:00 a.m., the Unit 4 Manager indicated she did her own investigation into the bruise on the resident's left breast area. She interviewed CNA 3, who worked on 7/14/24 when the fall happened. CNA 3 indicated she noticed the bruise hours after the fall and told LPN 2 while CNA 2 was standing there and witnessed the conversation. The Unit Manager interviewed LPN 4, who worked on		**deficient practice will not recur, i.e., what quality assurance program will be put into place?** Auditing 5 random residents' for compliance with blood pressure parameters. Auditing 5 random residents' skin assessment will be completed, of but not limited to new onset of edema and non-pressure skin conditions, to ensure that have been assessed, documented and addressed correctly. Audit of 5 random residents appointments will be completed to ensure transportation is scheduled and secured. DON/IDT auditing clinical charting in morning clinical meeting to ensure E-interact change of condition assessment has been completed. Audits will be completed daily x5, weekly x4 weeks, bi-monthly for 2 months, monthly x6, 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 the threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	7/13/24 on the 3-11 shift. He told the Unit Manager the bruise was not there on 7/13/24 because the resident removed her blouse and he could see her chest. The Unit Manager indicated she spoke with LPN 2 about the fall and LPN 2 told her nothing about the bruise. LPN 3 was interviewed as well and she informed the Unit Manager she had seen the bruise on 7/15/24, but just assumed everyone knew about it and it was from the fall. The Unit Manager indicated when the bruise was first observed, an assessment and a measurement should have been completed. 4. During an observation on 7/18/24 at 1:26 p.m., Resident K's legs were discolored and swollen. The resident lifted up his sweat pants and deep indentations were observed at the point where the elastic bands were resting on his skin. The resident was wearing plain socks to both feet. During an interview at that time, the resident indicated he was supposed to get "those special socks" to wear, but he had not yet received them. The record for Resident K was reviewed on 7/19/24 at 3:02 p.m. Diagnoses included, but were not limited to, heart failure, acute respiratory failure, atrial flutter, high blood pressure, COPD (chronic obstructive pulmonary disease), type 2 diabetes, and anemia. The 5/5/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making, The resident had no current skin issues. A Care Plan, revised on 4/2/24, indicated the resident had heart failure. The approaches were to monitor for dependent edema of the legs and feet.		**By what date the systemic changes for each deficiency will be completed?** 8-21-2024	

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	A Nurse Practitioner (NP) Progress Note, dated 7/11/24, indicated "patient is seen today for follow up visit. Bilateral lower extremity edema 2 plus. TED hose ordered. Wear while awake and take off for sleep." (sic) The physical exam indicated the resident had pitting edema to both lower extremities. Physician's Orders, dated 7/11/24, indicated to measure for TED hose (stockings specially designed to help prevent blood clots and swelling in the legs) for bilateral lower extremity swelling. Physician's Orders, dated 7/15/24, indicated TED hose to bilateral lower extremities, apply in the morning and remove at night for edema. The Head to Toe Weekly Skin Assessments, dated 7/6, 7/13, and 7/17/24, indicated the resident had no new or existing skin issues. Nursing Progress Notes, dated 7/1-7/17/24, indicated there was no documentation or an assessment of the resident's legs or edema. The Treatment Administration Record (TAR) for 7/2024, indicated the TED hose were signed out as being donned on 7/18/24. During an interview on 7/22/24 at 2:45 p.m., the Unit 3 Manager indicated the resident did refuse to wear his TED hose at times and she had to convince him today to put them on. There was no documentation in nursing progress notes or on the head to toe skin assessments of the pitting edema to the resident's lower legs. 5. During an observation in the activity room on 7/23/24 at 3:45 p.m., Resident D was interviewed. He indicated he was "bummed out" about missing his urology appointment yesterday. Resident D			

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	was told he had to reschedule his appointment because the facility did not have transportation to get him there. He indicated this appointment was important to him. Resident D's record was reviewed on 7/23/23 at 3:45 p.m. Diagnoses included, but were not limited to, chronic pain syndrome, benign prostatic hyperplasia with lower urinary tract symptoms, acute kidney failure, feeling of incomplete bladder emptying, and retention of urine. The Quarterly Minimum Data Set (MDS) assessment, dated 6/21/24, indicated the resident was cognitively intact. A Care Plan, dated 6/11/24, indicated Resident D had difficulty with toileting with occasional urinary incontinence episodes. Resident D had an Urology appointment scheduled for 7/22/24, which was rescheduled for 8/19/24 due to the facility not having the ability to transport the resident. During an interview with the Director of Nursing on 7/23/24 at 2:01 p.m., she indicated the payer source was an issue for a Medicaid resident regarding transportation. The facility currently had the nursing staff outsourcing the transportation needs for those residents until they got insurance in place for the newly hired driver, which may take a few weeks, resulting in some residents missing their appointments. 6. Resident E's record was reviewed on 7/23/23 at 3:19 p.m. Diagnoses included, but were not limited to, acute kidney failure, hypertensive heart and chronic kidney disease with heart failure and stage 1 through 4 chronic kidney disease, or			

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	unspecified chronic kidney disease. The Quarterly Minimum Data Set (MDS) assessment, dated 7/4/24, indicated the resident was cognitively intact. A Care Plan, dated 5/14/24, indicated Resident E had hypertensive heart disease with heart failure, and chronic kidney disease. Resident E had an Nephrology appointment scheduled for 7/22/24, which was rescheduled for 8/22/24 due to the facility not having the ability to transport the resident. During an interview with the Director of Nursing on 7/23/24 at 2:01 p.m., she indicated the payer source was an issue for a Medicaid resident regarding transportation. The facility currently had the nursing staff outsourcing the transportation needs for those residents until they got insurance in place for the newly hired driver, which may take a few weeks, resulting in some residents missing their appointments. 7. Resident F's record was reviewed on 7/23/24 at 2:30 p.m. Diagnosis included but not limited to, acute respiratory failure with hypoxia, tracheotomy status, and pneumonia unspecified organism. The Admission Minimum Data Set (MDS) assessment, dated 4/23/24, indicated cognitive skills for daily decision making for the resident were severely impaired. A Care Plan, dated 6/20/24, indicated Resident F had a tracheotomy, post cardiac arrest, and respiratory failure with hypoxia.			

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	Resident F had an Pulmonary appointment scheduled for 7/3/24 that was rescheduled for 7/17/24. During an interview with the Director of Nursing on 7/23/24 at 10:10 a.m., she indicated their facility driver resigned and they were outsourcing transportation, which had caused a few residents to miss their scheduled appointments. 8. On 7/18/24 at 11:01 a.m., Resident G was observed in bed. There was a rash all over the resident's face. The skin on top of the forehead was red, dry, and cracking. On 7/19/24 at 9:32 a.m. and 2:11 p.m., Resident G was observed in bed. At those times, the resident had a red rash on around their face. On 7/22/24 at 10:05 a.m. and 2:16 p.m., the resident was observed in bed. The rash on the resident's face was red, dry, and scabbed in areas. The record for Resident G was reviewed on 7/19/24 at 10:50 a.m. The diagnoses included, but were not limited to, fibromyalgia, heart failure, lupus, depression, anxiety, schizoaffective disorder, gout, hypertension (high blood pressure), insomnia (difficulty sleeping) and chronic pain syndrome. The Quarterly Minimum Data Set (MDS) assessment, dated 6/13/24, indicated the resident was severely impaired for daily decision making. The resident had impairment on both sides of the upper and lower extremities. A Care Plan, dated 6/11/24, indicated the resident had impaired skin integrity related to impaired mobility, and fibromyalgia. Interventions were to			

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	administer calmoseptine every shift, observe and assess skin with daily care, and report changes to nurse for further assessment and intervention. There was no physician order for Calmoseptine ointment. A Physician's Order, dated 11/4/23, indicated vital signs and a weekly skin check assessment were to be completed on every night shift, every Wednesday . A skin assessment and vitals were to be completed every Saturday. A Head to Toe Weekly Skin Assessment, dated 7/18/24, indicated the resident's skin was intact and they had no existing skin issues. During an interview on 7/22/24 at 2:22 p.m., the Director of Nursing (DON) indicated Resident G's rash was assessed on 7/21/24 and a call to the physician was made to get a treatment put in place. The facility would continue to monitor the resident's skin condition going forward. This citation relates to Complaint IN00433844 and IN00439030. 3.1-37(a) 3.1-37(b)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-			

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	§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and interview, the facility failed to ensure meal consumption logs were completed for a resident with a history of significant weight loss for 1 of 2 residents reviewed for nutrition. (Resident 68) Finding includes: On 7/23/24 at 12:32 p.m., Resident 68 was observed in his room seated on the side of his bed. He was served an open faced turkey sandwich, potatoes, and cauliflower. The resident was eating his lunch with his fingers. The record for Resident 68 was reviewed on 7/19/24 at 2:10 p.m. Diagnoses included, but were not limited to, lung cancer, dysphagia (difficulty swallowing), and vascular dementia with behavior disturbance. The 5 day Medicare Minimum Data Set (MDS) assessment, dated 6/21/24, indicated the resident was severely impaired for daily decision making and he needed set up or clean up assistance with eating. He also received a mechanically altered diet.	F 0692	**F692- Nutrition/Hydration Status Maintenance** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident currently resides in the facility and has had no adverse effects from alleged deficient practice. Resident will be reviewed in NAR meeting to ensure all interventions are in place to improve nutritional status. **How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action(s) be taken?** All residents have the potential to be affected by this alleged deficiency. An audit of all residents' weights will be completed to	08/21/2024

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	A Care Plan, revised on 6/20/24, indicated the resident had a nutritional problem or potential nutritional problem related to a past medical history of stroke, abnormal finding of the lung field, dementia with behavioral disturbance, and vitamin B12 deficiency. The resident had a history of significant weight changes and alterations in his ability to swallow requiring an altered diet and fluid consistency. The resident weighed 149 pounds on 6/5/24 and 135 pounds on 7/8, which indicated a 9.4% weight loss in 1 month. The resident weighed 159 pounds on 1/9/24, indicating a 14.5% weight loss in 6 months. The Food Consumption Logs, dated 6/24-7/23/24, indicated no dinner intake was documented on 6/25, no breakfast or lunch intake was documented on 7/3, 7/12, and 7/13, and there was no documentation of intake for any meal on 7/18/24. During an interview on 7/23/24 at 4:10 p.m., the Director of Nursing indicated the food consumption logs should have been completed for each meal. 3.1-46(a)(1)		identify residents with significant weight loss. An audit of meal consumption logs of residents with significant weight loss will be completed to ensure compliance with documentation. Education given to nursing staff of meal consumption policy and importance on completion. All residents identified will have routine monitoring performed by UM/designee for completion of meal consumption logs. **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur?** ·Education given to nursing staff of meal consumption policy ·Education to unit managers on the need to monitor meal consumption for residents presenting with history of significant weight loss. All residents identified will be reviewed in NAR meeting to ensure all interventions/supplements are in place to improve nutritional status. ·Unit managers/designee will complete audits per schedule below of meal consumption for completion and accuracy. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place? DON/Designee will complete audits on 5 random residents with significant weight loss to ensure the meal consumption documentation is being followed per policy. Audits will be completed daily x5, weekly x4 weeks, bi-monthly for 2 months, monthly x6, 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 the threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **By what date the systemic changes for each deficiency will be completed?** 8-21-2024	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan,			

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	the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure oxygen was set at the correct flow rate and a resident was transported to the Pulmonologist's office for an appointment for 1 of 2 residents reviewed for respiratory care. (Resident C) Finding includes: During a phone interview on 7/19/24 at 11:20 a.m., Resident C's POA (power of attorney) indicated her mother had missed a cardio/pulmonologist appointment due to the facility not having transportation. The appointment was made over a year ago for the resident to be evaluated for a c-pap (continuous positive airway pressure) machine (a machine used that used mild air pressure to keep breathing airways open while sleeping). During random observations on 7/22/24 at 1:20 p.m., 3:30 p.m., and 4:48 p.m., the resident was observed wearing oxygen per nasal cannula at 0.75 liters per minute. The resident was connected to a portable oxygen tank. During random observations on 7/23/24 at 7:50 a.m. and 11:55 a.m., the resident was observed wearing oxygen per nasal cannula at 2 liters per minute on the portable tank. The record for Resident C was reviewed on 7/22/24 at 10:50 a.m. Diagnoses included but were not limited to, respiratory failure, COPD (chronic obstructive pulmonary disease), Parkinson's disease, chronic bronchitis, heart disease, atrial fibrillation, and dementia.	F 0695	**F695- Respiratory/Tracheostomy Care and Suctioning** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident currently resides in the facility and has displayed no adverse effects, continues with normal daily routine ·Audit of resident respiratory appointments to ensure transportation is scheduled to prevent missed appointments. ·Audit of resident supplemental oxygen order for flow rate accuracy and corresponding orders. **How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action(s) be taken?** All residents have the potential to be affected by this alleged deficiency. Audit of all resident's supplemental oxygen order for flow rate accuracy and corresponding orders. Audit of all resident respiratory appointments to ensure transportation is scheduled and secured to prevent missed	08/21/2024

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	The 6/24/24 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for daily decision making and wore oxygen while a resident. A Care Plan, revised on 6/27/24, indicated the resident had COPD. Physician's Orders, dated 6/17/24, indicated continuous oxygen at 3 liters per minute per nasal cannula. Nurses' Notes, dated 7/17/24 at 12:04 p.m., indicated the resident had an appointment that afternoon to see a cardio/pulmonologist. Due to last minute transportation issues, the appointment had to be rescheduled for 8/7/24 at 12:30 p.m. The resident's daughter (POA) was made aware of the change due to her being the family member who requested the appointment. During an interview on 7/23/24 at 1:50 p.m., the Director of Nursing indicated the oxygen flow rate should be on as ordered by the physician. The transportation coordinator resigned and did not give notice to the facility, therefore, some residents were left without a ride to their appointments. The resident missed her appointment on 7/17/24 due to transportation issues. This citation relates to Complaints IN00439030 and IN00433844. 3.1-47(6)		appointments. **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur?** ·DON/Unit Managers/designee will be educated to review residents who receive supplemental oxygen for correct oxygen rate, appropriate orders, and manifestations of hypoxia. ·Unit Managers/designee will perform audit of care cards for flow rate accuracy. Care cards will be updated for any change's r/t resident orders/care preferences. ·Nursing staff will be educated on policy for oxygen flow rate monitoring and corresponding orders. Nursing staff will be educated on the policy and procedure for transportation to appointments, including, but not limited to, respiratory-specific consult appointments. DON/UM/ designee will review all scheduled appointments, , including, but not limited to, respiratory-specific consult appointments, to ensure that transportation has been scheduled prior to the appointment date. This review will occur daily in the morning clinical meeting. ·ED / designee will review all scheduled appointments, including, but not limited to, respiratory-specific consult	

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			appointments, in the daily morning IDT meeting. Transportation will be confirmed at that time **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/UM/Designee will conduct the respiratory audit tool to ensure that all residents who require supplemental oxygen have necessary respiratory orders, orders are in place and followed per MD order, and that all supplies are dated/labeled appropriately. DON/UM/Desginee will conduct the transportation to appointment audit tool to ensure that all residents with scheduled appointments, including, but not limited to, respiratory-specific consult appointments, have transportation scheduled DON/UM/Desginee will conduct the transportation to appointment audit tool to ensure that all residents with scheduled appointments, including, but not limited to, respiratory-specific consult appointments, attended their appointment via transportation Audits will be completed daily x5, weekly x4 weeks, bi-monthly for 2 months, monthly x6, and then quarterly to	

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			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 the threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **By what date the systemic changes for each deficiency will be completed?** 8-21-2024	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, record review, and interview, the facility failed to ensure nonpharmacological interventions were offered, documented, and the pain assessment lacked a pain scale when monitoring for 1 of 1 resident reviewed for pain. (Resident 45) Finding includes: During an interview on 7/18/24 at 10:52 a.m., Resident 45 indicated he was having pain in his stomach and penis and the nurses would not give him Tylenol. On 7/19/24 at 11:29 a.m., the resident was	F 0697	**F697- Pain Management** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident currently resides in the facility and continues normal daily routine. ·DON/Designee met with resident and reviewed pain medication and non-pharmacological treatment options. Resident care plan	08/21/2024

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	observed lying in bed. He indicated he was in a lot of pain but did not request medicine since the nursing staff always refused his requests. On 7/22/24 at 2:15 am., the resident was observed in bed. He indicated he still had pain in his lower stomach and penis and was not offered Tylenol when pain was expressed to the staff. The record for Resident 45 was reviewed on 7/19/24 at 10:56 a.m. The diagnoses included, but were not limited to, stroke, hypertension (high blood pressure), anxiety, hemiplegia (paralysis on one side of the body), benign prostatic hyperplasia (enlarged prostate gland), and opioid abuse. The Quarterly Minimum Data Set (MDS) assessment, dated 5/25/24, indicated the resident was cognitively intact for daily decision making. The resident had impairment on one side of the upper and lower extremities and used a wheelchair. A Care Plan, dated 7/19/24, indicated the resident had a history of alcohol abuse, cocaine abuse and opioid abuse. Interventions included ensuring medication was swallowed to prevent pocketing medication and reevaluate plan of care regarding pain management. A Care Plan, dated 5/17/24, indicated the resident was at risk of pain due to history of left knee pain, gastrointestinal discomfort (indigestion), general discomfort, and testicle pain. Interventions were to monitor daily physical symptoms associated with pain and to offer comfort measures as well as pain medication as needed. A Physician's Order, dated 5/17/24, indicated to		updated. ·Medication reconciliation with MD for pain management options. ·Implementation of alternative pain management pathways such as guided imagery, meditation, MBSR. **How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action(s) be taken?** All residents have the potential to be affected by this alleged deficiency. Audit of all resident's with a history of opioid/substance abuse for pain management control via audit tool. Audit of all residents' pain assessments for pain management control and accuracy. Implementation of alternative pain management pathways such as guided imagery, meditation, MBSR. **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur?** ·DON/Unit Managers/designee will be educated to review residents pain assessments and offer alternative pain management methods to aid in pain relief in current regimen is ineffective. ·Nursing staff will be educated to confer with MD if pain	

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	give one 5 milligram (mg) tablet of oxybutynin chloride by mouth twice a day for bladder hyperactivity related to benign prostatic hyperplasia. A Physician's Order, dated 5/17/24, indicated to monitor pain level every shift and if pain were present, to monitor, assess, and treat trying non-pharmacological interventions prior to medicating if appropriate. The physician was to be notified for uncontrolled pain and interventions and outcomes were to be documented every shift. A Physician's Order, dated 5/17/24, indicated to administer one Ibuprofen (pain/anti-inflammatory medication) 800 milligram (mg) tablet every 12 hours as needed by mouth for pain. The order was discontinued on 7/9/24. A Nurse's Progress Note, dated 7/9/24 at 8:49 a.m., indicated the resident had a vape pen and Motrin pills found in his wheelchair. The physician was notified and new orders were received to discontinue the resident's ibuprofen due to constant drug seeking behavior. The Medication Administration Record (MAR) pain assessment was signed out as completed every shift for the month of July 2024. The pain assessment did not include a pain level or if non pharmacological or pharmacological interventions were administered and effective. During an interview on 7/22/24 at 2:34 p.m., LPN 1 indicated the resident complained of pain this morning, but he didn't have anything for pain ordered, not even Tylenol. She asked another nurse and asked the Unit Manager for clarification since she was new to that hall, and was told the resident had his pain medicine discontinued. She		assessments reveal pain is uncontrolled for resident. ·Nursing staff will be educated on policy for pain management and corresponding orders. **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?** Auditing 5 random residents' pain assessments and offer alternative pain management methods to aide in pain relief in current regimen is ineffective. Pain management audit tool will be used to ensure pain is being managed appropriately. Audits will be completed daily x5, weekly x4 weeks, bi-monthly for 2 months, monthly x6, 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 the threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **By what date the systemic changes for each deficiency will be completed?** 8-21-2024	

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	was going to call the physician to see about getting him something for his pain, but did not get around to it yet. During an interview on 7/22/24 at 2:25 p.m., the Director of Nursing (DON) indicated the resident was pocketing pills and they had found medication in his wheelchair. The physician discontinued the resident's ibuprofen due to constant drug seeking behavior. The resident had seen his urologist and pain clinic recently with no new orders. The facility did not have any pharmacological or nonpharmacological interventions documented or in place. 3.1-37(a)			
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations;			

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	155530	A. BUILDING 00 B. WING	07/24/2024

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	§483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. Based on observation, record review, and interview, the facility failed to ensure each resident saw the dentist at least yearly for 2 of 2 residents reviewed for dental care. (Residents K and D) Findings include: 1. On 7/18/24 at 1:23 p.m., Resident K's teeth were observed to be decayed. During an interview at that time, the resident indicated he has asked to see a dentist but still has not. The record for Resident K was reviewed on 7/19/24 at 3:02 p.m. Diagnoses included, but were not limited to, heart failure, acute respiratory failure, atrial flutter, high blood pressure, COPD	F 0791	**F 791 Routine/Emergency Dental Services** We respectfully request paper compliance for this citation. **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident D and K was seen by Dentist on 7/31/24. Resident was not harmed by alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	08/21/2024

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	(chronic obstructive pulmonary disease), type 2 diabetes, and anemia. The 5/5/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. The resident had no oral issues with his teeth. There was no care plan for any dental issues. An Oral Assessment, dated 3/12/24 and completed by a dental hygienist, indicated the patient had intact teeth, broken teeth, missing teeth and root tips on both arches. The patient also had inflamed or bleeding gums or loose natural teeth. A dental consent was signed by the resident on 4/12/24. There were no visits from the actual dentist in the last year. During an interview on 7/22/24 at 10:35 a.m., the Social Service Director indicated he had the resident sign the consent form for the dentist in April 2024 and he was scheduled to see the dentist on 7/25/24. The dentist was last in the facility on 6/24/24, however, the resident was not seen at that time. During an interview on 7/24/24 at 8:55 a.m., the Nurse Consultant provided a dental action plan, dated 2/1/24, however, the resident still had not seen the dentist as of the action plan.2. During an interview on 7/18/24 at 10:45 a.m., Resident D indicated they spoke with social services because they wanted top teeth and had requested to see the dentist. Upon observation at that time, the residents was missing top teeth.		**actions(s) will be taken:** Residents interviewed for need for dental service follow up. Audit being performed to meet this requirement. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** SSD/IDT team will be educated on ensuring consultant and referral process for dental care and follow up to ensure that dental services are met for each resident. **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 will complete audit related to dental services to ensure that all notes, referrals and follow-up and appointments are made. Audits will be completed daily x5, x4 weeks, bi-monthly for 2 months, monthly for 6 months and quarterly until compliance is maintained for 2 consecutive quarters. Results will be reviewed by the QA committee overseen by the ED. IF non-compliance of 95% is not achieved a action plan will be developed to ensure compliance. **By what date the systemic changes will be completed:**	

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			8-21-24	
	The record for Resident D was reviewed on 7/19/24 at 11:04 a.m. The diagnoses included, but were not limited to, heart failure, stroke, diabetes, anxiety disorder, kidney failure, and urinary retention. The Quarterly Minimum Data Set (MDS) assessment, dated 6/21/24, indicated the resident was cognitively intact for daily decision making. The resident had impairment on one side of the upper and lower extremities and used a wheelchair. A Care Plan, dated 6/10/24, indicated the resident had oral and dental problems related to missing teeth and a history of a broken jaw. The resident's dental consent form was signed on 4/12/24. During an interview on 7/22/24 at 10:49 a.m., the Social Service Director (SSD) indicated Resident D had not been seen by the dentist since his admission date on 2/25/22. New dental consents were signed in April for all residents to see the dentist. The dentist was last in the facility on 6/24/24. He would try to get Resident D added to the next dental visit scheduled on 7/25/24. During an interview on 7/24/24 at 8:55 a.m., the Nurse Consultant provided an dental action plan, dated 2/1/24, however, the resident still had not seen the dentist as of the action plan. 3.1-24(a)(1)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary			

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	§483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure food was served and prepared under sanitary conditions related to touching food with ungloved hands, dirty food preparation equipment and greasy pipes for 1 of 1 residents observed for dining and 1 of 1 kitchens observed. (Resident L and the main kitchen) Findings include: 1. During a dining observation on 7/18/24 at 1:10 p.m., Resident L was observed in bed waiting for lunch. At that time, CNA 2 removed the lid off of the resident's tray. Resident L was served a hot dog on plain white bread. The CNA put ketchup on the hot dog and with her bare hands, broke the hot dog and bread in half and handed Resident L half of the sandwich to eat.	F 0812	**F-812 Food Procurement, Store/Prepare/Serve-Sanitary** We respectfully request paper compliance for this citation. **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** CNA that used their hands on handling resident food was educated on following procedures on proper handling of residents ensuring sanitary conditions are followed. The deep fryer was cleaned immediately that had a large accumulation of grease food drippings noted. Oven racks and doors with grease were	08/21/2024

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	During an interview at that time, the CNA was aware she should not use her bare hands to cut food in half. During an interview on 7/23/24 at 11:55 a.m., the Dietary Manager indicated staff were to use utensils to cut the resident's food in half. 2. During the brief kitchen sanitation tour on 7/18/24 at 9:22 a.m. with the Dietary Manager (DM), the following was observed: a. The deep fryer had a heavy accumulation of grease on the top and inside. The back splash had a large build up of burned food and both sides of the fryer had a large accumulation of grease and food drippings. b. The convection oven was observed with a large amount of burned food on the bottom and on the racks. The oven doors were greasy and dirty as well as the outside of the oven including the legs. c. The wells of the steam table were rusted with peeling and floating metal pieces. The shelf under the table where the pots and pans were housed was dirty with food crumbs and grease. d. The two standing fan blades and screens were dirty and dusty. Both fans were turned on and blowing towards the steam table and the dish machine. During an interview on 7/23/24 at 11:55 a.m., the DM indicated all of the above was in need of cleaning. This citation relates to Complaint IN00435118.		cleaned immediately, steam table wells were cleaned, fans were removed and cleaned, and shelves under where pots and pans are stored were cleaned the same day. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** Dietary staff/ manger will be educated on ensuring sanitation conditions are to be followed daily on making sure all areas are kept clean, and a cleaning schedule is followed. Staff will be in-serviced, ensuring proper food handling is done when assisting with resident meals. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Staff will be in-serviced on properly handling of food when assisting resident with a meal. The Dietary manager will monitor daily with a audit sheet done and turned into the ED for review for compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** A checklist audit will be completed by the Dietary	

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	3.1-21(i)(3)		manager/designee, audits will be completed and done daily x5, weekly x4 and monthly x3 months and quarterly thereafter until compliance is achieved and maintained for two consecutive quarters. Compliance will be overseen by dietary director and ED. All trends will be reviewed in QAPI committee meetings and if non-compliance noted at threshold at 95% of below with repeated checklist findings with deficiency practices, will result in retraining and progressive disciplinary action taken up to that includes termination. **By what date the systemic changes will be completed: 8-21-24**	