STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155653	A. BUILDING 00 B. WING	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARBOR HEALTH & REHAB	5025 MCCOOK AVE EAST CHICAGO, IN 46312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 8/9/24. Survey dates: September 24 and 25, 2024 Facility number: 000108 Provider number: 155653 AIM number: 100267410 Census Bed Type: SNF/NF: 61 Total: 61 Census Payor Type: Medicare: 3 Medicaid: 55 Other: 3 Total: 61 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 10/1/24.	F 0000		
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on record review and interview, the facility failed to ensure blood pressure medications were not administered outside of the physician-ordered parameters for 3 of 3 residents reviewed for blood pressure medications. (Residents 2, 3, and 7) Findings includes: 1. The record for Resident 2 was reviewed on	F 0684	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.	10/10/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Craig Clemons	Administrator	10/29/2024

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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	9/25/24 at 8:45 a.m. Diagnoses included, but were not limited to, Alzheimer's disease and high blood pressure. The 8/9/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making. Physician's Orders, dated 7/24/24, indicated the following: - Amlodipine (a medication used to treat high blood pressure) 10 milligrams (mg), give 1 tablet one time a day and hold for blood pressure less than 130/60. - Cozaar (a medication used to treat high blood pressure) 50 mg daily. Hold for blood pressure less than 130/80. The Medication Administration Record (MAR) for the month of 9/2024 indicated the Amlodipine and Cozaar were administered on 9/8/24 with a blood pressure of 112/66 and on 9/11/24 with a blood pressure of 119/63. During an interview on 9/25/24 at 10:30 a.m., the Director of Nursing indicated the resident's medications should have been held when outside of the physician-ordered parameters. The nursing staff needed more education on when to hold and administer the medications. 2. The record for Resident 3 was reviewed on 9/24/24 at 1:00 p.m. Diagnoses included, but were not limited to, infarction of the spinal cord, heart disease, high blood pressure, type 2 diabetes, major depressive disorder, and anxiety disorder. The 8/18/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making.		**The facility requests paper compliance for this citation** **F684 Quality of Care** **It is the policy of Harbor Healthcare to ensure its residents receive treatment and care in accordance with professional standards of practice.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** **R2, R3, R7- All remain in the facility and have had their medication administered as ordered by the physician within the specified parameters** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents residing in the facility have the potential to be affected by these alleged deficient practice **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	

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	Physician's Orders, dated 8/3/24, indicated Metoprolol Tartrate (a medication used to lower the blood pressure and the heart rate) 25 milligrams (mg), give 0.5 tablet by mouth three times a day (12.5 mg). Hold the medication for blood pressure less than 120/60. Physician's Orders, dated 8/5/24 indicated Midodrine HCl (a medication used to raise the blood pressure) 10 mg, give 1 tablet by mouth three times a day. Hold the medication for blood pressure greater than 110/60. The Medication Administration Record (MAR) for the month of 8/2024 indicated the a.m. Metoprolol dose on 8/29/24 was administered with a blood pressure of 115/63 and on 8/30/24 with a blood pressure of 94/68. The evening dose on 8/31/24 was administered with a blood pressure 100/70. The 9/2024 MAR indicated the Metoprolol was administered on 9/7/24 for the evening dose with a blood pressure of 104/60 and on 9/8/24 with a blood pressure of 100/60. The 9/2024 MAR indicated the Midodrine was administered for the midday dose on 9/16/24 with a blood pressure of 118/74. The evening doses were administered on 9/12/24 with a blood pressure of 120/74, 9/18/24 with a blood pressure of 138/76, 9/19/24 with a blood pressure of 130/74, and on 9/20/24 with a blood pressure of 138/74. For both the Metoprolol and the Midodrine, the medications were signed out with a "4" (meaning Vitals Outside of Parameters for Administration) and not administered on the following days: - a.m. doses on 9/20 and 9/22/24 - Midday doses on 9/4, 9/8, 9/18, and 9/20/24.		**practice does not recur.** All nursing staff have been in-serviced on the importance of assessing and administering medications as ordered by the physician within the specified parameters for administration. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place.** The Director of Nursing /Designee will complete Medication administration Record observations/audits 3x/ week x2 weeks then weekly for 6 months confirming that medications that have administration parameters are administered within those parameters. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly.	

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	During an interview on 9/25/24 at 10:30 a.m., the Director of Nursing indicated the resident's medications should have been held when outside of the physician ordered parameters. The nursing staff needed more education on when to hold and administer the medications. 3. The record for Resident 7 was reviewed on 9/24/24 at 10:41 a.m. Diagnoses included, but were not limited to, high blood pressure and chronic venous hypertension. The Annual Minimum Data Set (MDS) assessment, dated 6/26/24, indicated the resident was cognitively intact. Physician's Orders, dated 8/3/24, indicated Hydralazine (a medication used to lower the blood pressure) 100 milligrams (mg), 1 tablet three times a day and hold for blood pressure less than 130/60. The Medication Administration Record (MAR) for the month of 9/2024 indicated the Hydralazine was administered on the following dates: - 9/2/24 with a blood pressure of 112/68. - 9/5/24 with a blood pressure of 131/51. - 9/9/24 with a blood pressure of 115/66. - 9/10/24 with blood pressures of 109/66, 121/66, and 120/67. During an interview on 9/25/24 at 10:36 a.m., the Director of Nursing indicated the staff needed to be re-educated on the blood pressure parameters so they can correctly hold and administer the resident's medications. This deficiency was cited on 8/9/24. The facility failed to implement a systemic plan of correction to prevent recurrence.			

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F 0685 SS=D Bldg. 00	3.1-37(a) 483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision Based on observation, record review, and interview, the facility failed to ensure glasses were received as ordered and a follow up audiology (a physician who treats hearing issues) appointment was completed for 2 of 2 residents reviewed for vision and 1 of 1 resident reviewed for hearing. (Residents 4, 3, and 6) Findings include: 1. The record for Resident 4 was reviewed on 9/25/24 at 9:00 a.m. Diagnoses included, but were not limited to, type 2 diabetes and end stage renal disease. The Annual Minimum Data Set (MDS) assessment, dated 6/11/24, indicated the resident was cognitively intact. The resident was identified as having adequate vision with corrective lenses. A Care Plan, dated 9/7/21 and reviewed on 6/17/24, indicated the resident's vision was adequate with the use of glasses, which he utilized mainly for reading. Interventions included, but were not limited to, arrange consultation with eye care practitioner as required and ensure appropriate visual aids (glasses) were available to support the resident's participation in activities. The resident had an eye exam on 12/19/23. New glasses were recommended and were to be delivered upon approval. Documentation in the vision progress notes indicated the resident	F 0685	**Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** **The facility requests paper compliance for this citation F685 Treatment /Devices to Maintain Hearing/Vision** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 3: Resident added to audiology schedule and was seen on 9/30/2024. Medical clearance and audiometric test form completed by MD and sent back to audiologist for hearing aids. Resident 4 & 6: Attestation form for replacement glasses completed. Resident's glasses ordered and scheduled to be delivered to facility once glasses arrive to optometrist. Resident 4 &6 received glasses on 10/10/2024. **How the facility will identify other residents having the potential to be affected by the same deficient practice and**	10/25/2024

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	required glasses and full time use was to be encouraged for distance and reading. An entry in the Social Service Progress Notes, dated 9/23/24 at 3:08 p.m., indicated the Social Service Director had reached out to the optometry consultants to get information on how the resident could get his replacement glasses. A form was completed and submitted in an attempt to secure the resident's replacement eye glasses. An entry in the Social Service Progress Notes, dated 9/24/24 at 10:31 a.m., indicated the resident's glasses were ordered yesterday and the information was sent to the lab. Once the glasses were received, they would be shipped directly to the facility. During an interview on 9/25/24 at 9:30 a.m., the Social Service Director indicated the resident's glasses should have been ordered by the plan of correction date of 8/29/24. 2. During an interview on 9/24/24 at 1:40 p.m., Resident 3 indicated he had not seen an audiologist since last year. The record for Resident 3 was reviewed on 9/24/24 at 1:00 p.m. Diagnoses included, but were not limited to, infarction of the spinal cord, heart disease, high blood pressure, type 2 diabetes, major depressive disorder, and anxiety disorder. The 8/18/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. An Audiology Exam report, dated 9/6/23, indicated the staff or family had noticed a decrease in responsiveness from the resident. The resident had moderate to severe sensorineural hearing loss (damage in the inner ear) in both ears.		**what corrective action will be taken:** All facility residents requiring vision and/or audiology services have the potential to be affected by the alleged deficient practice. Whole house audit completed and those residents needing audiology and optometry services were added to the ancillary providers list. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Social Services Director received additional education on the following: Ensuring residents are added to the optometry visit list as needed and follow-up is completed for referrals including obtaining glasses. Ensuring residents are added to the audiology visit list as needed and follow-up is completed including obtaining hearing aides. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place:** Administrator/designee will audit 2x weekly for 1 month and then 1x weekly for 5 months to ensure residents on the optometry and/or audiology visit list are seen, and recommendations received are	

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	Impressions were taken and a hearing aid was recommended for a left ear half concha (the hollow depression in the middle auricle of the ear) and will return for hearing aid fitting. A Social Service Note, dated 9/23/24 at 2:37 p.m., indicated staff reached out to the audiologist to assist the resident with obtaining his hearing aid. The representative indicated, since the order for the hearing aids was over a year old, the resident would need to be re-evaluated by the audiologist. An appointment was requested for an audiology visit. The representative indicated they would reach out to the scheduling team to get the resident scheduled for a visit. A Social Service Note, dated 9/24/24 at 8:44 a.m., indicated the audiology re-evaluation appointment for the hearing aid was scheduled for 10/9/24. During an interview on 9/24/24 at 2:20 p.m., the Social Service Director (SSD) indicated he had just reached out to the audiologist's office on 9/23/24 to check into the hearing aid. The appointment was just scheduled today for October. During an interview 9/24/24 at 2:30 p.m., the Administrator indicated he had been looking at the SSD's audits and checking the clinical records and realized some things were not completed. He spoke with the SSD on 9/23/24 and told him he needed to take care of making the appointments and getting the ancillary services for the resident. The Plan of Correction indicated the resident was to be added to the facility's audiology visit. The weekly audits indicated there were no visits for 8/12-8/16, 8/19-8/23, 8/26-8/30, 9/2-9/6, and 9/9-9/13/24.3. During an interview on 9/24/24 at		followed up timely including obtaining eyeglasses and hearing aids. Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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	11:28 a.m., Resident 6 indicated he had not received his glasses and was still waiting for them. The record for Resident 6 was reviewed on 9/24/24 at 10:40 a.m. Diagnoses included, but were not limited to, chronic kidney disease, irritable bowel syndrome, depressive disorder, and unsteadiness on feet. The Quarterly Minimum Data Set (MDS) assessment, dated 9/4/24, indicated the resident was cognitively intact. The resident was also independent. A Care Plan, dated 5/23/24, indicated the resident had an impaired visual function and was being followed by the optometrist. The approaches were to utilize glasses and to arrange a consultation with the eye care practitioner as required. An Optometry Visit report, dated 12/19/23, indicated the resident was examined and encouraged to use glasses full time for distance and reading. New glasses were recommended and awaiting approval. During an interview on 9/25/24 at 9:10 a.m., the Social Service Director indicated he ordered the glasses yesterday, and had not gotten around to ordering them earlier. This deficiency was cited on 8/9/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-39(a)(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning			

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	Based on observation, record review, and interview, the facility failed to ensure oxygen was set at the correct flow rate for 1 of 3 residents reviewed for respiratory care. (Resident 5) Finding includes: On 9/24/24 at 2:00 p.m., Resident 5 was observed in her room after being outside smoking. The resident was not wearing any oxygen, the oxygen tank was off and in the corner of the room. On 9/25/24 at 9:27 a.m., and 10:01 a.m., the resident was not in her room, the oxygen was on, and the flow rate was set under 2 liters. On 9/25/24 at 10:14 a.m., 10:31 a.m., and 10:45 a.m., the resident had returned from smoking and was observed sitting in her wheelchair watching television. The oxygen was on and the flow rate was set under the 2 liter line. The resident was not wearing the oxygen. During an interview on 9/25/24 at 10:45 a.m., RN 1 indicated the resident's oxygen flow rate was not at 2 liters. The ball should be between the 2-liter line. She was unaware the resident was not wearing her oxygen. Resident 5's record was reviewed on 9/24/24 at 1:25 p.m. Diagnoses included, but were not limited to, diabetes, anemia (low iron), chronic obstructive pulmonary disease (COPD), depression and low back pain. The Quarterly Minimum Data Set (MDS) assessment, dated 9/2/24, indicated the resident was cognitively intact for daily decision making and required oxygen therapy.	F 0695	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **The facility requests paper compliance for this citation** **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.** **R5** remains in the facility with her oxygen on the correct settings **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents receiving oxygen have the potential to be affected by this deficient practice **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** All Staff were in-serviced with regards to monitoring and assuring that residents' concentrators are set to the correct parameters. 1:1 education given to non-clinical management team members on	10/10/2024

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	A Physician's Order, dated 8/27/24, indicated to administer oxygen at 2 liters per nasal cannula continuously every shift. The Medication Administration Record (MAR) for 9/2024 indicated oxygen was signed out as being administered at 2 liters on 9/24/24 and 9/25/24. During an interview on 9/25/24 at 10:59 a.m., the Administrator indicated he understood the oxygen concern and had no additional information to provide. During an interview on 9/25/24 at 11:18 a.m., the Director of Nursing (DON) indicated the resident required oxygen immediately after she smoked and should have had her oxygen on. This deficiency was cited on 8/9/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-47(6)		how to properly read oxygen settings on concentrator and to notify nursing if concentrator is not set to ordered liter flow. Additional item to check “02 liter flow set as ordered by physician” added to daily Angel Rounds checklist. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place.** The Director of Nursing /Designee will observe 5 residents with oxygen to ensure concentrator is set to correct liter flow as ordered. This will be completed 2x weekly for 6 months. Non-clinical management team will continue to utilize Angel Rounds sheet to audit those residents with oxygen orders to ensure concentrator is set to correct liter flow. This will be completed daily 5x week for 6 months. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly.	
F 0757 SS=D	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary			

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Bldg. 00	Drugs Based on record review and interview, the facility failed to appropriately monitor blood pressures (BP) related to medications with BP parameters, for 2 of 3 residents reviewed for blood pressure medications (Residents 2 and 3) Findings includes: 1. The record for Resident 2 was reviewed on 9/25/24 at 8:45 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, and high blood pressure. The 8/9/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making. Physician's Orders, dated 7/24/24, indicated the following: - Amlodipine (a medication used to treat high blood pressure) 10 milligrams (mg), give 1 tablet one time a day and hold for blood pressure less than 130/60. - Cozaar (a medication used to treat high blood pressure) 50 mg daily. Hold for blood pressure less than 130/80. The Medication Administration Record (MAR) for the month of 9/2024 indicated the Amlodipine and Cozaar was coded with a "4" (meaning Vitals Outside of Parameters for Administration) and they were not administered 9/6, 9/13, and 9/19/24. There was no documented blood pressure for those days. During an interview on 9/25/24 at 10:30 a.m., the Director of Nursing indicated the resident's blood pressures were not documented in the clinical record and nursing staff needed more education.	F 0757	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **The facility requests paper compliance for this citation** **F757 Drug regimen is free from unnecessary Drugs** **It is the policy of Harbor Healthcare to ensure that its residents blood pressure parameters related to blood pressure medications are appropriately monitored.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** R3 DON spoke with MD and received clarification on BP medications & parameters. New orders obtained from MD. R2 DON spoke with MD and received clarification BP parameters. New orders received to discontinue to parameters due controlled blood pressure. **How the facility will identify other residents having the potential to be affected by the same deficient practice and**	10/10/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. The record for Resident 3 was reviewed on 9/24/24 at 1:00 p.m. Diagnoses included, but were not limited to, infarction of the spinal cord, heart disease, high blood pressure, type 2 diabetes, major depressive disorder, and anxiety disorder. The 8/18/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. Physician's Orders, dated 8/3/24, indicated Metoprolol Tartrate (a medication used to lower the blood pressure and the heart rate) 25 milligrams (mg), give 0.5 tablet by mouth three times a day (12.5 mg). Hold the medication for blood pressure less than 120/60. Physician's Orders, dated 8/5/24, indicated Midodrine HCl (a medication used to raise the blood pressure) 10 mg, give 1 tablet by mouth three times a day. Hold the medication for blood pressure greater than 110/60. The Medication Administration Record (MAR) for 9/2024 indicated both medications were not administered and there was no documented blood pressure on 9/6/24 for the midday dose and on 9/22/24 for morning dose. A "4" was coded for both medications which indicated the medication was not given due to vitals were outside of parameters. During an interview on 9/25/24 at 10:30 a.m., the Director of Nursing indicated the resident's blood pressures were not documented in the clinical record and nursing staff needed more education. This deficiency was cited on 8/9/24. The facility		**what corrective action will be taken.** All residents receiving Blood pressure medication have the potential to be affected by this deficient practice **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** Nursing and QMA's received additional 1:1education on monitoring and documenting blood pressures. Additional education given on administering BP medications within ordered parameters. DON completed whole house audit on residents receiving BP medications. Resident physicians contacted for clarification on BP medications & parameters. Orders updated according to physician request. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place.** The Director of Nursing /Designee will audit those residents who are receiving blood pressure medications with parameters 5 days per week x2 weeks then bi-weekly for 6 months. The Administrator/designee will	

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	155653	A. BUILDING 00 B. WING	09/25/2024

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	failed to implement a systemic plan of correction to prevent recurrence. 3.1-48(a)(3)		present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly.	
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs Based on observation, record review, and interview, the facility failed to ensure a resident received routine dental services related to decayed and broken teeth for 1 of 3 residents reviewed for dental services. (Resident 3) Finding includes: During an interview on 9/24/24 at 1:40 p.m., Resident 3 indicated he still had seen the dentist since the survey on 8/9/24. No staff had asked him about seeing the dentist and he still would like to get dentures. During an observation at that time, the resident had obvious broken, loose and decayed teeth. The record for Resident 3 was reviewed on 9/24/24 at 2:00 p.m. Diagnoses included, but were not limited to, infarction of the spinal cord, heart disease, high blood pressure, type 2 diabetes, major depressive disorder, and anxiety disorder. The 8/18/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. A Dental Exam, dated 4/8/24, indicated there were root tips present on many teeth and the resident	F 0791	**Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** **The facility requests paper compliance for this citation** **F791 Routine/Emergency Dental Services in SNFs** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident 3 was seen by dental at facility on 10/01/2024. Facility received referral for resident to receive additional dental services outside of the facility. Resident follow-up appointment scheduled for 10/14/2024. **How the facility will identify**	10/25/2024

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	had non-restorable teeth. The gums were red and inflamed and there were caried and/or decayed teeth present at number 3, 13, 20, 21, 22, 23, 24, 27, and 28. The recommendations were to have xrays taken at the next visit as well as full mouth views and xrays and to set up a treatment plan. There were no other dental visits for the resident. During an interview on 9/24/24 at 1:40 p.m., the Social Service Director (SSD) indicated he was unsure if the resident had seen the dentist since the survey. A Social Service Note, dated 9/24/24 at 1:47 p.m., indicated staff met with the resident to discuss ancillary services. The resident requested to be enrolled into dental services and scheduled an appointment for 10/1/24. During an interview on 9/24/24 at 2:20 p.m., the SSD indicated the resident had not seen a dentist since the survey and scheduled an appointment for him to see one. He did not follow up with the resident after he wanted to see a dentist in 8/2024. During an interview on 9/24/24 at 2:30 p.m., the Administrator indicated he had been looking at the SSD's audits and checking the clinical records and realized some things were not completed. He spoke with the SSD on 9/23/24 and told him he needed to take care of making the appointments and getting the ancillary services for the resident. During an interview on 9/25/24 at 8:45 a.m., the SSD indicated the dentist was last in the facility on 9/3/24 and the resident was not seen. The Plan of Correction indicated the resident would be added to the next dental visit.		**other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents requiring dental services have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** Social service director received additional education on: Ensuring consent for dental services are obtained and resident is added to dental list timey. Reviewing dental services with residents regularly and as needed with residents/responsible parties Whole house audit completed and those residents requiring dental services were added to the ancillary providers list. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place.** Administrator/Designee will audit 2x weekly for 1 month and 1x weekly for 5 months to ensure new admissions and residents with needs for dental services are	

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	Weekly audits indicated no dental services were provided on the following weeks: - 8/12 through 8/16/24 - 8/19/24-8/23/24 - 8/26-8/30/24 - 9/2-9/6/24 dental services provided for 6 other residents - 9/9-9/13/24 This deficiency was cited on 8/9/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-24(a)(1)		added to the dental schedule recommendations are completed. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to documentation of a dialysis access site for 1 of 1 resident reviewed for dialysis. (Resident 4) Finding includes: The record for Resident 4 was reviewed on 9/25/24 at 9:00 a.m. Diagnoses included, but were not limited to, type 2 diabetes and end stage renal disease. The Annual Minimum Data Set (MDS) assessment, dated 6/11/24, indicated the resident was cognitively intact. The resident was receiving dialysis services. A Care Plan, reviewed on 6/17/24, indicated the resident had a right permacath (a flexible, soft plastic tube used for short term dialysis treatment)	F 0842	**Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance for this citation** **F842 Resident Records-Identifiable Information** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident 4 dialysis site access orders were clarified and updated.	10/10/2024

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	in place. Interventions included, but were not limited to, keep catheter site clean and dry, observe for redness, swelling, any discharge, increased pain or warmth due to infection. A Physician's Order, dated 8/26/24, indicated the resident's dialysis access site was to be assessed every shift for redness, swelling, pain, and drainage. The physician was to be notified with any symptoms and documentation was to be completed in the progress note. A "+" was to be documented for abnormalities and a "-" for no abnormalities. The September 2024 Medication Administration Record (MAR), indicated both a "+" and a "-" symbol were documented on the following dates and times: - Day shift: 9/1 and 9/2/24 - Evening shift: 9/1, 9/3, 9/5, 9/6, 9/9, and 9/12/24 - Night shift: 9/24/24 During an interview on 9/25/24 at 10:30 a.m., the Director of Nursing indicated more education would need to be provided regarding the documentation of the assessment of the permacath. Weekly audits, completed 9/2-9/6, 9/9-9/13 and 9/16-9/20/24, indicated documentation had been completed accurately. This deficiency was cited on 8/9/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-50(a)(2)		**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents who receive dialysis have the potential to be affected by this alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nursing staff received 1:1education by DON on how to assess and accurately document dialysis access sites in the medical record. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will audit the MAR for those residents receiving hemodialysis 2x weekly for 6 months to ensure there is an accurate assessment of the dialysis site documented in the medical record. DON/designee will present a summary of the audits to the Quality Assurance committee	

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			monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	