| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155070 | A. BUILDING 00<br>B. WING | 10/10/2023 |

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| GREEN VALLEY CARE CENTER | 3118 GREEN VALLEY RD<br>NEW ALBANY, IN 47150 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: October 3, 4, 5, 6, and 10, 2023<br><br>Facility number: 000028<br>Provider number: 155070<br>AIM number: 100275370<br><br>Census Bed Type:<br>SNF/NF: 113<br>Total: 113<br><br>Census Payor Type:<br>Medicare: 8<br>Medicaid: 81<br>Other: 24<br>Total: 113<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on October 12, 2023. | F 0000 | | |
| F 0550<br>SS=D<br>Bldg. 00 | 483.10(a)(1)(2)(b)(1)(2)<br>Resident Rights/Exercise of Rights<br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or | | | |

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

Greg Dattilo | Executive Director | 11/07/2023

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

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| | enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>Based on observation, record review, and interview, the facility failed to provide coverage and odor protection for a resident related to expressed embarrassment for 1 of 5 residents reviewed for dignity. (Resident 260)<br><br>Findings include:<br><br>During an observation, on 10/5/23 at 8:00 a.m., the resident's dressing to her left shoulder was laying | F 0550 | 550 – Resident Rights/Exercise of Rights<br>**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**Resident #260 has been evaluated by the Social Services team for any emotional or mental status changes. None were | 11/08/2023 |

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| | in the bed. The malignant tumor was exposed. The resident indicated she wrapped a towel around the tumor to catch the drainage. The pad on the resident's bed was soaked with serosanguineous drainage. The dressing was not dated but the time indicated 6:00 a.m. The resident indicated she did not get out of her room much, but she thought she should.<br><br>During an observation, on 10/5/23 at 10:00 a.m., the resident was sitting on the side of the bed and her tumor was exposed. The dressing remained in the resident's bed.<br><br>During an observation, on 10/5/23 at 10:30 a.m., LPN (Licensed Practical Nurse) 12 was providing wound care. She wrapped the tumor in a warm towel and left it on for about 15 minutes. The resident indicated the warm towel felt good to her. The LPN cleansed the tumor with wound cleanser. She patted dry the tumor and applied the antibiotic. The tumor had several small to dime size abrasion areas that were open. The middle of the tumor had olive green tissue and the tumor had some bleeding with serosanguinous drainage. Areas of the tumor had medium to large size nodules. The tumor was vascular and the peri skin around the wound was a bluish color. The tumor was approximately the size of a medium pumpkin and irregular in shape. She indicated the dressing would be changed 3 times a day and prn (as needed). When the resident's dressing became saturated or fell off the staff should have changed or applied a new dressing as needed.<br><br>The record for Resident 260 was reviewed on 10/4/23 at 9:30 a.m., the diagnoses included, but were not limited to, malignant neoplasm of the connective tissue and soft tissue, hypertension and localized swelling, mass and lump of the left | | noted. The care plan has been updated to reflect the current status of the resident. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**A one-time audit of current resident population with skin integrity issues has been completed to review for need of revision to wound care interventions. The nursing staff have been provided re-education on notification to the Licensed Supervisory Nurse should a dressing become soiled or dislodged and need additional attention above the current treatment order and conducting monitoring of wound dressings to maintain the integrity of the treatment order. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**It is the responsibility of the Licensed Supervisory Nurses to provide skin/wound care/treatments as per the attending physician order. The DON/designee will be responsible to complete auditing of a minimum of 2 resident's dressings to ensure they are completed as per MD order and are being maintained. Audits will be completed 5 days/week across shifts x 6 weeks, 3 days/week for 4 weeks, | |

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| | upper limb and thyrotoxicosis.<br><br>The Admission MDS (Minimal Data Set) assessment, dated 10/9/23 indicated the resident was cognitively intact.<br><br>During an interview on 10/6/23 at 10:34 a.m., the DON (Director of Nursing) indicated if the residents dressing was off, and the tumor was exposed nursing should have replaced the dressing or at least covered it with a temporary dressing until she could do the wound care. The resident should not have to sit there with the tumor exposed and could be observed from the doorway.<br><br>During an interview on 10/10/23 at 10:35 a.m., Resident 260 indicated she did not like for other people to see her tumor. She preferred to have it covered up or at least the door closed.<br><br>The Resident Rights policy, dated 11/21/22 included, but was not limited to, "... (1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident ..."<br><br>3.1-3(a) | | and then weekly for 2 weeks. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached.. **Date of Compliance: 11/8/23** | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>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 | | | |

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| | 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.<br>Based on observation, record review and interview, the facility failed to ensure treatment and interventions were provided for 1 of 5 residents reviewed for Quality of Care. (Resident 260)<br><br>Findings Include:<br><br>During an observation on 10/04/23 at 8:30 a.m., Resident 260's dressing to her left shoulder was saturated with a large amount of serosanguineous drainage, bright red blood, and dried dark colored blood. The dressing was falling off in places. The dressing had a foul odor and the resident indicated her dressing had not been changed. The resident indicated the odor had improved slightly but the wound still had a bad odor. The serosanguinous drainage was observed on the pad in her bed.<br><br>During an observation on 10/04/23 at 11:00 a.m., Resident 260's dressing to her left shoulder was saturated with a large amount of serosanguineous drainage, bright red blood, and dried dark colored blood. The dressing was loose and was falling off in places. The dressing had a foul odor and the resident indicated her dressing had not been changed yet.<br><br>During an observation on 10/04/23 at 1:00 p.m., Resident 260's dressing to her left shoulder was saturated with a large amount of serosanguineous drainage, bright red blood, and dried dark colored blood with a whitish colored drainage seeping through the dressing. The dressing was falling off | F 0684 | F 684 Resident Rights/Exercise of Rights<br>**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br>Resident #260 has been evaluated by the Social Services team for any emotional or mental status changes. None were noted. The skin impairment area has been reviewed to ensure the most appropriate treatments are in place to maintain intact dressings. The care plan has been updated to reflect the current status of the resident.<br>**How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**<br>A one-time audit of current resident population with skin integrity issues has been completed to review for need of revision to wound care interventions. The nursing staff have been provided re-education on notification to the Licensed Supervisory Nurse should a dressing become soiled or dislodged and need additional | 11/08/2023 |

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| | in places. The dressing had a foul odor and the resident indicated her dressing had not been changed yet.<br><br>The record for Resident 260 was reviewed on 10/3/23 at 9:30 a.m. The diagnoses included, but were not limited to, malignant neoplasm of the connective and soft tissue, hypertension, localized swelling, mass and lump of the left upper limb.<br><br>The Admission MDS (Minimum Data Set) assessment, dated 10/9/23, indicated the resident was cognitively intact.<br><br>The physician's order, dated 9/30/23, indicated staff were to cleanse the tumor to the left shoulder with normal saline, pat dry, crush the antibiotic and sprinkle directly on the wound, apply Dakin's half strength moist gauze to the area, cover with ABD (Abdominal Pads) and secure with tape. Flagyl 500 mg (milligrams) was to be applied to the resident's left shoulder topically three times a day for the tumor.<br><br>The care plan, dated 9/28/23, indicated the resident had a break in her skin integrity. The interventions included, but were not limited to, educate the resident and family regarding her skin problem and treatment, a pressure reducing mattress, treatments as ordered by the physician and weekly skin assessments.<br><br>The wound note, dated 9/28/23, indicated the wound measurements were 38 cm (centimeters) in length and 37 cm in width with 0 depth. The wound was a malignant tumor with slough and necrotic tissue. Drainage included a small amount of serosanguineous drainage and there was a foul odor. The treatment included cleanse with normal | | attention above the current treatment order and conducting monitoring of wound dressings to maintain the integrity of the treatment order.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**It is the responsibility of the Licensed Supervisory Nurses to provide skin/wound care/treatments as per the attending physician order. The DON/designee will be responsible to complete auditing of a minimum of 2 resident's dressings to ensure they are completed as per MD order and are being maintained. Audits will be completed 5 days/week across shifts x 6 weeks, 3 days/week for 4 weeks, and then weekly for 2 weeks. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee | |

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| | saline, pat dry, Alginate to area, cover with abdominal gauze pads and secure with tape every shift and prn (as needed).<br><br>During an interview on 10/04/23 at 2:07 p.m., LPN (Licensed Practical Nurse) 13 indicated the resident's dressing would be changed 3 times a day. The dressing was last changed between 7:00 and 8:00 am. The resident's dressing had a lot of drainage and the nurses could change the dressing if it became saturated. The dressing had not been changed since the morning. She indicated the dressing was not holding up for 8 hours with all the drainage.<br><br>During an interview on 10/5/23 at 11:30 a.m., the wound physician indicated she did see the resident per request of the facility. She indicated the tumor was inoperable and the resident's diagnosis was terminal. The tumor would eventually cave in on itself and there would be foul odor and drainage.<br><br>During an interview on 10/5/23 at 11:35 a.m., LPN 4 indicated the staff tried to give the resident a shower daily due to the odor. The odor had improved but was still there and the resident had to be put in a private room.<br><br>During an interview on 10/6/23 at 10:34 a.m., the DON (Director of Nursing) indicated if the resident's dressing was saturated, the nurse should have changed the dressing. The dressing change order was for three times a day and prn. The nursing staff should have changed the resident's dressing before it became that saturated. That was the reason the resident had an order for prn dressing changes.<br><br>3.1-37(a) | | meeting monthly for three months and then quarterly thereafter for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached.<br>**Date of Compliance: 11/8/23** | |

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| F 0689 SS=D Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, record review, and interview, the facility failed to develop and implement appropriate interventions to prevent falls for 1 of 5 residents reviewed for falls. (Resident 55)<br><br>Findings include:<br><br>The record for Resident 55 was reviewed on 10/5/23 at 8:11 a.m. The diagnoses included, but were not limited to, displaced intertrochanteric fracture of left femur, lack of coordination, muscle weakness, unsteadiness on feet, need for assistance with personal care, cognitive communication deficit, dementia, overactive bladder, history of falling, and pain in right hip.<br><br>The care plan, dated 5/21/22, indicated the resident had bowel and bladder incontinence at times and was at risk for skin breakdown and infection with ongoing incontinence. The intervention, initiated on 7/14/22, indicated staff were to check the resident every 2 hours and assist with toileting as needed.<br><br>The Annual MDS (Minimum Data Set) Assessment, dated 4/19/23, indicated the resident was moderately cognitively impaired,usually | F 0689 | F 689 – Free of Accident Hazards<br>**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br>Resident #55 has been reassessed by the Interdisciplinary Team for the most appropriate fall prevention interventions. The care plan has been revised to reflect the current status of the resident.<br>**How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**<br>A one-time review of fall interventions for current resident population has been completed to validate fall interventions remain current and appropriate. The Interdisciplinary Team has been provided re-education on implementation of appropriate fall prevention interventions, in addition to providing re-education | 11/08/2023 |

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| | incontinent of urine and always continent of bowel, and required extensive assistance of one staff member with toileting and personal hygiene.<br><br>The nurse's note, dated 6/14/23 at 6:40 a.m., indicated the resident was found sitting on the floor next to her bed with her walker in front of her. She indicated she was going to the bathroom and had slippers on. She complained of minimal discomfort to her lower back and she felt fine to go back to bed.<br><br>The nurse's note, dated 6/14/23 at 7:03 a.m., indicated the nurse went in to follow up on the resident and found her half off the bed with her right leg off and rotated out. The physician was notified with new orders were received to send the resident to the hospital to be evaluated and treated.<br><br>The nurse's note, dated 6/14/23 at 3:53 p.m., indicated the resident was admitted to the hospital with a fracture of her left hip.<br><br>On 6/15/23, the resident's risk for falls care plan was updated with a new intervention to provide a scoop mattress.<br><br>The nurse's note, dated 6/17/23 at 3:07 p.m., indicated the resident was re-admitted to the facility. She required assistance of 2 staff members. She was oriented times 2. She was educated on using her call light for assistance with toileting and any needs.<br><br>The nurse's note, dated 6/20/23 at 9:50 p.m., indicated the resident was able to make her needs known, required maximum assistance of 2 staff with bed mobility and transfers, was incontinent of bowel and bladder, and staff provided perineal | | to the staff when new interventions are to be implemented for fall prevention measures. The Nursing staff have been re-educated on care plan revisions with new interventions, and where to find the interventions per the care plan for each resident.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br>It is the responsibility of the facility staff to assist the residents with appropriate interventions for fall prevention. The DON/designee will be responsible for auditing fall occurrences 5 times a week for 12 weeks to ensure the IDT, Licensed Supervisory Nurses, and direct care providers have identified and implemented appropriate fall interventions and where to locate revisions to a resident care plan. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator.<br>**How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The results of these reviews will be discussed at the | |

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| | care every 2 hours and as needed.<br><br>The Social Services note, dated 6/22/23 at 7:47 p.m.,indicated the resident had an assessment and scored a 12 on her BIMS (Brief Interview of Mental Status) assessment which indicated her cognitive functioning was moderately impaired.<br><br>The nurse's note, dated 7/21/23 at 6:00 a.m., indicated the resident was found sitting on the floor, facing her bed, with her legs stretched out in front of her. The resident indicated she was trying to go to the bathroom. Staff encouraged the resident to use the call light for assistance.<br><br>The IDT (Interdisciplinary Team) note, dated 7/24/23 at 10:00 a.m., indicated the root cause of the resident's fall was the resident transferring herself without assistance. The new intervention was to encourage the resident to seek out staff for assistance with transfers.<br><br>The nurse's note, dated 8/12/23 at 2:11 a.m., indicated the resident was found lying on the floor. She had a large contusion of her left forehead that was bleeding. She also had a skin tear to her left arm. She was alert but slow to respond. She said she was going to the bathroom and did not want to bother anyone for help. Her call light was pinned to her blanket where she could reach it. The NP (Nurse Practitioner) ordered to send the resident to the hospital.<br><br>The nurse's note, dated 8/12/23 at 4:30 a.m., indicated the hospital reported the resident was returning. She had no fractures. The resident's family member spoke to the nurse and voiced concerns over the amount of falls the resident had recently. He asked for a care conference ASAP (as soon as possible) because he felt the resident's | | monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached.**Date of Compliance: 11/8/23** | |

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| GREEN VALLEY CARE CENTER | 3118 GREEN VALLEY RD<br>NEW ALBANY, IN 47150 |

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| | needs were not being met when she put her call light on and he would like it addressed immediately. The resident had not put her call light on earlier. The nurse informed the son she would pass the message on to the DON (Director of Nursing) and unit manager. The resident was being toileted before being helped into bed.<br><br>The IDT note, dated 8/14/23 at 9:49 a.m., indicated the intervention put into place was for staff to offer and assist with toileting every 2 hours throughout the night.<br><br>The nurse's note, dated 8/19/23 at 6:25 a.m., indicated the nurse heard a noise while sitting at the desk and looked up. The resident was sitting on her buttocks on the floor with her back against the dresser. Her wheelchair was next to her. The resident stated she was getting up to go to the bathroom. Her call light was not on. She had three abrasions to her back and two hematomas. One hematoma was present on her right and between her ring and pinky fingers, and the other one was present to her shin. She was assisted to her wheelchair, toileted and assisted to bed. She was reminded to use her call light to ask for assistance and not self transfer. She was to wear hipsters at all times.<br><br>The nurse's note, dated 8/23/23 at 3:33 a.m., indicated the nurse looked up and found the resident sitting on the end of her roommate's bed. No call light was on, and her wheelchair was not by her. The resident was toileted and assisted back to bed and encouraged to use her call light.<br><br>During an observation, on 10/6/23 at 11:02 a.m., Resident 55 was sitting in her wheelchair in her room, in front of her bed. A orange neon sign was on the shelf hanging up reminding her to use her | | | |

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| | 155070 | A. BUILDING 00<br>B. WING | 10/10/2023 |

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| | call light. Her call light was sitting on her bed, approximately 4 feet away from her and behind her, well out of her reach.<br><br>During an observation on 10/6/23 at 2:02 p.m. CNA (Certified Nurse Aide) 15 assisted Resident 55 to toilet. CNA 15 stood by as CNA 15 assisted the resident to stand at the grab bar, removed her brief and pants and onto the toilet.<br><br>During an interview on 10/6/23 at 2:03 p.m., CNA 15 indicated the resident toileted very well. She was an assist of one. The resident would let them know when she needed to use the resident. She never forgot to use her call light. She was really alert. She would use the restroom about every hour. She had some incontinence, but most of the time she was continent.<br><br>During an interview on 10/10/23 at 9:21 a.m., RN 17 indicated she was the nurse for Resident 55 and she was somewhat familiar with her. She hadn't been here to see any of her falls or even had to do neurological checks on her. She did know she was a fall risk. The resident knew her name but she had a lot more confusion lately. She was not sure if the resident used her call light anymore. It was usually within reach. She could provide education as best as she could but she was not sure if the resident would retain the education. To her, the resident's memory was not as intact as it was before she had her hospitalization for the broken hip. A couple months ago she was trying to transfer herself and she would not put her call light on. As the nurse, if a resident had a fall, they could make a suggestion on an interventions. With each fall they had to have a intervention. They would look at what had been done in the past and see if something better or new could be done. They usually went off of what happened | | | |

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| | with the fall and if it was something they could prevent in the future. If a resident was trying to toilet, they should do every two hour checks. The aide needed to be going in there every two hours and asking if they needed to use the restroom and provide education on using the call light<br><br>During an interview on 10/10/23 at 9:26 a.m., CNA 18 indicated if they did not ask the resident if she wanted to go to the restroom, she would lay there and be soaking wet. In regard to her mentality, she was very confused and it had been like that for a long time, as far as she could recall her being at the facility. She would try to take herself to the bathroom. As long as they asked her, she did really good. She offered the resident to go to the bathroom every two to three hours. She was not aware of any specific interventions for a toileting schedule. She did not think if staff told her to use her call light she would remember to use it. She would not put her call light on. To her knowledge, they had not tried any toileting schedules in the past.<br><br>During an interview on 10/10/23 at 9:33 a.m., the DON indicated if there was a fall, the floor nurse would call the manager on call and they helped make a new intervention. If the nurse had a problem coming up with it on their own, the IDT would review it. They were supposed to put an intervention that would immediately help with the fall and those interventions were reviewed in morning meeting. They did a root cause analysis. They looked at the BIMs. The resident's BIMs score was not high enough for education. The every two hours intervention on 8/18/23 would not have been an appropriate intervention since it was already on her care plan.<br><br>The Fall Management Policy, last revised 9/22/23, | | | |

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| | provided on 10/10/23 at 10:20 a.m. by the DON, included, but was not limited to, "... Federal Regulations... The facility must ensure that... Each resident receives adequate supervision and assistance devices to prevent accidents... Avoidable Accident - This means an accident occurred because the facility failed to... Implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan, and current professional standards of practice in order to eliminate the risk, if possible, and, if not, reduce the risk of an accident... Monitor the effectiveness of the interventions and modify the care plan if necessary... 4. The interdisciplinary team will review and revise the care plan, if indicated... upon a fall event and as needed thereafter..."<br><br>3.1-45(a)(1) | | | |
| F 0727<br>SS=E<br>Bldg. 00 | 483.35(b)(1)-(3)<br>RN 8 Hrs/7 days/Wk, Full Time DON<br>§483.35(b) Registered nurse<br>§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br><br>§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.<br><br>§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.<br>Based on record review and interview, the facility failed to schedule 8-hour consecutive RN | F 0727 | F 727 – RN coverage | 11/08/2023 |

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| | coverage for 3 of 3 months reviewed. (August, September and October 2023). This had the potential to affect all 113 residents currently residing in the facility.<br><br>Findings include:<br><br>The review of the August through October 2023 Licensed Nursing schedule indicated the following days were short of 8 hours consecutive RN coverage:<br><br>August:<br>Sunday 8/6 = only 6.0 hours<br>Saturday 8/12 = only 6.0 hours<br>Sunday 8/13 = only 6.0 hours<br>Sunday 8/20 = only 6.0 hours<br>Saturday 8/26 = only 6.0 hours<br>Sunday 8/27 = only 6.0 hours<br><br>September:<br>Saturday 9/2 = only 6.0 hours<br>Sunday 9/3 = only 6.0 hours<br>Saturday 9/9 = only 6.0 hours<br>Sunday 9/10 = only 6.0 hours<br>Saturday 9/16 = only 6.0 hours<br>Sunday 9/17 = only 6.0 hours<br>Saturday 9/23 = only 6.0 hours<br>Sunday 9/24 = only 6.0 hours<br><br>October:<br>Sunday 10/1 = only 6.0 hours<br><br>During an interview with the Director of Nursing on 10/5/23 at 3:30 p.m., she indicated she was aware of the RN coverage being short on the weekends and indicated they were trying to add more RNs to cover the daytime too.<br><br>3.1-17(b)(3) | | **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br>No residents were identified.<br>**How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**<br>A review of the upcoming schedule has been completed by the Administrator and DON to validate RN coverage is represented daily for the 8-hour shift. The Clinical Administrative team and scheduler have been provided re-education on the requirement for 8-hour shifts by an RN.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br>It is the responsibility of the facility team to validate the RN coverage is present for the 8-hour shift. The Administrator will be responsible for auditing the posted schedules to validate 8-hour RN coverage 5 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or | |

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| | | | Administrator.<br>**How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached.<br>**Date of Compliance: 11/8/23** | |
| F 0761<br>SS=E<br>Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. | | | |

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| | §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>Based on observation, record review, and interview, the facility failed to ensure appropriate storage and labeling of medications for 3 of 4 medication carts observed for medication storage and labeling. (100 Hall Front Medication Cart, 100 Hall Back Medication Cart, and 200 Hall Front Medication cart)<br><br>Findings include:<br><br>1. During an observation of the 100 Hall Front Medication Cart on 10/6/23 at 11:05 a.m., the following concerns were observed:<br><br>a. Resident 58's albuterol sulfate 90 mcg/act (micrograms per actuation) inhaler was stored lying on its side. The medication packaging storage instructions indicated to store the inhaler with the mouthpiece down.<br><br>The record for Resident 58 was reviewed on 10/6/23 at 11:45 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and asthma.<br><br>The physician's order, dated 5/21/23, indicated the resident received albuterol sulfate 108 (90 mcg base) every 6 hours as needed for COPD.<br><br>b. There were two unlabeled bottles of lidocaine | F 0761 | 761 – Label/Store Drugs/Biologicals<br>**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br>No residents were identified.<br>**How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**<br>A one-time medication cart audit has been completed to review proper storage and expiration dates has been completed by the Clinical Administrative team. The Licensed Supervisory Nurses have re-educated on the storage and labeling requirements of drugs and biologicals, expiration dates, and maintaining the medication carts.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br>It is the responsibility of the Licensed Nurses to maintain the | 11/08/2023 |

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| | 200 mg/20 mL (milligrams per milliliters) lying in the top drawer. One of the bottles was opened and partially used, with visible puncture marks present on the rubber seal.<br><br>During an interview on 10/6/23 at 11:07 a.m., LPN (Licensed Practical Nurse) 19 indicated the lidocaine was for Resident 100. She had been on an antibiotic, ceftriaxone, which had required being mixed with lidocaine. She was no longer on the medication.<br><br>The record for Resident 100 was reviewed on 10/6/23 at 1:00 p.m. The physician's order, dated 9/9/23, indicated the resident received ceftriaxone sodium injection 1 gram reconstituted intramuscularly at bedtime for three days. The order was completed on 9/12/23.<br><br>The record lacked documentation of any subsequent orders for lidocaine currently in use for the resident.<br><br>2. During an observation of the 100 Hall Back Medication Cart on 10/6/23 at 11:10 a.m., Resident 62's insulin aspart flex pen was observed to be opened, with an open date of 6/12/23 written on the pen. The pen had been opened and used, with approximately 100 units left in the pen.<br><br>During an interview on 10/6/23 at 11:16 a.m., LPN 19 indicated she could see the open date of 6/12/23 written on the pen. She thought the insulin pen was good for 90 days once opened.<br><br>The record for Resident 62 was reviewed on 10/6/23 at 12:05 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus and long term use of insulin. | | medication carts, ensure drugs and biologicals are properly labeled, are within the expiration date, and medications are stored as per manufacturer guidelines. The DON/designee will be responsible to audit 50% of medication carts for proper inhaler storage, medications not labeled, and expired medications 5 times a week for 6 weeks, 3 times a week for 4 weeks, and then weekly for 2 weeks. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator.<br>**How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached.**Date of Compliance: 11/8/23** | |

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| | The physician's order, dated 6/12/23, indicated the resident received insulin aspart per sliding scale subcutaneously twice daily for diabetes mellitus.<br><br>3. During an observation of the 200 Hall Medication Front Cart on 10/6/23 at 11:18 a.m., the following concerns were observed:<br><br>a. Resident 62 had a novolog flex pen on the medication cart. The pen was open with approximately 120 units left in the pen. The pen was located in a bag with another resident's name on it. The open date on the insulin pen was 6/1/23.<br><br>During an interview on 10/6/23 at 11:20 a.m., QMA (Qualified Medication Aide) 1 indicated Resident 62's insulin should not have been on the 200 Hall Front Medication Cart. She was not on her hall and never had been.<br><br>During an interview on 10/6/23 at 11:33 a.m., LPN 19 indicated Resident 62 was on the 100 Hall and there was no reason why her insulin should be on the 200 Hall medication cart.<br><br>b. Resident 84's novolog flex pen was opened, with a date of 6/28/23 written on the bag in fading ink pen which was barely legible.<br><br>During an interview on 10/6/23 at 11:21 a.m., QMA 1 indicated she thought the insulin was good for 30 days once opened and indicated the medication should have been pulled and discarded. She thought they had a reference for how long the medications were good for but she could not locate it.<br><br>The record for Resident 84 was reviewed on 10/6/23 at 12:10 p.m. The diagnoses included, but were not limited to, diabetes mellitus type 2 and | | | |

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| | pre-diabetes.<br><br>The physician's order, dated 11/7/22, indicated the resident received novolog flex pen per sliding scale every morning and at bedtime.<br><br>c. Resident 53's insulin glargine pen was opened, with approximately 130 units left in the pen. The open date on the pen's bag was 8/21/23.<br><br>The record for Resident 53 was reviewed on 10/6/23 at 12:15 p.m. The diagnoses included, but were not limited to, diabetes mellitus type 2 and long term use of insulin.<br><br>The physician's order, dated 7/26/23, indicated the resident received insulin glargine 10 units subcutaneously daily.<br><br>d. Resident 6's albuterol HFA 90 mcg/act was stored on its side. The medication package indicated to store the inhaler with the mouthpiece down.<br><br>The record for Resident 6 was reviewed on 10/6/23 at 12:20 p.m. The diagnoses included, but were not limited to, congestive heart failure and obstructive sleep apnea.<br><br>The physician's order, dated 6/18/23, indicated the resident received albuterol HFA 109 (90 mcg base) every 4 hours as needed for shortness of air.<br><br>During an interview on 10/6/23 at 11:35 a.m., the DON (Director of Nursing) indicated the staff should have a reference for medication storage dates in their toolbox.<br><br>The Novolog (insulin aspart) injection storage conditions insert, provided on 10/10/23 at 8:00 | | | |

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| | a.m. indicated the 3 mL single patient use flex touch pens were to be discarded after 28 days once opened.<br><br>The insulin Lispro injection storage conditions insert, provided on 10/10/23 at 8:00 a.m. indicated the 3 mL single patient use pens were to be discarded after 28 days once opened.<br><br>The insulin glargine injection storage conditions insert, provided on 10/10/23 at 8:00 a.m., indicated the 3 mL single patient use pens were to be discarded after 28 days once opened.<br><br>3.1-25(j) | | | |
| F 0770 SS=D Bldg. 00 | 483.50(a)(1)(i)<br>Laboratory Services<br>§483.50(a) Laboratory Services.<br>§483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.<br>(i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.<br>Based on record review and interview, the facility failed to ensure a urine and blood work were sent to the laboratory for testing as ordered by the physician for 1 of 3 residents reviewed for laboratory testing. (Resident 45)<br><br>Findings include:<br><br>The record for Resident 45 was reviewed on 10/4/23 at 9:31 a.m. The diagnoses included, but were not limited to, benign prostatic hyperplagic (BPH) without lower urinary tract symptoms, retention of urine, muscle weakness, | F 0770 | F 770 – Lab Services<br>**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br>Resident #45 has been reassessed by the Clinical Administrative team. There were no identified concerns with the ordered labs being a baseline lab. The care plan has been reviewed to reflect the current status of the | 11/08/2023 |

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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 |
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| | rhabdomyolysis, hypertensive ischemic heart disease, and supraventicular tachycardia.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 9/26/23, indicated the resident had severe cognitive impairment; required extensive assist of 2 staff for bed mobility, transfers and toilet use; was non-ambulatory; was frequently incontinent of bladder; and had bilateral lower and upper impairments in functional range of motion.<br><br>A care plan, initiated on 6/29/19 and revised on 8/3/21, indicated the resident had an altered cardiovascular status related to coronary artery disease and hyperlipidemia. The goal indicated the resident would be free from cardiac complications. The approaches included, but were not limited to, administer medications as ordered and labs as ordered.<br><br>A care plan, dated 11/8/22, indicated the resident had a history of bladder incontinence and was at risk for complications of infection and had a diagnosis of history of BPH. The goal was for the resident to have a reduced risk for UTI (urinary tract infection). The approaches included, but were not limited to, labs as ordered and notify physician of s/s (signs/symptoms) of a UTI.<br><br>A nurse's note, dated 9/11/23 at 11:32 a.m., indicated new orders for thyroid function testing (TSH - thyroid stimulating hormone, Free T3, Free T4) and Hepatic function ( CBC - complete blood count and CMP - comprehensive metabolic profile) to be drawn now (for baseline) and every 6 months per pharmacy recommendation related to the use of amiodarone.<br><br>Documentation was lacking of the resident's | | resident.<br>**How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**<br>A one-time audit for the past 30 days (from September 10, 2023, to October 10, 2023) of ordered baseline labs and urinalysis samples has been completed to validate timely collection of samples has been completed. The Licensed Supervisory Nurses have been re-educated on review of lab book on each shift and to validate ordered labs are obtained as per schedule.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br>It is the responsibility of the Licensed Supervisory Nurses to ensure labs are obtained as per order and timely. The DON/Designee will be responsible to audit lab orders 5 times a week for 6 weeks, 3 times a week for 4 weeks, and then weekly for 2 weeks. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator.<br>**How will the corrective actions** | |

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| | 155070 | A. BUILDING 00<br>B. WING | 10/10/2023 |

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| | laboratory test having been drawn now per order and were not drawn until 9/19/23 - 8 days later.<br><br>A nurse's note, dated 9/29/23 at 4:15 p.m., indicated new orders for a UA (urinalysis) CS (culture and sensitivity) and a CBC and CMP related to possible UTI.<br><br>Documentation was lacking in the clinical record of the UA and blood work having been collected.<br><br>During an interview with QMA (Qualified Medication Aide) 1 on 10/6/23 at 9:55 a.m., she indicated that if a UA was ordered during the week, it would be collected and sent out the next day. If it was the weekend, then it would be collected on Sunday and then sent out Monday morning. Labs were done right away as there was only a limited time the specimen could sit. She had worked on the resident's hall and had not been made aware of that there was an order for a UA or blood work to be done.<br><br>During an interview with RN 2 on 10/6/23 at 1:50 p.m., she indicated It was human error that the UA was not put into the lab book to be completed as ordered and that the only reason she could find for the nurse to get that order for a UA was because the NP (Nurse Practitioner) noted confusion in the resident. The UA and blood work should have been drawn as ordered. She also indicated that the reason the labs were never drawn until 9/19/23 was because he already had standing orders for those labs scheduled for 9/19, so they were just combined with his routine labs. It was a pharmacy recommendation on 8/31/23 that since he was on the amiodarone, he should have thyroid function tests and hepatic function test done every 6 months. | | **be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached.<br>**Date of Compliance: 11/8/23** | |

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| | When the pharmacy recommendation was shown to her that it was recommended for a baseline be drawn now and then compared again in 6 months, she indicated she did not see that part of the recommendation.<br><br>3.1-49(a)(2) | | | |
| F 0943 SS=E Bldg. 00 | 483.95(c)(1)-(3)<br>Abuse, Neglect, and Exploitation Training<br>§483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-<br><br>§483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.<br><br>§483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property<br><br>§483.95(c)(3) Dementia management and resident abuse prevention.<br>Based on record review and interview, the facility failed to ensure staff completed dementia training for 8 of 10 employee records reviewed.<br><br>Findings include:<br><br>The Employee Records were reviewed on 10/6/23 and 10/10/23. The following staff had not completed their required initial and/or annual dementia training:<br><br>- Laundry Aide 3 was hired on 1/30/12. The Laundry Aide's employee record lacked the | F 0943 | F 943 – Abuse, Neglect, and Exploitation Training<br>**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br>No residents were identified.<br>**How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** | 11/08/2023 |

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| | annual 3 hours dementia training<br><br>- CNA (Certified Nurse Aide) 4 was hired on 2/15/23. The CNA's employee record lacked the initial 6 hours dementia training<br><br>- CNA 5 was hired on 10/11/18. The CNA's employee record lacked the annual 3 hours dementia training<br><br>- CNA 6 was hired on 1/24/23. The CNA's employee record lacked the initial 6 hours dementia training<br><br>- ADON (Assistant Director of Nursing)/RN 2 was hired on 4/4/23. The ADON's employee record lacked the initial 6 hours dementia training<br><br>- RN 7 was hired on 12/13/16. The RN's employee record lacked the annual 3 hours dementia training<br><br>- QMA (Qualified Medication Aide) 9 was hired on 1/21/21. The QMA's employee record lacked the annual 3 hours dementia training.<br><br>- Cook 10 was hired on 1/25/05. The Cook's employee record lacked the annual 3 hours dementia training.<br><br>During an interview on 10/10/23 at 9:00 a.m., the ED (Executive Director) indicated the staff reviewed had not completed their dementia training.<br><br>During an interview on 10/10/23 at 9:34 a.m., the Dementia Unit Manager, indicated the ADON, RN 7, CNA 4, CNA 5, and QMA 9, had worked in the dementia unit.<br><br>On 10/10/23 at 10:39 a.m., the DON (Director of | | A one-time audit of current associates has been completed to validate dementia training has been completed as per requirements. The Clinical Administrative Team has been re-educated on the requirements for dementia training at time of hire, and then ongoing on an annual basis.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br>It is the responsibility of the IDT to ensure the dementia training is completed at time of hire and then annually ongoing. The DON/designee will be responsible for auditing dementia training completion weekly for 6 weeks, bimonthly for one month, and then monthly for 2 months. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator.<br>**How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>The results of these reviews will be discussed at the monthly facility Quality Assurance | |

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| | Nursing) indicated they did not have a policy for dementia training, but they did follow the State Guidelines. They required 6 hours of dementia training within 6 months of hire. If a staff was working on the dementia unit the 6 hours would have to be completed within 30 days and the 3 hours of dementia training would have to be completed annually. | | Committee meeting monthly for three months and then quarterly thereafter for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached.**Date of Compliance: 11/8/23** | |