STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155840	A. BUILDING 00 B. WING	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
IGNITE MEDICAL RESORT DYER LLC.	1532 CALUMET AVENUE DYER, IN 46311

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaints IN00424703, IN00424731, IN00426055, IN00426751, IN00427100, IN00427561, and IN00429885. This visit included a State Residential Licensure Survey. Complaint IN00424703 - Federal/State deficiencies related to the allegations are cited at F554. Complaint IN00424731 - Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00426055 - No deficiencies related to the allegations are cited. Complaint IN00426751 - Federal/State deficiencies related to the allegations are cited at F554. Complaint IN00427100 - No deficiencies related to the allegations are cited. Complaint IN00427561 - No deficiencies related to the allegations are cited. Complaint IN00429885 - Federal/State deficiencies related to the allegations are cited at F677. Survey dates: March 4, 5, 6, 7, 8, and 11, 2024. Facility number: 013462 Provider number: 155840 AIM number: 201330210 Census Bed Type: SNF/NF: 7 SNF: 91	F 0000	Ignite Medical Resorts 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. This facility respectfully requests a desk review for the given citations in this survey. Please see all attached documentation for your consideration.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Megan Matula	Administrator	04/18/2024

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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	Residential: 28 Total: 126 Census Payor Type: Medicare: 36 Medicaid: 7 Other: 55 Total: 98 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 3/19/24.			
F 0554 SS=E Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders to administer their own medications, orders were present for the medications, and a self-administration of medication assessment was completed, for 5 of 5 residents reviewed for self-administration of medication. (Residents J, L, H, M, and K) Findings include: 1. During a random observation on 3/4/24 at 2:45 p.m., a bottle of Nasal Relief nasal spray was observed on the window ledge in Resident J's room. During random observations on 3/5/24 at 9:09 a.m. and 11:15 a.m., the nasal spray remained on the resident's window ledge.	F 0554	**POC for F554 – Resident Self-Admin Meds-Clinically Appropriate** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by this alleged deficient practice. All medication in residents rooms J, L, H, M, and K have been removed. **How will you identify other residents having the potential to be affected by the same deficient practice and what**	04/05/2024

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	The record for Resident J was reviewed on 3/5/24 at 2:44 p.m. Diagnoses included, but were not limited to, type 1 diabetes and acute respiratory failure with hypoxia (low levels of oxygen in the body tissue). The Admission Minimum Data Set (MDS) assessment, dated 2/15/24, indicated the resident was cognitively intact. The March 2024 Physician's Order Summary (POS), indicated the resident had no order for the Nasal Relief nasal spray and they did not have an order to self administer their medications. The resident did not have a Self-Administration of Medication assessment. During an interview on 3/6/24 at 3:49 p.m., the Northwest Unit Manager indicated the nasal spray was removed from the resident's room on 3/5/24. 2. During random observations on 3/4/24 at 2:55 p.m. and 3:45 p.m., an Albuterol inhaler was observed on Resident L's over bed table. During a random observation on 3/5/24 at 8:45 a.m., the inhaler remained on the resident's over bed table. The record for Resident L was reviewed on 3/6/24 at 11:59 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), oxygen dependent, and asthma. The 3/6/24 Brief Interview for Mental Status Evaluation, indicated the resident was cognitively intact for daily decision making.		**corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. House audit was completed of all residents rooms to ensure no medications are in residents room that do not have a self-administration of medication assessment, Physicians order, and an updated careplan to reflect self-administration. WhWhat measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Nursing staff was educated on ensuring medications are not left at bedside unless there is a self-administration assessment, a physician order, and an updated careplan for self-administration of medications. DOH was educated to notify nursing staff if any medications accompany guest while completing inventory of belongings upon admission to the facility. All staff educated to notify nursing staff if they notice medications in rooms while completing daily rounds and/or answering call lights.	

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	The March 2024 Physician's Order Summary (POS), indicated the resident did not have an order to self administer their medications. The resident did not have a Self-Administration of Medication assessment. During an interview on 3/6/24 at 2:49 p.m., the Director of Nursing indicated the inhaler should not have been left at the resident's bedside. 3. During random observations on 3/4/24 at 2:15 p.m.,and 3:34 p.m., and on 3/5/24 at 8:40 a.m., there was a Breo Ellipta inhaler on top of Resident H's night stand. During random observations on 3/5/24 at 2:37 p.m. and on 3/6/24 at 9:38 a.m., the Breo Ellipta inhaler was now inside the night stand drawer. The record for Resident H was reviewed on 3/5/24 at 3:03 p.m. Diagnoses included, but were not limited to, COPD and shortness of breath. The 2/21/24 Modification of the 5 day Medicare Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for decision making. Physician's Orders, dated 2/28/24, indicated Fluticasone Furoate-Vilanterol Inhalation Aerosol Powder Breath Activated (Breo Ellipta inhaler) 100-25 micrograms, inhale 1 puff orally one time a day for shortness of breath. There was no order for the resident to self-administer their own medications or a Self-Administration of Medication Assessment completed. During an interview on 3/6/24 at 10:50 a.m., the		HwHow will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? CNO/Designee will audit 15 residents weekly on alternating shifts to ensure no medications are left at resident's bedside unless there is a self-administration assessment, a physician order, and updated care plan for the self-administration of medications. CNO/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. **Date of compliance: 4/5/2024**	

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	Assistant Director of Nursing indicated the resident had no orders or an assessment to self-administer their own medication. 4. During random observations on 3/4/24 at 1:50 p.m., and 3:43 p.m., on 3/5/24 at 8:43 a.m., and at 2:34 p.m., and on 3/6/24 at 9:38 a.m., there was an Albuterol Sulfate hand held inhaler on Resident M's over bed table inside a basket. The record for Resident M was reviewed on 3/6/24 at 10:34 a.m. Diagnoses included, but were not limited to, brain and lung cancer, COPD, respiratory failure, and high blood pressure. The 1/22/24 Admission Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for daily decision making. Physician's Orders, dated 1/15/24, indicated Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) micrograms, inhale 2 puffs orally every 6 hours as needed for wheezing. There was no Physician's Order or a Self-Administration of Medication Assessment for the resident to administer the inhaler herself. During an interview on 3/6/24 at 10:50 a.m., the Assistant Director of Nursing indicated the resident had no orders or an assessment to self-administer her own medication.5. On 3/4/24 at 10:05 a.m., Resident K was observed lying in bed asleep. On the bedside table were a bottle of Tums and a bottle of eye drops. On 3/4/24 at 11:21 a.m., the resident was observed awake in bed. The bottle of Tums and eye drops remained on the beside table.			

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	On 3/5/24 at 9:25 a.m., the resident was observed eating breakfast. The bottle of Tums and eye drops were observed in a wash basin on the bedside table. On 3/6/24 at 9:38 a.m., the resident was observed getting ready for physical therapy. On the bedside table, there was a bottle of Tums, eye drops, and a tube of oral pain reliever. The record for Resident K was reviewed on 3/6/24 at 9:56 a.m. Diagnoses included, but were not limited to, heart failure, weakness, esophageal obstruction (abnormal narrowing of the esophagus), gastroesophageal reflux disease (acid reflux), low back pain, and a muscle disorder. The 2/26/24 Admission Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making. . There was no Care Plan to self-administer his medications. There was no Self-Administer of Medication Assessment completed for the resident. There were no Physician's Orders for the Tums, eye drops, or oral pain reliever. During an interview on 3/06/24 at 1:54 p.m., the Director of Nursing (DON) indicated he understood, and had no additional information to provide. A Policy provided by the DON on 5/11/24 at 9:30 a.m., titled "Self Administration of Medications and Treatments", indicated ..."1. Assessment of the ability to self-administer medications will be done by nursing using the tool "Assessment for			

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	Self-Administrations of Medications". The assessment will review if the resident is fully capable, able with assist, or unable to perform assessment criteria. 6. A careplan is made for a resident who self administers medications, and documentation should be present in the nursing notes of teaching related to self administration of medications or treatments"... This citation relates to Complaint IN00424703 and IN00426751. 3.1-11(a)			
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Based on record review and interview, the facility failed to implement a system to prevent misappropriation of resident property, related to no documentation of narcotics being signed out of the facility's emergency medication machine, for 1 of 1 residents reviewed for pain management. (Resident Q) Finding includes: During an interview on 3/4/24 at 11:28 a.m., Resident Q indicated nursing staff have told him more than once they have run out of his Norco (a narcotic medication) (Hydrocodone) medication and he was in a lot of pain. He indicated one day,	F 0602	**POC for F602 – Free from Misappropriation/Exploitation** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by this alleged deficient practice. Resident Q still resides in facility. **How will you identify other**	04/05/2024

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	the nurse told him there would be no Norco available until the next day, and that was at 3:00 p.m. The record for Resident Q was reviewed on 3/6/24 at 12:08 p.m. The resident was admitted to the facility on 2/12/24. Diagnoses included, but were not limited to, peripheral vascular disease, pulmonary embolism, osteomyelitis, high blood pressure, absence of the left toes, and adult failure to thrive. The 2/18/24 Admission Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact and required as needed (prn) pain medication. He had frequent and moderate pain in the last 5 days that occasionally affected his sleep. A Care Plan, dated 3/4/24, indicated the resident was receiving opioid medications. A Care Plan, dated 2/22/24, indicated the resident had potential for pain. The approaches were to administer medications as ordered, anticipate the resident's need for pain relief and respond immediately to any complaints of pain, and identify and record previous pain history and management of that pain and impact on function. Physician's Orders, dated 2/12/24, indicated Hydrocodone-Acetaminophen oral tablet 5-325 milligrams (mg), give 1 tablet by mouth every 4 hours as needed for pain. The Medication Administration Record (MAR), dated 2/2024, indicated the resident received 1 Hydrocodone tablet on 2/12-2/15/24. He received 2 tablets on 2/16/24 and then 1 tablet on 2/17-2/20/24. He did not receive any Hydrocodone		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. MAR to cart audit was completed to ensure all ordered medications were available for all residents. CNO/Pharmacy completed audit of RX Now machine to ensure most commonly used medications are on hand and par level is appropriate. Nursing staff audit completed to ensure all nurses/QMAs have access to our RX now machine and educated on appropriate usage. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Nursing staff was educated on what medications are available in RX Now (EDK), how to access medications from RX Now (EDK), and notification to CNO/MD/Pharmacy when a medication from RX Now (EDK) is unavailable.	

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	on 2/21/24. The Narcotic Sheet indicated 30 tablets of the Hydrocodone was received on 2/22/24 (10 days after the resident was admitted). The 2/2024 MAR indicated after the 30 tablets of Hydrocodone were received the resident consistently asked for the pain medication at least 3 times a day for the rest of the month. During an interview on 3/7/24 at 9:30 a.m., the Pharmacy Account Manager indicated the first order they received for the Hydrocodone was on 2/21/24. The medication would have been sent out on 2/22/24 and should have arrived at the facility on that day. The second request for the Hydrocodone was on 3/2/24 and that was sent to the facility as well. The facility had a RX Now medication machine to dispense medications that were not available or that they had not yet received from the pharmacy. The Account Manager verified the Hydrocodone 5-325 mg was in the RX Now machine. He indicated he was just at the facility on 2/13/24 and did an audit of all the medications. On that day, there were 17 Hydrocodone 5-325 mg tablets available to dispense. The Pharmacy Account Manager was able to look in the RX Now medication records to see what days the Hydrocodone was pulled for Resident Q. He indicated from 2/12-2/20/24 there was no documentation the Norco was pulled for Resident Q during that time frame. During an interview on 3/7/24 at 10:00 a.m., the Director of Nursing (DON) indicated he had called 2 of the nurses who signed the medication out as being administered from 2/12-2/20/24 and they both indicated they pulled it from the RX Now machine, however, there was no documentation to		**How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** CNO/Designee will audit all new admissions daily to ensure all medications including but not limited to pain management medications are available. CNO/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. **Date of compliance: 4/5/2024**	

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	prove they did. The DON indicated he was unaware and did not know why the script for the Hydrocodone was not sent to pharmacy right after the resident was admitted. He had no additional information to review. 3.1-28(a)			
F 0637 SS=A Bldg. 00	483.20(b)(2)(ii) Comprehensive Assessment After Signifcant Chg §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) Based on record review and interview, the facility failed to ensure a Significant Change Minimum Data Set (MDS) assessment was completed after hospice services were initiated, for 1 of 27 MDS assessments reviewed. (Resident 11) Finding includes: The record for Resident 11 was reviewed on 3/7/24 at 3:00 p.m. Diagnoses included, but were not limited to, Parkinson's disease and palliative care. A Quarterly Minimum Data Set (MDS) assessment, dated 12/10/23, indicated the resident was not receiving hospice services.	F 0637	Education was completed to ensure MDS aware of new hospice orders.	04/05/2024

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	A Quarterly MDS assessment, dated 3/11/24, was in progress. A Physician's Order, dated 1/11/24, indicated the resident was admitted to hospice services. A Significant Change MDS assessment had not been initiated. During an interview on 3/11/24 at 9:45 a.m., the MDS Coordinator indicated they were going to do a Significant Change Assessment today. 3.1-33(d)(1)			
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to provide ADL (activities of daily living) assistance to dependant residents, related to completing scheduled showers, nail care, removing facial hair, hair washing, and oral care, for 5 of 6 residents reviewed for ADL care. (Residents P, Q, M, C, and N) Findings include: 1. During an interview on 3/4/24 at 2:41 p.m., Resident P indicated they had not been taken to the shower room for at least a month and a half. The record for Resident P was reviewed on 3/6/24 at 10:51 a.m. Diagnoses included, but were not	F 0677	**POC for F677 ADL Care Provided for Dependent Residents** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No harm came to any residents related to this alleged deficient practice. Resident P and Q still resides in facility. Resident P shower	04/05/2024

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	limited to, type 2 diabetes and need for assistance with personal care. The Quarterly Minimum Data Set (MDS) assessment, dated 1/8/24, indicated the resident was moderately impaired for daily decision making and the resident was not able to bathe themselves. A Care Plan, dated 1/5/24, indicated the resident had an ADL self-care performance deficit and limitation in physical mobility. Interventions included, but were not limited to, maximum assistance with showering and bathing. The Shower Sheet for the month of February 2024, indicated the resident received a sponge bath on 2/12, 2/26, and 2/29/24. The Shower Sheet for the month of March 2024, indicated the resident received a sponge bath on 3/7/24. The resident had no showers documented for February and March 2024. During an interview on 3/7/24 at 3:55 p.m., the Northwest Unit Manager indicated the shower room was not in use at the time. She also indicated the shower sheets should have been thoroughly completed. 2. During an interview on 3/4/24 at 11:15 a.m., Resident Q indicated his hair had not been washed since he has been there. The record for Resident Q was reviewed on 3/6/24 at 12:08 p.m. The resident was admitted to the facility on 2/12/24. Diagnoses included, but were not limited to, peripheral vascular disease, pulmonary embolism, osteomyelitis, high blood pressure, absence of the left toes, and adult failure		preferences reviewed with resident/family and ADL care/shower was offered and provided. Resident Q shower preferences reviewed with resident and ADL care/hair washing was offered and provided. Resident M was immediately offered to have facial hair shaved and fingernails cut. Resident N was provided a new toothbrush and assistance with oral care immediately. Resident C, M, and N no longer reside in facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. Full house audit was completed to ensure showers/baths are being provided as scheduled. Full house audit of nails was completed to ensure residents nails are trimmed and clean.	

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	155840	A. BUILDING 00 B. WING	03/11/2024

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	to thrive. The 2/18/24 Admission Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact, and it was very important for him to choose between a shower or bath. He needed partial to moderate assistance with bathing. A Care Plan, dated 2/12/24, indicated the resident had ADL self-care performance deficits and limitations in physical mobility related to surgical amputation. The shower sheets indicated the resident received a sponge bath on 2/15, 2/19, and on 3/4/24. He refused a bath on 2/22 and 2/26/24. There was no documentation indicating the resident's hair was washed. During an interview on 3/7/24 at 11:30 a.m., the Unit Manager indicated there was no documentation the resident had his hair washed since admission. During an interview on 3/7/24 at 2:30 p.m., the Director of Nursing indicated there was no documentation the resident's hair was washed. 3. During an interview on 3/4/24 at 1:50 p.m., Resident M indicated she had not received a bath in 2 weeks. She had a large amount of facial hair observed on her upper lip and chin, as well as long fingernails. The resident indicated at that time, she wanted her nails trimmed and would like the facial hair removed, she would have never let it grow that long. On 3/5/24 at 8:43 a.m., and 2:34 p.m., and on 3/6/24 at 9:38 a.m., the resident was still observed with		Full house audit of facial hair was completed to ensure shaves were completed as needed/requested. Full house audit was completed to ensure all residents have a toothbrush and oral care is being completed as needed/requested. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Nursing staff was educated on the importance of providing ADL care as scheduled/requested including but not limited to showers/baths, nail care, shaving, and oral care. Shower record has been updated to include documentation for hair washing, nail, shaving, and oral care. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** CNO/Designee will audit 10 dependent residents weekly on alternating shifts to ensure ADL care has been provided, including	

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	long facial hair on her upper lip and chin and had long fingernails. The record for Resident M was reviewed on 3/6/24 at 10:34 a.m. Diagnoses included, but were not limited to, brain and lung cancer, COPD, respiratory failure, and high blood pressure. The 1/22/24 Admission Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for daily decision making. It was very important for the resident to choose between a bath or a shower. The resident needed substantial to maximal assistance for bathing, and partial to moderate assistance with personal hygiene. A Care Plan, dated 1/16/24, indicated the resident had ADL self-care performance deficits and limitations in physical mobility. The Shower Sheets for 1/2024 indicated the resident received sponge baths on 1/16, 1/19, 1/23, 1/26, and 1/30/24. The nail care and shave areas were blank and not checked as being done. The Shower Sheets for 2/2024 indicated the resident received a shower on 2/2, 2/6, 2/9, 2/13, 2/18 and 2/20/24. She received a sponge bath on 2/23 and 2/27/24, and there was documentation nail care and a shave was completed. The Shower Sheet for the month of 3/2024, indicated the resident was to receive a shower on 3/1 and 3/5/24. Both days were blank and not completed, indicating she did not receive a bath on those days. During an interview on 3/6/24 at 10:55 a.m., the Unit Manager indicated the 3/2024 showers were		but not limited to showers/baths, hair washed, nail care, and oral care. CNO/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. **Date of compliance: 4/5/2024**	

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	blank and not completed, and there was no documentation the resident had a shave or that nail care was completed. 4. The closed record for Resident C was reviewed on 3/7/24 at 8:33 a.m. The resident was admitted to the facility on 12/5/23 and left the facility on 12/22/23. Diagnoses included, but were not limited to, fracture of the right wrist, major depressive disorder, Parkinson's disease, seizures, schizophrenia, and dementia without behaviors. The Admission Minimum Data Set (MDS) assessment, dated 12/12/23, indicated the resident was moderately impaired for daily decision making. The resident had no impairment in range of motion to both lower and upper extremities and needed partial to moderate assistance with eating, oral care, personal hygiene, and was dependent on staff for showers and toileting. A Care Plan, dated 12/5/23, indicated the resident has ADL self-care performance deficits and limitations in physical mobility. The Shower Sheets for the month of 12/2023 were received from the Unit Manager from her office. The sheets indicated a shower or sponge bath was checked on 12/7, 12/11, 12/14, and 12/21/23, however, there was no nurse or CNA signatures to indicate they were all completed. A shower was checked for 12/18 and signed by the Unit Manager and CNA. A sponge bath was checked for 12/25/23, and a shower was checked for 12/28/23, both signed by the Unit Manager and CNA, however, the resident was discharged from the facility on 12/22/23. During an interview on 3/7/23 at 11:30 a.m., the Unit Manager indicated she had signed that the			

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	resident had a shower or sponge on 12/25 and 12/28/23, and did not know that he was already discharged. She claimed she did not look at the resident's name and she had probably signed off for another resident. During an interview on 3/7/24 at 2:30 p.m. the Director of Nursing indicated both the nurse and CNA were supposed to sign the shower sheets after they had been completed. Residents were supposed to receive 2 showers a week. 5. During an interview on 3/5/24 at 10:48 a.m., Resident N indicated she did not receive a toothbrush when she was first admitted to the facility. She finally received a toothbrush last Friday. She also needed help getting her toothbrush and paste set up so she could complete oral care for herself. During an interview on 3/6/24 at 1:30 p.m., the resident indicated she was not provided anything to brush her teeth thus far today. The record for Resident N was reviewed on 3/5/24 at 3:30 p.m. The resident was admitted to the facility on 2/22/24. Diagnoses included, but were not limited to, COPD, severe obesity, repeated falls, osteoporosis, depression, and pain in the left knee. The Admission Minimum Data Set (MDS) assessment, dated 2/27/24, indicated the resident was cognitively intact daily decision making and it was very important to choose what kind of bath she wanted. The resident had a limited range of motion to both upper extremities and needed supervision or touching assistance with oral hygiene, and substantial/max assistance for showers.			

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	A Care Plan, dated 2/24/24, indicated the resident had an ADL self-care performance deficit and limitations in physical mobility. The Point of Care Task responses indicated oral hygiene was not documented as being completed on 3/1, 3/2, and 3/3/4. There was only 1 time entered for oral hygiene on 2/23, 2/25, 2/27, 2/28, 2/29, and 3/4/24. The Shower Sheets indicated the resident had a shower on 2/29/24 and refused a shower on 3/2/24. The resident was moved to a different room on 3/4/24, and her shower days changed at that time as well. She was supposed to get a shower on Mondays and Thursdays in her new room. The Shower Sheet, dated 3/4/24, was blank and not completed. During an interview on 3/6/24 at 10:55 a.m., the Unit Manger indicated the resident transferred rooms before shift change during the day on 3/4/24, and a shower could have been offered to her that day. During an interview on 3/7/24 at 2:30 p.m., the Director of Nursing indicated the resident was given a toothbrush in her welcome packet on admission. Her sister had observed the bed pan on the sink by the toothbrush and requested a new one. Staff might have taken some time in getting her a new toothbrush. Nursing staff were to assist in set up for the resident to perform oral hygiene. This citation relates to Complaints IN00424731 and IN00429885. 3.1-38(a)(2)(A)			

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	3.1-38(a)(3)(B) 3.1-38(a)(3)(C) 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review, and interview, the facility failed to ensure an ongoing activity program was implemented for cognitively impaired dependent residents, for 1 of 2 residents reviewed for activities. (Resident 26) Finding includes: During random observations on 3/4/24 at 10:15 a.m. and 1:56 p.m., Resident 26 was seated in a broda chair and positioned next to a table in the Northwest Lounge area. His eyes were closed and the television was turned on. During a random observation on 3/5/24 at 9:30 a.m., the resident was again seated in a broda chair and positioned at the table in the Northwest Lounge area. His eyes were closed and the television was turned on. During random observations on 3/7/24 at 9:04	F 0679	**POC for F679 – Activities Meet Interest/Needs Each Resident** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No harm came to any residents by this alleged deficient practice. Resident 26 activity preferences were reviewed with resident/family and care plans updated. **How will you identify other residents having the potential to be affected by the same deficient practice and what**	04/05/2024

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	a.m., 11:26 a.m., and 12:18 p.m., the resident was again seated in a broda chair and positioned at the table in the Northwest Lounge area. His eyes were closed and the television was turned on. At 2:00 p.m., the resident was in his room in bed sleeping. A music activity was taking place in the main dining room. The record was reviewed on 3/5/24 at 3:09 p.m. Diagnoses included, but were not limited to, intellectual disabilities, bipolar, and intermittent explosive disorder. The 2/23/24 Annual Minimum Data Set (MDS) assessment, indicated the resident had short and long term memory problems and he was severely impaired for daily decision making. It was very important for the resident to listen to music, do things with groups of people, do his favorite activities, and participate in religious activities. A Care Plan, dated 2/20/23 and reviewed on 3/4/24, indicated the resident's activity involvement during the COVID-19 pandemic would be reflective of personal preferences and focus on abilities the resident had, while at the same time maintaining safe social distance as much as possible. The resident currently engaged in the following leisure/recreation pursuits: attend activity groups daily, enjoy observing his peers play a variety of table games, watch a variety of television programs, movies and the news daily, is social with family during visits. A Care Plan, dated 2/20/23 and reviewed on 3/4/24, indicated the resident would maintain psycho-social well being and quality of life through meaningful activities until the next review. Interventions included, but were not limited to, Provide activity programming		**corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. House audit was completed for all residents to ensure their activity interests/needs are being met including but not limited to group and independent activities. House audit was completed for all cognitively impaired residents to ensure participation in and documentation of appropriate activities including but not limited to 1:1 activities. House audit was completed to ensure all guests have a current activity assessment, participation notes, and care plan in place. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** DOE/Activity Department was educated on appropriate documentation including but not limited to activity assessments, care plans, activity notes, and 1:1 documentation for cognitively impaired/dependent residents. DOE educated on activity regulations and provided with an	

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	consistent with physical and psychosocial abilities. Help the resident monitor his energy level and recognize over-activity, as well as under-activity. There was no Care Plan indicating he refused to attend activities. The resident had no current activity notes nor an activity assessment. The 1:1 program and group documentation indicated there was no participation documentation for the last 30 days. The February 2024 Activity Calendar indicated the resident had 1 to 1 visits for the month, which included giving him daily chronicles. No group activities were attended. One to one visits were received on 2/6, 2/15, and 2/29/24. The resident was asleep on 2/6 and 2/29/24. The March 2024 Activity Calendar indicated no group activities were attended. One to one visits were attempted on 3/4 and 3/7/24 but the resident was asleep. During an interview on 3/11/24 at 10:00 a.m., the Activity Director indicated she had only been in this role for 3 weeks. She was in the process of hiring more activity aides to help her out, however, currently she was responsible for the entire building, including assisted living. She was unaware residents who were cognitively impaired and dependent needed 1 to 1 activities if they were not going to participate in group sessions. The resident had not attended any group activities during 2/2024 and 3/2024.		updated copy. Activity Assistant has been hired and trained to assist with both group and 1:1 activities. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** General Manager/Designee will audit 10 dependent residents weekly to ensure residents are participating in group activities and/or 1:1 sessions. General Manager/Designee will audit 10 charts weekly to ensure activity assessment, care plans, activity participation, and/or 1:1 participation are in place for all guests. General Manager/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. **Date of compliance: 4/5/2024**	

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	3.1-33(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure areas of bruising were assessed and monitored for 1 of 2 residents reviewed for skin conditions non-pressure related. The facility also failed to ensure treatment orders were obtained for excessive diarrhea for 1 of 1 residents reviewed for constipation and transportation was arranged for surgical appointments for 1 of 1 residents reviewed for change in condition. (Residents 13, Q, and 5) Findings include: 1. On 3/4/23 at 3:15 p.m., Resident 13 was observed with areas of scattered purple bruising to his left forearm and right arm. During an interview at that time, the resident indicated the bruises were from lab draws. The record for Resident 13 was reviewed on 3/6/24 at 2:13 p.m. Diagnoses included, but were not limited to, Parkinson's disease and chronic kidney disease.	F 0684	**POC for F684 – Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No harm came to any residents related to this alleged deficient practice. Orders obtained for Resident 13 to monitor bruising until resolved. Resident 13 has discharged to his Assisted Living Apartment. Resident Q attended his wound care appointment. Resident 5 receiving antidiarrheal medication per orders.	04/05/2024

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	The Admission Minimum Data Set (MDS) assessment, dated 2/10/24, indicated the resident was cognitively intact for daily decision making. A Care Plan, dated 3/4/24, indicated the resident was receiving anticoagulant therapy. Interventions included, but were not limited to, document and report as needed (PRN) adverse reactions of anticoagulant (blood thinner) therapy such as bruising. Physician's Orders, dated 2/5/24, indicated the resident was to receive a Lovenox (a blood thinner) injection, 0.4 milliliters (ml) one time a day for DVT (deep vein thrombosis) prophylaxis and skin checks weekly. The Daily Skilled Nursing Evaluation, dated 3/5/24, indicated there was no documentation related to bruising. There were no Physician's Orders to monitor the bruising. During an interview on 3/6/24 at 3:49 p.m., the Northwest Unit Manager indicated orders should have been obtained to monitor the bruising. Nurses' Notes, dated 3/6/24 at 4:05 p.m., indicated the resident was noted with scattered bruising to the right and left upper extremities. The resident indicated the bruising happened after blood draws. Orders were received to monitor the bruising every shift until resolved. 2. During an interview, on 3/4/24 at 11:17 a.m., Resident Q indicated he could not go to the wound clinic to have a surgeon complete the treatment to his left foot. He had been going for the last 2 weeks, and then on 2/29/24, the facility told him he could not go due to insurance		Resident Q and Resident 5 still reside in facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. House audit was completed for all residents in house to ensure all bruises are documented with treatment orders in place. House audit was completed for all residents to ensure all guests with diarrhea have appropriate orders in place and are receiving medications as ordered. House audit was completed for all residents with scheduled appointments to ensure transportation has been arranged. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Nursing staff educated to ensure all bruises are documented with orders in place to monitor every shift until bruising is resolved.	

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	reasons. The facility wanted him to sign a paper so their wound Nurse Practitioner (NP) could take over and provide wound care. He indicated he refused, as he wanted a Physician to complete the wound care. The record for Resident Q was reviewed on 3/6/24 at 12:08 p.m. The resident was admitted to the facility on 2/12/24. Diagnoses included, but were not limited to, peripheral vascular disease, pulmonary embolism, osteomyelitis, high blood pressure, absence of the left toes, and adult failure to thrive. The 2/18/24 Admission Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact, and it was very important for him to choose between a shower or bath. He needed substantial assistance with bathing and received scheduled and as needed (prn) pain medication. He had frequent and moderate pain in the last 5 days that occasionally effected his sleep. The resident received an anticoagulant and antiplatelet medication while a resident. A Care Plan, dated 2/29/24, indicated the resident had arterial ulcer to the left dorsal foot. The resident was transported to the wound clinic on 2/15 and 2/22/24. The last visit indicated a follow up appointment was scheduled for 2/29/24 at 9:00 a.m. A Nurses' Note, dated 2/22/24 at 1:13 p.m., indicated the resident went to a Wound Doctor for a follow up appointment. The next appointment was scheduled for 2/29/24 at 9:00 a.m. During an interview, on 3/7/24 at 11:30 a.m., the		Interdisciplinary team members and floor staff/ all departments educated on reporting areas of bruising to floor nurse to ensure appropriate documentation and orders are in place. HIM educated on ensuring all guests with scheduled appointments have transportation arranged. All staff educated on residents rights to choose physician/follow up appointments and ensure HIM is notified of any transportation needing scheduled. CNA staff educated on reporting episodes of loose stools to nurse immediately. Nursing staff educated to assess all guests with loose stools and administer antidiarrheal medication as ordered. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** CNO/Designee will audit 10 residents weekly to ensure all bruises are documented with monitoring orders in place.	

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	155840	A. BUILDING 00 B. WING	03/11/2024

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	Assistant Director of Nursing and the Unit Manager both indicated they had heard the resident was not going out to see his physician for wound care because the facility had its own wound care and Wound NP. During an interview, on 3/7/24 at 11:45 a.m., the Wound Nurse indicated she performed the bandage changes and did the treatments, however, he had refused to see the facility's own Wound NP. She thought they were waiting on a surgical consult because the wound was not healing, and the resident had decided on another amputation. She was not sure why he did not go to his wound clinic appointment on 2/29/24. During an interview, on 3/7/24 at 12:18 p.m., the Administrator indicated the resident missed his appointment on 2/29/24 and did not go to the wound clinic. She was unsure why he missed it, but thought staff probably told the resident he could not go to his appointment because his insurance wound not pay to be treated at both places. The Administrator indicated that was not true, and the resident had the right to choose his own wound care. The resident did go to the wound clinic today for treatment the wound on his left foot. 3. On 3/4/24 at 11:18 a.m., Resident 5 was observed in bed watching television. At that time, she indicated she has had diarrhea every morning for over a month. On 3/5/24 at 2:36 p.m. the resident was sitting in bed watching television. The resident indicated she had diarrhea again that morning. On 3/6/24 at 9:47 a.m., the resident was observed eating breakfast. She indicated she was starting to have diarrhea at that moment.		CNO/Designee will audit 10 residents weekly to assess for loose stools and ensure orders are in place and being administered as needed. General Manager/Designee will audit 10 residents weekly to ensure residents are able to attend all scheduled appointments. General Manager/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. **Date of compliance: 4/5/2024**	

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	On 3/06/24 at 11:30 a.m., the resident was observed watching television. She indicated she was just cleaned up and had diarrhea again. The record for Resident 5 was reviewed on 3/6/24 at 11:04 a.m. Diagnoses included, but were not limited to, hemiplegia, diabetes, chronic obstructive pulmonary disease (respiratory disease), dementia, hypertension (high blood pressure), gout, acute and chronic respiratory failure. The 2/22/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was severely impaired with daily decision making. A Physicians' Order, dated 2/29/24, indicated to administer Imodium A-D oral tablet 2 milligrams(MG), and to give 1 tablet by mouth every 4 hours as needed (prn) for an antidiarrheal. The Medication Administration Record (MAR) indicated the prn antidiarrheal was not signed out at all from the order date of 2/29/24 through 3/6/24. Bowel movements were documented as loose/diarrhea on the following dates: 2/12/24, 2/13/24, 2/15/24, 2/17/24, 2/18/24, 2/19/24, 2/21/24, 2/22/24, 2/28/24, 2/29/24, 3/1/24, 3/2/24, and 3/5//24. During an interview, on 3/6/24 at 11:32 a.m., CNA 1 indicated the resident had diarrhea this morning and that every time the resident had a bowel movement she has had diarrhea. During an interview on 3/6/24 at 1:54 p.m., the Director of Nursing (DON) indicated he understood the resident had not received antidiarrheal medication despite multiple, ongoing			

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	episodes of diarrhea, and had no additional information to provide. 3.1-37(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure oxygen was set at the correct flow rate for 3 of 4 residents reviewed for respiratory care (Residents M, 5 and 45) Findings include: 1. During random observations on 3/4/24 at 1:50 p.m., on 3/5/24 at 8:43 a.m. and 2:34 p.m., and on 3/6/24 at 9:38 a.m., Resident M was observed wearing oxygen via nasal cannula. The oxygen flow rate was above 3.5 liters per minute. The record for Resident M was reviewed on 3/6/24 at 10:34 a.m. Diagnoses included, but were not limited to, brain and lung cancer, COPD, respiratory failure, and high blood pressure. The 1/22/24 Admission Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for daily decision making.	F 0695	**POC for 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?** No harm came to any residents related to this alleged deficient practice. Residents M no longer resides in facility. Residents 5 still resides in facility and is receiving oxygen at ordered flow rate.	04/05/2024

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	The resident used oxygen while a resident. The Care Plan, dated 1/16/24, indicated the resident required oxygen therapy related to lung cancer and COPD. The approaches were to administer oxygen per Physician's Orders. Physician's Orders, dated 1/15/24, indicated provide continuous oxygen at 2 liters per minute. During an interview on 3/6/24 at 10:50 a.m., the Assistant Director of Nursing indicated the resident's oxygen should be on per Physician's Orders. 2. On 3/4/24 at 11:18 a.m., Resident 5 was observed in bed wearing oxygen via nasal cannula. The flow rate was set at 3.5 liters. On 3/5/24 at 2:36 p.m., the resident was sitting in bed watching television. She was wearing oxygen via nasal cannula at 3.5 liters. On 3/6/24 at 9:47 a.m., the resident was observed eating breakfast. The resident was wearing her oxygen and the flow rate was on at 4 liters. The record for Resident 5 was reviewed on 3/6/24 at 11:04 a.m. Diagnoses included, but were not limited to, hemiplegia, diabetes, chronic obstructive pulmonary disease (respiratory disease), dementia, hypertension (high blood pressure), gout, acute and chronic respiratory failure. The 2/22/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was severely impaired with daily decision making. A Care Plan, dated 2/22/24, indicated the resident had COPD. Interventions included, but were not limited to, giving oxygen therapy as ordered by		Resident 45's orders updated to include oxygen administration with flow rate. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by this alleged deficient practice. Full house audit of all residents completed to ensure oxygen orders entered for any residents on oxygen, and that oxygen is being administered at ordered flow rate. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Nursing staff was educated on ensuring that residents on oxygen therapy have orders in place and are receiving oxygen at	

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	the physician and monitoring and documenting any side effects and effectiveness.. A Care Plan, dated 2/22/24, indicated the resident received oxygen therapy related to respiratory failure. Interventions included, but were not limited to, giving oxygen therapy as ordered by the physician and observing and documenting any side effects and effectiveness. A Physicians' Order, dated 8/21/23, indicated to administer oxygen via nasal cannula every shift at 3 liters per minute. The Medication Administration Record (MAR) indicated oxygen was signed out at 3 liters every shift from 3/1/24 to 3/6/24. During an interview, on 3/6/24 at 1:54 p.m., the Director of Nursing (DON) indicated he understood the resident had oxygen on at the incorrect flow rate, and had no additional information to provide. 3. On 3/4/24 at 10:13 a.m., and 11:44 a.m., Resident 45 was observed wearing oxygen via nasal cannula at a flow rate of 2 liters. On 3/5/24 at 9:26 a.m., the resident was observed in her room eating breakfast. She had oxygen on at 2 liters via nasal cannula. On 3/6/24 at 9:42 a.m., the resident was observed in her room watching television. She had oxygen on at 2 liters via nasal cannula. The record for Resident 45 was reviewed on 3/6/24 at 10:22 a.m. Diagnoses included, but were not limited to, stroke, respiratory failure, anxiety, obstructive uropathy and hypertension (high		the ordered flow rate. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DON/designee will monitor 20 residents weekly to ensure that residents wearing oxygen have orders in place and are receiving oxygen at ordered flow rate. DON/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue. **Date of compliance: 04/05/24**	

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	blood pressure). The 2/7/24 Admission Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact with daily decision making. A Care Plan, dated 2/7/24, indicated the resident received oxygen therapy related to respiratory failure with hypoxia. Interventions included, but were not limited to, giving oxygen therapy as ordered by the physician, observe and document side effects and effectiveness, and observe for signs of respiratory distress and report to physician. There was no Physician's Order to administer oxygen. A Nurses' Note, dated 2/1/24, indicated the resident was receiving oxygen at 3 liters via nasal cannula. During an interview, on 3/06/24 at 1:54 p.m., the Director of Nursing (DON) indicated he understood the resident was wearing oxygen without a Physician's order, and had no additional information to provide. 3.1-47(a)(6)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility	F 0697	**POC for F697 – Pain**	04/05/2024

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	failed to administer pain relief medication as ordered by the Physician, related to the administration of narcotic medication, for 1 of 1 residents reviewed for pain management. (Resident Q) Finding includes: During an interview, on 3/4/24 at 11:28 a.m., Resident Q indicated nursing staff had told him more than once they have run out of his Norco (Hydrocodone) medication, and he was in a lot of pain. He indicated one day, the nurse told him there would be no Norco available until the next day, and that was at 3:00 p.m. The record for Resident Q was reviewed on 3/6/24 at 12:08 p.m. The resident was admitted to the facility on 2/12/24. Diagnoses included, but were not limited to, peripheral vascular disease, pulmonary embolism, osteomyelitis, high blood pressure, absence of the left toes, and adult failure to thrive. The 2/18/24 Admission Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact, and received scheduled and as needed (prn) pain medication. He had frequent and moderate pain in the last 5 days that occasionally affected his sleep. A Care Plan, dated 3/4/24, indicated the resident was receiving opioid medications. A Care Plan, dated 2/22/24, indicated the resident had potential for pain. The approaches were to administer medications as ordered, anticipate the resident's need for pain relief and respond immediately to any complaints of pain, identify and record previous pain history and management		**Management** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident Q still resides in facility. No harm came to resident Q from this alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents with pain medication orders have the potential to be affected by this alleged deficient practice. Full house audit was completed to ensure residents received appropriate pain medication per orders. Full house audit was completed to ensure that all pain medications were received from pharmacy and available for administration.	

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	of that pain and its impact on function, and identify previous response to analgesia including pain relief, side effects and its impact on function. Physician's Orders, dated 2/12/24, indicated Hydrocodone-Acetaminophen oral tablet 5-325 milligrams (mg), give 1 tablet by mouth every 4 hours as needed for pain. The Medication Administration Record (MAR), dated 2/2024, indicated the resident received 1 Hydrocodone tablet on 2/12-2/15/24. He received 2 tablets on 2/16/24 and then 1 tablet on 2/17-2/20/24. He did not receive any Hydrocodone on 2/21/24. The Narcotic Sheet indicated 30 tablets of the Hydrocodone was received 2/22/24 (10 days after the resident was admitted). The 2/2024 MAR indicated after the 30 tablets of Hydrocodone were received, the resident consistently asked for the pain medication at least 3 times a day for the rest of the month. The facility had a RX Now medication machine to dispense medications that were currently unfilled, and Hydrocodone 5-325 mg was available. During an interview, on 3/7/24 at 10:00 a.m., the Director of Nursing indicated he was unaware and did not know why the script was not sent to the pharmacy right after the resident was admitted. He had no additional information to review. 3.1-37(a)		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Nursing staff educated on ensuring that residents with complaints of pain receive the proper pain medication per physician orders. Nursing staff educated that medications not on hand should be pulled from the RxNow machine and administered per orders. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** CNO/designee will monitor 15 residents with orders for pain medications to ensure that medications are available and administered per orders. CNO/Designee will present the summaries of the audits to the	

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			Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue. **Date of compliance: 4/5/24**	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility	F 0757	**POC for F757 – Drug Regimen**	04/05/2024

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	failed to ensure medications were managed appropriately, related to missed doses of an anticoagulant medication, for 1 of 5 residents reviewed for unnecessary medications (Resident Q) Finding includes: During an interview, on 3/4/24 at 11:22 a.m., Resident Q indicated he had missed his Lovenox (anticoagulant) injections many times. Some days he only received 1 shot, and on other days he did not receive any of them. The record for Resident Q was reviewed on 3/6/24 at 12:08 p.m. The resident was admitted to the facility on 2/12/24. Diagnoses included, but were not limited to, peripheral vascular disease, pulmonary embolism, osteomyelitis, high blood pressure, absence of the left toes, and adult failure to thrive. The 2/18/24 Admission Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact and received an anticoagulant and antiplatelet medication while a resident. A Care Plan, dated 2/12/24, indicated the resident received an anticoagulant medication. The approaches were to administer the medication as ordered. Physician's Orders, dated 2/13/24, indicated Enoxaparin (Lovenox) Sodium Injection Solution Prefilled Syringe 100 milligrams/milliliters (mg)/(ml) Inject 1.025 ml subcutaneously two times a day for 29 days. The 2/2024 Medication Administration Record (MAR), indicated the Enoxaparin was signed out		**is Free from Unnecessary Drugs** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No harm came to resident Q from this alleged deficient practice. Resident Q still resides in facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by this alleged deficient practice. Full house audit was completed to ensure residents receiving anticoagulation medication were receiving medication per orders. **What measures will be put**	

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	as being administered on 2/12-2/20/24 two times a day. On 2/21/24 a "9" was coded for both the 9:00 a.m. and 5:00 p.m. doses, indicating to see nurses' notes. The rest of the month, 2/22-2/29/24, the Enoxaparin was signed out as being administered for 2 times a day. Nurses' Notes, dated 2/21/24, indicated the Enoxaparin was not available. The 3/2024 MAR indicated the Enoxaparin was signed out as being administered 3/1-3/4/24 twice a day. On 3/5/24, a "9" was coded for 5 p.m. dose, and on 3/6/24, a "9" was coded for 9 a.m. dose. Nurses' Notes, dated 3/5/24 at 5:46 p.m., indicated the Enoxaparin was on order. Nurses' Notes, dated 3/6/24 at 8:01 a.m., indicated the Enoxaparin medication was unavailable and was reordered with pharmacy. During an interview, on 3/7/24 at 9:30 a.m., the Pharmacy Account Manager indicated they sent over 10 doses (enough for 5 days) of the Enoxaparin on 2/14/24. They sent another 10 doses (enough for 5 days) on 2/27/24. They received an order for more, however, the medication was on backorder and they had not sent any since 2/27/24. The Account Manager indicated the medication was available in the RX Now machine, so staff could have used that medication so the resident would not go without, however, he verified there was no documentation the Enoxaparin was signed out for the resident from the RX Now medication machine. A total of 20 doses (enough for 10 days) were received from the pharmacy and the resident had already been residing in the facility for 24 days.		**into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Nursing staff educated on ensuring that residents are receiving medications as ordered including but not limited to anticoagulation medications. Nursing staff was educated on what medications are available in RX Now (EDK), how to access medications from RX Now (EDK), and notification to CNO/ACNO/MD/Pharmacy when a medication from RX Now (EDK) is unavailable. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** CNO/designee will monitor 15 residents with orders for anticoagulation medications to ensure that medications are available and administered per orders. CNO/Designee will present the summaries of the audits to the Quality Assurance committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155840	A. BUILDING 00 B. WING	03/11/2024

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	On 3/7/24 at 10:00 a.m., the Director of Nursing entered the medication room where the RX Now machine was located. At that time, he used his fingerprint and was able to open the machine to remove the 100 mg of Enoxaparin prefilled syringes. There were a total of 8 syringes available for use. During an interview at that time, the DON indicated he was unaware the Enoxaparin medication was even available in the RX Now machine. During an interview, on 3/7/24 at 10:30 a.m., the DON had informed RN 1 about the Lovenox being available in the RX Now machine. She indicated at that time, she was unaware it was in there. 3.1-48(a)		monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue. **Date of compliance: 4/5/24**	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 3 of 6 residents observed during medication pass. Three errors were observed during 29 opportunities for errors during medication administration. This resulted in a medication error rate of 10.34%. (Residents 49, 41, and J) Findings include: 1. On 3/6/24 at 9:41 a.m., LPN 1 was observed	F 0759	**POC for F759 – Free of Medication Error Rts 5 Prcnt or More** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	04/05/2024

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	preparing Resident 49's medications. She crushed different oral medications at one time, including one Isosorbide Mononitrate ER Tablet Extended Release 24 hour 30 milligrams (mg) tablet. A total of 13 crushed pills were observed in the medication cup. The record for Resident 49 was reviewed on 3/6/24 at 9:28 a.m. There was no physician's order to crush medications. LPN 1 contacted the pharmacy to verify if the Isosorbide ER tablet could be crushed. The pharmacy indicated the medication should not be crushed. During an interview, on 3/6/24 at 9:19 a.m., LPN 1 indicated the extended release medications should not be crushed. 2. On 3/6/24 at 10:23 a.m., LPN 2 was observed administering Incruse Ellipta 62.5 milligrams/micrograms (mg/mcg) inhaler to Resident 41. She handed the inhaler to the resident, and instructed the resident to take two puffs of the inhaled medication. Resident 41 took two quick puffs of the inhaler and closed the inhalation device. LPN 2 continued to administer the rest of the medications to the resident. During an interview, on 3/6/24 at 10:37 a.m., LPN 2 indicated she forgot to instruct the resident to wait two minutes between puffs. 3. On 3/6/24 at 11:51 a.m., LPN 2 was preparing Resident J's insulin injection. The resident was to receive 7 units of Humalog 100 unit/Insulin Lispro 100. LPN 2 prepared Resident J's insulin pen without properly priming the insulin pen. LPN 2 entered the resident's room, cleaned her hands,		No harm came to any residents related to this alleged deficient practice. LPN 1 was immediately educated on not crushing extended release medications. LPN 2 educated on waiting appropriate time between inhalations of medications and priming of insulin pens prior to administration. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by this alleged deficient practice. All nurses/QMAs received a competency check on medication administration via all routes. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	

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	applied gloves and administered Resident J's insulin without priming the insulin pen. During an interview on 3/6/24 at 12:33 p.m., LPN 2 indicated she didn't know she had to prime the pen before giving the insulin. 3.1-48(c)(1)		Nursing staff educated on proper medication administration technique including, but not limited to, not crushing extended release tablets, waiting the appropriate amount of time between the inhalation of medications, and priming insulin pen needles prior to administration of insulin. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** CNO/designee will monitor 10 medication administrations weekly on alternating shifts to ensure proper technique is being used, with a focus on crushed medications, inhaled medications, and insulin administration. CNO/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	

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			Date of compliance: 4/5/24	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §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. §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. Based on observation, record review, and interview, the facility failed to ensure medications were properly stored, related to one unlabeled insulin vial and loose pills inside the medication drawers, for 1 of 4 medication carts observed. (North East Cart 2).	F 0761	**POC for F761 – Label/Store Drugs and Biologicals** **What corrective action(s) will be accomplished for those residents found to have been**	04/05/2024

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	Findings include: 1. During a medication storage observation, on 3/6/24 at 11:51 a.m., the North East Hall medication cart was observed with LPN 2. There was one unlabeled and undated insulin vial in the medication cart. During an interview, on 3/6/24 at 11:51 a.m., LPN 2 indicated the insulin vial should have been properly discarded. 2. During a medication storage observation, on 3/7/24 at 5:59 p.m., the North East Hall medication cart was observed with LPN 3. At that time, there were 15 loose pills inside the drawer of the medication cart. The pills ranged in size and color. During an interview, on 3/7/24 at 5:59 p.m., LPN 3 indicated she should have cleaned her cart out and properly disposed of the loose medications. A facility policy, titled, "Medication Labeling and Storage", provided by the Director of Nursing as current, indicated, " ... "Medication are labeled in accordance with facility requirements and state and federal laws". 3.1-25(j)		**affected by the deficient practice?** No harm came to any resident from this alleged deficient practice. LPN 2 immediately educated on proper labeling of medications including, but not limited to, insulin vials. LPN 3 immediately educated on cart cleanliness and on proper disposal of loose pills inside of medication cart. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by this alleged deficient practice. Full house audit completed of all medication carts to ensure all medications, including, but not limited to, insulin vials are labeled appropriately. Full house audit completed of all medication carts to ensure	

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			that no loose pills are present, and any loose pills are disposed of appropriately. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Nursing staff educated on proper labeling of all medications. Nursing staff educated on cart cleanliness, ensuring no loose pills are present in cart, and proper disposal of any loose pills. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** CNO/Designee will audit all medication carts weekly to ensure all medications are appropriately labeled and that no loose pills are present in medication carts. CNO/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months.	

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			Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue. **Date of compliance: 4/5/24**	
F 0842 SS=E Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;			

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	(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on record review and interview, the facility	F 0842	**POC for F842 Resident**	04/05/2024

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	failed to ensure clinical records were complete, related to meal consumption intake, for 4 of 6 residents reviewed for food. (Residents Q, M, E, and N) Findings include: 1. The record for Resident Q was reviewed on 3/6/24 at 12:08 p.m. The resident was admitted to the facility on 2/12/24. Diagnoses included, but were not limited to, peripheral vascular disease, pulmonary embolism, osteomyelitis, high blood pressure, absence of the left toes, and adult failure to thrive. The 2/18/24 Admission Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact. Physician's Order, dated 2/15/24, indicated a no salt packet, regular texture and consistency diet. The Meal Consumption Logs for February & March 2024, indicated all three meals were blank and not documented on 2/13, 2/15, 2/19, 2/22, 2/24, 2/29, and 3/5/24. There was no breakfast meal documented on 2/14/24 and no lunch meal documented on 2/17/24. The dinner meal was not documented on 2/14, 2/16, 2/18, 2/20, 2/21, 2/23, 2/25, 2/27, 3/2, and 3/3/24. During an interview on 3/7/24 at 2:30 p.m., the Director of Nursing indicated meals were to be documented every day for all 3 meals consumed. 2. The record for Resident M was reviewed on 3/6/24 at 10:34 a.m. Diagnoses included, but were not limited to, brain and lung cancer, COPD, respiratory failure, and high blood pressure.		**Records-Identifiable Information** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No harm came to any resident from this alleged deficient practice. Residents M, E, and N no longer reside in facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by this alleged deficient practice. House audit of all residents completed to ensure that clinical records were complete related to meal consumption intake. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All clinical staff educated to properly document meal consumption intake within POC. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** CNO/designee will review 5 resident charts daily 5x a week to ensure food consumption is	

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	The 1/22/24 Admission Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for daily decision making. The resident was to receive a regular diet. The Meal Consumption Logs for February & March 2024, indicated there was no documentation of any meal on 2/9, 2/10, 2/11, 2/15, 2/19, 2/28, and 2/29/24. There was no documentation of breakfast on 2/6, 2/16, 2/20, 2/23, 2/26, 3/2, 3/3 and 3/5/24 and no documentation of the dinner meal on 2/7, 2/8, 2/12, 2/13, 2/14, 2/17, 2/18, 2/21, 2/14, and 2/25/24 During an interview on 3/7/24 at 2:30 p.m., the Director of Nursing indicated meals were to be documented every day for all 3 meals consumed. 3. The Closed record for Resident E was reviewed on 3/7/24 at 10:20 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes, anxiety, major depressive disorder, high blood pressure, and atrial fibrillation. The Quarterly Minimum Data Set (MDS) assessment, dated 12/8/23, indicated the resident was moderately impaired for daily decision making and needed set up and clean up assist for eating. The Meal Consumption Logs for December 2023 and January 2024, indicated there was no documentation of any meal on 12/2, 12/3, 12/5, 12/8, 12/9, 12/10, 12/13, 12/16, 12/17, 12/19, 12/21, 12/25, 12/27, 12/8, 12/29, 12/31, 1/2, 1/8, 1/10, 1/17, 1/20, 1/27, 1/28 and 1/31/24 During an interview on 3/7/24 at 2:30 p.m., the Director of Nursing indicated meals were to be documented every day for all 3 meals consumed.		documented appropriately. ·CNO/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue. **Date of compliance: 4/5/24**	

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	4. The record for Resident N was reviewed on 3/5/24 at 3:30 p.m. The resident was admitted to the facility on 2/22/24. Diagnoses included, but were not limited to, COPD, severe obesity, repeated falls, osteoporosis, depression, and pain in the left knee. The Admission Minimum Data Set (MDS) assessment, dated 2/27/24, indicated the resident was cognitively intact daily decision making. Physician's Orders, dated 2/29/24, indicated the resident was to receive a low concentrated sweets, regular textured diet. The Meal Consumption Logs for February & March 2024, indicated all three meals were blank and not documented on 2/28, 2/29, and 3/5/24. There was no breakfast meal documented on 3/2 and 3/3/24 and no dinner meal documented on 2/23, 2/24, 2/25, 2/26, and 3/4/24 During an interview on 3/7/24 at 2:30 p.m., the Director of Nursing (DON) indicated meals were to be documented every day for all 3 meals consumed The current 5/2023 "Meal Monitoring" policy, provided by the DON as current on 3/11/24 at 9:30 a.m., indicated each resident will have the percentage of meals recorded after each meal and snack. 3.1-50(a)(1)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an			

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

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	155840	A. BUILDING 00 B. WING	03/11/2024

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	organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, related to improper disposal of a used lancet placed in the garbage can, for 1 of 1 residents observed for glucometer use. (Resident 41) Finding includes: On 3/6/24 at 10:23 a.m., LPN 2 was observed preparing to check Resident 41's blood sugar. She removed the glucometer, lancet, alcohol swabs,	F 0880	**POC for F880 – Infection Prevention & Control** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 41 suffered no ill	04/05/2024

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	and the test strips from the medication cart. She performed hand hygiene and donned gloves to both hands and proceeded to walk into the resident's room. At that time, she checked the resident's blood sugar and threw all of her supplies into the resident's garbage can when she was finished. During and interview on 3/6/24 at 10:26 a.m., LPN 2 indicated she was rushing and accidentally tossed everything in the garbage can. She was aware the lancet was to be disposed of into a sharps container. A Policy, titled, "Injection Safety and Sharps Injury Protection Plan", presented by the DON as current on 3/8/24 at 3:00 p.m., indicated, ..."Used disposable needles/sharps shall be discarded immediately after use without recapping into an approved sharps container"... 3.1-18(b)		effects from this alleged deficient practice. Resident 41 no longer resides in facility. LPN 2 educated that all sharps, including but not limited to glucometer lancets, have to be properly disposed of in an approved sharps container immediately after use. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by this alleged deficient practice. All medication carts audited to ensure that each had an approved functional sharps container attached. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	

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			Nurses educated that all sharps, including but not limited to glucometer lancets, need to be immediately disposed of in an approved sharps container. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** CNO/designee will audit 10 insulin administrations a week to ensure that all sharps, including but not limited to glucometer lancets, are immediately disposed of in an approved sharps container. CNO/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue. **Date of compliance: 04/05/24**	

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F 0887 SS=E Bldg. 00	483.80(d)(3)(i)-(vii) COVID-19 Immunization §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the			

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	benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).			
	Based on record review and interview, the facility failed to ensure infection control guidelines for vaccinations were in place and implemented, related to offering and providing the COVID vaccine, for 4 of 5 residents reviewed for vaccinations. (Residents 41, 77, 198, and 247) Findings include: The COVID vaccine records were reviewed on 3/8/24 at 9:40 a.m. a. Resident 41 was admitted on 2/13/24. There was no documentation of a signed consent or refusal of the COVID vaccine or of education being provided. b. Resident 77 was admitted on 2/14/24. There was no documentation of a signed consent or refusal of the COVID vaccine or of education being	F 0887	**POC for F887 – COVID-19 Immunization** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents suffered any ill effects from this alleged deficient practice. Residents 41, 77, 198, and 247 no longer reside in facility.	04/05/2024

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	provided. c. Resident 198 was admitted on 2/22/24. There was no documentation of a signed consent or refusal of the COVID vaccine or of education being provided. d. Resident 247 was admitted on 3/3/24. There was no documentation of a signed consent or refusal of the COVID vaccine or of education being provided. During an interview on 3/8/24 at 10:46 a.m., the Infection Prevention (IP) manager indicated they had not been offering COVID vaccinations since their new pharmacy transitioned in January 2024. The pharmacy would not send the vials for the vaccinations to be administered by staff, however, the pharmacy staff have come and provided clinics for the COVID-19 vaccine previously. Staff have requested consent forms for COVID vaccinations, but have not yet received them. During an interview, on 3/8/24 at 12:56 p.m., the Director of Nursing (DON) indicated he was unclear on the specifications of offering the COVID vaccine. 3.1-18(b)		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by this alleged deficient practice. House audit of all residents completed to ensure that all residents have been offered the Covid-19 vaccine, education provided, consent/declination obtained, and resident provided with vaccine if consent was obtained. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Nurses educated that Covid-19 vaccination needs to be offered to all residents on admission, education provided, consent/declination obtained and documented, and IP nurse/CNO notified of any consents so vaccine can be administered.	

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R 0000			Covid-19 Vaccination Consent/Declination Evaluation added to PCC and set to trigger on all new admissions to ensure vaccine is offered to all residents. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** CNO/Designee will audit all new admissions to ensure that Covid-19 vaccine was offered, education provided, consent/declination obtained, and vaccine administered if consented. CNO/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue. **Date of compliance: 04/05/24**	

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Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Complaints IN00424703, IN00424731, IN00426055, IN00426751, IN00427100, IN00427561, and IN00429885. Complaint IN00424703 - Federal/State deficiencies related to the allegations are cited at F554. Complaint IN00424731 - Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00426055 - No deficiencies related to the allegations are cited. Complaint IN00426751 - Federal/State deficiencies related to the allegations are cited at F554. Complaint IN00427100 - No deficiencies related to the allegations are cited. Complaint IN00427561 - No deficiencies related to the allegations are cited. Complaint IN00429885 - Federal/State deficiencies related to the allegations are cited at F677. Survey dates: March 4, 5, 6, 7, 8, and 11, 2024. Facility number: 013462 Residential Census: 28 Ignite Medical Resort Dyer Llc was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on 3/19/24.	R 0000	Ignite Medical Resorts 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. This facility respectfully requests a desk review for the given citations in this survey. Please see all attached documentation for your consideration.	

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