| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155690 | A. BUILDING 00<br>B. WING | 08/30/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| ENVIVE OF ANDERSON | 1821 LINDBERG RD<br>ANDERSON, IN 46012 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00388147.<br><br>Complaint IN00388147 Substantiated. Federal/State deficiencies related to the allegations are cited at F684.<br><br>Survey dates: August 22, 23, 24, 25, 26, 29 and 30, 2022<br><br>Facility number: 000027<br>Provider number: 155690<br>AIM number: 100266180<br><br>Census Bed Type:<br>SNF/NF: 45<br>Total: 45<br><br>Census Payor Type:<br>Medicare: 5<br>Medicaid: 40<br>Total: 45<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on September 9, 2022. | F 0000 | PLAN OF CORRECTION FOR ENVIVE OF ANDERSON<br>F000 INITIAL COMMENTS<br><br>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Recertification and State Licensure with a Complaint Survey IN 00388147 completed on August 30, 2022.<br>Please accept this Plan of Correction as the provider's credible allegation of compliance as of September 25, 2022. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. | |
| F 0578<br>SS=D<br>Bldg. 00 | 483.10(c)(6)(8)(g)(12)(i)-(v)<br>Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental | | | |

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

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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| | research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.<br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br>Based on interview and record review, the facility | F 0578 | **1. What corrective action(s)** | 09/25/2022 |

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| | failed to ensure a resident's clinical record, care plan, and orders accurately reflected his chosen advanced directive/code status for 1 of 4 residents reviewed for the right to formulate an advanced directive (Resident 24).<br><br>Findings include:<br><br>Resident 24's clinical record was reviewed on 8/22/22 at 1:51 p.m. Current diagnoses included, but were not limited to, bladder cancer, chronic obstructive pulmonary disease, and diabetes mellitus. The resident had a current, 8/3/22, order for hospice services. An August 2022 physician's recapitulation of orders indicated the resident was a full code, which was in conflict with the resident's advanced directives.<br><br>The resident also had a "POST form - Physician Orders For Scope or Treatment" (advanced directive), dated 7/3/22, which indicated the resident had chosen to be DNR- Do Not Attempt Resuscitation (no CPR) .<br><br>The resident had a current 7/6/22, care plan need which indicated he desired to be a full code (attempt resuscitation), in conflict with his POST form/advanced directive.<br><br>The resident profile sheet, located in the resident's clinical record, indicated he was a full code, which was in conflict with his advanced directives.<br><br>During an interview, on 8/29/22 at 10:21 a.m., the DON indicated a resident's code status should be listed on their profile in the clinical record. She indicated she had identified not all code statuses were correct and up to date. She additionally indicated Resident 24's profile page,care plan, and orders did not match his decision listed on his | | **will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>Resident 24 and family were interviewed, and it was determined that the resident would like to be a DNR. This order was obtained and placed in the chart.<br><br>**2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?**<br>All residents admitted have the potential to be affected by the alleged deficient practice.<br>DNS/designee will audit all current residents by 9/25/22 to ensure advanced directives are in place, completed, care planned, and documented per resident direction and physician order.<br>**3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?**<br>Admissions will obtain advanced directives from resident/POA upon admission.<br>DNS/designee will review all new admissions during clinical meeting (Mon-Fri) to ensure advanced directives, care plans, and physicians order are in place and documented appropriately. | |

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| | POST form for DNR.<br><br>During an interview, on 8/29/22 at 11:04 a.m., LPN 8 indicated the resident's code status (request regarding resuscitation) was listed on their profile sheet. The LPN indicated she would check the profile sheet in the resident's electronic clinical record and follow the resident's choice, which was listed there.<br><br>During an interview, on 8/29/22 at 11:07 a.m., RN 1 indicated a resident's code status was listed on the resident's profile sheet. She would review the resident's profile page and follow the instructions regarding resuscitation.<br><br>A current, 8/2022 facility policy titled "Self Determination of Care," provided by the RN Consultant on 8/30/22 at 11:02 a.m., indicated the following:<br><br>"...1. Residents have the right to participate in their medical care and refuse medications and treatment or have care choices...<br>2. Documentation pertaining to a resident's care decision shall include, as a minimum: Open a Self Determination of Care Observation form in the Electronic Record...<br>b. The resident's response and reason(s) for denial or choice...."<br><br>A current undated facility document, contained in the Admission Packet, titled "Indiana Resident Rights & Facility Responsibilities," provided by the Administrator on 8/23/22 at 10:10 a.m., indicated the following:<br><br>"...(4) Provide written information to each resident concerning the following:...<br>(ii) formulate advanced directives... | | All licensed clinical staff will be in-serviced on:<br>· "Advanced Directives Policy"<br><br>**4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?**<br>DNS/designee will audit 5 residents daily (Mon-Fri) x 4 weeks, then three times a week x 4 weeks, then twice a week x 4 weeks, then weekly x 3 months to ensure advanced directives are in place, completed, documented, and care planned.<br>The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.<br>**5.** | |

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| | (5) Document in the resident's clinical record whether the resident has executed an advances directive and include a copy of such directive in the clinical record...."<br><br>3.1-4(f)(4)(A)(ii) | | | |
| F 0623 SS=E Bldg. 00 | 483.15(c)(3)-(6)(8)<br>Notice Requirements Before Transfer/Discharge<br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility | | | |

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| | would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or<br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br>(i) The reason for transfer or discharge;<br>(ii) The effective date of transfer or discharge;<br>(iii) The location to which the resident is transferred or discharged;<br>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;<br>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and | | | |

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| | (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice.<br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). | | | |
| | Based on interview and record review, the facility failed to provided written transfer and discharge notice and notify the Ombudsman of discharges/transfers for 4 of 4 residents reviewed for transfer and discharge notice (Residents 24, 21, 27 and 26).<br><br>Findings include:<br><br>1. Resident 21's clinical record was reviewed on 8/25/22 at 10:39 a.m. Current diagnosis include, but were not limited to chronic obstructive | F 0623 | **1. What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?**<br>Resident's 24, 21, 27, and 26 have returned to the facility. Transfer/discharge paperwork will be sent to the Ombudsman.<br>**2. How other residents having the potential to be affected by the same deficient** | 09/25/2022 |

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| | pulmonary disease (COPD) and diabetes mellitus.<br><br>Review of Minimum Data Set (MDS) assessment records indicated the resident was discharged from the facility with an anticipated return on 4/5/22 and 6/6/22.<br><br>The clinical record lacked documentation of the resident or their representative being given a transfer and discharge notice for the 4/5/22 and 6/6/22 hospitalizations.<br><br>2. Resident 24's clinical record was reviewed on 8/22/22 at 1:51 p.m. Current diagnoses included, but were not limited to, bladder cancer, chronic obstructive pulmonary disease, and diabetes mellitus.<br><br>Review of Minimum Data Set (MDS) assessment records indicated the resident was discharged from the facility with an anticipated return on 6/6/22 and 6/18/22.<br><br>The clinical record lacked documentation of the resident or their representative being given a transfer and discharge notice for the 6/6/22 and 6/18/22 hospitalizations.<br><br>3. Resident 26's clinical record was reviewed on 8/22/22 at 1:51 p.m. Current diagnoses included, but were not limited to, diabetes mellitus and end stage renal disease.<br><br>Review of Minimum Data Set (MDS) assessment records indicated the resident was discharged from the facility with an anticipated return on 6/11/22.<br><br>The clinical record lacked documentation of the resident or their representative being given a | | **practice will be identified and what corrective action will be taken.**<br>Any residents who is being transferred/discharged has the potential to be affected by the alleged deficient practices. DNS/designee will audit all residents who discharge from the facility to ensure transfer discharge paperwork is included in the discharge and notification is sent to the Ombudsman at the beginning of the month for the previous month.<br>**3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br>DNS/designee will audit all discharged residents in the last 30 days by 09/25/22 to ensure discharge documentation is sent with the resident, ombudsman is notified, and documents are in residents' chart.<br>All licensed clinical staff will be in-serviced on:<br>· Transfer/discharge policy<br><br>**4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put in place?**<br>DHS/designee will audit 5 discharged residents daily (Mon-Fri) x 4 weeks, then three times a week x 4 weeks, then | |

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| | transfer and discharge notice for the 6/11/22 hospitalization.<br><br>4. Resident 27's clinical record was reviewed on 8/23/22 at 11:26 a.m. Current diagnoses included, but were not limited to, schizophrenia and seizure disorder.<br><br>Review of Minimum Data Set (MDS) assessment records indicated the resident was discharged from the facility with an anticipated return on 4/12/22 and 6/13/22.<br><br>The clinical record lacked documentation of the resident or their representative being given a transfer and discharge notice for the 4/12/22 and 6/13/22 hospitalizations.<br><br>During an interview, on 8/29/22 at 11:33 a.m., the DON indicated the facility had no transfer discharge notice paperwork, nor verification of Ombudsman notification of discharge, for any of the 2022 hospitalizations for Resident 21, 24, 26 or 27.<br><br>A current, 8/2022, facility policy titled "Hospital Discharge/Transfer", provided by the DON on 8/30/22 at 1:10 p.m., indicated the following: "...Nursing will complete an emergency transfer observation and attach copies of...Notice of Transfer/Discharge...."<br><br>3.1-12(a)(6)(A) | | twice a week x 4 weeks, then weekly x 3 months to ensure transfer/discharge documents are included in the discharge packet and Ombudsman is notified.<br>The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends, and continued recommendations for process monitoring and improvement until 100% compliance is achieved. | |
| F 0636 SS=D Bldg. 00 | 483.20(b)(1)(2)(i)(iii)<br>Comprehensive Assessments & Timing<br>§483.20 Resident Assessment<br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of | | | |

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| | each resident's functional capacity.<br><br>§483.20(b) Comprehensive Assessments<br>§483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:<br>(i) Identification and demographic information<br>(ii) Customary routine.<br>(iii) Cognitive patterns.<br>(iv) Communication.<br>(v) Vision.<br>(vi) Mood and behavior patterns.<br>(vii) Psychological well-being.<br>(viii) Physical functioning and structural problems.<br>(ix) Continence.<br>(x) Disease diagnosis and health conditions.<br>(xi) Dental and nutritional status.<br>(xii) Skin Conditions.<br>(xiii) Activity pursuit.<br>(xiv) Medications.<br>(xv) Special treatments and procedures.<br>(xvi) Discharge planning.<br>(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).<br>(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.<br><br>§483.20(b)(2) When required. Subject to the | | | |

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| | timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.<br>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)<br>(iii)Not less than once every 12 months.<br>Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS) assessments were completely and accurately completed for 2 of 2 resident's reviewed for accurate MDS admission assessments (Residents 97 & E).<br><br>Findings include:<br><br>1. Resident 97's clinical record was reviewed on 8/24/22 at 12:03 p.m. Current diagnosis included but were not limited to, schizoaffective disorder, schizophrenia, anxiety, and hallucinations. The resident was admitted to the facility on 8/4/22.<br><br>Review of an 8/8/22, Admission/Medicare 5 day, Minimum Data Set (MDS) assessment indicated section C-Cognitive Patterns-Brief Interview for Mental Status nor section D-Mood/Resident Mood Interview were not completed.<br><br>Progress notes during the MDS assessment period included, but were not limited to, the following: | F 0636 | **1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br>Resident 97 & E MDS will review and corrected.<br>**2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.**<br>All residents have the potential to be affected by the alleged deficient practices.<br>MDS/designee will audit all new admissions in last 30 days to ensure they are completed and are accurate.<br><br>**3. What measures will be put in place or what systemic changes will be made to** | 09/25/2022 |

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| | 155690 | A. BUILDING 00<br>B. WING | 08/30/2022 |

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| ENVIVE OF ANDERSON | 1821 LINDBERG RD<br>ANDERSON, IN 46012 |

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| | a. An 8/8/2022 3:47 a.m., Skilled Charting Note indicated, "Resident has no c/o [complaints of] pain. They are alert. Oriented to person. Oriented to place. Oriented to time. No change in cognitive status. No behaviors observed this shift.... No new orders today. Resident is A&O able to voice wants & needs with clear speech. denies pain/discomfort. resident had no complications/exacerbations to any medical diagnosis this shift. call light within reach."<br><br>b. An 8/7/2022, 8:48 p.m., Skilled Charting Note indicated, "Resident has no c/o pain. They are alert. Oriented to person. Oriented to place. Oriented to time. No change in cognitive status. No behaviors observed this shift. ...[name] is receiving skilled care for: Cardiovascular conditions, Endocrine conditions, Resident noted to have an extensive psychiatric history with diagnosis of Schizoaffective disorder, bipolar disorder, Schizophrenia, Anxiety/Depression and Hallucinations. Resident is currently noted to be pleasant and cooperative with staff. Speech is clear and easily understood, is able to make wants and needs known without difficulty. No hallucinations/delusions or delirium noted at this time."<br><br>c. An 8/6/2022, 3:31 p.m., Skilled Charting Note indicated-" They are alert. Oriented to person. Oriented to place. Oriented to time. No change in cognitive status. No behaviors observed this shift. ... Resident is currently noted to be pleasant and cooperative with staff. Speech is clear and easily understood, is able to make wants and needs known without difficulty. No hallucinations/delusions or delirium noted at this time." | | **ensure that the deficient practice does not recur?**<br>MDS/designee will review all new admissions (Mon-Fri) to ensure all MDS assessments are completed and accurate.<br>MDS will be in-serviced on:<br>· RAI manual for completion/accuracy<br><br>**4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put in place?**<br>MDS/designee will audit 5 residents daily (Mon-Fri) x4 weeks, then three times a week x4 weeks, then twice a week x4 weeks, then weekly x3 months to ensure MDS assessments are being completed and documented accurately and timely<br><br>The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. | |

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| | d. An 8/6/2022, 10:20 a.m. Skilled Charting Note indicated "Resident is currently noted to be pleasant and cooperative with staff. Speech is clear and easily understood, is able to make wants and needs known without difficulty. No hallucinations/delusions or delirium noted at this time. ...Resident exhibiting symptoms of anxiety/depression. ...Speech is clear and easily understood, is able to make wants and needs known without difficulty. "<br><br>During an interview, on 8/26/22 at 1:03 p.m., the DON indicated Resident 97's 5-Day MDS assessment sections C and D were not completed due to the facility not having a Social Services Director during this period of time.<br><br>2. Resident E's clinical record was reviewed on 8/29/22 at 1:39 p.m. Current diagnoses included, but were not limited to, end stage renal disease, insulin dependent diabetes mellitus, diabetic retinopathy, dependence on renal dialysis, long term use of insulin, and hallucinations. The record indicated the resident was admitted to the facility on 8/8/22.<br><br>Review of an 8/12/22, Admission/Medicare 5-day, MDS assessment indicated section C-Cognitive Patterns-Brief Interview for Mental Status nor section D-Mood/Resident Mood Interview were not completed.<br><br>Progress notes during the MDS assessment period included, but were not limited to, the following:<br><br>a. An 8/9/2022, 10:02 p.m., Skilled Charting Note indicated, "Resident has no c/o pain. They are alert. Oriented to person. Oriented to place. No change in cognitive status. No behaviors | | | |

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| | observed this shift."<br><br>b. An 8/9/2022 ,1:15 a.m., Incident Note indicated, "Nurse called to pt [patient] room by CNA with report pt laying on floor. When arrived, pt laying on R [right] side next to bed. Pt A&O x 3 [alert and orients times 3], stated she was getting out of bed to make breakfast and slid of the side to the floor. "<br><br>c. An 8/8/2022, 9:54 p.m., Admission Summary indicated, "New resident admitted to room...this shift. DNR status. Resident is confused at baseline, but is alert x2 to self and location. Resident is incontinent of bowel and bladder, wears briefs. Foley catheter pulled prior to admission, has not voided yet. Orders per discharging provider ok to anchor foley if no post void for 24 hours. Bladder scanned at 7:30 pm and was 0. Resident has a hx of heart failure, COVID, Parkinson's and stroke on July 30. Resident has hemodialysis with a R sided subclavian port. head to toe completed. Heart sounds normal, no abnormal sounds heard. Lung sounds slightly diminished..."<br><br>During an interview on 8/30/22 at 10:03 a.m., the DON indicated Resident E's 5 Day MDS assessment section C and D were not completed due to the facility not having a Social Services Director during this period of time.<br><br>Review of a current, 8/2022, facility policy titled "MDS Assessments", provided by the DON on 8/30/22 at 12:34 p.m., indicated the following:<br><br>"...The MDS coordinator and IDT [Intra disciplinary team] will complete Medicare MDS assessments following the guidelines for documentation a completion as outlined...." | | | |

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| | 3.1-31(c)(3)<br>3.1-31(c)(7)<br>3.1-31(c)(12) | | | |
| F 0645<br>SS=D<br>Bldg. 00 | 483.20(k)(1)-(3)<br>PASARR Screening for MD & ID<br>§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.<br><br>§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:<br>(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services; or<br>(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. | | | |

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| | §483.20(k)(2) Exceptions. For purposes of this section-<br>(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.<br>(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-<br>(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,<br>(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and<br>(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.<br><br>§483.20(k)(3) Definition. For purposes of this section-<br>(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).<br>(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. | | | |
| | Based on interview and record review, the facility failed to ensure PASRR (Preadmission Screening and Resident Review) assessments were | F 0645 | **1. What corrective actions will be accomplished for those residents found to have been** | 09/25/2022 |

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| | completed for 1 of 3 residents reviewed for PASRR assessments (Resident 3).<br><br>Findings include:<br><br>Resident 3 was admitted to the facility on 5/26/22 from another nursing home. She had a Level of Care Determination assessment completed on 11/24/21, with approval for 120 days of skilled nursing care for a short term stay. The approval end date was 3/24/22.<br><br>Review of Resident 3's clinical record was completed on 8/23/22 at 3:10 p.m. Diagnoses included, but were not limited to, schizoaffective disorder, anxiety and major depressive disorder.<br><br>During an interview on 8/24/22 at 11:22 a.m., the Administrator indicated he was aware the short term Level of Care (LOC) had expired and a PASRR screening had not been completed. The resident was on a list of those in need of these assessments. The facility Social Service Director had left employment with the facility and had not completed the applications.<br><br>Review of a current facility policy titled, "Indiana PASRR," revised 8/2022 and provided by the Director of Nursing (DON) on 8/30/22 at 12:55 p.m., indicated the following:<br><br>"...SNF {Skilled Nursing Facility} to SNF Transfer...For patient's transferring to your center from another SNF request the Level I and Level of Care outcome letters from the current SNF...."<br><br>3.1-16(d)(1)(A)<br>3.1-16(d)(1)(B) | | **affected by the deficient practice?**<br>PASRR assessments will be completed for resident 3<br>**2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.**<br>All residents have the potential to be affected by the alleged deficient practice.<br>SS/designee will audit all current residents for completion of PASRR assessments by 09/25/2022. Any issues noted will be addressed immediately.<br>**3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br>SS/designee will review new resident's charts during clinical meeting (Mon-Fri) to ensure all PASRR assessments are completed<br>Social Service staff will be in-serviced on:<br>o "PASSR assessment policy"<br><br>**4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?**<br>SS/designee will audit 5 residents daily (Mon-Fri) x4 weeks, then three times a week x4 weeks, | |

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| | | | then twice a week x4 weeks, then weekly x3 months to ensure PASRR assessments are being completed and documented.<br><br>The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. | |
| F 0684<br>SS=G<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>Based on observation, interview, and record review, the facility failed to clarify an insulin order, administer needed insulin, and monitoring blood sugar levels, for a resident with a diagnoses of insulin dependent diabetes mellitus who also received hemodialysis. This deficient practice resulted in the resident experiencing 19 days without insulin administration or blood sugar monitoring and a blood sugar reading of greater than 500 (five hundred) and being admitted to the hospital. The facility also failed to administer insulin as ordered; failed to maintain a wound vac | F 0684 | **F684 - Quality of Care**<br>"Based on observation, interview, and record review, the facility failed to clarify an insulin order, administer needed insulin, and monitoring blood sugar levels, for a resident with a diagnosis of insulin dependent diabetes mellites who also received hemodialysis. This deficient practice resulted in the resident experiencing 19 days | 09/25/2022 |

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| | as ordered. This deficient practice resulted in redness and swelling at the wound site and increased pain for the resident; The facility also failed to obtain weights as ordered for a resident with congestive heart failure for 4 of 15 residents reviewed for provision of nursing services. (Residents E, B, G and F)<br><br>Findings include:<br><br>1. During an 8/29/22, 3:41 p.m., interview Resident E's spouse indicated the resident was an insulin dependent diabetic and received renal dialysis. She had received insulin daily at home. While at home, she received Lantus at a set amount and Humolog per sliding scale daily. After his wife had been at the facility approximately 19 days he realized he had never seen her have any blood sugar checks or receive any insulin. He continued that although his wife has confusion, she was at times reliable. When he asked his wife if they checked her blood sugar, she indicated no. He then on 8/27/22 (a Saturday) went to the nurse at the station and told them he was concerned his wife had not had accu-checks since admission. He further indicated the nurse at the station told him they would let the doctor know, however nothing would most likely be done until Monday because it was a weekend. This troubled him and he considered what he should do. The next morning 8/28/22, he brought his wife her blood sugar monitoring device from home and checked her blood sugar. His wife tested at a blood sugar level of 560 on the home device. He promptly got a nurse who check the resident's blood sugar and obtained a result of "500 and some". The facility notified the doctor and the resident was given 10 units of insulin immediately. The resident was put on insulin daily that day 8/28/22, 19 days after her admission. He indicated the facility only became | | without insulin administration or blood sugar monitoring and a blood sugar reading of greater than 500 and being admitted to the hospital. The facility also failed to administer insulin as ordered; failed to maintain a wound vac as ordered. This deficient practice resulted in redness and swelling at the wound site and increased pain for the resident; the facility also failed to obtain weights as ordered for a resident with congestive heart failure for 4 of 15 residents reviewed for provision of nursing services."<br>**1. What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?**<br>Affected resident's orders will be reviewed and confirmed with MD. Affected residents will be assessed head to toe and MD notified of any issues immediately.<br>**2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.**<br>All residents with diabetes, CHF or wound vacs have the potential to be affected by the alleged deficient practice<br>DNS/designee will audit all current diabetics, wound vacs and CHF residents by 09/25/22 to ensure orders are in place and completed | |

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| | aware of the problem with no insulin being given and no blood sugar test after he brought the error to the facility's attention.<br><br>Resident E's clinical record was reviewed on 8/29/22 at 1:39 p.m. Current diagnoses included, but were not limited to, end stage renal disease, insulin dependent diabetes mellitus, diabetic retinopathy, dependence on renal dialysis, long term use of insulin, and hallucinations. The record indicated the resident was admitted to the facility on 8/8/22.<br><br>An 8/28/2022 ,11:15 a.m., Nurses Note indicated "Resident's husband to front Nurses station visibly upset states that he checked his wife's blood sugar with her home glucometer because he thought it might be high due to her behavior. Per the Resident's husband her blood sugar was 560. Writer to Resident's room and observed Resident sitting up in wheelchair with eyes open, noted to be very pleasant and cooperative with staff. Resident able to tell Writer her name, date of birth and Husband's name, unable to tell Writer month or year or where she was which is baseline for Resident. Speech is clear and easily understood. No signs or symptoms of hyperglycemia noted. Writer used facility glucometer to check blood sugar at this time and obtained an accu-check reading of 506. Vital signs 133/65, 70, 18, 98.0, 18. No signs or symptoms of distress noted. Writer returned to Nurses station and contacted the On Call Practitioner and received new orders for Humalog 100 unit/ml solution 10 units to be administered subcutaneously x1 dose NOW. Staff to perform accu-check 1 hour after administration of Humalog 10 unit x1 dose NOW. If blood sugar continues to be over 400 contact Practitioner on call for further orders. New order received for accu-checks before meals and at bedtime with | | and documented per physician order.<br>**3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br>DNS/designee will review MARS daily during clinical meeting (Mon-Fri) to ensure insulin, weights, and wound treatment orders have been completed and documented per physician order.<br>All licensed clinical staff will be in-serviced on:<br>o “Skin/Wound Policy”<br>o “Insulin administration policy”<br>o “Weights policy”<br>o “Change in condition policy”<br>o “Physician’s orders policy”<br><br>**4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?**<br>DHS/designee will audit 5 residents with wounds, 5 diabetics, and 5 diagnosed with CHF daily (Mon-Fri) x4 weeks, then three times a week x4 weeks, then twice a week x4 weeks, then weekly x3 months to ensure all orders, wound treatments, and daily weights are in place and being completed and documented as ordered.<br>The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director | |

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| | Humalog sliding scale as directed. Writer to Resident's room immediately with Humalog 10 units and administered subcutaneously to the right upper extremity. Resident tolerated well. Resident's husband in room and made aware of all new orders. Resident's husband expressed appreciation for the quick actions of the facility. Call light is within easy reach. Will continue to monitor."<br><br>An 8/28/2022, 12:15 p.m. Nurses Note indicated "Writer to Resident's room to perform follow up accu-check. Resident is sitting in wheelchair with lunch tray in front of her eating. Writer advised Resident again of new order and requested permission to perform accu-check, which Resident allowed without incident. Blood sugar noted to be 392 at this time. Vital signs obtained 130/60, 66, 17, 97.9, 96% on room air. Resident is not noted to be exhibiting signs or symptoms of hyperglycemia at this time. No signs or symptoms of distress noted. Call light is within easy reach."<br><br>The resident had a current, 8/28/22, physician's order for:<br>"HumaLOG Solution 100 UNIT/ML (Insulin Lispro)<br>Inject as per sliding scale:<br>if 0 - 69 Notify Practitioner;<br>70 - 150 = 0 Units;<br>151 - 200 = 2 Units;<br>201 - 250 = 4 Units;<br>251 - 300 = 6 Units;<br>301 - 350 = 8 Units;<br>351 - 400 = 10 Units;<br>401+ 401+ Notify Practitioner, subcutaneously before meals and at bedtime for Hyperglycemia."<br><br>Resident E's medication administration record from 8/8/22 to 8/27/22 indicated the resident did | | for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. | |

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| | not receive any insulin or accu-checks for this nineteen (19) day period of time.<br><br>The resident had the following blood sugar results recorded in her record after the 8/28/22 10:45 a.m. result of 506:<br>8/28/22, 12:03 p.m.-392<br>8/28/22, 4:25 p.m.-258<br>8/28/02, 10:01 p.m.-400<br>8/29/22, 10:06 a.m.-275<br><br>The resident had a current 8/16/22, care plan problem/need regarding a diagnosis of diabetes mellitus and a risk for complications. Approaches to this need included diabetes medication as ordered and monitor for hyperglycemia.<br><br>The resident had an 8/12/22 (this test was completed after 3 days without receiving insulin) Hemoglobin A1C (cumulative blood sugar test) laboratory test result of 6.5 High, range 4.8-5.9%.<br><br>An 8/8/22 hospital discharge summary indicated the resident was to "continue these medications which have not changed...Send copy of sliding scale commonly known as Humalog insulin. Last time this was given was August 8, 2022, 12:21 p.m."<br><br>The resident had an 8/4/22, hospital progress note which indicated the following:<br>",,,Active Problems:<br>...Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene, with long -term current use of insulin<br>...Mild nonproligerative diabetic retinopathy of both eyes associated with type 2 diabetes mellitus ESRD [end stage renal disease]...<br>Assessment /Plan:<br>...5, Diabetes mellitus, insulin dependent. The | | | |

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| | patient will be placed on Humalog weight-based sliding scale, and we would defer any long-acting insulin at present. blood sugar 154, 244..."<br><br>Resident progress notes from her 8/8/22 admission to 8/30/22 included, but were not limited to the following:<br><br>a. An 8/9/2022, 1:15 p.m., Incident Note indicated "Nurse called to pt room by CNA with report pt [patient] laying on floor. When arrived, pt laying on R side next to bed. Pt A&O x 3, [alert and oriented times 3] stated she was getting out of bed to make breakfast and slid of the side to the floor..."<br><br>b. An 8/9/2022, 10:02 p.m., Skilled Charting Note General Assessment indicated, "Resident lethargic has slept most of the shift."<br><br>c. An 8/13/2022, 10:15 a.m., Skilled Charting Note General Assessment indicated, "Resident is alert and oriented to person with confusion to time, place and situation noted. Speech is mumbling in nature, incoherent at times, tangential thought processes noted, does not answer questions appropriately if at all. ... Staff has replaced resident's oxygen via nasal cannula multiple times this shift, as Resident continues to choose to remove cannula...."<br><br>d. An 8/27/2022, 1:19 a.m., Skilled Charting Note General Assessment indicated "Delusions present. Resident noted climbing out of bed around on matt & floor staff & writer assisted resident back into bed several time throughout the night. resident noted digging bowel from her brief laying bowel onto floor into individual groupings naming them & having conversation with each group of bowel. staff attempted several times to | | | |

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| | clean bowel off resident & under nails the resident refused care."<br><br>e. An 8/28/2022, 3:38 a.m., Behavior Note indicated, "Resident alert with baseline confusion. no s/s of pain or distress at this time. resident crawled out of bed & witnessed crawling down the hall. writer & staff assisted resident into wheel chair took her to foyer area activity & snacks provider to resident. resident allowed staff at that time to provide nail care. resident is happy & without behaviors at this time."<br><br>f. An 8/30/2022, 6:00 a.m., Nurses Note Incomplete Documentation [late entry] indicated "Resident lethargic during patient care. Resident easily aroused when called by name. Assisted resident with daily ADLS and breakfast set up. Resident goes into a deeper sleep where there is snoring present. Writer verbally calls out to resident by name, resident responds without issue. Writer checks BS d/t resident being a diabetic. Bs [blood sugar]WNLs [within normal limits] (around 240) coverage was given. Resident sent to dialysis where she became unresponsive, Resident sent to [name] hospital for evaluation and was later admitted."<br><br>During an observation on 8/25/22 at 9:06 a.m., Resident E was in her room seated in a wheelchair, eyes closed, chin to chest. The resident's husband continually poked her in the arm and asked in a loud voice for her to open her eyes and look at him. The resident would occassionally stir slightly, but did not open her eyes.<br><br>During an 8/29/22, 4:00 p.m., interview, the DON indicated the facility did not administer insulin to Resident from 8/8/22 to 8/28/22 when the problem was identified by her spouse. The facility was | | | |

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| | looking into the issue to prevent future concerns.<br><br>A professional resource titled "Hyperglycemia in diabetes" found at the Mayo Clinic web site "https://ww.mayoclinic,org/disease-conditions/hyperglycemia/symptoms-causes/syc-20373631" indicated the following:<br>"Long-term Complications keeping blood sugar in a healthy range can help prevent many diabetes-related complications. Long-term complications of hyperglycemia that isn't treated include:<br>Cardiovascular disease<br>Nerve damage (neuropathy)<br>Kidney damage (diabetic nephropathy) or kidney failure<br>Damage to blood vessels of the retina (diabetic retinopathy) that could lead to blindness'<br>Feet problems caused by damaged nerves or poor blood flow that can lead to serious skin infection, ulcerations and, in some cases, amputation<br>Bone and joint problems<br>Teeth and gum infection<br>...If blood sugar raises very high or if blood sugar levels are not treated, it can lead to two serious conditions.<br>Diabetic ketoacidosis...when fat is broken down for energy in the body, it produces toxic acids called ketones....If it isn't treated, diabetic ketoacidosis can lead to a diabetic coma that can be life threatening...<br>Hyperosmolar hyperglycemic state...if you develop this condition, your body can't use either glucose or fat for energy....can lead to life-threatening dehydration and coma."<br><br>A current, 8/2022, facility policy titled, Nursing Admission/Return Admission Policy and Procedure", which was provided by the RN Consultant on 8/30/22 at 9:29 a.m., indicated the | | | |

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| | following:<br>" 2. The admission nurse must review the pre-admission assessment, history and physical, hospital discharge summary, fall history, urinary continence prior to admission, usual bowel pattern, date of last BM, and physician orders...<br>Physician orders:<br>1. Upon admission, physician orders must be obtained.<br>2. Transcribe the admission orders from the original orders sent from the hospital or physician's office."<br><br>A current 8/2022, facility policy titled, "Blood Glucose Monitoring", indicated the following: " If the resident has not received specific blood glucose call parameters the physician will be notified of any blood glucose less that 70 or greater than 400."2. The clinical record for Resident B was reviewed on 8/26/22 at 10:26 a.m. Diagnoses included, but were not limited to, diabetes mellitus type II and history of stroke.<br><br>A health care plan, dated 3/7/22, indicated the resident had diabetes mellitus and was a risk for complications. Interventions included, but were not limited to, diabetes medication as ordered by doctor.<br><br>Review of the electronic medication administration record (eMAR) for the month of June, included, but was not limited to the following:<br><br>a. Insulin Detemir Solution (to treat diabetes) 100 units per ML (milliliter). Inject 10 units at bedtime for diabetes. The order was dated 5/21/22. The eMAR indicated "no insulin required" on 6/4/22, and lacked an entry of administration for 65/22. The clinical record lacked documentation regarding the missed insulin administration. | | | |

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| | b. Admelog SoloStar Solution (to treat diabetes) 100 units per ML. Inject per sliding scale, three times daily with meals: 80-149 = 0 units, 150-190= 2 units, 191-230 = 4 units, 231-270 = 6 units, 271-310 = 8 units, and 311-350 = 10 units. The order was dated 4/12/22.<br><br>The eMAR indicated on 6/10/22 at 12:00 p.m., the resident's blood sugar was 168. The record indicated "no insulin required."<br><br>A current facility policy, revised April 2019, titled, "Administering Medications," provided by the Nurse Consultant on 8/26/22 at 2:57 p.m., included, but was not limited to, the following:<br><br>"Policy Interpretation and Implementation....4. Medications are administered in accordance with prescriber orders...22. The individual administering the medication initials the resident's MAR {Medication Administration Record} on the appropriate line after giving each medication and before administering the next ones."<br><br>3. During an interview on 8/22/22 at 10:23 a.m., Resident G indicated she had a surgical wound on her right upper thigh due to necrotizing fasciitis and had a wound vac (appliance to treat open wounds) applied to the area. She indicated two "agency nurses" that worked over the past weekend, 8/13/22 and 8/14/22, had "neglected my wound and it's infected again." She reported that her wound vac had stopped working and the nurses had not done anything for her. The wound vac remained in place all weekend without working.<br><br>During an interview on 8/25/22 at 2:20 p.m., RN 1 indicated Resident G's wound vac stopped working the weekend of 8/13/22 and 8/14/22. The | | | |

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| | agency nursing staff working the 500 hall failed to notify the physician or the Director of Nursing and had not removed the wound vac and place a wet-to-dry dressing. On 8/15/22, RN 1 arrived to work and was informed by the resident that the wound vac had stopped working over the weekend and was not taken care of by the nursing staff. RN 1 removed the wound vac. She indicated the wound was warm, red, and swollen. The resident had a temperature. She called the nurse practitioner and received an order for an antibiotic and immediate (STAT) lab work, and reapplied the wound vac. The wound vac had difficulty remaining sealed due to the increased swelling. Prior to weekend the residents wound was managed and improving.<br><br>Resident G's clinical record was reviewed on 8/28/22 at 1:44 p.m. Diagnoses included, but were not limited to, necrotizing fasciitis of the right upper leg, diabetes mellitus type 2, and nicotine dependence/cigarettes.<br><br>A physicians order, dated 7/30/22, and discontinued 8/18/22, indicated to cleanse right thigh wound with hibiclens, then pack with lightly moistened kerlix, secure with kerlix and apply mesh briefs or other snug fitting garment to secure dressing for comfort. Do not use tape.<br><br>A skilled charting note, dated 8/12/22 included, but was not limited to, "Wound vac in place to R {right} upper thigh/groin wound and functioning appropriately."<br><br>The clinical record lacked an order physician notification regarding the wound vac during the weekend of 8/13/22 and 8/14/22.<br><br>A skilled charting note, dated 8/16/22, indicated | | | |

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the resident's temperature was 100.6.

A nurses note, dated 8/16/22 at 7:35 a.m., indicated the resident was tearful and reporting right lower extremity pain to touch. Her temperature was 100.6. Facility physician was contacted provided the following orders:
a. STAT labs including complete blood count and comprehensive metabolic profile.
b. Keflex (antibiotic) 500 mg (milligram), every 8 hours for 7 days.

A nurses note, dated 8/16/22 at 12:10 p.m., indicated the resident had no fever following Tylenol administration. The resident's wound vac had to be changed three times in the last 24 hours.

During an interview on 8/25/22 at 3:00 p.m., the Director of Nursing indicated the agency nurses who worked the weekend of 8/13/22 and 8/14/22 should have reported the wound vac had not been functioning to the physician or herself, but she had not been contacted.

During an interview on 8/26/22 at 9:40 a.m., the Wound Care Physician indicated she had not been notified of the wound vac malfunction on the weekend of 8/13/22-8/14/22 or the need for antibiotics due to increased swelling and redness, until her follow-up visit on 8/19/22 when she performed wound rounds at the facility. She updated wound orders at that time to include wet-to-dry dressing orders in case the wound vac failed.

4. The clinical record for Resident F was reviewed on 8/24/22 at 10:19 a.m. Diagnoses included, but were not limited to, diastolic congestive heart failure, shortness of breath and edema. The resident admitted to the facility on 5/4/22.

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A current physician's order, dated 5/5/22, indicated the resident was to be weighed weekly for four weeks, then monthly and as needed.

A current health care plan, dated 5/9/22, indicated the resident had altered cardiovascular status related to hypertension. Interventions included, but were not limited to, monitor/document/report as needed any changes in lung sounds on auscultation, edema, and changes in weight.

The clinical record indicated the following weights:
a. On 5/4/22 (on admission), the resident weighed 279 pounds.

b. On 5/24/22, the resident weighed 291.9 pounds, a 12.9 pound gain (4.62%) in 20 days.

c. On 7/5/22 315.5 pounds, a 23.6 pound gain (8.08%) in 42 days and a gain of 36.5 pounds (13.08%) in two months.

d. On 8/2/22 316.7 pounds, a 37.7 pound gain (13.51%) in three months.

The clinical record lacked physician notification of the weight gains.

During an interview on 8/29/22 at 2:35 p.m., the Director of Nursing (DON) indicated resident had an order for weekly weights x 4, then monthly and results were not present in the medical record. The facility progress notes lacked notification of physician notification of weight gains.

A current facility policy, revised 8/2022, titled, "Resident Change of Condition," provided by the Nurse Consultant on 8/30/22 at 11:02 a.m.,

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| | included, but was not limited to, the following:<br><br>"Policy<br>It is the policy of this facility that all changes in the resident's condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place."<br><br>This Federal tag relates to Complaints IN00388147.<br><br>3.1-37(a)<br>3.1-37(b) | | | |
| F 0689 SS=D Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>A. Based on observation, interview, and record review, the facility failed to assess a newly admitted resident for the risk of elopement (Resident 97).<br><br>B. Based on observation, interview, and record review, the facility failed to complete smoking assessments for a resident who smoked for 2 of 2 residents reviewed for accidents (Resident G).<br><br>Findings include:<br><br>A. During a random observation, on 8/22/22 11:36 a.m., Resident 97 was walking in the hallway | F 0689 | **F689 Free of Accident Hazards/Supervision/Devices**<br>*"Based on observation, interview, and record review, the facility failed to assess a newly admitted resident for the risk of elopement (Resident 97)."*<br>*"Based on observation, interview, and record review, the facility failed to complete smoking assessments for a resident who smoked for 2 of 2 residents reviewed for accidents (Resident G).* | 09/25/2022 |

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| | pulling a rolling suitcase.<br><br>During a random observation, on 8/23/22 at 8:25 a.m., facility staff were noted walking about the facility grounds, looking around in all directions.<br><br>Resident 97's clinical record was reviewed on 8/24/22 at 12:03 p.m. Current diagnosis included but were not limited to, schizoaffective disorder, schizophrenia, anxiety, and hallucinations. The resident had been admitted to the facility within the previous 30 days.<br><br>An 8/8/22, Admission/Medicare 5-day, Minimum Data Set (MDS) assessment did not have sections Section C-Cognitive Patterns-Brief Interview for Mental Status or section D-Mood/Resident Mood Interview completed.<br><br>A Late Entry Nurses Note, dated for 8/23/2022 at 8:15 a.m., indicated the following: "At approximately 8:15 am resident was able to exit facility through side door, staff was alerted to door alarm and responded immediately. Resident was noted in back parking lot, staff had resident in sight and was able to maintain safety until other staff arrived and was able to return resident back to facility with out incident/injury. This writer performed skin assessment and found no new areas. Notified family, provider, and HFA [Healthcare Facility Administrator]. Order received to place resident on 1:1 and to contact adult psych unit for evaluation."<br><br>An 8/25/2022 at 8:08 p.m., Behavior Note indicated the following: "Resident attempted to exit building down 200 hall. Staff was with her and able to eventually redirect her, but resident did push on door, triggering alarm. Door did not open, resident was with staff the entire time. ED, DON notified." | | **1. What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?**<br>· Resident 97 no longer resides in facility<br>· Resident G smoking status assessment completed, and care plan updated<br><br>**2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken**<br><br>· All new residents have the potential to be affected by the alleged deficient practice.<br>· DNS/designee will audit all current residents for elopement risk by 09/25/2022 anyone found to be at risk will have care plan reviewed to ensure appropriate preventative measures are in place.<br>· DNS/designee will audit all current smokers to ensure assessments are up to date by 09/25/22 care plans will be reviewed to ensure appropriate interventions are in place.<br><br>**3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** | |

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| ENVIVE OF ANDERSON | 1821 LINDBERG RD<br>ANDERSON, IN 46012 |

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| | Review of progress notes dated 8/4/22 to 8/23/22 (when the resident exited the building and staff followed) indicated, but were not limited to, the following:<br><br>a. An 8/21/2022 at 4:27 p.m., Skilled Charting Note indicated, "Resident exhibiting symptoms of anxiety/depression.... Noted to have an extensive psychiatric history with diagnosis of Schizoaffective disorder, schizophrenia, bipolar depression, depression and anxiety and hallucinations. Resident noted to frequently be talking to herself or carrying on a conversation with someone who isn't there."<br><br>b. An 8/21/2022 at 12:59 p.m., Skilled Charting Note indicated, " Noted to have an extensive psychiatric history with diagnosis of Schizoaffective disorder, schizophrenia, bipolar depression, depression and anxiety and hallucinations. Resident noted to frequently be talking to herself or carrying on a conversation with someone who isn't there. "<br><br>c. An 8/20/2022 at 5 :41 p.m., Behavior Note indicated, "Resident noted to be sitting in chair in common area of main lobby by herself. Resident is noted to be carrying on a conversation with herself, answering herself using a different tone of voice. Conversation is not noted to be 'violent or heated' in nature. Resident is not exhibiting signs or symptoms of distress related to or during said conversation. Will continue to monitor."<br><br>d. An 8/20/2022 at 4:46 p.m., Skilled Charting Note indicated, " Resident exhibiting symptoms of anxiety/depression... Noted to have an extensive psychiatric history with diagnosis of Schizoaffective disorder, schizophrenia, bipolar | | · All licensed clinical staff will be in-serviced on:<br>o "Elopement risk policy"<br>o "Smoking policy"<br>**4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?**<br>· DNS/designee will audit 5 new residents daily (Mon-Fri) x4 weeks, then three times a week x4 weeks, then twice a week x4 weeks, then weekly x3 months to ensure elopement and smoking assessments are completed and documented as ordered.<br>The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved<br>**5. Date of completion:**<br>09/25/2022 | |

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| | depression, depression and anxiety and hallucinations. Resident noted to frequently be talking to herself or carrying on a conversation with someone who isn't there."<br><br>e. An 8/20/2022 at 11:17 a.m., Skilled Charting Note indicated "Resident exhibiting symptoms of anxiety/depression...Resident noted to frequently be talking to herself or carrying on a conversation with someone who isn't there."<br><br>f. An 8/18/2022 at 9:18 a.m. note titled "COMMUNICATION - with Physician" indicated "Situation: Resident complaining of auditory hallucinations. She states she hears the business office manager calling her 'in my head' calling her to come to the office. Background: Resident has diagnosis of schizophrenia, schizoaffective disorder, and anxiety... Resident is agitated, expressing frustration, stomping across the lobby of the facility. She comes to business office multiple times daily, expressing that she is hearing the manager calling her...Recommendations: New order from psych NP [Nurse Practitioner] to increase olanzapine [an anti-psychotic medication] to 10 mg [every night],...Psych NP will see her on 8/24/22 if she is still admitted."<br><br>g. An 8/16/2022 at 9:11 a.m., Behavior Note indicated, "BOM [Business Office Manager] reports resident has been coming in and out of her office repeatedly over the last few days. Reports she consistently states to the BOM she is reporting to her per the BOM request. BOM states she did not request her to come to her office. Resident pulling her suitcase around stating she is ready to leave when she is allowed to. Resident does not show exit seeking behaviors."<br><br>h. An 8/15/2022 at 11:06 p.m., Skilled Charting | | | |

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| | Note indicated, "The resident has behavior regulation deficits. The resident needs extra time with conversations...Res has been observed talking to herself and answering as well. Although resident has been seen sitting near the entrances and doors she has never been reported or witnessed in attempting to exit or open the exterior doors of the building."<br><br>i. An 8/15/2022 at 10:11 p.m., Skilled Charting Note indicated "Resident exhibiting symptoms of anxiety/depression."<br><br>j. An 8/14/2022 at 6:25 p.m., Skilled Charting Note indicated "Resident noted to frequently be talking to herself or carrying on a conversation with someone who isn't there. Is noted to frequently sit by the doors, as though waiting on someone, but makes no attempts to open doors or leave. Resident's daughter visited this evening. Notable decrease in 'behaviors listed above' noted. "<br><br>k. An 8/14/2022 at 9:56 a.m., Skilled Charting Note indicated, "Resident exhibiting symptoms of anxiety/depression...Resident noted to frequently be talking to herself or carrying on a conversation with someone who isn't there. Is noted to frequently sit by the doors, as though waiting on someone, but makes no attempts to open doors or leave."<br><br>l. An 8/12/2022 at 11:50 p.m., Skilled Charting Note indicated, "Resident wondered up & down the halls this shift with rolling suitcase does not seem to be exit seeking, seems pleasant & happy to be here at this facility. resident is laying in her bed at this time. call light within reach."<br><br>m. An 8/7/2022 at 8:48 p.m., Skilled Charting Note indicated, "Resident exhibiting symptoms of | | | |

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anxiety/depression..."

The resident's admission assessment had a section of the assessment labeled elopement assessment and was left blank.

The clinical record lacked an elopement risk assessment completed anytime from admission through 8/23/22, when the resident exited the facility.

The record lacked a care plan for potential elopement risk, including the resident pulling her suit case or sitting near the door for long periods of time.

Review of a current, 3/2019 facility policy titled, "Wandering and Elopement," provided by the RN Consultant on 8/26/2022 at 12:57 p.m., indicated the following:

"...The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents...1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include stratifies and interventions to maintain the resident's safety...."B. Resident G's clinical record was reviewed on 8/28/22 at 1:44 p.m. Diagnoses included, but were not limited to, necrotizing fasciitis and nicotine dependence/cigarettes.

The resident had an 8/5/22 care plan which indicated her desire to use tobacco products. Interventions included, but were not limited to, complete a smoking assessment.

During an interview, on 8/26/22 at 2:30 p.m., the Nurse Consultant indicated the facility had not

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| | completed a smoking assessment for Resident G. The assessment should have been completed on admission.<br><br>Review of a current facility policy, revised July 2017, titled "Smoking Policy-Residents," and provided by the Nurse Consultant on 8/26/22 at 2:57 p.m., indicated the following:<br><br>"...Policy Interpretation and Implementation...6. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include:...d. Ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation)....7. The staff shall consult with the Attending Physician and the director of Nursing Services to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation...."<br><br>3.1-45(a)(1)<br>3.1-45(a)(2) | | | |
| F 0698 SS=D Bldg. 00 | 483.25(l)<br>Dialysis<br>§483.25(l) Dialysis.<br>The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>Based on interview and record review, the facility failed to provided pre- and post-dialysis nursing services and/or maintain a dialysis communication for 2 of 3 residents reviewed for dialysis care (Residents 2 and 17).<br><br>Findings include: | F 0698 | **F698 Dialysis**<br>*"Based on interview and record review, the facility failed to provide pre- and post-dialysis nursing services and/or maintain a dialysis communication for 2 of 3 residents reviewed for dialysis* | 09/25/2022 |

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| | 1. During an interview, on 8/23/22 at 10:00 a.m., Resident 2 indicated she believed she received dialysis on Tuesday, Thursday and Saturday. However, if today was Tuesday, she didn't think she went today. She then indicated she was confused about her dialysis day.<br><br>Resident 2's clinical record was reviewed on 8/25/22 at 11:26 a.m. Current diagnoses included, but were not limited to, diabetes mellitus, end stage renal disease, and Alzheimer's disease.<br><br>The resident had the following current physicians orders related to renal dialysis:<br><br>"Res [resident] receives Dialysis M/W/F [Monday/Wednesday/Friday] at [provider's name and address] resident is transported via [hospice provide] pick up at 5:30 a.m." This order originated 8/3/2022.<br><br>"Apply lidocaine cream provided by dialysis center to left fistula and wrap with plastic wrap one time a day every Monday, Wednesday and Friday. The Lidocaine cream is in dialysis bag." This order originated 5/25/22 and the scheduled days of the week were the resident's current dialysis days.<br><br>"Obtain vital signs and write in dialysis book every night shift every Tuesday, Thursday, Sunday for Dialysis." This order originated 4/25/22. The days of the week for the assessment did not reflect the resident's current dialysis days.<br><br>"Post-Dialysis: Assess thrill/bruit. [an assessment to monitor for heavy bleeding from dialysis] Chart + if present and - if absent. Notify dialysis center if absent. Assess access site and document N for | | *care (Residents 2 and 17)."*<br>**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?**<br>· Residents 2 and 17 were assessed pre- and post- dialysis nothing abnormal was noted.<br>**2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.**<br>· All dialysis residents have the potential to be affected by the alleged deficient practice.<br>· DNS/designee will audit all dialysis residents by 09/25/2022 to ensure orders for pre and post dialysis assessments are in place and dialysis communication binder is in place.<br>**3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br>· All licensed clinical staff will be in-serviced on:<br>o "Dialysis assessment policy"<br>o "Dialysis Coordination/Facility Services Policy"<br>**4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?**<br>· DNS/designee will audit 5 dialysis residents daily (Mon-Fri) | |

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| | normal, B for s/sx [signs/symptoms] bleeding, or I for s/sx infection and notify dialysis for bleeding or s/sx infection. Assess cognition and document A for alert, C for confused, or D for disoriented. every day shift every Monday, Wednesday, Friday for dialysis" This order originated 5/13/22 and the days of the week reflected the residents current dialysis days.<br><br>"Pre-Dialysis: Assess thrill/bruit. Chart + if present and - if absent. Notify dialysis center if absent. Assess access site (SPECIFY LOCATION/TYPE) and document N for normal, B for s/sx bleeding, or I for s/sx infection and notify dialysis for bleeding or s/sx infection. Assess cognition and document A for alert, C for confused, or D for disoriented. every night shift every Tuesday, Thursday, Sunday for dialysis." This order originated 5/13/22 and the days of the week listed did not reflect the resident's current dialysis days.<br><br>Review of the resident's medication and treatment/assessment administration record for 8/1/22 through 8/24/22 indicated the following:<br><br>a. The resident's Pre-Dialysis Assessment was listed to be completed on Tuesday, Thursday and Sunday (in conflict with the resident's current dialysis days). The record was blank or had the code to see progress notes for all days of the month.<br><br>The clinical record lacked indication Pre-Dialysis Assessments had been completed at any time during the month of August 2022.<br><br>b. Lidocaine-Prilocain Cream (a topical pain medication), to be applied topically at the dialysis site and cover with plastic wrap before the | | x4 weeks, then three times a week x4 weeks, then twice a week x4 weeks, then weekly x3 months to ensure pre and post dialysis assessments completed and documented per orders and dialysis binder is in place and communication documented.<br>The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.<br><br>**5. Date of completion:**<br>09/25/2022 | |

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| | resident leaves for dialysis on Tuesday, Thursday, and Sunday. These days were in conflict with the resident's current dialysis schedule of Monday, Wednesday and Friday. The topical pain medication was not documented as administered on Monday, Wednesday or Friday at any time during August 2022.<br><br>The pain medication was documented as having been administered 9 days when the resident did not receive dialysis during August 2022: 8/4/22, 8/7/22, 8/11/22, 8/14/22, 8/16/22, 8/18/22, 8/21/22 and 8/23/22.<br><br>The medication and treatment administration notes from 8/1/22 to 8/25/22 indicated the resident did not receive a treatment/assessment because it was not the resident's dialysis days:<br><br>a. Thursday, 8/25/2022 at 4:50 a.m. Orders - Administration Note: Pre-Dialysis: Assessment was not completed. "Res [resident] does not attend dialysis on this date."<br><br>b. Tuesday, 8/23/2022 at 4:05 a.m., Orders - Administration Note: Pre-Dialysis: Assessment was not completed. "Res does not have dialysis on this date."<br><br>c. Sunday, 8/21/2022 at 5:51 a.m., Orders - Administration Note: Pre-Dialysis: Assessment was not completed. "Resident has dialysis Monday morning."<br><br>d. Friday, 8/18/2022 at 4:06 a.m., Orders - Administration Note: Pre-Dialysis: Assessment was not completed. "No dialysis on this date."<br><br>e. Tuesday, 8/16/2022 at 7:24 a.m., Orders - Administration Note: Pre-Dialysis: Assessment | | | |

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| | was not completed. "Resident does not have dialysis on this date."<br><br>f. Sunday, 8/14/2022 at 5:22 a.m., Orders - Administration Note: Pre-Dialysis: Assessment was not completed. "Res does not have dialysis on this date."<br><br>g. Thursday, 8/11/2022 at 8:21 a.m., Orders - Administration Note: Pre-Dialysis: Assessment was not completed, "Res is not scheduled for dialysis on this date."<br><br>h. Tuesday, 8/9/2022 at 8:10 a.m., Orders - Administration Note: Pre-Dialysis: Assessment was not completed. "Res does not receive dialysis this date."<br><br>The record lacked documentation of attempts made to clarify or change the assessment to the correct days.<br><br>Review of Resident 2's dialysis log for 7/25/22 to 8/24/22 contained only three communication log sheets of 11 to 13 scheduled dialysis appointments. The resident had declined dialysis on 8/8/22.<br><br>During an interview, on 8/25/22 at 2:13 p.m., the DON indicated when a nurse discovered the resident was scheduled to receive a topical pain medication, pre-dialysis assessments and or post dialysis assessment on a day which conflicted with their dialysis days, the nurse should seek a clarification order in order to ensure the medication and treatment record reflected the correct days. She indicated the nurses had not done so when they identified the contradiction. The facility had no assessments to provide for the days that were blank on the medication and | | | |

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| | treatment record. The was no documentation to show the resident received her topical pain medication prior to dialysis. There were no additional dialysis communication forms available for the period of time from 7/25/22 to 8/24/22. 2. Resident 17's clinical record was reviewed on 8/29/22 at 10:08 a.m. Diagnoses included, but were not limited to, end stage renal disease and dependence on renal dialysis. The record indicated the resident went for dialysis treatments every Tuesday, Thursday, and Saturday.<br><br>A Minimum Data Set (MDS) assessment, dated 7/29/22, indicated the resident received dialysis and was cognitively intact.<br><br>A review of the resident's dialysis binder, used to communicate between the facility and the dialysis provider, lacked documentation of dialysis visits since 8/11/22 (visits on 8/13/22, 8/18/22, 8/20/22, 8/23/22, 8/25/22, and 8/27/22).<br><br>A current facility policy titled "Dialysis,"revised 8/2022 and provided by the Director of Nursing on 8/29/22 at 12:38 p.m., indicated the following: "...Purpose...To provide communication to Dialysis Providers and monitoring of resident receiving dialysis. Procedures...4. A report (may be written or verbal) shall be requested from the Dialysis Provider that will alert the community regarding: a. Tolerance to procedure, b. vitals signs, c. medications administered, d. other information deemed necessary for ongoing provision of care...."<br><br>3.1-37(a) | | | |
| F 0726<br>SS=D<br>Bldg. 00 | 483.35(a)(3)(4)(c)<br>Competent Nursing Staff<br>§483.35 Nursing Services | | | |

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| | The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.<br><br>§483.35(c) Proficiency of nurse aides.<br>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br>Based on observation and interview, the facility failed to ensure staff was trained to properly to manage a physician prescribe wound vacuum for 1 of 1 residents reviewed for non-pressure skin conditions. (Resident G)<br><br>Findings included: | F 0726 | **F726 Competent Nursing Staff**<br>*"Based on observation and interview, the facility failed to ensure staff was trained to properly manage a physician prescribed wound vacuum for 1 of 1 resident reviewed for non-pressure skin conditions* | 09/25/2022 |

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| | During an interview, on 8/22/22 at 10:23 a.m., Resident G indicated she had a surgical wound on her right upper thigh due to necrotizing faciitis and had a wound vacuum (appliance to treat open wounds) applied to the area. She indicated two "agency nurses" had worked over the past weekend, 8/13/22 and 8/14/22, and had "neglected my wound and it's infected again." She reported her wound vacuum had stopped working and the nurses had not done anything for her. The non-functioning wound vacuum had remained in place all weekend.<br><br>During an interview, on 8/25/22 at 2:20 p.m., RN 1 indicated Resident G's wound vacuum stopped working the weekend of 8/13/22 and 8/14/22. The agency nursing staff working the hall failed to notify the physician or the Director of Nursing and had not removed the wound vacuum and placed a wet-to-dry dressing. On 8/15/22, RN 1 arrived to work and was informed by the resident that the wound vacuum had stopped working over the weekend and was not taken care of by the nursing staff. RN 1 removed the wound vacuum and the wound was warm, red, and swollen. The resident had a temperature. She called the nurse practitioner and received an order for an antibiotic and immediate (STAT) lab work, and reapplied the wound vacuum. The wound vacuum had difficulty remaining sealed due to the increased swelling. The weekend prior, the resident's wound was managed and improving.<br><br>Resident G's clinical record was reviewed on 8/28/22 at 1:44 p.m. Diagnoses included, but were not limited to, necrotizing fasciitis of the right upper leg, diabetes mellitus type 2, and nicotine dependence/cigarettes.<br><br>A physicians order, dated 7/30/22 and | | *(Resident G)."*<br>**1. What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?**<br>· Wound vac was discontinued from resident G and new wound care orders were provided. No other resident has a wound vac<br>**2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.**<br>· All residents with wound vacs have the potential to be affected by the alleged deficient practice.<br>· All residents with wound vacs reviewed and no deficiencies noted.<br>**3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br>· All licensed clinical staff will be in-serviced on:<br>o "Skin/Wound Policy"<br>o Wound vac training provided by AMT wound care manufacturer with hands on competency check offs.<br>· DNS/Designee will observe and complete competences weekly until all nurses pass with 100%.<br>· DNS/Designee will provide wound vac competency training | |

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| | 155690 | A. BUILDING 00<br>B. WING | 08/30/2022 |

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| | discontinued 8/18/22, indicated to cleanse right thigh wound with hibiclens, then pack with lightly moistened kerlix, secure with kerlix and apply mesh briefs or other snug fitting garment to secure dressing for comfort. Do not use tape.<br><br>The clinical record lacked an order regarding the wound vacuum during the weekend of 8/13/22 and 8/14/22.<br><br>A skilled charting note, dated 8/12/22 indicated, but was not limited to, "Wound vac in place to R {right} upper thigh/groin wound and functioning appropriately."<br><br>A skilled charting note, dated 8/16/22, indicated the resident's temperature was 100.6.<br><br>A nurses note, dated 8/16/22 at 7:35 a.m., indicated the resident was tearful and reporting right lower extremity pain to touch. Her temperature was 100.6. The physician was contacted and provided the following orders:<br><br>a. STAT labs including complete blood count and comprehensive metabolic profile.<br>b. Keflex (antibiotic) 500 mg (milligram), every 8 hours for 7 days.<br><br>A nurses note, dated 8/16/22 at 12:10 p.m., indicated the resident's wound had to be changed three times in the last 24 hours.<br><br>During an interview, on 8/26/22 at 9:40 a.m., the Wound Care Physician indicated she had not been notified of the wound vac malfunction on the weekend of 8/13/22-8/14/22 or the need for antibiotics due to increased swelling and redness, until her follow-up visit on 8/19/22 when she performed wound rounds at the facility. | | with licensed clinical staff upon hire and annually thereafter.<br>· DNS/designee will provide quarterly wound vac refresher training.<br><br>**4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?**<br>· DNS/designee will perform wound vac observations on 5 residents with wound vacs daily (Mon-Fri) x4 weeks, then three times a week x4 weeks, then twice a week x4 weeks, then weekly x3 months to ensure wound treatments are in place and being completed and documented as ordered.<br>· DNS/designee will audit all licensed clinical staff weekly x4 weeks, then biweekly x2 months, then monthly x 3 months to ensure wound vac training completed for all current and newly hired licensed clinical staff. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.<br>**5. Date of completion:**<br>09/25/2022 | |

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| | During an interview on 8/30/22 at 12:55 p.m., the DON indicated there was no orientation provided or required for agency staff working in the facility.<br><br>No policy was provided prior to exit of survey.<br><br>NOT IN STATE RULE | | | |
| F 0744 SS=D Bldg. 00 | 483.40(b)(3)<br>Treatment/Service for Dementia<br>§483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.<br>Based on observation, interview, and record review, the facility failed to identify and monitor targeted behaviors or develop non-chemical interventions for the reduction or elimination of antipsychotic medications for 1 of 1 residents reviewed for dementia services (Resident 45).<br><br>Findings include:<br><br>During an observation on 8/23/22 at 10:23 a.m., Resident 45 was asleep in bed, facing the window.<br><br>During an observation on 8/25/22 at 9:36 a.m., the resident was in bed in his room. The room was dark. The TV was on.<br><br>During an observation on 8/26/22 at 9:19 a.m., the resident was resting calmly in bed.<br><br>During an observation on 8/30/22 at 1:36 p.m., the resident was resting calmly in bed.<br><br>During random observations on 8/22/22, 8/23/22, | F 0744 | **F744 Treatment/Service for Dementia**<br>*"Based on observation, interview, and record review, the facility failed to identify and monitor targeted behaviors or develop non-chemical interventions for the reduction or elimination of antipsychotic medications for 1 of 1 resident reviewed for dementia services (Resident 45)."*<br>**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?**<br>· A pharmacy review will be requested of resident's medications to determine the possibility of GDR of any psychotropic medications. Behavior monitoring and non-chemical interventions will be | 09/25/2022 |

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| | 8/24/22, 8/25/22, 8/26/22, 8/29/22 and 8/30/22, the resident was not observed displaying maladaptive behaviors.<br><br>Resident 45's clinical record was reviewed on 8/25/22 at 10:29 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, delirium, chronic kidney disease, and dementia with behavioral disturbances. The resident was admitted to the facility on 8/1/22.<br><br>The resident had a current, 8/1/22, physician's order for ziprasidone (anti-psychotic) 40 mg- take 1 tablet two times daily for Alzheimer's disease and dementia with behavioral disturbances.<br><br>An 8/5/22 Medicare 5-Day Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired, received an antipsychotic daily, and had not displayed any maladaptive behaviors during the assessment period.<br><br>The clinical record lacked any documented maladaptive behaviors since admission, lacked documentation of any identified targeted behavior being treated by the antipsychotic medication.<br><br>He had a current, 8/8/22, care plan problem/need regarding delusions related to Alzheimer's disease and delirium. Approaches to this problem included, but were not limited to, Behavior Monitoring Program as indicated.<br><br>He had a current, 8/8/22, care plan problem/need regarding the use of an antipsychotic medications and is at risk for complications. Approaches to this problem included, but were not limited to, monitor/record occurrence of for target behavior symptoms and document per facility protocol. | | implemented.<br>**2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.**<br>· All residents using antipsychotics have the potential to be affected by the alleged deficient practice.<br>· SS/designee will audit all residents that use antipsychotic medication to ensure behavior monitoring and non-chemical interventions are in place.<br>**3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br>· All licensed clinical staff will be in-serviced on:<br>o "Behavior Assessment/Monitoring"<br>**4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?**<br>· SS/designee will audit 5 residents receiving antipsychotics daily (Mon-Fri) x4 weeks, then three times a week x4 weeks, then twice a week x4 weeks, then weekly x3 months to ensure behavior assessment/monitoring and non-pharmacologic interventions are in place.<br>The results of these audits will be reviewed by the QAPI committee | |

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| | The record lacked any resident specific non-chemical interventions for psychotic or maladaptive behaviors.<br><br>During an interview, on 8/25/22 at 10:11 a.m., the DON indicated the facility had not identified targeted behaviors being treated with the antipsychotic medication, nor was there a method of behavior monitoring in place. She indicated she believed the resident was placed on the medication in the hospital due to delirium. She believed the medication had not been identified as an antipsychotic upon admission.<br><br>Review of a current facility policy titled, "Behavior Assessment/Monitoring," dated August 2022, provided by the RN Consultant on 8/30/22 at 12:18 p.m., indicated the following:<br><br>"...The facility will provide and residents will receive behavioral health services as needed to attain the highest practicable physical, mental and psychosocial well-being...<br><br>6. The facility will comply with regulatory requirements related to the use of medications to manage behavioral changes...<br><br>a. Appropriate assessment and treatment of behavioral symptoms requires differentiating between behavioral symptoms that can be managed by treating underlying factors, and those that cannot.<br>...Interventions and approaches will be based on a detailed assessment...<br><br>d. Targeted and individualized interventions...<br><br>10. When medications are prescribed for | | overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.<br><br>**5. Date of completion:**<br>09/25/2022 | |

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| | behavioral symptoms, documentation will include:...<br><br>b. Potential underlying causes for behavior.<br><br>e. Specific target behaviors and expected outcome...."<br><br>3.1-37(a) | | | |
| F 0759 SS=D Bldg. 00 | 483.45(f)(1)<br>Free of Medication Error Rts 5 Prcnt or More<br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br>Based on observation, interview and record review, the facility failed to administer medications according to manufacturers guidelines and as ordered by the physician, resulting in an 8.33% medication error rate (Resident 4 and 39).<br><br>Findings include:<br><br>1. During a medication administration observation, on 8/25/22 at 9:06 a.m., RN 1 prepared medications for Resident 4, including a hydroxyzine hydrochloride 50 mg tablet, and administered the medication. She then asked the resident if she wanted her "nervous pill" and the resident indicated she did. The nurse removed another hydroxyzine hydrochloride 50 mg tablet and prepared to administer the medication to the resident. During an interview, at the time of the observation, RN 1 indicated she had not realized she had already administered the hydroxyzine hydrochloride, as she usually gave the medication without checking, because Resident 4 continually requested the medication each morning. She | F 0759 | **F759 Free of Medication Error Rts 5% or More**<br>Based on observation, interview, and record review the facility failed to administer medications according to manufacturer's guidelines and as ordered by the physician resulting in an 8.33% medication error rate (Resident 4 and 39).<br>**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?**<br>Residents 4 and 39 were immediately assessed and no issues were noted. MD was made aware of situation and no new orders noted<br>**2: How other residents having the potential to be affected by the same deficient practice will** | 09/25/2022 |

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| | should not have administered an "as needed medication" prior to assessing the resident's need for the medication.<br><br>RN 1 then obtained a Levemir FlexTouch pen, applied a new needle, and dialed a dose of five units. During an interview, at the time of the observation, RN 1 indicated she had not been educated regarding the need to prime the insulin needle. She proceeded to press the administration button dispensing the five units with the pen pointed down towards the floor. She indicated she was unsure how many units to perform the priming procedure with, so she just used what was there. She dialed five units again and proceeded to administer the medication to the resident.<br><br>Review of Resident 4's clinical record indicated the following orders: hydroxyzine hydrochloride (a medication to treat anxiety) 50 mg (milligram), one tablet every 24 hours as needed for anxiety and Levemir FlexTouch (insulin pen to treat diabetes), administer five units one time a day for diabetes mellitus.<br><br>During an interview on 8/25/22 at 10:49 a.m., the Director of Nursing (DON) indicated she was unaware of a procedure to prime a needle on an insulin pen. She provided documentation, titled, "Levemir FlexTouch," which indicated the following:<br><br>"...For each injection: 1. Select a dose of 2 units...3. With the pen pointing up, tap the insulin to move the air bubbles to the top. 4. Press the button all the way in and make sure insulin comes out of the needle...5. Check that the dose counter shows "0" after the safety test...." | | **be identified and what corrective action will be taken.**<br>All residents have the potential to be affected by the alleged deficient practice.<br>DNS/designee immediately educated the identified staff in regard to manufactures guidelines and self-administration<br>**3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br>DNS/designee will audit random med passes daily (Mon-Fri) to ensure medications are administered per manufacturer's directions and not by residents unless all appropriate measures are in place.<br>All licensed clinical staff will be in-serviced on:<br>o "Administering Medications policy"<br>o "Self-administration of medication Policy"<br>**4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?**<br>DHS/designee will audit 5 residents during med passes daily (Mon-Fri) x4 weeks, then three times a week x4 weeks, then twice a week x4 weeks, then weekly x3 months to ensure medications are administered per manufacturer's directions and | |

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| | 2. During a medication administration observation, on 8/26/22 at 8:38 a.m., QMA 9 prepared medications to administer to Resident 39 and then handed the resident a fluticasone propionate suspension bottle. The resident inserted the tip into her right nostril and pumped the applicator two times while breathing in through her nose. The resident switched to her left nostril and pumped the applicator two times while breathing in through her nose.<br><br>Review of Resident 39's clinical record indicated the following physician's order: fluticasone propionate suspension (to treat seasonal allergies) 50 mcg/act (micrograms per action) one spray in each nostril daily for allergic rhinitis.<br><br>During an interview with QMA 9 at the time of administration, she indicated she was unsure if the resident had been assessed for self-administration of medication for the nasal spray.<br><br>During an interview on 8/26/22 at 2:30 p.m., the Nurse Consultant indicated the resident had not been assessed for self-administration of the nasal spray.<br><br>Review of a current facility policy titled, "Administering Medications," revised April 2019 and provided by the Nurse Consultant on 8/26/22 at 2:57 p.m., indicated the following:<br><br>"...Policy Interpretation and Implementation...10. The individual administering the medication checks the label THREE (3) times to verify...right dosage....27. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the | | appropriate items are in place for self-administration.<br>The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. | |

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| | decision-making capacity to do so safely...."<br><br>3.1-48(c)(1) | | | |