STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING 00 B. WING	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00		F 0000		

This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00417109 and IN00418378.

Complaint IN00417109 - Federal/State deficiencies related to the allegations are cited at F677.

Complaint IN00418378 - Federal/State deficiencies related to the allegations are cited at F684, F842 and F849.

Survey dates: September 25, 26, 27, 28 and 29, 2023

Facility number: 000149
Provider number: 155245
AIM number: 100266840

Census Bed Type:
SNF: 6
NF: 35
Total: 41

Census Payor Type:
Medicare: 6
Medicaid: 35
Total: 41

These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.

Quality review completed on October 6, 2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Guthrie	DON	10/18/2023

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

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F 0565 SS=D Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other			

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	residents in the facility. Based on interview and record review, the facility failed to ensure grievances were addressed and followed up timely for 1 of 1 residents reviewed for grievances and 12 of 12 residents attended in a resident council meeting. (Residents' 3, 7, 8, 9, 14, 18, 19, 23, 25, 31, 32, 39) Findings include: 1. The clinical record for Resident 39 was reviewed on 9/27/23 at 11:00 a.m. The resident's diagnosis included, but was not limited to, stroke. Resident 39 was admitted to facility on 7/21/23. An interview was conducted with Resident 39 and Family Friend 22 on 9/27/23 at 11:06 a.m. They indicated Resident 39 was missing 2 blankets since admission on July 2023. The first blanket that had been brought in on admission was sent to laundry and never has returned. A second blanket was brought in and sent to laundry and it also has not been returned. The resident was on his third blanket. After discussion with the former Administrator about the missing blankets he reported the laundry supervisor was on medical leave, and the laundry was mixed up. There was no other discussion about if the blankets would be looked for by the Administrator. The discussion with the Administrator was weeks ago. An interview was conducted with the Director of Nursing (DON) and Executive Director (ED) on 9/27/23 at 3:41 p.m. The ED nor the DON indicated they were unaware of Resident 39's missing blankets. The ED indicated he did not have any grievances as he should of Resident 39's missing blankets. If they were unable to be found; the facility would replace. This incident had happened prior to the current ED taking over the building.	F 0565	1. Immediate action(s) taken for the resident(s) found to have been affected include: An Ad Hoc Resident Council meeting was held where the residents invited the administrator. At that time, the administrator updated the residents on grievance/concern processes and communicating resolutions. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Inservice education was conducted with all staff by the Director of Nursing Services (DON) on 10/11/2023. Proper procedures for addressing resident concerns/grievances were discussed. Individual education was completed with the Activity Director, on 10/17/2023, regarding taking concerns from resident council, follow-up related to the concern, and communication of concern resolution. 4. How the corrective action(s) will	10/24/2023

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	The laundry supervisor was on medical leave. An interview was conducted with ED, DON, Resident 39, and Family Friend 22 on 9/27/23 at 3:50 p.m. Family Friend 22 and Resident 39 indicated Family Friend 22 had spoken to Maintenance Director about the missing blankets that day. He was able to locate 1 of the missing blankets. At this time, the resident was only missing 1 cream blanket. 2. During a resident council meeting conducted on 9/26/23 at 2:00 p.m., the council indicated they were not receiving snacks. The Resident Council President (Resident 23) indicated after reading the resident council minutes from July, August and September, the concerns that was discussed about the availability of snacks have repeatedly been mentioned in resident council meetings. The July 2023, August 2023, and September 2023 resident council minutes were provided by the Activities Director on 9/26/23 at 2:53 p.m. The following minutes indicated the discussions the residents reporting concerns with not receiving snacks: The July 2023 resident council minutes indicated the residents were not getting snacks at 4:00 p.m. The kitchen would "make snack bags and give to nursing staff to pass out..." The August 2023 resident council minutes indicated "residents asked again for snacks to be passed at 4:00 p.m." The grievance indicated resolution "dietary to put snacks in nutrition pantry daily and nursing will pass snacks as necessary." The July 2023 and August 2023 resident council		be monitored to ensure the practice will not recur: The administrator or designee will monitor grievance process by reviewing new, outstanding, and resolved Grievances daily, Monday through Friday. Indefinitely. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: 10/24/2023	

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	grievances regarding the availability of snacks was not followed up on with resident council to ensure it was addressed. An interview was conducted with the Director of Nursing (DON) and Executive Director (ED) on 9/27/23 at 3:50 p.m. They indicated the former ED was not following up with residents and/or resident council concerns to ensure the grievances were addressed. 3.1-3(l)			
F 0582 SS=A Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per			

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	diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on interview and record review, the facility failed to issue NOMNC (Notices of Medicare Non Coverage) to 2 of 2 residents reviewed for beneficiary notification. (Residents 248 and 249) Findings include: The Entrance Conference Worksheet Beneficiary Notice Residents Discharged Within the Last Six Months form indicated Resident 248 and Resident 249 were discharged home with benefit days	F 0582	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident # 248 and 249 have been discharged. 2. Identification of other residents having the potential to be affected was accomplished by:	10/24/2023

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	remaining. The completed SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review forms for Resident 248 and Resident 249 were provided by the BOM (Business Office Manager) on 9/25/23 at 2:56 p.m. 1. The review form for Resident 248 indicated his Medicare Part A services started on 6/17/23; the last covered day of services was 7/2/23; and he was not issued a NOMNC. The 6/29/23 physician progress note indicated, Resident 248 was planning for discharge. Resident 248 was to discharge with orders for physical and occupational therapy for strength training and skilled nursing for disease management, education and medication assistance. Aide for ADL (Activities of Daily Living) assist. Home health is necessary for safe transition home. Pt. continues to require assistive device/s and taxing effort to travel from the home. Medications reconciled; prescriptions sent to pharmacy of choice . Patient instructed to follow up with PCP (Primary Care Provider) next available. Resident verbalized understanding of all discharge instructions. Discharge order written. A nursing note dated 7/2/23 indicated, Resident 248's discharge summary was completed and signed by the resident. Also, a three day supply of medication per request sent with resident. 2. The review form for Resident 249 indicated his Medicare Part A services started on 5/4/23; the last covered day of services was 5/19/23; and he was not issued a NOMNC.		The facility has determined that residents with a qualifying hospital stay and Medicare Part A benefit days available have the potential to be affected. 2. Actions taken/systems put into place to reduce the risk of future occurrence include: The Administrator educated the following personnel on the facility's NOMNC policy: Business Office Manager, Social Services Director, MDS Coordinator, Director of Nursing, and Rehabilitation Program Manager on 10/19/2023. 3. How the corrective action(s) will be monitored to ensure the practice will not recur: The Social Service Director, or designee, will conduct a random audit of residents weekly for four (4) consecutive weeks to verify that notices were issued timely and appropriately. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: 10/24/2023	

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	The 5/19/2023 Social Services note indicated, Resident 249 discharged home today with home health. A nursing note dated 5/19/2023 at 2:25 p.m. indicated, Resident 249 was discharged home and his wife picked him up at 11 a.m. An interview was conducted with the BOM on 9/29/23 at 12:56 p.m. She indicated, both Resident 248 and 249 should have received NOMNC notices. She stated, the former Social Services Director, who was in charge of issuing the NOMNC forms failed do so prior to the residents discharge. 3.1-4(f)(3)			
F 0607 SS=C Bldg. 00	483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care			

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	facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. Based on interview and record review, the facility failed to have written procedures for investigating abuse, neglect, misappropriation, and exploitation that included providing complete and thorough documentation of the investigation. This affected 41 of 41 residents in the facility. Findings include: The clinical record for Resident 41 was reviewed on 9/27/23 at 3:07 p.m. Her diagnoses included, but were not limited to, chronic obstructive pulmonary disease, fibromyalgia, and major depressive disorder. She discharged from the facility on 6/27/23. On 9/27/23 at 11:40 a.m., the DON (Director of Nursing) provided the 5/26/23 reportable incident report for Resident 41. It read, "Brief Description of Incident...[Name of Resident 41] stated that a staff member was tired the other day. And that we were all tired the other day. [Name of Resident 41] stated that they all looked a little tired. This morning [name of Resident 41] was asleep in her room. A female entered her room. [Name of Resident 41] was not able to identify her, and this	F 0607	1. Immediate action(s) taken for the resident(s) found to have been affected include: The facility's policy for reporting allegations of abuse/neglect/exploitation revised to include "complete and thorough documentation". 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The policy for reporting allegations of abuse/neglect/exploitation was reviewed and revised to ensure compliance with current state and federal regulations. An in-service was conducted by the Director of	10/24/2023

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	person was verbally coming at [name of Resident 41.] [Name of Resident 41] stated that she has a history of being abused while she is asleep. [Name of Resident 41] stated she reacts badly when people speak to her in an ill manner. [Name of Resident 41] thinks this happened because she stated to staff the other day that they were tired....Follow up added - 6/2/2023 Psycho-social support provided to resident. [Name of Resident 41] with no signs or symptoms of distress or anxiety. Statements obtained by this writer from employees and none indicate that their was verbal abuse or that anyone has witnessed abuse of any kind. All residents that reside in the same hall as resident [name of Resident 41] interviewed and none indicated that they had ever been abused or have ever seen any other resident be abused. Abuse education provided to all employees. This writer concludes that this allegation cannot be substantiated." The ED provided the investigative file into the above allegation on 9/27/23 at 3:04 p.m. The file included an interview with Resident 41 by the previous ED and 7 resident interviews regarding abuse. There were no staff interviews included in the file or evidence of the abuse training provided that was referenced in the 6/2/23 follow-up section of the 5/26/23 incident report. An interview was conducted with the ED on 9/27/23 at 3:04 p.m. He indicated this was all the evidence of the investigation that he could find. He contacted the previous ED to see if there was more and was awaiting a return call. An interview was conducted with the ED in the presence of the Administrator Consultant and DON on 9/28/23 at 11:17 a.m. The ED indicated the previous ED conducted the investigation. From		Nursing Services, on 10/11/2023, with all staff regarding this new policy. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: A thorough investigation of any allegations will be conducted, and the findings will be reported to the appropriate agencies in accordance with current facility policy. The Administrator, Director of Nursing Services, or designee will complete the investigation audit form with each reportable incident. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: 10/24/2023	

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	what he gathered, he believed the previous ED did the things he said he did in the 6/2/23 follow-up, but he was unable to locate evidence of that, including any employee statements/interviews or abuse in-service logs. They indicated they would continue to look for a policy referencing provision of complete and thorough documentation of the investigation. The Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy was provided by the DON on 9/26/23 at 11:09 a.m. It did not reference provision of complete and thorough documentation of the investigation. The Abuse Investigation and Reporting policy was provided by the ED on 9/28/23 at 10:33 a.m. It did not reference provision of complete and thorough documentation of the investigation. The Investigating Allegations of Abuse policy was provided by the ED on 9/28/23 at 12:08 p.m. It did not reference provision of complete and thorough documentation of the investigation. 3.1-28(a)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.			

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	§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to maintain documentation of a thorough investigation for 1 of 1 resident reviewed for abuse. (Resident 41) Findings include: The clinical record for Resident 41 was reviewed on 9/27/23 at 3:07 p.m. Her diagnoses included, but were not limited to, chronic obstructive pulmonary disease, fibromyalgia, and major depressive disorder. She discharged from the facility on 6/27/23. On 9/27/23 at 11:40 a.m., the DON (Director of Nursing) provided the 5/26/23 reportable incident report for Resident 41. It read, "Brief Description of Incident...[Name of Resident 41] stated that a staff member was tired the other day. And that we were all tired the other day. [Name of Resident 41] stated that they all looked a little tired. This morning [name of Resident 41] was asleep in her room. A female entered her room. [Name of Resident 41] was not able to identify her, and this person was verbally coming at [name of Resident 41.] [Name of Resident 41] stated that she has a history of being abused while she is asleep. [Name of Resident 41] stated she reacts badly when people speak to her in an ill manner. [Name of Resident 41] thinks this happened because she stated to staff the other day that they were	F 0610	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #41 no longer resides at the facility. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service was conducted by the Director of Nursing Services, on 10/11/2023 with all staff addressing circumstances that require reporting for timely investigations, and their responsibilities related to investigations. 4. How the corrective action(s) will be monitored to ensure the practice will not recur:	10/24/2023

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	tired....Follow up added - 6/2/2023 Psycho-social support provided to resident. [Name of Resident 41] with no signs or symptoms of distress or anxiety. Statements obtained by this writer from employees and none indicate that their was verbal abuse or that anyone has witnessed abuse of any kind. All residents that reside in the same hall as resident [name of Resident 41] interviewed and none indicated that they had ever been abused or have ever seen any other resident be abused. Abuse education provided to all employees. This writer concludes that this allegation cannot be substantiated." The ED provided the investigative file into the above allegation on 9/27/23 at 3:04 p.m. The file included an interview with Resident 41 by the previous ED and 7 resident interviews regarding abuse. There were no staff interviews included in the file or evidence of the abuse training provided that was referenced in the 6/2/23 follow-up section of the 5/26/23 incident report. An interview was conducted with the ED on 9/27/23 at 3:04 p.m. He indicated this was all the evidence of the investigation that he could find. He contacted the previous ED to see if there was more and was awaiting a return call. An interview was conducted with the ED and Administrator Consultant on 9/28/23 at 11:17 a.m. The ED indicated the previous ED conducted the investigation. From what he gathered, he believed the previous ED did the things he said he did in the 6/2/23 follow-up, but he was unable to locate evidence of that, including any employee statements/interviews or abuse in-service logs. The Abuse Investigation and Reporting policy was provided by the ED on 9/28/23 at 10:33 a.m. It		The Administrator, Director of Nursing Services, or designee will complete the investigation audit form with each reportable incident. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: 10/24/2023	

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	read, "Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident." 3.1-28(d)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and			

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	desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on record review and interview, the facility failed to ensure a care plan was initiated for a resident who was totally dependent on the assistance of others for ADL (Activities of Daily Living) care for 1 of 16 care plans reviewed. (Resident 12) Findings include: The clinical record for Resident 12 was reviewed on 9/28/23 at 11:31 a.m. Resident 12's diagnoses included, but not limited to, hemiplegia (paralysis of one side of body), diabetes type II, anxiety, and aphasia (loss of ability to understand or express speech) Resident 12's quarterly MDS (Minimum Data Set) dated 8/6/23 indicated, she required extensive assistance of two persons for bed mobility; totally dependent on assistance of two persons for transfers, toileting, and bathing; and totally dependent on assistance of one person for personal hygiene.	F 0656	**1. Immediate action(s) taken for the resident(s) found to have been affected include:** The care plan(s) of the resident identifier(s) RI#(s) 12 were reviewed and updated as indicated. A 100% audit was conducted for ADL care plan completion, with no other findings. 2. Identification of other residents having the potential to be affected was accomplished by:	10/24/2023

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	Resident 12's Care Plan initiated on 5/4/23 and last revised on 8/17/23 did not contain a care plan related to her total dependence for ADL care nor any interventions with the specific care and services that would be implemented. An interview with MDSC (Minimum Data Set Coordinator) conducted on 9/28/23 at 3:47 p.m. indicated, Resident 12's care plan should have contained a care plan with interventions and services to be provided for a resident who requires assistance with ADLs. A Comprehensive Person-Centered Care Plans policy received on 9/29/23 at 9:13 a.m. from DON (Director of Nursing) indicated, "A comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident...7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical mental, and psychosocial well-being... c. includes the resident's stated goals upon admission and desired outcomes... e. reflects currently recognized standards of practice for problem areas and conditions... 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change..." 3.1-35(a)		The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All interdisciplinary care plan team members responsible for writing care plans have been educated on the facility's policy and procedure for developing Comprehensive Care Plans on 10/11/2023. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinator(s). All care plans will be updated as indicated. The Director of Nursing Services (DNS), or designee, will complete random weekly audits of care plans for six (6) consecutive weeks. Random audits will be completed to ensure that comprehensive care plans are developed for residents. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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			Corrective action completion date: 10/24/2023	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to ensure care plan meetings were conducted for 1 of 1 residents reviewed for care plan meetings. (Resident 26)	F 0657	1. Immediate action(s) taken for the resident(s) found to have been affected include: An audit of care plan meetings	10/24/2023

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	Findings include: The clinical record for Resident 26 was reviewed on 9/26/23 at 12:00 p.m. The resident's diagnosis included, but was not limited to, Autistic disorder. A Quarterly MDS (Minimum Data Set) Assessment dated 7/23/23 indicated Resident 26 was moderately cognitively impaired. A care plan meeting dated 4/13/23 indicated the social worker and family attended the care plan meeting that day. An interview was conducted with Resident 26 on 9/26/23 at 12:03 p.m. He indicated he has not had a care plan meeting in a long time. An interview was conducted with the Social Services Director on 9/28/23 at 11:06 a.m. She indicated the resident's last care plan meeting was conducted in April 2023. He should have had a care plan meeting after the quarterly July 2023 MDS. 3.1-35(d)(2)(B)		was conducted with care plan meetings being scheduled in correlation with the MDS Schedule. 2. Identification of other residents having the potential to be affected was accomplished by: All residents of the facility have the potential to be affected by this practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All interdisciplinary care plan team members responsible for coordinating care plan conferences have been educated on the facility's policy and procedure related to care plan conferences on 10/11/2023. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Social Services Director, or designee, will conduct a random weekly audit of residents for a period of six (6) consecutive weeks or until all residents have a care plan scheduled to ensure that the resident/resident representative has been invited to a care conference on a regular basis (initial, quarterly etc.). This plan of correction will be	

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			monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: 10/24/2023	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview and record review, the facility failed to provide the necessary services to maintain good grooming and personal hygiene for a resident who was unable to carry out activities of daily living by not ensuring twice weekly showers/complete bed baths for 2 of 3 residents and at least weekly hair washing for 1 of 3 residents reviewed for activities of daily living (ADLs). (Residents 12 and 26) Findings include: 1. The clinical record for Resident 12 was reviewed on 9/28/23 at 11:31 a.m. Resident 12's diagnoses included, but not limited to, hemiplegia (paralysis of one side of body), diabetes type II, anxiety, and aphasia (loss of ability to understand or express speech) Resident 12's quarterly MDS (Minimum Data Set) dated 8/6/23 indicated, she required extensive assistance of two persons for bed mobility; totally dependent on assistance of two persons for	F 0677	1. Immediate action(s) taken for the resident(s) found to have been affected include: A shower/Bed bath with shampooing of hair was provided for resident(s) #_12 and 26 on 09/27/2023. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service was conducted by the Director of Nursing Services	10/24/2023

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	transfers, toileting, and bathing; and totally dependent on assistance of one person for personal hygiene. An interview with Resident 12's husband was conducted on 9/26/23 at 3:48 p.m. He indicated, his wife, Resident 12, was not receiving showers/complete bed baths at least twice weekly. Resident 12's bathing sheets for August and September 2023 were provided by DON (Director of Nursing) on 9/27/23 at 2 p.m. The bathing sheets indicated, Resident 12 received a bed bath on the following dates: 8/1; 8/11; 8/18; 9/8; 9/12; 9/19; 9/21; and 9/22. None of the shower sheets indicated, Resident 12 received a shower during August or September of 2023. An interview with DON conducted on 9/28/23 at 3:18 p.m. indicated, she was unable to locate any additional bathing sheets for Resident 12 during the months of August and September 2023. She further stated, showers or complete bed baths should be done at least twice weekly or per the residents' preference. 2. The clinical record for Resident 26 was reviewed on 9/26/23 at 12:00 p.m. The resident's diagnosis included, but was not limited to, Autistic disorder. A Quarterly MDS (Minimum Data Set) Assessment dated 7/23/23 indicated Resident 26 was moderately cognitively impaired. The resident was a total dependence with 1 staff person for bathing and personal hygiene. A September 2023 shower schedule indicated Resident 26 was to receiving showers on day shift Wednesdays and Saturdays.		with all direct care staff addressing shower schedules, documentation, and completion of shower sheets, and what to do if a resident refuses a shower/bed bath on 10/11/2023. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services, or designee, will conduct an audit 2 times weekly X 1 month, then weekly X 2 months, to assure shower/bed bath/hair washing completion or until substantial compliance is achieved or as otherwise determined by the Risk Management/Quality Assurance Committee. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: 10/24/2023	

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	An observation was made of Resident 26 on 9/26/23 at 11:59 a.m. The resident's hair was observed greasy and his face was unkempt with food splatter around his mouth and eyes had yellow substance on eyelashes. An interview was conducted with Resident 26 on 9/26/23 at 12:00 p.m. He indicated he does not receive hair washings. The following days in August 2023 and September 2023, the resident had not receive bathing that included hair washing: August: 8/9/23, 8/12/23, 8/16/23, 8/26/23, 8/30/23, September: 9/2/23, 9/6/23, 9/9/23, and 9/27/23. An interview was conducted with the Director of Nursing on 9/27/23 at 2:00 p.m. She indicated she was unable to provide any additional shower sheets that included hair washing for Resident 26. An observation was made of Resident 26 on 9/28/23 at 3:09 p.m. Resident 26's hair was observed to be greasy and had white flaky substance in it. A Supporting Activities of Daily Living (ADLs) policy received on 9/29/23 at 9:13 a.m. from DON indicated, "Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish...Appropriate care and services will be provided for residents who are unable to carry out ADLs independently...including appropriate support and assistance with: a. hygiene(bathing, dressing, grooming, and oral care)... 7. The resident's response to interventions will be monitored, evaluated and revised as appropriate."			

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	This Federal tag relates to complaint IN00417109. 3.1-38(a)(2) 3.1-38(a)(3) 3.1-38(b)(2)			
F 0684 SS=G Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed: to provide routine suprapubic catheter care and to provide routine nephrostomy tube care to a resident, resulting in a hospitalization for sepsis, acute kidney injury, and UTI (urinary tract infection) associated with his nephrostomy catheter for 1 of 3 residents reviewed for urinary catheter care (Resident 36); and ensure the residents' medications were administered as ordered for 2 of 6 residents reviewed for unnecessary medications (Resident 23 and Resident 32). Findings include: 1. The clinical record for Resident 36 was reviewed on 9/26/23 at 2:00 p.m. His diagnoses included, but were not limited to: metastatic prostate cancer, bladder cancer, deep vein thrombosis, type 2 diabetes, and hypertension. He	F 0684	1. Immediate action(s) taken for the resident(s) found to have been affected include: On 9/29/2023, Nephrostomy care orders were obtained from NP for resident 36. NP completed head to toe assessment on 9/29/2023 of resident 36 with no acute findings. Nephrostomy care completed. On 9/29/2023, Indwelling urinary catheter orders were obtained from NP for resident 36. Indwelling urinary catheter care completed. Resident 23 eye drops were ordered STAT and paid for by the facility on 9/29/2023. Resident 32 had Zoloft available in cart on 9/29/2023.	10/24/2023

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	was readmitted to the facility from the hospital on 8/13/23. The 8/13/23 hospital discharge paperwork read, "Admission Date: 8/2/2023. Discharge Date: 8/13/2023...I need my outpatient team to followup on the following issues: 1. Confusion caused by UTI - You had an infection which was making you confused when you came in. You were treated for UTI with ampicillin and ceftriaxone, and then a change of your suprapubic catheter was carried out. 2. Acute kidney injury - You had an acute injury to your kidney when you came in. You were treated with fluids and we held medications that could worsen your kidney function. 3. Metastatic Prostate Cancer - We held your cancer medication while you were in patient. We would like you to follow up with your hematologist to restart your medication. You were still taking your prednisone while in patient, and this should be carried on after your discharge. 4. Excess fluid in your kidney - You were found to have an increased amount of fluid in both your kidneys due to a back up of urine. Two tubes were placed close to your kidneys to help them drain this increased fluid. Fluid collected should be drained regularly. You will need to have these tubes checked in 4 weeks time." The facility physician's orders indicated to provide urinary catheter care every shift and as needed, to include emptying of the drain bag, peri-care, ensuring positioning of the catheter bag and tubing was below the level of the bladder, to ensure tubing was free of kinks and securement device was in place, and to notify the physician of any abnormalities, starting 8/14/23. The August, 2023 TAR (treatment administration record) indicated this order was carried out every shift from 8/14/23 through 8/31/23.		2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service was conducted by the Director of Nursing Services, on 10/11/2023, with all direct care staff addressing pharmacy processes and how to obtain a medication when it is unavailable, what is available in the EDK, documentation, order transcription, and necessary notifications related to unavailable medication. Nephrostomy Care and Indwelling Urinary Catheter Care check offs completed for all direct care staff on 10/11/2023 and 10/13/2023. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services, or designee, will conduct a random audit of residents receiving medications for eight (8) consecutive weeks. The residents' charts will be audited for medication availability in correlation to physician orders.	

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	The 8/13/23, 5:11 p.m. nurse's note read, "resident came back from the hospital, vital sign is within the normal range. resident has has [sic] a nephrostomy tube Right and left that need to be change every shift." There were no care plans to address Resident 36's nephrostomy tubes. The 8/15/23, NP (Nurse Practitioner) note, written by NP 12, read, "...Pt [Patient] was admitted to hospital 8/2 during hematology/oncology appointment. Pt with AMS [altered mental status] and confusion. With E.Coli and E. Faecalis UTI. Treated with ampicillin and ceftriaxone. SPT [suprapubic catheter] exchanged. AKI [acute kidney injury] with hydronephrosis. Bilateral nephrostomy tubes placed 8/8. Pt did require one unit PRBC [packed red blood cell] and 1g IV iron. Pt with metastatic prostate cancer; secondary sites include bone and bladder. Goals of care were discussed and pt was changed to DNR [do not resucitat.] Hospitalization complicated by pt testing Covid +. Medications adjusted: metoprolol increased, glargine decreased to 10U qhs [every evening], mirtazapine added. Today, pt seen resting in bed. VSS [vital signs stable.] Patient denies any complaints at the time of visit. Denies c/o [complaints of] pain. Pt would not sign POST [physician orders for scope of treatment] form when reviewed with this provider. Nursing aware. Nursing reports no acute concerns. A change in condition is likely at any time and without 24-hour care there is a reasonable likelihood that untoward outcomes may occur. Faxes, Laboratory studies, and imaging studies reviewed. Nursing notes, orders, medications noted. Chart reviewed. Labs ordered...Genitourinary: Suprapubic Cath [catheter,] Bilateral nephrostomy		The Director of Nursing Services, or designee, will conduct audits, 2 x weekly for 8 weeks of Admissions and Readmissions within 24-72 hours to assure all orders are in place. The previous day (s) “packing slip” and “integrated pharmacy alert” reports from the pharmacy will be reviewed daily Monday through Friday indefinitely, to assure medications ordered have arrived to the facility. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: 10/24/2023	

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	155245	A. BUILDING 00 B. WING	09/29/2023

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	tubes...Genitourinary: SPT draining clear urine; SPT site with out erythema or drainage, Bilateral nephrostomy tubes - draining clear, yellow urine, scant blood noted...GeriCare Assessment/Treatment Plan Diagnosis...Breakdown (mechanical) of nephrostomy catheter...." The physician's orders indicated to empty his nephrostomy catheter every shift to drain urine, starting 8/14/23. The August TAR indicated this order was carried out every shift from 8/14/23 through 8/31/23. There were no physician's orders to ensure his left and right nephrostomy catheters were in place; to provide left and right nephrostomy catheter care; or to monitor and record output of his left and right nephrostomy catheters after his 8/13/23 readmission with nephrostomy tubes until 8/31/23. The physician's orders read, "Nephrostomy Left side : Indwelling Catheter in place. Catheter Care Q [every] shift and PRN [as needed] every shift for Catheter Care related to MALIGNANT NEOPLASM OF OVERLAPPING SITES OF URINARY ORGANS (C68.8) Empty drain bag & provide peri-care. Position catheter bag & tubing below level of the bladder, check tubing is free of kinks & securement device in place. Notify MD of abnormalities (unusual urine appearance, burning, pain, feeling of full bladder)," with a start date of 8/31/23. The physician's orders indicated the same for his right side nephrostomy tube, starting 8/31/23. The 8/18/23 NP note read, "...Genitourinary: SPT draining clear urine; SPT site with out erythema or drainage, Bilateral nephrostomy tubes - draining clear, yellow urine. scant blood noted."			

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	The 8/21/23, 3:33 p.m. nursing note read, "Resident resting in bed at this time. Bilateral nephrostomy tubes remain intact and patent. Suprapubic catheter intact and patent. Resident continues to deny any pain. Assisted with all adls [activities of daily living] as needed. Call light within reach. Will continue to monitor." The 9/1/23 NP note read, "...seen today for a federally mandated visit for management of chronic diseases. Resident is alert and oriented, requires assist with transfers, medication management, and ADLs [activities of daily living.] PMH [past medical history] of DM [diabetes mellitus,] prostate cancer with mets [metastisis] to bladder, bone, and lung, anemia, HTN [hypertension], depression. All are reviewed and stable. No acute concerns reported by resident at this time. Labs reviewed and stable. Full Code status. VSS. Weight stable. Regular Diet. Pt with significant overall decline due to cancer. Continues to defer DNR or hospice services. Today, nursing stating bilateral nephrostomy tubes were clamped. Upon opening, urine malodorous and thick in appearance. DON [Director of Nursing] aware. Order to flush bilateral nephrostomy tubes and SPT. Ordered UA, C+S [urinalysis, culture and sensitivity,] PICC [peripherally inserted central catheter] placement, IVF [intravenous fluids] and rocephin via PICC until C+S results. CrCl [Creatinine clearance] 32.87. Pt alert and oriented. VSS. Denies c/o pain or nausea. Afebrile. NAD [no abnormality detected.] Pt. seen at this time for scheduled ECF regulatory visit. This is a complex patient with complex co-morbidities. As a result, Pt. continues to reside in ECF. A change in condition is likely at any time and without 24hr care there is a reasonable likelihood that untoward outcomes may occur. Faxes, laboratory studies, and imaging studies			

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	reviewed. Nurses notes, orders, meds noted. Chart reviewed." The 9/1/23, 10:34 p.m. nurse's note read, "Resident was sent to the hospital at 20:50 Pm. Resident appears lethargy. Bp [blood pressure:] 71/35, pulse: 136 and was having difficulty following direction . Family, Doctor and DON were notified." The 9/1/23 hospital admission note read, "Patient presents with Fatigue BIBA [brought in by ambulance] from ECF [extended care facility.] Per medics, patient has been sick for the past week. Increased weakness over the past 24 hrs [hours.] Patient is typically verbal + can hold conversations, but is currently not answering questions. Hx [History] kidney cancer, has nephrostomy and suprapubic in place....Assessment and Plan 1. Urosepsis: Febrile, tachycardic, initially hypertensive. No leukocytosis. UA shows [greater than sign] 100 WBCs [white blood cells,] large leuks. CT shows distended urinary bladder. Last Ucx [urine culture] on 7/11 negative for growth. Resume broad-spectrum Vanc [Vancomyocin,] Zosyn monitor renal function closely. BP still low normal s/p 3 L IVF. Consider pressors if necessary 2. Bilateral nephrostomy tubes: Previously had chronic indwelling Foley. S/p [Status post] bilateral nephrostomy tubes at VA [Veterans Affairs] last month, per daughter. Urology consulted for management....History of Present Illness...presenting to [name of hospital] with a chief complaint of shortness of breath. Brought in by EMS [emergency medical services] from skilled nursing facility. Per EMS, is normally responsive however has not been responsive in the ED [emergency department.] Staff reported increased weakness for the past 24 hours. Was febrile on arrival at 102. Was additionally hypotensive			

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	however responded well to IV fluids...." The 9/6/23 hospital note read, "presents for routine bilateral nephrostomy exchange. 1. Sepsis, due to unspecified organism...2. AKI (acute kidney injury)...3. Urinary tract infection associated with nephrostomy catheter...4. Abnormal EKG [electro cardiogram."] The 9/10/23 hospital discharge summary read, "Caring for your nephrostomy tube. Your care team will instruct you on how to care for your nephrostomy tube. You'll have to inspect your tube on a daily basis as well as empty any urine that has collected in the drainage bag. Inspection of your nephrostomy tube. When you inspect your nephrostomy tube, you should check the following: Verify that your dressing is dry, clean, and secure. If it's wet, dirty, or loose, it will need to be changed. Check your skin around the dressing to make sure there's no redness or rash. Look at the urine that has collected in your drainage bag. It shouldn't have changed in color. Be sure there are no kinks or twists in the tubing that leads from your dressing to the drainage bag." The 9/10/23 hospital discharge Medication List indicated to start taking IV Zosyn 4.5 gram/100 mL, inject into the vein every 6 hours for 8 doses. The 9/10/23, 11:55 p.m. facility nurse's note read, "Resident returned to facility per [name of ambulance company.]" The facility physician's orders did not include orders for urinary catheter care or nephrostomy tube care after his 9/10/23 return from the hospital. An interview and observation was conducted			

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	with Resident 36 on 9/26/23 at 2:15 p.m. He was lying in bed in his room. His catheter tubing was draining dark, sedimentary looking urine into the bag. Resident 36 indicated staff did not regularly come in to provide him catheter care. An interview was conducted with LPN (Licensed Practical Nurse) 5 on 9/28/23 at 3:15 p.m. She indicated she provided catheter care to Resident 36 when she worked, but she hadn't worked in a while. She reviewed Resident 36's orders and indicated he went out to the hospital, and the catheter and nephrostomy care orders were not put back into the computer upon his return. He used to have orders for care of both every shift. She indicated there was no way to verify the care was being done. She was going to inform the DON and unit manager now, so that orders could be placed. An interview was conducted with the NC (Nurse Consultant) on 9/29/23 at 2:08 p.m. She indicated she did not see any nephrostomy tube care orders after Resident 36's 8/13/23 readmission with nephrostomy tubes until 8/31/23 and there was no care plan referencing the nephrostomy tubes. The September, 2023 MAR (medication administration record) indicated Resident 36 only received 7 of the 8 ordered doses of Zosyn. An interview was conducted with LPN 1 on 9/29/23 at 2:40 p.m. She indicated she administered the noon dose of Zosyn on 9/12/23, to equal a total of 8 doses administered, but was unable to sign off on it, because a QMA (Qualified Medication Aide) already signed it off as medication on order. An interview was conducted with NP 12 on			

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	9/29/23 at 12:47 p.m. She indicated Resident 36 should have had orders for his nephrostomy tube care upon his 8/13/23 hospital return and his 9/10/23 hospital return, including to flush as needed, routine dressing changes, monitoring of the site, and recording of output every shift. On 9/1/23, one of the nurses came to get her to look at one of the outputs from the tube and one of the tubes was clamped. After opening, the urine output was thick and white in color. The tubes should always be open. She had no idea how they got clamped, maybe during care. She saw him this morning to look at one of his nephrostomy tubes, because there were concerns one of the sutures came out of one side, but the tube was still in place, with output flowing freely. An observation of Resident 36's right side nephrostomy tube care was made on 9/29/29 at 11:49 a.m. The care was performed by LPN 1. There was no redness at the site and no kinks in the tubing. The urine draining from the tubing was dark yellow. Betadine was used to clean the surrounding skin and tubing. The tubing was irrigated with 3 ml of saline. Gauze/drain sponges were placeed on the site and tegiderm dressing was placed on top. The Care of Nephrostomy Tube policy was provided by the DON on 9/29/23 at 9:15 a.m. It read, "1. Verify that there is a physician's order for this procedure. 2. Review the resident's care plan to assess for any special need of the resident...Check placement of the tubing and integrity of the tape during assessments...Empty drainage bag once per shift and as needed....Measure output as follows: a. Initially every hour x [times] 4 hours; then b. Every 4 hours x 24 hours; then c. Every 8 hours....Measure output from the right and left kidneys separately.			

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	(Record urinary and nephrostomy output separately....) Change dressings every 1-3 days, or as ordered...."2. The clinical record for Resident 23 was reviewed on 9/27/23 at 10:00 a.m. The resident's diagnosis included, but was not limited to, anxiety disorder. A Quarterly MDS (Minimum Data Set) Assessment dated 7/23/23 indicated Resident 26 was cognitively intact. A physician order dated 8/30/23 indicated Resident 23 was to receive 1 drop in each eye of carboxymethylcellulose sodium ophthalmic solution for dry eyes. The September 2023 Medication/Treatment Administration Record (MAR/TAR) indicated the following days the resident did not receive her eye drops due to medication was not available: 9/2/23 - day shift, 9/4/23 - day shift, 9/5/23 - day and evening shift, 9/6/23 - day shift, 9/7/23 - day shift, 9/11/23 - day and evening shift, 9/12/23 - day and evening shift, 9/13/23 - day shift, and 9/14/23 - day shift An interview was conducted with Resident 23 on 9/28/23 at 1:34 p.m. She indicated she does not routinely receive her eye drops. An interview was conducted with the Director of Nursing on 9/29/23 at 9:02 p.m. She indicated Resident 23 was running out of her eye drops prior to her insurance covering the cost for more. She was unaware of the resident not receiving her			

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	eye drops. She would address. 3. The clinical record for Resident 32 was reviewed on 9/27/23 at 1:00 p.m. The resident's diagnosis included, but was not limited to, depression. A physician order dated 6/14/23 indicated Resident 32 was to receive 25 milligrams of zoloft daily. The September 2023 Medication Administration Record indicated the following days the resident had not received the 25 milligrams of zoloft due to unavailable medication: 9/11/23, 9/12/23, 9/13/23 An interview was conducted with the Director of Nursing on 9/29/23 at 9:02 a.m. She indicated Resident 32 had missed the 25 milligrams zoloft for 3 days due to unavailable. A "Medication Ordering and Receiving From Pharmacy" policy was provided by Director of Nursing on 9/27/23 at 10:29 a.m....Policy: Medications and related products are received from the dispensing pharmacy on a timely basis. The facility maintains accurate records of medication and receipt...2. If not automatically refilled by the pharmacy, repeat medications (refills) are written on a medication order form/ordered by utilizing the pharmacy provided reorder sticker and placing it in the appropriate area on the order form provided by the pharmacy for that purpose and or ordered electronically order as follows:...c. Reorder medication five days in advance of need, as directed by the pharmacy order and delivery schedule, to assure an adequate supply is on hand..." This Federal tag relates to complaint IN00418378.			

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	3.1-37 3.1-37(a)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the			

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	posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on interview and record review, the facility failed to accurately post the actual hours worked by direct care staff with the potential to affect 41 of 41 residents residing at the facility. Findings include: On 9/29/23 at 10:53 a.m., the Director of Nursing provided the Direct Care Staffing Postings for June 23, 24, and 25, 2023 which indicated there were no Registered Nursing hours that were worked on those dates. On 9/29/23 at 10:53 a.m., the Director of Nursing provided the daily schedules as worked for June 23, 24, and 25, 2023 which indicated the following: 6/23/23-2 Registered Nurses had provided direct patient care on the day shift and 1 Registered Nurse had provided direct patient care on the evening shift. 6/24/23- 1 Registered Nurse had provided direct patient care on the day shift and 1 Registered Nurse had provided direct patient care on the evening shift. 6/25/23 -1 Registered Nurse had provided direct patient care on the day shift and1 Registered Nurse had provided direct patient care on the evening shift. During an interview on 9/29/23 at 11:26 a.m., the Nurse Consultant indicated the Direct Care Staffing Postings should have included the Registered Nursing hours. On 9/29/23 at 11:26 a.m., the Nurse Consultant provided the Posting Direct Care Daily Staffing	F 0732	1. Immediate action(s) taken for the resident(s) found to have been affected include: No residents are affected by the deficiency. 2. Identification of other residents having the potential to be affected was accomplished by: No residents are affected by the deficiency. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The Director of Nursing Services completed education with the staffing coordinator regarding accuracy of staff posting and updating as the schedule changes on 10/11/2023. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing, or designee will audit staff posting as it relates to the schedule for accuracy, 2 X weekly for 30 days, then 1 X weekly for 8 weeks. Corrective action completion date: 10/24/2023	10/24/2023

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	Numbers policy, last revised August 2022, which read "...Daily, the number of licensed nurses [RNs, LPNs, and LVNs] and the number of unlicensed nursing personnel...directly responsible for resident care is posted in a prominent location [accessible to residents and visitors] and in a clear and readable format..."			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to properly store foods in the kitchen. This affected 38 of 41 residents in the facility who eat food from the kitchen. Findings include:	F 0812	1. Immediate action(s) taken for the resident(s) found to have been affected include: Unmarked lemon juice in dry storage was immediately thrown away. Staff personal items	10/24/2023

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	A tour of the kitchen and interview was conducted with the Dietician on 9/26/23 at 11:00 a.m. During the tour, the clean dish racks were observed. There was an open, half bottle of water and an open sandwich bag containing small candies and suckers on one of the shelves next to clean dishes. The dietician indicated the bag of candy and water bottle were not supposed to be there. The dietician removed the bag of candy and water bottle from the shelf and placed it elsewhere in another part of the kitchen. During the tour the dry storage room was observed. There was an open bottle of lemon juice with 2/3 of the contents remaining on a shelf. The label on the bottle indicated to refrigerate after opening. The dietician indicated there was some lemon juice missing, so it needed tossed out. The dietician removed the lemon juice from the shelf. During the tour, a counter near the stove was observed. There were four, clear bins with blue lids on the bottom shelf of the counter. One contained flour; one contained brown sugar; one contained powdered sugar; and one contained white sugar. None of the 4 blue lids were sealed to their respective bins, open to air. The dietician sealed each blue lid, one at a time, to their respective bins. The Food Receiving and Storage policy was provided by the ED (Executive Director) on 9/27/23 at 2:00 p.m. It read, "Foods shall be received and stored in a manner that complies with safe food handling practices....Dry foods that are stored in bins will be removed from original packaging, labeled and dated ("use by" date). Such foods will be rotated using a "first in-first		removed from the kitchen. Dry storage bins sealed immediately by dietician. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents who consume food by mouth have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All dietary staff have been in-serviced on the facility's policies and practice guideline for food storage and receiving policy. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Dietary Manager or designee will complete random validation reports of dietary staff performing procedures to ensure staff performance is in accordance with the facility policy. Validation checklists will be reviewed by the Registered Dietitian, (RD) until such time consistent substantial compliance has been achieved as determined by the committee. This plan of correction will be	

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	out" system....Refrigerated foods must be stored below 41 F [Fahrenheit] unless otherwise specified by law." The Mechanical Cleaning and Sanitizing of Utensils and Portable Equipment policy was provided by the ED on 9/28/23 at 2:43 p.m. It read, "Store all cleaned and sanitized utensils and equipment and all single-service articles at least 6 inches above the floor in a clean, dry location in a way that protects the from contamination by splash, dust and other means." 3.1-21(i)(3)		monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: 10/24/2023	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records,			

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	regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and			

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	determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on observation, interview and record review, the facility failed to ensure accurate documentation of a resident's MAR (medication administration record) for 1 of 1 resident reviewed for hospice (Resident D) and 2 of 6 residents reveiwed for unnecessary medications (Resident 23 and Resident 32). Findings include: 1. The clinical record for Resident D was reviewed on 9/26/23 at 12:20 p.m. His diagnoses included, but were not limited to, delusional disorder and dyskinesia. He was admitted to the facility on 5/4/22 and to hospice services on 3/10/23. An interview was conducted with Family Member 6 on 9/28/23 at 5:48 p.m. He indicated he was Resident D's Medical POA (power of attorney.) Hospice Nurse 7 called him to inform him a nurse from the facility had contacted her about discontinuing one of his medications. He had a meeting with Hospice Nurse 7 and the facility's Wound Nurse at the facility on Monday, 9/25/23, to discuss it. Family Member 6 questioned why the discontinuation of the medication was suggested and was told it had something to do with how expensive the medication was. During the meeting, the staff checked Resident D's record and informed him that Resident D was still receiving the medication, as it had not been discontinued. He was uncertain who the nurse was at the facility who first called hospice to discuss it. He asked the Wound Nurse on 9/25/23 to have the facility's ED (Executive Director) call	F 0842	1. Immediate action(s) taken for the resident(s) found to have been affected include: Medication records for RI #_D, 23, and 32_ have been reviewed and medications are available and being administered per MD orders. 2. Identification of other residents having the potential to be affected was accomplished by: All residents receiving medications have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The Director of Nursing Services conducted an in service to all staff that pass medications on proper documentation of medications provided to residents on 10/11/2023. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Service or designee will monitor documentation of medications for random records for 1 X week for	10/24/2023

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	him to discuss further, but had yet to receive a call. An interview was conducted with Hospice Nurse 7 on 9/29/23 at 10:25 a.m. She indicated hospice received a phone call from the facility, LPN 1 she believed, wanting to know if they could discontinue the Ingrezza medication. Discontinuation of the medication was "not necessarily a hospice decision." She called Family Member 6 a couple of hours later to see if the facility had discussed it with him and what he'd decided. She just wanted to know what he'd decided to do with the medication, so they'd both be on the same page, but Family Member 6 hadn't received a phone call about it at this point. Resident D had tremors and needed the medication. Hospice Nurse 7 told the hospice on call nurse that all medication and treatment changes were to be reviewed with Family Member 6 first. Since she wasn't the on call nurse at the time, she informed the on call nurse on duty that they needed to contact Family Member 6. It was currently her understating the Ingrezza continued and never was discontinued. Resident D was on the same medications he'd been on when he was admitted to hospice. She stated, "I'm his hospice nurse and responsible for him." If LPN 1 had called her, she would have called Family Member 6 first to see what he thought, then contact the nurse practitioner, if Family Member 6 wanted to move forward with discontinuing the medication. When she spoke with Family Member 6, he informed her that he did not want anything changed. After she, Family Member 6, and the Wound Nurse met at the facility, she thought the facility was on the same page as far as order of discussion for a treatment change. She stated, "Since we don't cover the medication, we felt like the facility needed to contact [name of Family		(1) month then every (2) weeks for (2) months. Discrepancies will be promptly reported to the Director of Nursing Services. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: 10/24/2023	

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	Member 6.]" Hospice Nurse 7 suggested they all meet at the facility on 9/25/23 to discuss it. "It was all very civil. I think we left on the same page." An interview was conducted with the Wound Nurse on 9/29/23 at 9:38 a.m. in the presence of the DON (Director of Nursing.) She indicated the meeting on 9/25/23 was because Family Member 6 had a concern about one of Resident D's medications, the Ingrezza. One of the facility nurses wanted to know if the Ingrezza could be discontinued, but hospice said no. Family Member 6 was happy and pleasant when he left the meeting. The Wound Nurse thought LPN (Licensed Practical Nurse) 1 was the nurse who originally contacted hospice about discontinuing the medication. Then Hospice Nurse 7 contacted Family Member 6 to discuss it. At the meeting, Family Member 6 informed he would like the DON to contact him to discuss it further. The DON indicated, during this interview, that she hadn't had a chance to call him back yet, as this just happened 4 days ago. An observation of a conversation between Family Member 6 and the DON was conducted on 9/29/23 at 1:13 p.m. Family Member 6 reiterated to the DON that he was bothered by a facility nurse suggesting a medication be discontinued for Resident D. The DON reassured Family Member 6 that Resident D was still on the Ingrezza and that she would talk to Hospice Nurse 7 and reeducate nursing that communication needed streamlined. The physician's orders indicated for two 40 mg capsules of Ingrezza to be administered at bedtime for dyskinesia (uncontrolled, involuntary muscle movement,) starting 9/14/22. The order read, "Medication located in separate white bottle - second drawer inside medication cart. (CALL			

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	DON BEFORE RE-ORDERING.)" The August and September, 2023 MARs (medication administration records) indicated the Ingrezza was administered everyday each month from 8/1/23 through 9/28/23. An interview was conducted with LPN 1 on 9/29/23 at 2:42 p.m. She indicated she called hospice about discontinuing the Ingrezza, because the nurse that was to administer the medication said she couldn't find it. LPN 1 looked for it too, but couldn't find it either. "I said let me call pharmacy to see if I can get it in STAT [immediately.]" They said they were going to send it out, but then the pharmacist said they were not sending it out, because it cost $8000. "I called hospice and they said we're not paying $8000 for the med [medication.]" An observation of the medication cart that held Resident D's medications was made with LPN 1 and the DON on 9/29/23 at 2:55 p.m. They could not find any Ingrezza in the cart for Resident D. LPN 1 reviewed Resident D's Ingrezza order in the computer and indicated it was last filled by the pharmacy on 6/28/23. LPN 1 stated, "Hospice wont pay for it. They're supposed to pay for it." On 9/29/23 at 3:15 p.m., the DON provided the 6/29/23, 2:03 a.m. pharmacy manifest. An interview was conducted with her at this time. The manifest indicated ninety 40 mg capsules of Ingrezza was delivered to the facility for Resident D. The DON indicated if 90 capsules were delivered at the end of June, 2023, the medication would have ran out in the middle of August, 2023, yet nursing was documenting they're still giving it. The DON asked, "At what point is hospice responsible for paying for it?"			

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	An interview was conducted with the Pharmacy Consultant on 9/29/23 at 3:34 p.m. She indicated a quantity of 30 capsules of Ingrezza was delivered to the facility for Resident D on 6/29/23, not 90 capsules, and it didn't make sense that the manifest provided by the DON indicated 90. On 9/29/23 at 3:40 p.m., the Pharmacy Consultant emailed a copy of the 6/29/23, 2:03 a.m. pharmacy manifest. Everything on the manifest matched the manifest the DON provided, except the quantity of Ingrezza capsules, which indicated 30, a 15 day supply, on the pharmacy provided manifest. The Administering Medications policy was provided by the DON on 9/29/23 at 3:20 p.m. It read, "The individual administering the medication initials the resident's MAR on the appropriate line aftter giving each medication and before administering the next ones."2. The clinical record for Resident 32 was reviewed on 9/27/23 at 1:00 p.m. The resident's diagnosis included, but was not limited to, depression. A physician order dated 6/14/23 indicated Resident 32 was to receive 25 milligrams of zoloft daily. The September 2023 Medication Administration Record indicated the following days the resident had not received the 25 milligrams of zoloft due to unavailable medication: 9/11/23 - documented medication unavailable, 9/12/23 - documented as administered as ordered, and 9/13/23 - documented as medication unavailable An interview was conducted with the Director of			

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	Nursing on 9/29/23 at 9:02 a.m. She indicated Resident 32 had missed the 25 milligrams zoloft for 3 days due to unavailable. On 9/12/23, the zoloft was not administered as ordered. It was signed off in error. This Federal tag relates to Complaint IN00418378. 3.1-50(a)(2)			
F 0849 SS=D Bldg. 00	483.70(o)(1)-(4) Hospice Services §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least			

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	the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management			

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	of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team			

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	member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific			

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	to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. Based on observation, interview and record review, the facility failed to coordinate the provision of a medication with hospice to ensure administration, as ordered, for 1 of 1 resident reviewed for hospice. (Resident D) Findings include: The clinical record for Resident D was reviewed on 9/26/23 at 12:20 p.m. His diagnoses included, but were not limited to, delusional disorder and dyskinesia. He was admitted to the facility on 5/4/22 and to hospice services on 3/10/23. The 3/22/23 hospice care plan, revised 9/8/23, indicated the goal was for resident's comfort to be maintained through the review date. An interview was conducted with Family Member	F 0849	1. Immediate action(s) taken for the resident(s) found to have been affected include: Director of Nursing Services and Hospice Case Manager had care conference regarding medication of resident D. No other residents were affected. 2. Identification of other residents having the potential to be affected was accomplished by: All residents receiving Hospice Services have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future	10/24/2023

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	6 on 9/28/23 at 5:48 p.m. He indicated he was Resident D's Medical POA (power of attorney.) Hospice Nurse 7 called him to inform him a nurse from the facility had contacted her about discontinuing one of his medications. He had a meeting with Hospice Nurse 7 and the facility's Wound Nurse at the facility on Monday, 9/25/23, to discuss it. Family Member 6 questioned why the discontinuation of the medication was suggested and was told it had something to do with how expensive the medication was. During the meeting, the staff checked Resident D's record and informed him that Resident D was still receiving the medication, as it had not been discontinued. He was uncertain who the nurse was at the facility who first called hospice to discuss it. He asked the Wound Nurse on 9/25/23 to have the facility's ED (Executive Director) call him to discuss further, but had yet to receive a call. An interview was conducted with Hospice Nurse 7 on 9/29/23 at 10:25 a.m. She indicated hospice received a phone call from the facility, LPN 1 she believed, wanting to know if they could discontinue the Ingrezza medication. Discontinuation of the medication was "not necessarily a hospice decision." She called Family Member 6 a couple of hours later to see if the facility had discussed it with him and what he'd decided. She just wanted to know what he'd decided to do with the medication, so they'd both be on the same page, but Family Member 6 hadn't received a phone call about it at this point. Resident D had tremors and needed the medication. Hospice Nurse 7 told the hospice on call nurse that all medication and treatment changes were to be reviewed with Family Member 6 first. Since she wasn't the on call nurse at the time, she informed the on call nurse on duty that		occurrence include: The Director of Nursing conducted an in service to All licensed staff on coordinating care of hospice residents with facility, on 10/11/2023. Current Hospice companies in use at facility are to be educated on communicating resident changes with a member of management at each hospice visit by 10/23/2023. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: 10/24/2023	

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	they needed to contact Family Member 6. It was currently her understating the Ingrezza continued and never was discontinued. Resident D was on the same medications he'd been on when he was admitted to hospice. She stated, "I'm his hospice nurse and responsible for him." If LPN 1 had called her, she would have called Family Member 6 first to see what he thought, then contact the nurse practitioner, if Family Member 6 wanted to move forward with discontinuing the medication. When she spoke with Family Member 6, he informed her that he did not want anything changed. After she, Family Member 6, and the Wound Nurse met at the facility, she thought the facility was on the same page as far as order of discussion for a treatment change. She stated, "Since we don't cover the medication, we felt like the facility needed to contact [name of Family Member 6.]" Hospice Nurse 7 suggested they all meet at the facility on 9/25/23 to discuss it. "It was all very civil. I think we left on the same page." An interview was conducted with the Wound Nurse on 9/29/23 at 9:38 a.m. in the presence of the DON (Director of Nursing.) She indicated the meeting on 9/25/23 was because Family Member 6 had a concern about one of Resident D's medications, the Ingrezza. One of the facility nurses wanted to know if the Ingrezza could be discontinued, but hospice said no. Family Member 6 was happy and pleasant when he left the meeting. The Wound Nurse thought LPN (Licensed Practical Nurse) 1 was the nurse who originally contacted hospice about discontinuing the medication. Then Hospice Nurse 7 contacted Family Member 6 to discuss it. At the meeting, Family Member 6 informed he would like the DON to contact him to discuss it further. The DON indicated, during this interview, that she hadn't had a chance to call him back yet, as this just			

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	happened 4 days ago. An observation of a conversation between Family Member 6 and the DON was conducted on 9/29/23 at 1:13 p.m. Family Member 6 reiterated to the DON that he was bothered by a facility nurse suggesting a medication be discontinued for Resident D. The DON reassured Family Member 6 that Resident D was still on the Ingrezza and that she would talk to Hospice Nurse 7 and reeducate nursing that communication needed streamlined. The physician's orders indicated for two 40 mg capsules of Ingrezza to be administered at bedtime for dyskinesia (uncontrolled, involuntary muscle movement,) starting 9/14/22. The order read, "Medication located in separate white bottle - second drawer inside medication cart. (CALL DON BEFORE RE-ORDERING.)" The August and September, 2023 MARs (medication administration records) indicated the Ingrezza was administered everyday each month from 8/1/23 through 9/28/23. An interview was conducted with LPN 1 on 9/29/23 at 2:42 p.m. She indicated she called hospice about discontinuing the Ingrezza, because the nurse that was to administer the medication said she couldn't find it. LPN 1 looked for it too, but couldn't find it either. "I said let me call pharmacy to see if I can get it in STAT [immediately.]" They said they were going to send it out, but then the pharmacist said they were not sending it out, because it cost $8000. "I called hospice and they said we're not paying $8000 for the med [medication.]" An observation of the medication cart that held Resident D's medications was made with LPN 1			

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	and the DON on 9/29/23 at 2:55 p.m. They could not find any Ingrezza in the cart for Resident D. LPN 1 reviewed Resident D's Ingrezza order in the computer and indicated it was last filled by the pharmacy on 6/28/23. LPN 1 stated, "Hospice wont pay for it. They're supposed to pay for it." On 9/29/23 at 3:15 p.m., the DON provided the 6/29/23, 2:03 a.m. pharmacy manifest. An interview was conducted with her at this time. The manifest indicated ninety 40 mg capsules of Ingrezza was delivered to the facility for Resident D. The DON indicated if 90 capsules were delivered at the end of June, 2023, the medication would have ran out in the middle of August, 2023, yet nursing was documenting they're still giving it. The DON asked, "At what point is hospice responsible for paying for it?" An interview was conducted with the Pharmacy Consultant on 9/29/23 at 3:34 p.m. She indicated a quantity of 30 capsules of Ingrezza was delivered to the facility for Resident D on 6/29/23, not 90 capsules, and it didn't make sense that the manifest provided by the DON indicated 90. On 9/29/23 at 3:40 p.m., the Pharmacy Consultant emailed a copy of the 6/29/23, 2:03 a.m. pharmacy manifest. Everything on the manifest matched the manifest the DON provided, except the quantity of Ingrezza capsules, which indicated 30, a 15 day supply, on the pharmacy provided manifest. The 3/10/23 Hospice Services Agreement between Resident D's hospice company and the facility was provided by the ED via email on 10/2/23 at 1:23 p.m. It read, "With respect to Resident who are under Hospice's care, Hospice shall be responsible for providing the following in accordance with applicable law: ...drugs			

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	necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions...Hospice shall designate an interdisciplinary group member who shall be responsible for coordinating with Facility the provision of hospice services to each Resident under Hospice's care and communicating with facility and other health care providers participating in the provision of care for the Resident's terminal illness and related conditions, and other conditions, to ensure quality of care for the Resident and family....Facility shall maintain responsibility for care planning for any Resident conditions that are not related to the Resident's terminal illness....Facility shall continue to provide to Residents who are under Hospice's care, notwithstanding their admission to Hospice, all services normally provided to Residents who are not under Hospice care, based on each Resident's plan of care, except those services that are otherwise being provided pursuant to the hospice plan of care." The Hospice Program policy was provided by the DON on 9/29/23 at 3:39 p.m. It read, "In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. These responsibilities include the following: ...b. Administering prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care." This Federal tag relates to Complaint IN00418378.			
F 0880 SS=D	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control			

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Bldg. 00	§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:			

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	(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview and record review, the facility failed to ensure infection control was maintained during tracheostomy care for 1 of 1 residents reviewed for tracheostomy (artificial airway in neck) (Resident 14); and maintain an infection prevention and control program by staff touching the insides of medication cups, not performing hand hygiene at appropriate times, mixing contents of a medication cup with a gloved finger for 1 of 4 reviewed for	F 0880	1. Immediate action(s) taken for the resident(s) found to have been affected include: The License Practical Nurse (LPN #_26_) was immediately sent home from facility related to observations and was placed on a DNR (Do Not Return). The Registered Nurse (RN # _2_)	10/24/2023

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	medication administration (Resident 12). Findings include: 1. The clinical record for Resident 14 was reviewed on 9/26/23 at 11:55 a.m. The resident's diagnosis included, but was not limited to, tracheostomy. An observation was made with Registered Nurse (RN) 2 and License Practical Nurse (LPN) 1 providing tracheostomy care for Resident 14 on 9/29/23 at 11:09 a.m. During the care, RN 2 was observed donning sterile gloves. She indicated her left hand would be non-sterile and her right hand would be sterile during the procedure. Using her left sterile hand, RN 2 removed the resident's inner cannula of her tracheostomy and discarded it. She then using the same left hand reached into her sterile field; picked up the new inner cannula to prep for insertion, cleaned the resident's site and inserted the new inner cannula. After completing the tracheostomy care she removed her gloves. An interview was conducted with RN 2 and LPN 1 on 9/29/23 at 11:30 a.m. LPN 1 indicated RN 2 had mixed up her hands and broke sterile field. A tracheostomy care policy was provided by the Nurse Consultant on 9/29/23 at 2:08 p.m. It indicated "...Purpose: The purpose of this procedure is to guide tracheostomy care and the cleaning of reusable tracheostomy cannulas...General Guidelines. 1. Aseptic technique must be used:..c. During tracheostomy tube changes, either reusable or disposable..."2. The clinical record for Resident 12 was reviewed on 9/28/23 at 11:31 a.m. Resident 12's diagnoses included, but not limited to, hemiplegia (paralysis		and Licensed Practical Nurse (LPN # _1_) were immediately in serviced on Tracheostomy Care related to infection control. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The Director of Nursing Services conducted an in-service with all direct care staff regarding infection control practices with medication administration and Tracheostomy Care on 10/11/2023 and 10/13/2023. Random Medication Pass and Tracheostomy Care Observations. Findings are reviewed with all personnel. Corrective action is provided as needed. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services (DNS), or designee, will complete random Validation Checklists of direct care staff performing medication pass and Tracheostomy Care. To ensure	

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	of one side of body), diabetes type II, anxiety, and aphasia (loss of ability to understand or express speech) A current physician's order without a date indicated, Resident 12 was in Enhanced Barrier Precautions. An observation of LPN (Licensed Practical Nurse) 26's medication administration for Resident 12 was conducted on 9/27/23 at 11:33 a.m. Resident 12's room had an enhanced barrier precautions sign indicating staff were to wear isolation gown and gloves when administering anything into the G-tube. LPN 26 had pushed the medication cart in front of Resident 12's doorway. On the medication cart, LPN 26 had some plastic medication cups facing upward already on her cart. LPN 26 proceeded to grab one of the medication cups to move it closer to her. LPN 26 pinched the medication cup by inserting her index finger with a long artificial nail inside the cup and held it against her thumb. LPN 26 did not perform any hand hygiene prior to picking up the cup with her right hand. She then, still with her right hand, touched the computer mouse, put her hand into her pocket, pulled out her cell phone, and dialed teammate. After attempting to call a teammate, she opened a drawer on the medication cart and retrieved a medication card containing Resident 12's Zinc 50 mg (milligram) tablets. She popped one Zinc tablet into the medication cup she had previously inserted her index finger into and then grabbed a disposable, plastic pouch which the facility uses to crush medications. In order to open the plastic sleeve, LPN 26 stuck her right index finger inside the plastic sleeve and then poured the Zinc tablet from cup into sleeve. After crushing the Zinc tablet, she again inserted the right index finger inside the sleeve to open it up		personnel are performing Medication Pass and Tracheotomy Care in accordance with our facility's infection control policy and procedures, random monitoring will occur each week for 4 weeks. This plan of correction will be monitored at the monthly Quality Assurance meeting until such a time consistent substantial compliance has been met. Corrective action completion date: 10/24/2023	

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	and pour the contents into the same medication cup. No hand hygiene had been performed. She then pushed her medication cart down the hallway near the medication room. She entered the med room and came out with a bottle of liquid Lansoprazole for Resident 12. She grabbed another medication cup which was already face up on her med cart and when grabbing it, she pinched it the same way she had previously done with her index finger inside the cup. LPN 26 then poured the correct dose of Lansoprozole into that cup and spilling some onto the top of the med cart. She grabbed some paper towels and wiped up what had spilled. Without performing any hand hygiene, LPN 26 grabbed another med cup, using the same technique as the previous two cups and then popped Resident 12's Vitamin C and Vitamin D3 tablets into the cup. She again, grabbed a disposable, plastic sleeve and inserted her index finger into it to open it, poured the tablets into it, crushed the medications. After crushing the medications, she inserted the index finger again into the sleeve to open the pouch then pour the contents back into the med cup. She had not performed hand hygiene at any point during the process. Once the medications were ready, LPN 26 pushed the med cart down the hallway to Resident 12's doorway. LPN 26 performed hand hygiene, touched the computer mouse, knocked on the door, locked her cart, and entered Resident 12's room and donned an isolation gown and gloves. Resident 12 had a G-tube for medication administration. LPN 26 prepped the G-tube and had administered some medications, when she realized she had not added water to one of the medication cups that contained crushed tablets in it. With her one gloved hand holding the G-tube with a syringe attached to it, she took the other hand and poured some water into the dry med			

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	cup. She attempted to mix the contents by swirling the cup around on the bedside table but, was unsuccessful and spilled some of the contents on the table. LPN 26 then placed her gloved finger into the medication cup and attempted to mix the contents with her finger. LPN 26 stopped, removed her finger, took off her gloves, performed handy hygiene, and got a spoon from the medications cart, and used the spoon to completely mix the contents of the cup. After administering Resident 12's medications, LPN 26 removed her isolation gown and gloves at the doorway and disposed of them in the trash, however, prior to performing hand hygiene, after removing the gown and gloves, she touched her hair to push it out of her face. An interview with DON (Director of Nursing) was conducted on 9/27/23 at 12:23 p.m. DON indicated, LPN 26 should not have placed fingers and/or fingernails inside of a medication cup or the plastic sleeve pouches. At no time should a nurse used a gloved finger to mix contents within a medication cup, and hand hygiene should be done prior to setting up medications for administration and after removing gloves. A Handwashing/Hand Hygiene policy received on 9/27/23 at 2:50 p.m. from DON indicated, "Use an alcohol-based hand rub...or...soap and water for the following situations... b. Before and after direct contact with residents... c. Before preparing or handling medications... e. Before and after handling an invasive device... l. After contact with objects...in the immediate vicinity of the resident... 8. Hand Hygiene is the final step after removing and disposing of personal protective equipment... 10. Single use disposable gloves should be used...			

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	b. when anticipating contact with blood or body fluids; and c. when in contact with a resident, or the equipment or environment of a resident, who is on contact precautions. 11. Wearing artificial fingernails is strongly discouraged among staff members with direct resident-care responsibilities, and is prohibited among those caring for severely ill or immunocompromised residents.... Procedure... Applying and removing gloves 1. Perform hand hygiene before applying non-sterile gloves. 3.1-18(b) 3.1-18(l)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a safe comfortable environment for 2 of 4 resident rooms reviewed for environment and 1 of 2 facility dryers reviewed for environment. (Resident 5 and 26). Findings include: On 9/26/23 at 11:38 a.m., Resident 5's room was observed. The wall by the Resident 5's bed was marred and the paint was chipped. Resident 5 indicated the wall had been that way for a while. On 9/26/23 at 12:07 p.m., Resident 26's room was observed. The walls of the room had multiple	F 0921	1. Immediate action(s) taken for the resident(s) found to have been affected include: The walls for Resident# 5 and 26 were repaired and painted. The Dryer Vent was cleaned. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected.	10/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING 00 B. WING	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	areas of chipped paint. On 9/29/23 at 1:50 p.m., environmental tour of the facility was conducted the DM (Director of Maintenance). Resident 5's room was observed with the DM who indicated the wall by Resident 5's bed was scrapped and had missing paint due to the bed scrapping against the wall and should be repainted. Resident 26's room was observed with the DM, who indicated that Resident 26's room did have multiple areas of chipped pain and should be repainted. During the environmental round the laundry area of the facility was observed. The DM was observed to open the lint area of the dryer by the door. The lint area of the dryer had square of lint, approximately 3 inches thick, that had fallen to the floor of the lint collection area. The DM used both hands to gather the lint from the dryer area and removed a ball of lint that was approximately the size of a soccer ball. The DM used both hands to take the lint to the trash bin. During an interview on 9/29/23 at 2:10 p.m., the DM indicated it appeared that the lint had not been removed from the dryer lint area for a day or two. He checked the dryer lint areas every week on Monday's but did not check them daily. On 9/29/23 at 3:10 p.m., the Executive Director provided the manufactures instructions for use for the facility dryer which read "...Clean any lint from the lint compartment and screen daily to maintain proper airflow and avoid overheating..." 3.1-19(a)(4) 3.1-19(f)(5)		3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education program was conducted by The Director of Nursing Services on 10/11/2023. The in-service addressed the importance of identifying unsafe items and communicating information regarding equipment to the maintenance supervisor via TELS. Dryer Vent cleaning is now a daily task in TELS. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Administrator or designee will conduct random audits of resident rooms and laundry area weekly times 4 weeks to assure a safe/comfortable environment. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: 10/24/2023	