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	04/22/2022

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: April 18, 19, 20, 21, and 22, 2022 Facility number: 000149 Provider number: 155245 AIM number: 100266840 Census Bed Type: SNF/NF: 32 Total: 32 Census Payor Type: Medicare: 1 Medicaid: 23 Other: 8 Total: 32 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 2, 2022	F 0000	**Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. Castleton Health Care Center maintains the alleged deficiencies do not individually jeopardize the health and / or safety of its residents nor are they of such character as to limit the providers capacity to render adequate resident care. Furthermore, Castleton Health Care asserts that it is in substantial compliance regulations governing the operation of long -term-care facilities, and this Plan of Correction in its entirely constitutes the providers credible allegation of compliance.**	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident			

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

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

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	self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.			
	Based on observation, interview, and record review, the facility failed to honor a resident's preference to be out of bed daily and to ensure bathing time preference were honored for 1 of 3 residents reviewed for Activities of Daily Living and 1 of 1 resident reviewed for choices (Resident 15 and Resident 30). Findings include: 1. The clinical record for Resident 15 was reviewed on 4/19/22 at 9:30 a.m. The Resident's	F 0561	**F561 – Self Determination** **1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** a. DON/Designee interviewed the representative of resident 15 about ADL preferences, assignment sheets and care plan updated to reflect ADL preferences. b. DON/Designee interviewed	05/20/2022

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	diagnosis included, but were not limited to, traumatic brain injury and epilepsy. A care plan, revised on 12/5/21, indicated he required total assistance with ADL (Activities of Daily Living) care. The goal, revised on 2/9/22, was for him to be clean and odor free daily. The interventions included, but were not limited to, he required total assistants with transfers, toileting, and eating. An Annual MDS (Minimum Data Set) Assessment, completed 2/25/22, indicated he had short and long term memory problems and severly impaired decision making skills. On 4/19/22 at 9:47 a.m., He was observed laying in his bed with his television on. During an interview on 4/19/22 at 11:20 a.m., FM (Family Member) 20 indicated he was in bed a lot. She wanted him to get up every day and go out of his room for some stimulation. She had told the facility that she preferred he sit in his chair daily. On 4/20/22 at 10:40 a.m., he was observed laying in bed wearing a hospital gown. On 4/20/22 at 1:54 p.m., he was observed laying in bed. During an interview on 4/20/22 at 2:10 p.m., CNA (Certified Nursing Assistant) 12 indicated that he did not get out of bed very often. When he did it was usually just for a little while. He didn't tolerate sitting up in his chair very long. On 4/21/22 at 8:37 a.m., the ED (Executive Director) provided the Follow Up Questions Report from 3/6/22 through 4/20/22. The report indicated he		the representative of resident 30 about ADL preferences, assignment sheets and care plan updated to reflect ADL preferences. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** **a.** All residents have the potential to be affected alleged deficient practice. **3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** **a.** DON/designee interviewed all residents and families about ADL preferences. b. DON/Designee in-serviced staff on ADL preferences. **4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** a. DON/Designee will complete 10 resident/family interviews weekly X 4 weeks then monthly until substantial compliance has been maintained. b. Findings will be reported monthly at the QA/Risk management meeting until such time until substantial compliance has been maintained. 5. DOC: 05/20/22	

had not been transferred out of bed on the following days: March 9th, 11th, 15th, 17th, 18th, 19th, 20th, 23rd, 25th, 29th, 30th, April 1st, 3rd, 5th, 6th, 7th, 8th, 9th, 10th, 13th, 14th, 15th, 16th, 17th, 19th, and 19th, 2022.

On 4/21/22 at 10:10 a.m., He was observed laying in his bed with his eyes closed.

During an interview on 04/21/22 at 2:51 p.m., CNA 11 indicated he did not get up every day. When he did get up, it was usually on the evening shift. He should be in his chair every day
2. The clinical record for Resident 30 was reviewed on 4/19/22 at 11:40 a.m. The resident's diagnoses included, but were not limited to, vascular dementia and hemiplegia following a stroke.

A care plan dated 2/4/22 indicated "ADL's [Activity of Daily Living]: Resident requires up to extensive assist with ADL's r/t [related to] dx [diagnosis] of hemiplegia and hemiparesis...Resident/family aware of ability to use spa room for personal and toileting needs. Interventions:...Showers on per resident/family preference.."

The CNA (Certified Nursing Assistant) Report Sheet indicated Resident 30 was scheduled to receive showers Tuesdays and Fridays in the evening.

An interview was conducted with Resident 30's representative on 4/19/22 at 11:54 a.m. She indicated she would like the resident to receive a shower 3 to 4 times a week. She does not believe Resident 30 was provided showers.

An interview was conducted with the Executive

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	Director on 4/21/22 at 3:37 p.m. She indicated the Activities Director had assisted with nursing regarding residents' preferences and had spoken to families/representatives and residents regarding preferences with ADLs a couple of months ago. An interview was conducted with CNA 10 on 4/21/22 at 2:08 p.m. She indicated Resident 30 receives showers Tuesdays and Fridays on the evening shift. A preference sheet was provided by the Activities Director on 4/22/22 at 12:19 p.m. It indicated as of 2/11/22, Resident 30's Representative requested the resident to receive showers twice a week on day shift. A accommodation of needs policy was provided on 4/21/22 at 2:55 p.m. It indicated "...Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and wellbeing...1. The resident's individual needs and preferences will be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered..." 3.1-3(u)(1)(3)			
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or			

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	chemical restraint not required to treat the resident's medical symptoms. Based on interview and record review, the facility failed to ensure a medication that was prescribed to a resident was not diverted by a staff person for 1 of 4 reportable incidents reviewed. (Resident 18) Findings include: The clinical record for Resident 18 was reviewed on 4/19/22 at 12:30 p.m. The resident's diagnoses included, but were not limited to, chronic kidney disease, cancer of tonsil. A pharmacy form dated 11/25/21, indicated a request for a prescription from the medical provider for Resident 18's 5-325 milligrams of hydrocodone. A prescription written by Medical Provider 35 dated 11/29/21, indicated Resident 18 was to receive 1 to 2 tablets of 5-325 milligrams of hydrocodone/Acetaminophen every 4 hour to 6 hours PRN. The quantity total of 120 tablets. A pharmacy form dated 1/18/22, indicated a request for a prescription from the medical provider for Resident 18's 5-325 milligrams of hydrocodone. A prescription written by Medical Provider 35 dated 1/19/22, indicated Resident 18 was to receive 1 to 2 tablets of 5-325 milligrams of hydrocodone/Acetaminophen every 4 hour to 6 hours PRN. The quantity total of 240 tablets. A pharmacy form dated 3/21/22, indicated a request for a prescription from the medical provider for Resident 18's 5-325 milligrams of hydrocodone. A prescription written by Medical Provider 35 dated 3/22/22, indicated Resident 18 was to receive 1 to 2 tablets of 5-325 milligrams of hydrocodone/Acetaminophen every 4 hour to 6	F 0602	F602 – Misappropriation/Exploitation **1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** a. 5/13/2022, pharmacy reversed billing to resident 18 insurance and will bill the facility. b. Pharmacy reconciled medications for resident 18 on 4/13/2022. c. LPN 7 was immediately suspended on 4/12/2022 pending investigation and terminated on 4/13/2022. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** **a.** All residents have the potential to be affected alleged deficient practice. **3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** a. DON/designee completed narcotic audit. b. DON/designee in-serviced staff on Misappropriation/exploitation, dispensing, documentation and reconciliation of medication. 4. **How will the facility monitor its corrective actions to**	05/13/2022

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	hours PRN. The quantity total of 240 tablets. Resident 18's clinical record did not have documentation a physician order for 5-325 milligrams of hydrocodone was placed on November 2021, December 2021 January 2022, February 2022, March 2022 and/or April 2022. The record did not include a controlled drug count record for the administration of 5-325 milligrams of hydrocodone to the resident on January 2022, February 2022, March 2022, and April 2022. An incident reported to Indiana Department of Health dated 4/13/22 indicated "...incident date 4/12/22...Brief Description of Incident...4/13/22...Interim DON [Director of Nursing] was reviewing PRN [as needed] medications, utilizing the ADU [Automatic Dispensing Unit] Controlled Dispense Report. Interim DOM {sic} noted that [Resident 18]'s Hydro/APAP [hydrocodone/Acetaminophen] tab [tablets]5-325 mg [milligrams] that had been dispensed through the [name of pharmacy] and noted a discrepancy with medication amounts being dispensed. No documentation of resident receiving medications was recorded...Immediate Action taken...Physician notified. Police contacted and report obtained. Facility is requesting information from pharmacy. Family notified. Investigation initiated...Prevention [License Practical Nurse (LPN) 7] is suspended pending investigation. Investigation is ongoing at this time. Continue to monitor narcotic report daily. Pharmacy has been contacted to submit facility requested information. Resident [18] had no negative outcome..." The investigation file for the reported incident was provided by the Executive Director (ED) on 4/20/22 at 8:45 a.m. It included the following:		**ensure that the deficient practice will not recur?** a. DON/Designee will review medication pulls to ensure reconciliation compliance daily x 4 then every 2 weeks x 2 months, then monthly until substantial compliance has been maintained. b. Findings will be reported monthly at the QA/risk management meeting until such time until substantial compliance has been maintained. 5. DOC: 05/20/22	

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An ADU Controlled Dispenses report dated 4/8/22 indicated at 7:50 a.m., LPN 7 had pulled 3 tablets of 5-325 milligrams of Hydrocodone PRN for Resident 18 from the ADU. LPN 7 had pulled at 12:39 p.m., 4 tablets of 5-325 milligrams of hydrocodone PRN for Resident 18 from the ADU.

A pharmacy report dated January 2022, February 2022, March 2022, and April 2022 indicated the following dates and total of tablets LPN 7 had pulled 5-325 milligrams of hydrocodone for Resident 18 from the ADU:

January 2022
1/12/22, 1/17/22, 1/19/22, 1/21/22, 1/23/22, 1/24/22, 1/26/22 and 1/31/22= total of 16 tablets pulled by LPN 7.

February 2022
2/1/22, 2/5/22, 2/6/22, 2/18/22, 2/19/22, 2/20/22, 2/21/22, 2/23/22, and 2/25/22 = total of 33 tablets pulled by LPN 7,

March 2022
3/6/22, 3/7/22, 3/9/22, 3/11/22, 3/14/22, 3/18/22, 3/19/22, 3/20/22, 3/21/22, 3/23/22, 3/25/22, 3/28/22, 3/30/22 = total of 70 tablets pulled by LPN 7,

April 2022
4/1/22, 4/3/22, 4/6/22, and 4/8/22 = total of 28 tablets pulled by LPN 7,

A total of 147 tablets of 5-325 milligrams of hydrocodone was pulled by LPN 7 for Resident 18 from January 2022 - April 2022.

The file indicated LPN 7's nursing license was placed on probation as of of 2/8/21, due to a regulation violation.

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	The court documentation by the Indiana Professional Licensing Agency file date 3/9/20 indicated LPN 7's nursing license was placed on probation indefinitely. The findings concluded were inappropriate handling of narcotic medications at two other nursing facilities LPN 7 had previously had employment with. The occurrences were unwitnessed counting of narcotic medication and unwitnessed destruction of narcotic medications. She was ordered by the licensing board which included, but was not limited to, "onsite supervision while working." A signed statement by LPN 7 dated 4/13/22 indicated "[LPN 7] came into review the text messages sent to [ED] to confirm accuracy. [LPN 7] did confirm that they were from her and were accurate and signed off that they were from her. [LPN] 7 did come to the facility willingly to provide her statement of the events in question. [LPN 7] did admit to taking the medications; however could not recall the date she actually started taking them. [LPN 7] stated that she did not feel she was taking medications from a resident as it was an order that the resident was not using at the time. She was asked what prompted her to take the medications and she explained she was having issues from a previous medical procedure and that her husband was out of work and they could not afford the medications. [LPN] was asked about her license being on probation and she explained that the allegations were unfounded and they put her license on probation and she has never been part of an ISNAP program [Indiana State Nursing Program]. [ED] explained that they are looking at about 150 pills that are missing. [LPN 7] explained that she did not believe she took that many and that it was more around 40 pills. It was explained			

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	that all the missing medications were signed out under her name...[LPN 7] did express remorse for her actions but that it was purely for medical reasons that she took the medications and that at no time were any of the missing medications sold." An interview was conducted with the Director of Nursing [DON] 1 on 4/20/22 at 1:33 p.m. She indicated she had recognized the medication discrepancy within three days of her employment to the facility. The pharmacy sends an ADU Controlled Dispense Report daily. The report indicates the removal of medications from the ADU. The DON had reviewed a daily report dated 4/8/22, and thought it was "weird" LPN 7 had removed 3 tablets of 5-325 milligrams of hydrocodone for Resident 18, and then a few hours later that same day removed 4 more tablets of 5-325 milligrams of hydrocodone for the same resident. The total that day was 7 tablets. The medication was PRN, and it was uncommon for a nurse to remove 3 tablets at one time. After further investigation, the resident did not have a physician order for the 5-325 milligrams of hydrocodone nor was it on his Medication Administration Record (MAR). There also was no documentation of a controlled count record for Resident 18's hydrocodone. During the investigation, it had been identified the pharmacy had directly sent requests for prescriptions for the resident's hydrocodone to the medical provider. The medical provider had written prescriptions for the resident's hydrocodone and directly sent them back to the pharmacy. The facility was unaware Resident 18 had been prescribed the PRN hydrocodone, and the availability of the medication was in the ADU. He had previously taken hydrocodone medication in the past, but it was believed the hydrocodone was discontinued.			

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	After reviewing of the pharmacy reports, LPN 7 had pulled multiple dosages of the PRN hydrocodone for Resident 18, and she did not work on the unit he resides. An interview was conducted with ED on 4/20/22 at 3:44 p.m. She indicated LPN 7's hire date was on 1/10/22. As of 1/12/22, LPN 7 was working on the floor. She had previously worked in the facility in October 2021, and was familiar with the processes in the facility. LPN 7 upon hire date, did have a drug screen prior to working, and it had come back negative. The former DON was responsible for verification of her nursing license, and she should have looked into why her nursing license was on probation. LPN 7 had not indicated her nursing license was on probation upon hire date. It was not identified until during the investigation of the incident with the medication discrepancy. During the investigation, the pharmacy had sent a report that indicated the dispensing of Resident 18's PRN hydrocodone from January 2022 through April 2022. The report had indicated LPN 7 had pulled a total of 147 tablets of 5-325 milligrams of hydrocodone that was prescribed to Resident 18 PRN from 1/12/22 through 4/8/22. There was no record the resident had received any of the tablets. LPN 7 was cooperative during the investigation with the facility and the authorities. She was remorseful for taking the medication that was prescribed to Resident 18. The abuse policy was provided by the ED on 4/19/22 at 2:52 p.m. It indicated, "...Policy: Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Property, collectively known and referred to as ANEMM and as hereafter defined, will not be tolerated by anyone, including staff, patients, volunteers, family members or legal guardians, friends or any other			

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	individuals...Definitions:...Misappropriation of patient property: the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a patient's belongings or money without the patient's consent..." 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. §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 2 residents reviewed for abuse. (Resident 14) Findings include: The clinical record for Resident 14 was reviewed on 4/20/22 at 9:45 a.m. The diagnoses included, but were not limited to, asthma, hypertension, and bipolar disorder.	F 0610	**1. How will corrective action be accomplished for those residents found to been affected by this deficient practice?** **Executive Director did revisit resident since allegation and voiced no concerns with care. C.N.A whom allegation was reported on is no longer employed.**	05/20/2022

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	The 2/18/22 Quarterly MDS (Minimum Data Set) assessment indicated he required extensive assistance of 2 staff persons for transfers. It indicated he had a BIMS (brief interview for mental status) score of 15, indicating he was cognitively intact. An interview was conducted with Resident 14 on 4/19/22 at 10:38 a.m. He indicated a CNA (Certified Nursing Assistant) was abusive with him about a month ago. She threw him into his wheel chair, which caused a bruise to his left leg, and his game controller was broken during the transfer. The NC (Nurse Consultant) addressed the incident. His game controller was replaced, and the CNA was terminated. An interview was conducted with Resident 14 on 4/20/22 at 1:55 p.m. He indicated the incident occurred in his room. CNA 14 came in with a bad attitude and started yelling. He was in bed and she was assisting him into his wheel chair by herself. He got a bruise on the left side of his leg. No one else was in the room. She was slamming his stuff into his white, 3 drawer bins near the wall, and his stuff hit the floor. He informed RN (Registered Nurse) 17 about the incident that same day, but no one came to discuss the incident with him for at least a week. An interview was conducted with RN 17 on 4/21/22 at 3:55 p.m. He indicated he'd been working full time at the facility for a year, and he cared for Resident 14 a couple weeks ago. He didn't recall a situation where Resident 14 informed him of being thrown into his wheel chair, but Resident 14 did inform him about a staff member breaking his Nintendo Switch, but Resident 14 didn't give any specific details at the		**2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to affected by the alleged deficient practice. Executive Director / Designee will thoroughly investigate any allegations to include staff statements regardless of time lapse.** 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not reoccur. Executive Director re-educated with emphasis on investigation protocol. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? Findings will be reported monthly at the QA/ Risk management meeting until such time substantial compliance has been maintained. 5. DOC: 5/20/2022	

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time. Resident 14 wanted to talk to the SSD (Social Services Director) about it, but the SSD was already gone for the day. RN 17 didn't inform anyone about Resident 14's concerns at the time, because "I thought they already knew about it." This was the first time anyone had inquired with him (RN 17) about this incident.

An interview was conducted with CNA 14 on 4/20/22 at 10:16 a.m. She indicated she remembered the incident in Resident 14's room. She did not break his Nintendo Switch. Someone else broke it.
CNA 15 was also present in the room and was the one who transferred him into his wheel chair, while she stood back and watched. She thought it was the controller to his Nintendo that was broken. She was straightening up his room, when Resident 14 informed her that it dropped and broke when one of the other aides who was cleaning his room. She asked him if he told anyone, but he didn't know who to tell. She thought she told the ED about the situation.

An interview was conducted with CNA 15 on 4/21/22 at 10:57 a.m. She indicated she worked at the facility through an agency for about 8 months, Monday through Friday. She did not recall transferring Resident 14 while CNA 14 was present in his room. Resident 14 never reported any allegations of abuse to her or anything about his Nintendo Switch or other belongings getting broken.

An interview was conducted with the NC on 4/21/22 at 4:03 p.m. She indicated she couldn't recall why she was in Resident 14's room on 3/11/22, but he informed her that CNA 14 threw him into his wheel chair, and broke his phone and Nintendo Switch. She then informed the ED and

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they went to interview him.

The investigative file into the above incident was provided by the ED (Executive Director) on 4/20/22 at 8:30 a.m. The file included a 3/15/22 follow-up incident report. The report read, "Resident reported on 3/11/2022 [name and title of CNA 14] was transferring him and threw him into chair approximately 2 weeks ago. Resident stated he obtained a bruise on left leg. Resident also reported his Nintendo Switch was damaged....Social Service interviewing alert/oriented residents....Follow up added - 3/15/2022 Facility replaced Nintendo Switch which arrived 3/15/22. CNA was terminated prior to resident voicing concern to Executive Director. Resident was happy with outcome and has not voiced any further concerns. No other resident voiced any concerns through interviews. Resident Rights and Abuse in-service is ongoing. Resident has not shown any psychosocial distress. Resident does feel safe in facility."

The investigative file included multiple resident interviews, an interview with Resident 14, Resident 14's face sheet, CNA 14's license, the 3/1/22 corrective action form for CNA 14 indicating she was terminated, the residents rights and abuse inservice sign in sheet, the residents rights policy, and the abuse policy. The file did not include interviews with any staff who may have witnessed or had information regarding the alleged incident or an interview or attempted interview with the alleged perpetrator or an interview with the NC who received the initial allegation.

An interview was conducted with the ED on 4/20/22 at 2:31 p.m. She indicated Resident 14 initially reported the incident to the NC on 3/11/22.

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	They both immediately went to interview him about it. She did not obtain a direct statement from the NC, because they both went to interview him immediately. She did not interview any other staff who was working at the time of the alleged incident, because Resident 14 identified CNA 14 as the alleged perpetrator, so she didn't see the need to interview other staff members. She attempted to contact CNA 14 for an interview, but CNA 14 hung up on her. She did not document and include this attempted interview in the investigative file, and was unsure as to why not. The Abuse, Neglect, Exploitation, and Misappropriation of Property Prevention, Protection and Response Policy and Procedure was provided by the ED on 4/19/22 at 2:52 p.m. It read, "Investigative Issues: ...Policy: All events reported as possible ANEM will be investigated to determine whether ANEM occurred. Procedure: THE ANEM PREVENTION COORDINATOR will initiate investigative action." 3.1-28(d)			
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;			

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	(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical			

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	record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.			
	Based on interview and record review, the facility failed to send transfer paperwork to the hospital with a resident for 1 of 2 residents reviewed for hospitalization. (Resident 35) Findings include:	F 0622	**F622 – Transfer and Discharge requirements** 1. **How will corrective action be accomplished for those residents found to have been affected by the deficient practice?**	05/20/2022

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	The clinical record for Resident 35 was reviewed on 4/22/22 at 12:21 p.m. His diagnoses included, but were not limited to, chronic respiratory failure and hypertension. The 3/28/22, 10:13 a.m. progress note read, "Called to residents room by niece who stated that resident is diabetic and needs his blood sugar checked. Writer checked residents blood sugar and it is 190 after breakfast. VSS [Vital signs stable] at this time and resident resting in bed with eyes closed no s/s [signs/symptoms] of any distress noted. While in the room residents daughter called neices [sic] phone and stated that he has pneumonia and this is how he acted right before he bottomed out and things got real bad.' Residents daughter requesting that resident be sent to ER [emergency room] for eval [evaluation] and tx [treatment.] Writer contacted MD who gave the order to send resident per family request. Called [sic] placed and EMS [emergency medical services] in route family requesting that resident be sent to [name of hospital.]" There was no information in the clinical record to indicate what information was sent to the hospital with Resident 35. An interview was conducted with the NC (Nurse Consultant) on 4/22/22 at 12:43 p.m. She indicated when a resident was transferred to the hospital, they sent the face sheet, orders, code status, bed hold policy, immunizations, and recent labs. It should be documented in the progress notes that the information was sent. The NC reviewed Resident 35's clinical record at this time and indicated, "I see the bed hold policy scanned in there, but nothing else." 3.1-12(a)(3)		a. Resident 35 has been discharged from facility. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** **a.** All residents have the potential to be affected alleged deficient practice. **3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** a. DON/Designee in-serviced staff on discharge paperwork. **4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** a. SSD to complete discharge audits 2 times a week 4 week then weekly until substantial compliance has been maintained. a. Findings will be reported monthly at the QA/risk management meeting until such time until substantial compliance has been maintained. **5.** DOC: 05/20/22	

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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 that care plan conferences were completed timely for 2 of 2 residents reviewed for care planning (Resident 25 and 29). Findings include: 1. The clinical record for Resident 29 was	F 0657	**F 657 Care Plan Timing and Revision** **1. How will corrective action be accomplished for those Residents found to been affected by this deficient practice?** **1. Resident # 29 and Resident # 25 attended Care**	05/20/2022

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	reviewed on 4/19/22 at 1:30 p.m. The Resident's diagnosis included, but were not limited to, heart failure and hemiplegia (paralysis) of the left side. He was admitted to the facility on 12/17/22. A Quarterly MDS (Minimum Data Set) Assessment, completed 3/23/22, indicated he was cognitively intact. During an interview on 4/19/22 at 1:45 p.m., he indicated he had not attended a care plan meeting since he had been at the facility. On 4/21/22 at 9:35 a.m., the Executive Director provided the most recent Multidisciplinary Care Conference Note, dated 12/29/21 and indicated there were no other Multidisciplinary Care Confrence Notes in his clinical record. 2. The clinical record for Resident 25 was reviewed on 4/20/22 at 11:51 a.m. Resident 25's diagnoses included, but not limited to, chronic kidney disease, diabetes mellitus, and hypertension. An Ddmission MDS (minimum data set) Assessment was completed on 2/20/22 indicating he was cognitively intact. A quarterly MDS was completed on 3/22/22. An interview with Resident 25 was conducted on 4/19/22 at 11:13 a.m. He indicated, he had not been invited to his interdisciplinary care plan meetings, but would like to be involved as he had questions regarding his discharge plan. Resident 25's clinical record did not contain any documentation which indicated, he had been invited to his care plan meeting nor an explanation if he refused participation or was determined to be		**Plan Meeting on 5/12/2022.** **How will the facility identify other residents having the potential to be affected by the same deficient practice?** **2. All residents have the potential to affected by the same deficient practice. Social Service will complete an audit to ensure current residents have attended at least 1 care plan meeting in the last 60 days.** 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not reoccur. Social Service was provided education on emphasis F657 components and invitations for care plan meetings Social Service will distribute a monthly calendar to the IDT team from MDS in progress schedule and will add any new admissions accordingly. Social Service will use a formal invitation inviting residents to scheduled care plan meeting. Social Service will telephone responsible parties for time and date. Social Services and or Designee will randomly audit care plan meetings weekly x4 weeks, then monthly thereafter. 4. How will the facility monitor	

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	impracticable. An interview with SSD (Social Services Director) was conducted on 4/21/22 at 10:20 a.m. SSD indicated, she had not documented any evidence of an IDT (Interdisciplinary team) care plan meeting had occurred for Resident 25, the members who where in attendance, or if he was involved. SSD further stated there should have been documentation in the clinical record. A Comprehensive Person-Centered Care Plan policy was received on 4/20/22 at 10:52 a.m. from DON (Director of Nursing). The policy indicated, "...1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident...3. The IDT includes: a. the attending physician; b. a licensed or registered nurse who has responsibility for the resident; c. a nurse aide who has responsibility for the resident; d. a member of the food and nutrition service staff; e. the resident and the resident's legal representative (to the extent practicable); and f. other appropriate staff or professionals as determined by the resident's needs or as requested by the resident. Each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care...5. A resident will be informed of his or her right to participate in her of her treatment. 6. An explanation will be included in a resident's medical record if the participation of the resident and		its corrective actions to ensure that the deficient practice will not recur? Findings will be reported monthly at the QA/ Risk management meeting until such time substantial compliance has been maintained. DOC: 5/20/2022	

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	his/her resident representative for developing the resident's care plan is determined to not be practicable...14. The interdisciplinary team must review and update the care plan: a. when there has been a significant change in the residents condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment..." 3.1-35(c)(2)(C) 3.1-35(d)(2)(B) 3.1-35(e)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			
	Based on observation, interview, and record review, the facility failed to administer an antibiotic as ordered and to timely address a skin conditionfor 1 of 5 residents reviewed for unnecessary medications and 1 of 1 resident reviewed for skin conditions (Resident 18 and Resident 22). Findings include:	F 0684	F684 – Quality of Care 1. **How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** a. Resident 18 medications were reconciled. Assessment conducted on Resident # 18, with no observed change in condition. b. Resident 22 treatments	05/20/2022

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	1. The clinical record for Resident 18 was reviewed on 4/19/22 at 12:30 p.m. The resident's diagnoses included, but were not limited to, chronic kidney disease, cancer of tonsil. A physician order dated 3/24/22 indicated Resident 18 was to receive 100 milligrams of diffucan once daily for 14 days for a Urinary Tract Infection (UTI). The March 2022 Medication Administration Record (MAR) indicated Resident 18 had received the daily diffucan on the following days: 3/26/22, 3/27/22, 3/28/22, 3/29/22, 3/30/31 and 3/31/22 (6 dosages) The April 2022 MAR indicated Resident 18 had received the daily diffucan on the following days: 4/1/22, 4/3/22, 4/4/22 and 4/5/22 (4 dosages) A nursing progress note dated 4/2/22 indicated the medication was unavailable. A nursing progress note dated 4/6/22 indicated the staff was "waiting arrival" for medication. A nursing progress note dated 4/7/22 indicated the diffucan medication was on order. A nursing progress note dated 4/8/22 indicated the diffucan medication had been sent 4 days ago and "medication supply exhausted." An interview was conducted on 4/21/22 at 3:00 p.m. She indicated she was unsure why the resident had not received the diffucan medication 14 days as ordered.		were clarified on. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** **a.** All residents have the potential to be affected alleged deficient practice. **1.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** a. DON/Designee completed audit on all ATB order and treatments. b. DON/Designee in-serviced staff on medication/tx administration and orders. **1.How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** a. DON/Designee will review new orders for antibiotics and treatments weekly x 4 weeks then monthly until substantial compliance has been maintained. 1.Findings will be reported monthly at the QA/risk management meeting until such time until substantial compliance has been maintained. **5.** DOC: 05/20/22	

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	2. The clinical record for Resident 22 was reviewed on 4/19/22 at 10:02 a.m. The Resident's diagnosis included, but were not limited to, Parkinson's disease and protein calorie malnutrition. A care plan, initiated on 2/4/22, indicated she was a risk for skin tears and bruises related to a decreased subcutaneous skin layer secondary to the aging process. The goal was to reduce risk factors in order to attempt to avoid skin tears and bruising. The interventions, initiated on 2/4/22, included to administer medications as ordered, apply lotion as needed, notify the physician and the family as needed and to keep nails trimmed and filed as needed. A Hospice Communication note, dated 3/31/22, indicated she had a sore on her left check that she had scratched. There was dried blood on the pillowcase when it was changed. A Weekly Wound Observation, dated 4/6/22, indicated there was an area on her left check, acquired 4/6/22, which was 1.6 cm (Centimeter) long x 1.0 cm wide x 0.2 cm deep. The current treatment plan was to cleanse with normal saline, pat dry, apply betadine (antiseptic solution) and cover with calcium alginate/ Abd pad (type of dressing) and wrap with kerlix (gauze wrap) secured with tape daily and as needed. A Hospice Physician Order, dated 4/8/22, indicated that her left check was to be cleaned and an antibiotic ointment applied. It was to be covered with a transparent film dressing with a pad every other day and as needed for dislodgement. This was to start on 4/8/22. A physician's order, dated 4/8/22, indicated to			

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	apply bacitracin ointment (antibiotic) to the left cheek every other day on the evening shift for wound care and as needed every 24 hours. The April 2022 TAR (Treatment Administration Record) indicated the bacitracin had been applied to her left cheek on 4/10/22 and 4/12/22. She had refused the treatment on 4/14/22. The order was discontinued on 4/15/22. A Weekly Wound Observation, dated 4/13/22 at 4:44 p.m., indicated that the area on her left cheek was 1.5cm x 1.5 cm x 0.2 cm. The current treatment plan was to cleanse with normal saline, pat dry and apply Bactroban (antibiotic ointment) to wound twice daily. A physician's order, dated 4/15/22, indicates to apply Mupirocin (antibiotic cream equivalent to Bactroban) to left cheek topically two times a day for skin irritation. The start date of the order was 4/19/22. The April 2022 TAR indicated the Mupirocin cream had not been applied to her left cheek from 4/15/22 through 4/19/2022 at 9:00 a.m. During an interview on 4/20/22 at 10:29 a.m., HN (Hospice Nurse) 3 indicated that Resident 22 tended to pick at her face often. She had written an order for the antibiotic order and a transparent dressing on 4/8/22 due to the open area on her left cheek. She was unsure why the order had not been completed by the nursing staff. She had communicated the order to one of the staff nurses when she wrote it. She was unaware that it had not been completed or that it had been changed. On 4/20/22 at 10:49 a.m., Resident 22 was observed sitting in a wheelchair at her bed side.			

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	She had a red, scratched area on her left cheek which appeared to be the size of a dime and was scabbed. During an interview on 4/20/22 at 1:10 p.m., the Executive Director indicated she was unsure why the area on her left cheek had not been addressed when it was discovered. On 4/20/22 at 1:10 p.m., the Executive Director provided the Pressure Ulcers/ Skin Breakdown-Clinical Protocol, revised 4/2018, which read "...Treatment/ Management 1. The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings...and application of topical agents... 3.1-37			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to prevent the	F 0686	F686 – treatment/svcs to Prevent/Heal Pressure Ulcer	05/13/2022

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	development of a pressure ulcer and providing the necessary treatment to promote the healing of a pressure ulcer for 1 of 1 residents reviewed for pressure ulcers. (Resident 25) Findings include: The clinical record for Resident 25 was reviewed on 4/20/22 at 11:51 a.m. Resident 25's diagnoses included, but not limited to, chronic kidney disease, diabetes mellitus, and hypertension. Resident 25 was admitted to the facility on 2/13/22. At the time of admission, Resident 25 did not have a pressure wound to his right heel. A Baseline Care plan for Resident 25 dated 2/4/22 indicated, Resident 25 required the assistance of two staff members for bed mobility, transfers, and bathing. It also indicated, Resident 25 had the following skin issues: fragile skin, risk for pressure injuries, and a current pressure injury to his sacrum and buttocks. The interventions in place were to turn and repositition and treatments as ordered. An Admit/Readmit Screen dated 2/4/22 indicated, under the skin integrity section the following was listed: - right buttock had redness - left bottock had redness - right lower leg (front) had moist fragile skin and edema - left lower leg (front) had moist fragile sking and edema The facility completed a weekly summary with weekly skin checks on the following dates: 2/14/22, 2/21/22, 3/7/22, 3/14/22 and 3/15/22. None of the weekly summary with weekly skin checks noted any changes to Resident 25's right heel.		1. **How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** a. Resident 25 treatment was completed 4/20/2022. b. Resident 25 had pressure relieving interventions initiated on 4/20/2022. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** **a.** All residents have the potential to be affected alleged deficient practice. **1.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** a. DON/Designee completed dressing change and pressure relieving interventions audit on residents with wounds. b. DON/Designee in-serviced staff on pressure ulcer prevention and dressing changes, ie turning / repositioning. Changing treatments per order, sign off after you administer a treatment / medication. c. Resident #22 treatment orders were reviewed and clarified. **1.How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?**	

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	A weekly wound observation was performed on 3/16/22. At that time, it indicated, a right heel wound was first observed. It was listed as unstageable; measured 4 cm x 4.5 cm; had 67-100% necrotic tissue including eschar in wound bed; and necrotic tissue was present. A physician's order dated 3/16/22 indicated, encourage the resident to float heels when in bed and document compliance or refusal each shift. A physician's order dated 3/16/22 indicated, to cleanse the wound on the right heel with normal saline, pat dry, paint with betadine, cover with abdominal pad, and wrap with kerlix every day shift and as needed for soilage or dislodgement.. Resident 25's care plan dated 3/30/22 indicated, he had an unstageable area to his right heel. The interventions included, but not limited to, apply treatment as ordered, float heels when in bed, and measure area weekly. An observation of Resident 25's right heel was made on 4/19/22 at 11:22 a.m. Resident 25 had a pressure wound on the bottom of his right heel. The wound appeared black in color and left open to air. Resident 25 did not have his heels floated nor was there anything in place at the end of his bed to float his heels on. An observation of Resident 25 was made on 4/20/22 at 11:42 a.m. Resident 25 had on non-slip socks on both feet and the right sock was pushed down to his ankle. A dressing to the heel was not observed. An interview with Resident 25, conducted at the same time as the observation, indicated, his right heel wound treatment was not done yet that day.		a. DON/Designee will audit dressing changes and pressure relieving interventions weekly x 4 weeks then monthly until substantial compliance has been maintained. 1.Findings will be reported monthly at the QA/risk management meeting until such time until substantial compliance has been maintained. **5.** DOC: 05/20/22	

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	Resident 25's Medication Administration Report (MAR) was reviewed 4/20/22 at 11:42 a.m. while in the resident's room. The MAR indicated, the right heel wound treatment had been completed. An interview with ADON (Assistant Director of Nursing) and Resident 25 was conducted on 4/20/22 at 11:44 a.m. in Resident 25's room. ADON had asked Resident 25 again, if his heel treatment had been completed for the day and Resident 25 indicated, it had not been done. ADON indicated, the wound treatment should not have been documented as completed when it was not completed. 3.1-40(a)(1) 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on interview and record review, the facility failed to transfer a resident with 2 staff members, as care planned, for 1 of 2 residents reviewed for abuse. (Resident 14) Findings include: The clinical record for Resident 14 was reviewed on 4/20/22 at 9:45 a.m. The diagnoses included,	F 0689	**F689 – Free of Accident Hazards/Supervision/Devices** 1. **How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** a. A licensed therapist completed an evaluation on	05/20/2022

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	but were not limited to, asthma, hypertension, and bipolar disorder. The 2/18/22 Quarterly MDS (Minimum Data Set) assessment indicated he required extensive assistance of 2 staff persons for transfers. It indicated he had a BIMS (brief interview for mental status) score of 15, indicating he was cognitively intact. The fall risk care plan indicated he required extensive assistance of 2 staff for transfers, effective 11/5/21. An interview was conducted with Resident 14 on 4/19/22 at 10:38 a.m. He indicated a CNA (Certified Nursing Assistant) threw him into his wheel chair about a month ago, which caused bruising to his left leg. The investigative file into the above incident was provided by the ED (Executive Director) on 4/20/22 at 8:30 a.m. The file included a 3/15/22 follow-up incident report. The report read, "Resident reported on 3/11/2022 [name and title of CNA 14] was transferring him and threw him into chair approximately 2 weeks ago. Resident stated he obtained a bruise on left leg." An interview was conducted with Resident 14 on 4/20/22 at 1:55 p.m. He indicated the incident occurred in his room. He was in bed, and CNA 14 was assisting him into his wheel chair by herself. She did not use a gait belt, and would lift him from underneath his arms. Sometimes one staff member would assist him into transferring him into his wheel chair, and sometimes it was 2 staff members. The transfers went more smoothly when done with 2 staff members.		Resident 14 on (date) to determine appropriate transfer status. b. The licensed therapist placed dycem in resident number 30's wheelchair on 4/21/22, as a slip prevention and positioning enhancement. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** **a.** All residents have the potential to be affected alleged deficient practice. **1.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** a. A licensed therapist completed an evaluation on Resident 14 on 05/17/22 to determine appropriate transfer status. b. DON/Designee completed audit on all fall interventions. c. DON/designee conducted in-service training for staff to know the transfer status of residents and to use proper transfer technique, based on transfer status. d. DON/Designee will complete 3 observations of transfer weekly x 4 weeks, then monthly until substantial compliance has been maintained. **1.How will the facility**	

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	An interview was conducted with CNA 14 on 4/20/22 at 10:16 a.m. She indicated she recalled the incident with Resident 14. She thought CNA 15 was present at the time, and CNA 15 was the one who transferred him, while she (CNA 14) "stood back and watched." CNA 15 informed her Resident 14 was able to transfer himself. CNA 15 put her arm under his arm and transferred him into his wheel chair. She stated, "There were times I transferred him by myself, maybe once a week." They went smoothly for the most part. An interview was conducted with CNA 15 on 4/21/22 at 10:57 a.m. She indicated she worked at the facility through an agency, for approximately 8 months, Monday through Friday. She was familiar with Resident 14 and he transferred "pretty well." She didn't think he needed 2 staff members to transfer him. "He tries to act like he needs lifted, but he can transfer by himself." She did not recall assisting CNA 14 with transferring Resident 14, as they only worked together "like twice." 3.1-45(a)(2) Based on observation, interview and record, the facility failed to ensure a fall intervention was implemented for 1 of 1 residents reviewed for positioning. (Resident 30) Findings include:		**monitor its corrective actions to ensure that the deficient practice will not recur?** a. DON/designee will complete audits on transfer status weekly x 4 weeks then monthly until substantial compliance has been maintained. b. DON/Designee will complete audits on fall interventions weekly x 4 weeks then monthly until substantial compliance has been maintained. 1.Findings will be reported monthly at the QA/risk management meeting until substantial compliance has been maintained. **5.** DOC: 05/20/22	

The clinical record for Resident 30 was reviewed on 4/19/22 at 11:40 a.m. The resident's diagnoses included, but were not limited to, vascular dementia and hemiplegia following a stroke.

A care plan dated 2/4/22 indicated "Fall Risk: Resident is at risk of injury related to falls due to dx [diagnosis] of hemiplegia and hemiparesis...Interventions: dycem to w/c [wheelchair]..."

A nursing progress note dated 3/9/22, indicated "...fall from 3/8/2022. Resident had fall from w/c. Resident witnessed to slide from w/c to floor. Resident observed for injuries with none noted, nurse stated resident did not hit her head. Resident unable to state what she was attempting to do. Interventions in place at time of fall: call light within reach, non-skid footwear on, environment well lit and clutter free. Resident assisted up and into bed. Dycem to be placed in w/c."

An interview was conducted with Resident 30's Representative on 4/19/22 at 2:23 p.m. She indicated the resident slides out of her chair.

An observation was made of Resident 30's wheelchair on 4/20/22 at 9:53 a.m. The resident's wheelchair did not have dycem placed in her chair.

An observation was made with Certified Nursing Assistant (CNA) 10 of Resident 30's wheelchair on 4/21/22 at 2:08 p.m. There was no observation of dycem placed in the chair. CNA 10 indicated at that time, she can not recall if dycem was ever placed in the resident's chair. She had only seen the pad, and that was placed for the resident to have additional comfort while she sits in the chair.

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	An observation was made of Resident 30's wheelchair with the Rehabilitation Director on 4/21/22 at 2:33 p.m. The resident's wheelchair was observed in the bathroom with no dycem placed under the pad on the wheelchair. She indicated at that time, the pad on the wheelchair does have material that will help with sliding, but there was no dycem. She does recall giving the nursing staff dycem to place in her chair after she fell, but unsure what happened to it. 3.1-45(a)(1)			
F 0690 SS=G Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder			

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	receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to coordinate care to address a resident's continued use of a Foley catheter resulting in the resident developing a urinary tract infection for 1 of 1 residents reviewed for catheter care. (Resident 25) Findings include: The clinical record for Resident 25 was reviewed on 4/20/22 at 11:51 a.m. Resident 25's diagnoses included, but not limited to, chronic kidney disease, diabetes mellitus, and hypertension. Resident 25 was admitted to the facility on 2/13/22. At the time of admission, Resident 25 had a Foley catheter in place. An observation of Resident 25 occurred on 4/19/22 at 11:17 a.m. Resident 25 had a Foley catheter and the drainage bag was hanging on the side of his bed. An interview with Resident 25 was conducted on 4/19/22 at 11:17 a.m. Resident 25 indicated, he was not sure why he had a Foley catheter. He stated, prior to his admission to the facility, he lived at an Assisted Living and did not have a urinary catheter.	F 0690	F690 – Bowel/Bladder Incontinence, Catheter, UTI **1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** a. DON/Designee obtained appropriate dx on residents 25 catheter. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** **a.** All residents have the potential to be affected alleged deficient practice. **1.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** a. DON/Designee completed audit on all residents who have catheters for appropriate dx. b. DON/Designee in-serviced staff on appropriate catheter use dx.	05/20/2022

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	A Discharge Summary dated 2/4/22 from [local hospital's name] was received on 4/21/22 from NC (Nurse Consultant). It indicated, Resident 25's discharge diagnoses included, but not limited to, pneumonia, acute kidney injury, acute respiratory failure, diabetes mellitus, and chronic kidney disease. Under the section "Hospital course", it indicated, "Urology was consulted for hematuria [sic, blood in urine] s/p [sic, status post] traumatic Foley placement, and Foley was hand irrigated...Will need eventual cystoscopy [sic, endoscopy of the urinary bladder via the urethra] and stent removal versus exchange..." Post discharge instructions indicated, Resident 25 had a follow up appointment with Urology physician on 2/9/22 at 9:10 a.m. Resident 25 was unable to attend the Urology appointment on 2/9/22 because he was re-admitted to the hospital on 2/8/22. An interview with NC was conducted on 4/21/22 at 2:01 p.m. When asked what the clinical indication for Resident 25's Foley catheter was, she was unable to identify why he still had a Foley catheter. She then indicated, she remembered having a conversation with the Nurse Practitioner regarding the indication for the continued use of a Foley catheter for Resident 25. NC indicated, the Nurse Practitioner wanted to keep the Foley catheter in until Resident 25 was seen by Urology and they would determine when and if to remove the Foley catheter. A physician's progress note dated, 3/15/2022 at 3:55 p.m. indicated, "He does have Urology appt today for f/u [sic, follow up] on Foley catheter/possible voiding trial." A Urology visit note dated 3/15/22 was provided		**1.How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** a. DON/Designee will complete audits on catheter dx weekly x 4 weeks then monthly until substantial compliance has been maintained. 1.Findings will be reported monthly at the QA/risk management meeting until such time substantial compliance has been maintained. **5.** DOC: 05/20/22	

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	on 4/21/22 by SCH (scheduler) 51. It did not indicate the reason for continued use of Resident 25's Foley catheter. It did indicate, "with his chronic Foley, he will need a urine culture at least 10-14 days preoperatively and be placed on culture specific antibiotics." The visit note did not address when or if the Foley should be removed or a voiding trial. A physician's order placed on 3/18/22 indicated, perform a complete blood count and a urinalysis with reflux and culture as stat (immediate) labs. Resident 25's urinalysis report dated 3/19/22 indicated, Resident 25's urine was orange, cloudy, contained large amount of blood and a large amount of white blood cells. The results were abnormal. A physician's order placed on 3/22/22 indicated, nursing needed to request the results of the urine culture that was performed on 3/18/22 from the laboratory and notify physician of results. A copy of Resident 25's urine culture result dated 3/23/22 at 4:30 p.m. was received from NC on 4/21/22 at 3:45 p.m. The urine culture result indicated, the culture could not be performed as the specimen quality was "inadequate...Test not performed. The specimen exceeds stability for the test requested." Resident 25's clinical record did not contain a progress note indicating the results of the urine culture from 3/23/22 were communicated to the physician. An interview with NP was conducted on 04/21/22 at 3:31 p.m. NC indicated, the nurse should have notified the physician of the result of the urine			

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	culture and ask if they wanted to repeat the order and get it sent out. On 4/5/22, a physician to facility message was sent. A copy of the message was received on 4/21/22 at 3:45 p.m. from NC. The message indicated, Resident 25's urine was yellow but a little cloudy and to order a urinalysis for the next lab day. A physician's order was placed on 4/19/22. The order indicated, to administer one 500 mg Cipro (an antibiotic) tablet once a day for 7 days for a urinary tract infection. An interview with Resident 25's Urologist was conducted on 4/21/22 at 3:49 p.m. Urology indicated, when a new patient comes in with a urinary catheter already in place, they usually do not inquire about the indication for its use. They were not given any information from the facility which indicated they wanted Urology to address the indication for continued use or determine when/if it could be removed nor had Urology ordered the Foley. As of 4/21/22, Resident 25 still had a Foley catheter. Resident 25's care plan dated 3/30/22 indicated, he was at risk for a urinary tract infection related to Foley catheter use and cystitis (inflammation of bladder). The interventions included, but not limited to: encourage fluids, monitor for signs/symptoms of urinary tract infection, and to monitor labs as ordered. 3.1-41(a)			

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to administer humidification, as ordered by a physician, to 1 of 1 resident reviewed for tracheostomy care (Resident 26). Findings include: The clinical record for Resident 26 was reviewed on 4/19/22 at 11:50 a.m. The Resident's diagnosis included, but were not limited to, chronic obstructive pulmonary disease and tracheostomy. A physician's order, dated 2/19/2020, indicated to apply humidification collar for tracheostomy. Apply it every night at bedtime. Use distilled water only. A physician's order, dated 2/19/2020, indicated to remove the humidification collar every morning. A Quarterly MDS (Minimum Data Set) Assessment, dated 3/23/22, indicated she was cognitively intact. A care plan, revised on 3/30/22, indicated she had	F 0695	F695 – Respiratory/Tracheostomy Care and Suctioning 1. **How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** a. DON/Designee obtained an order to d/c humidification for resident 26 on 5/13/2022 **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** **a.** All residents have the potential to be affected alleged deficient practice. **1.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** 1.DON/Designee in-serviced staff on following physician orders for tracheostomy care. **2.How will the facility**	05/20/2022

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	a tracheostomy. The goal was for her to have clear and equal breath sounds. An intervention, dated 12/31/2019, was to provide adequate oral/ tracheostomy care daily and as needed. The April 2022 TAR (Treatment Administration Record) indicated the humidity collar had been applied on the following days: 4/2/22, 4/3/22, 4/5/22, 4/6/22, 4/7/22, 4/8/22, 4/12/22, 4/13/22, 4/14/22, 4/16/22, 4/18/22, 4/19/22, and 4/20/22. On 4/21/22 at 3:46 p.m., her room was observed with LPN 4. There was no humidification machine present in the room. During an interview on 4/21/22 at 3:50 p.m., Resident 26 indicated that she did not have a humidity machine anymore. It had been gone for a while and she was doing fine without it. She did not want to use it. During an interview on 4/21/22 at 3:55 p.m. LPN 4 indicated the order for humidification should have been discontinued when the machine was removed from the room. 3.1-47(a)(6)		**monitor its corrective actions to ensure that the deficient practice will not recur?** a. DON/Designee will complete audits on tracheostomy care orders weekly x 4 weeks then monthly until substantial compliance has been maintained. 1.Findings will be reported monthly at the QA/risk management meeting until such time substantial compliance has been maintained. **5.** DOC: 05/20/22	
F 0697 SS=G Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to adequately address a resident's pain after a fall with hip fracture resulting in continued	F 0697	F697 – Pain Management **1. How will corrective**	05/20/2022

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	extreme pain for 1 of 1 residents reviewed for death. (Resident 36) Findings include: The clinical record for Resident 36 was reviewed on 4/20/22 at 10:53 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease and Covid-19. She was admitted to the facility on 12/30/21. The 1/16/22 progress note read, "Resident tested positive for covid 19, resident moved immediately with N95 into red zone precautions, MD and family notified." The 1/21/22, 10:02 p.m. nurse's note, written by the NC (Nurse Consultant) read, "Resident alert to self with moderate to severe confusion. Severe tremors in all extremities. Unable to hold drink or use eating utensils. respirations 21 BP [blood pressure] =118/94 HR [heart rate] =100. Resident appears fearful. She doesn't know where she is and does not answer direct questions such as her DOB [date of birth.] Needs reassurance and coaching to help slow her breathing and calm her. Periods of calm are brief and she begins to panic again. Called on-call provider who ordered STAT [immediately, without delay] CBC [complete blood count,] BMP [basic metabolic panel,] and UA [urinalysis.] Daughter of resident notified and states the she has noticed a decline in the resident's status. She also states her mother does have a history of anxiety. DON [Director of Nursing] also notified of resident's current status." The 1/22/22, 5:41 a.m. nurse's note, written by LPN (Licensed Practical Nurse) 19, read, "Resident resting in bed at this time. Frequently wakes up		**action be accomplished for those residents found to have been affected by the deficient practice?** a. Resident 36 has discharged from facility **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** **a.** All residents have the potential to be affected alleged deficient practice. **1.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** a. DON/Designee conducted an audit of post-fall pain evaluations. b. DON/Designee completed re-education with nursing staff regarding post-fall pain evaluations, pain relieving interventions, administering analgesics and documentation. **1.How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** a. DON/Designee will conduct audits of post-fall pain evaluations weekly x 4 weeks then monthly until substantial compliance has been maintained. 1.Findings will be reported monthly at the QA/risk management meeting until such time substantial compliance has	

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	due to a productive cough. No SOB [shortness of breath] noted. Resident has significant weakness in her lower extremities. Requires assistance with sitting up in bed, transfers, and ADLs [activities of daily living.]" The 1/22/22, 2:25 p.m. nurse's note, written by LPN 19, read, "Res [Resident] was heard yelling out in room. Upon entering room, res had gotten out of bed by self and fallen to floor. Res was asked where she was going, and res stated she was getting ready for her first day of school. Increased anxiety and confusion continues. Res was assessed for injuries and a skin tear to R elbow was noted. Res was transferred back to bed and vitals were taken., BP 139/78, P [Pulse] 96, R [Respirations] 20, 02 95% 1 L 02, T. [Temperature] 98.4. Pain noted to R [right] side. Skin tear to R elbow was cleaned and bandaged. Res repositioned to L [left] side in bed and bed is in lowest position. Family notified and is at bedside, and NP [Nurse Practitioner] aware. Neuros [Neurological checks] will be started and will continue to monitor." The 1/22/22, 2:54 p.m. nurse's note, written by LPN 19, read, "NP was made aware of the pain res is having to R hip, writer asked if a R hip xray was able to be obtained and NP agreed. Writer ordered STAT xray from [name of lab company." The 1/22/22, 6:29 p.m. nurse's note, written by LPN 19, read, "Res is resting in room at this time. Neuros continues and family continues to be at bedside. Awaiting Lab to obtain test. Vitals WNL [within normal limits.] Pain continues to R side. Lying on L to alleviate pain. Continues with ATB [antibiotic.] No a/r d/t ATB. T. 9.78. Fluids encouraged. Cough and congestion continues. Will continue to monitor."		been maintained. **5.** DOC: 05/20/22	

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The 1/22/22, 6:45 p.m. nurse's note, written by LPN 19, read, "Res had a fall this afternoon and had an order to obtain a xray to R hip, unable to obtain xray until tomorrow and res is having increased pain to R side. Family in agreeance to send to ER [emergency room] for further eval [evaluation] and tx [treatment.] 911 called and EMT [emergency medical technicians] on way to transport. Family at bedside."

The 1/22/22, 7:05 p.m. nurse's note, written by LPN 19, read, "Resident transported to the hospital by EMS [emergency medical services.]"

The 1/22/22 evening shift pain level was a 5 on a scale of 1 to 10, and that nonpharmacological interventions were not applicable.

The physician's orders indicated as 650 mg of as needed Acetaminophen could be given every 4 hours for pain or fever, effective 1/1/22.

The January, 2022 MAR (medication administration record) indicated Resident 36 did not receive any as needed Acetaminophen or any other pain medication to address her continued pain after her fall. The last pain medication given, prior to going to the hospital, was 650 mg of regularly scheduled Tylenol at 8:00 a.m., before her fall.

An interview was conducted with the NC on 4/20/22 at 1:35 p.m. in the presence of the ADON (Assistant Director of Nursing). She indicated, if she were the nurse on duty during Resident 36's fall, she would normally have given pain medication afterwards to address her pain.

An interview was conducted with the NC on

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4/20/22 at 3:45 p.m. She indicated she couldn't find any verification that pain medication was given to address Resident 36's continued pain after her fall.

An interview was conducted with LPN 19 on 4/22/22 at 10:08 a.m. She indicated she found Resident 36 on the floor. She was complaining of hip pain, so she called the physician and got an order for an x-ray. She called the NP back, because the lab wasn't coming to do the x-ray, so the NP told her to go ahead and send her out to the hospital. Resident 36 she was very confused prior to the fall, agitated, antsy, and not understanding what was going on. LPN 19 was working the Covid-19 unit at the time and only caring for a total of 3 residents, including Resident 36. The fall occurred while she was caring for another resident. It was the weekend, and she got the order for the x-ray, but the lab was unable to come. She made sure Resident 36 left to go to the hospital, before she ended her shift.
She stated, "I felt really bad for her, because we waited for so long." If you had to move her, she let me know she hurt. When you moved her, she was guarding the area and would say ouch. I don't know if she had any scheduled pain medications. Tylenol was able to be given, but she couldn't remember if she gave any, and she didn't think she had any as needed pain medications that were available to be given. She couldn't recall exactly what she told the on call physician/NP, but she'd been a nurse for a while and she didn't feel right leaving the without her being sent out. Her shift was over at 6:00 p.mm. and she didn't leave until Resident 36 actually left in the ambulance. She had a feeling something was wrong. Either her hip was "really, really bruised, if not broken."

An interview was conducted with NP 18 on 4/22/22 at 9:39 a.m. She suggesting reviewing the

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facility's paging system records to find out whether the on call provider was notified of the pain. She stated, "I can't tell you why they wouldn't administer pain meds [medicatins] in that time frame." I would have been off that day, so it would have been the on call NP who would have responded.

The 1/22/22 paging system records were provided by the ADON on 4/22/22 at 10:47 a.m. They indicated the thread between LPN 19 and the NP began on 1/22/22 at 2:11 p.m. There was a total of 5 communications as follows:

LPN 19 - "Res had a fall this afternoon.Vitals WNL. Confusion and anxiety is increasing. Stated she was going to get ready for first day of school. Skin tear to R elbow measuring 2 cm X 1 cm. Found on R side and is complaining of pain. Can we obtain xray of R hip?"

NP - "Yes"

LPN 19 - "Thank you"

LPN 19 - "[Name of x-ray company] won't be able to be here until tomorrow, can we go ahead and send to ER. Res is in extreme pain?

NP - "Yes!!"

The 1/23/22, 5:56 a.m. progress note read, "Resident admitted to [name of hospital] with hip fracture."

The 1/22/22 hospital notes indicated, "Assessment/Plan: Principal Problem: Closed fracture of right hip, initial encounter...1. Right Closed fracture right hip: 2/2 [secondary to] Unwitnessed fall. Orthostatic hypotension with

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	debility likely contributing. X-ray right hip shows acute mildly displaced right femur transcervical neck fracture....Ortho consulted with no surgical plans at this time. Trend troponins. Echo in the morning. NPO [nothing by mouth.] Pain control....4. Hypertensive emergency: Blood pressure 200 systolic. Does have AKI [acute kidney injury,] likely pain contributing....On arrival she is alert but not oriented. Not following commands or answering questions. She is moaning in pain...moving all extremities except right hip due to pain...." The 1/25/22 Palliative Care Consult Note from the hospital read, "Plan: 1) acute pain/closed R hip fracture - continues comfort care. 2) Palliative care - placed hospice consult - will continues support pt [patient] and family as able." The Pain - Clinical Protocol was provided by the ED (Executive Director) on 4/20/22 at 4:05 p.m. It read, "2. The nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain." 3.1-37(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.			

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	§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			
	Based on observation, interview and record review, the facility failed to timely recognize an irregularity of a resident's medication regarding inappropriate monitoring/tracking and handling of a narcotic medication that was removed from an automatic drug dispensing unit (ADU). (Resident 18) Findings include: The clinical record for Resident 18 was reviewed on 4/19/22 at 12:30 p.m. The resident's diagnoses included, but were not limited to, chronic kidney disease, cancer of tonsil.	F 0755	F755 – Pharmacy Srvcs/Procedures/Pharmacist/Records **1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** a. Pharmacy reconciled medications for resident 18 on 4/13/2022. **2. How will the facility identify other residents having the potential to be affected by**	05/20/2022

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	A physician order dated 7/27/21 indicated Resident 18 was to receive 1 tablet of 5-325 milligrams of hydrocodone every 6 hours PRN (as needed) for pain. A physician order dated 11/12/21 indicated Resident 18's PRN 5-325 milligrams of hydrocodone medication was to be discontinued due to the resident was not using. A pharmacy form dated 11/25/21, indicated a request for a prescription from the medical provider for Resident 18's 5-325 milligrams of hydrocodone. A prescription written by Medical Provider 35 dated 11/29/21, indicated Resident 18 was to receive 1 to 2 tablets of 5-325 milligrams of hydrocodone/Acetaminophen every 4 hour to 6 hours PRN. The quantity total of 120 tablets. A pharmacy form dated 1/18/22, indicated a request for a prescription from the medical provider for Resident 18's 5-325 milligrams of hydrocodone. A prescription written by Medical Provider 35 dated 1/19/22, indicated Resident 18 was to receive 1 to 2 tablets of 5-325 milligrams of hydrocodone/Acetaminophen every 4 hour to 6 hours PRN. The quantity total of 240 tablets. A pharmacy form dated 3/21/22, indicated a request for a prescription from the medical provider for Resident 18's 5-325 milligrams of hydrocodone. A prescription written by Medical Provider 35 dated 3/22/22, indicated Resident 18 was to receive 1 to 2 tablets of 5-325 milligrams of hydrocodone/Acetaminophen every 4 hour to 6 hours PRN. The quantity total of 240 tablets. Resident 18's clinical record did not have documentation a physician order for a 5-325		**the same deficient practice?** **a.** All residents have the potential to be affected alleged deficient practice. **3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** a. DON/designee completed narcotic audit. b. DON/designee in-serviced staff on ADU narcotic pulls, documentation and reconciliation of medication. **4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** a. DON/Designee will review medication pulls to ensure reconciliation compliance daily x 4 weeks, then every 2 weeks x 2 months, then monthly until substantial compliance has been maintained. b. Findings will be reported monthly at the QA/risk management meeting until such time substantial compliance has been maintained. **5.** DOC: 05/20/22	

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	milligrams of hydrocodone PRN was placed on November 2021, December 2021 January 2022, February 2022, March 2022 and/or April 2022. The record did not include a controlled drug count record for the administration of 5-325 milligrams of hydrocodone to the resident on January 2022, February 2022, March 2022, and April 2022. An incident reported to Indiana Department of Health dated 4/13/22 indicated "...incident date 4/12/22...Brief Description of Incident...4/13/22...Interim DON [Director of Nursing] was reviewing PRN [as needed] medications, utilizing the ADU [Automatic Dispensing Unit] Controlled Dispense Report. Interim DOM {sic} noted that [Resident 18]'s Hydro/APAP [hydrocodone/Acetaminophen] tab [tablets]5-325 mg [milligrams] that had been dispensed through the [name of pharmacy] and noted a discrepancy with medication amounts being dispensed. No documentation of resident receiving medications was recorded...Immediate Action taken...Physician notified. Police contacted and report obtained. Facility is requesting information from pharmacy. Family notified. Investigation initiated...Prevention [License Practical Nurse (LPN) 7] is suspended pending investigation. Investigation is ongoing at this time. Continue to monitor narcotic report daily. Pharmacy has been contacted to submit facility requested information. Resident [18] had no negative outcome..." The investigation file for the reported incident was provided by the Executive Director (ED) on 4/20/22 at 8:45 a.m. It included the following: An ADU Controlled Dispenses report dated 4/8/22 indicated at 7:50 a.m., LPN 7 had pulled 3 tablets of 5-325 milligrams of Hydrocodone PRN			

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for Resident 18 from the ADU. LPN 7 had pulled at 12:39 p.m., 4 tablets of 5-325 milligrams of hydrocodone PRN for Resident 18 from the ADU.

A pharmacy report dated January 2022, February 2022, March 2022, and April 2022 indicated the following dates and total of tablets LPN 7 had pulled 5-325 milligrams of hydrocodone for Resident 18 from the ADU:

January 2022
1/12/22, 1/17/22, 1/19/22, 1/21/22, 1/23/22, 1/24/22, 1/26/22 and 1/31/22= total of 16 tablets pulled by LPN 7.

February 2022
2/1/22, 2/5/22, 2/6/22, 2/18/22, 2/19/22, 2/20/22, 2/21/22, 2/23/22, and 2/25/22 = total of 33 tablets pulled by LPN 7,

March 2022
3/6/22, 3/7/22, 3/9/22, 3/11/22, 3/14/22, 3/18/22, 3/19/22, 3/20/22, 3/21/22, 3/23/22, 3/25/22, 3/28/22, 3/30/22 = total of 70 tablets pulled by LPN 7,

April 2022
4/1/22, 4/3/22, 4/6/22, and 4/8/22 = total of 28 tablets pulled by LPN 7,

A total of 147 tablets of 5-325 milligrams of hydrocodone was pulled by LPN 7 for Resident 18 from January 2022 - April 2022.

A signed statement by LPN 7 dated 4/13/22 indicated "[LPN 7] came into review the text messages sent to [ED] to confirm accuracy. [LPN 7] did confirm that they were from her and were accurate and signed off that they were from her.... [LPN 7] did admit to taking the medications; however could not recall the date she actually

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	started taking them. [LPN 7] stated that she did not feel she was taking medications from a resident as it was an order that the resident was not using at the time...[ED] explained that they are looking at about 150 pills that are missing, [LPN 7] explained that she did not believe she took that many and that it was more around 40 pills. It was explained that all the missing medications were signed out under her name..." An interview was conducted with the Director of Nursing [DON] 1 on 4/20/22 at 1:33 p.m. She indicated she had recognized the medication discrepancy within three days of her employment to the facility. The pharmacy sends an ADU Controlled Dispense Report daily. The report indicates the removal of medications from the ADU. On 4/12/22, the DON had reviewed a daily report dated 4/8/22, and thought it was "weird" LPN 7 had removed 3 tablets of 5-325 milligrams of hydrocodone for Resident 18, and then a few hours later that same day removed 4 more tablets of 5-325 milligrams of hydrocodone for the same resident. The total that day was 7 tablets. The medication was PRN, and it was uncommon for a nurse to remove 3 tablets at one time. After further investigation, the resident did not have a physician order for the 5-325 milligrams of hydrocodone nor was it on his Medication Administration Record (MAR). There also was no documentation of a controlled medication count record for Resident 18's hydrocodone. During the investigation, it had been identified the pharmacy had directly sent requests for prescriptions for the resident's hydrocodone to the medical provider. The medical provider had written prescriptions for the resident's hydrocodone and directly sent them back to the pharmacy. She was unaware Resident 18 had been prescribed the PRN hydrocodone, and the availability of the medication was in the			

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	ADU. The resident had previously taken hydrocodone medication in the past, but it was believed the hydrocodone was discontinued. After reviewing of the pharmacy reports, LPN 7 had pulled multiple dosages of the PRN hydrocodone for Resident 18, and she did not work on the unit he resides. During the interview, an observation was made of the ADU with DON 1. It was revealed during the investigation some residents' PRN medications are pulled from the ADU. LPN 7 had been pulling the hydrocodone utilizing the ADU and not recording the removal on a narcotic count record. At that time, the DON was observed utilizing the ADU. She indicated if you type the residents name all the medications that are available to that resident are listed. The ADU will allow nursing to remove the entire day of medications the residents were able to receive that day per the physician orders; regardless if the medications are PRN or scheduled. Since the incident she has requested pharmacy to send all PRN medications in bubble cards (medication punch card) instead of using the ADU unit so the facility was able to track the medications. An interview was conducted with ED on 4/20/22 at 3:44 p.m. She indicated the pharmacy had sent a report that indicated the dispensing of Resident 18's PRN hydrocodone from January 2022 through April 2022. The report had indicated LPN 7 had pulled a total of 147 tablets of 5-325 milligrams of hydrocodone that was prescribed to Resident 18 PRN from 1/12/22 through 4/8/22. There was no record the resident had received any of the tablets. An interview was conducted with the Nurse Consultant on 4/21/22 at 9:00 a.m. She indicated			

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	she had previously been acting as the DON prior to DON 1 after LPN 7's hire date. The pharmacy does send an ADU Controlled Dispense Report daily, but she had not utilized and/or reviewed the report to track medications that were removed the from the ADU. She did not believe reconciliation of medications removed from the ADU was being done. An interview was conducted with the Pharmacy Technician Supervisor (PTS), Pharmacy Representative (PR) 31 and the Nurse Consultant on 4/21/22 at 9:38 a.m. PTS indicated the pharmacy had received a discontinue order of Resident 18's PRN hydrocodone on 11/12/21. On 11/22/21, the pharmacy had then received another order by an ears, nose throat medical provider (Otolaryngology). Resident 18 was to receive 12 tablets of 5-325 milligrams of hydrocodone. The order was then put into their electronic system, and at that time, the availability of the hydrocodone was in the ADU for Resident 18. The pharmacy did fax over requests for Medical Provider 35 for prescriptions if he would like to continue with the resident's hydrocodone order on 11/25/21, 1/18/22, and 3/21/22. The pharmacy had received prescriptions to continue the PRN hydrocodone for Resident 18 by Medical Provider 35, so the hydrocodone continued to be available in the ADU for the resident to receive. The Nurse Consultant indicated she was unaware the resident was provided an order from an ears, nose and throat medical provider for 12 tablets of 5-325 milligrams of hydrocodone, and the continued availability of the PRN hydrocodone in the ADU for the resident. PR 31 and PST indicated the pharmacy staff do not reconcile the ADU, but the pharmacy does send daily ADU Controlled Dispense Reports, and the facility staff should receive a report that indicates excess usage by			

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	one staff person removing multiple medications out of the ADU. The Nurse Consultant indicated the facility does receive the excess usage report. The agency staff utilized in the facility are unable to remove medications from the ADU, so it is not uncommon that one individual would pull multiple medications out of the ADU. The report was lengthy, so it would be difficult to identify irregularities. A nursing progress note dated 11/18/2021 at 2:11 p.m., indicated Resident 18 was having a laryngoscopy with biopsy on 11/22/21. An after visit summary from an Otolaryngology medical provider that included pre and post operative instructions and a post operative instructions was provided by the Nurse Consultant on 4/21/22 at 10:51 a.m. The visit summary dated 11/22/22, indicated Resident 18 was seen, and the information on the summary included pre and post-operative instructions for a procedure the resident would be having. The visit summary did not address the ordered 5-325 milligrams of PRN hydrocodone. An Otolaryngology post operative instructions form dated 11/29/21 indicated Resident 18 had a direct laryngoscopy with biopsy that day. The post instructions had not address the ordered 5-325 milligrams of PRN hydrocodone. An interview was conducted with the Nurse Consultant on 4/21/22 at 10:55 a.m. She indicated the otolaryngology office had not sent paperwork that notified the facility staff PRN hydrocodone had been ordered for Resident 18 after his procedure. The nursing staff should have clarified with the clinic if there new orders after the resident's procedure.			

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	A Controlled Substances policy was provided by the ED on 4/21/22 at 10:28 p.m. It indicated "...Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. Procedures: A. The Director of Nursing and the consultant pharmacist in collaboration maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications...E. Accurate accountability of the inventory of all controlled drugs is maintained at all times. When a controlled substance is administered, the licensed nurse administrating the medication immediately enters the following information on the accountability record and the medication administration record (MAR): 1) Date and time of administration (MAR, Accountability Record). 2) Amount administered (Accountability Record). 3) Remaining quantity (Accountability Record). 4) Initials of the nurse administrating the dose, completed after the medication is actually administered (MAR, Accountability Record)..." 3.1-25(b)(3)(e)(2)(3)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and			

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	(iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility failed to monitor and document behaviors, as	F 0758	**F758 – Free from Unnec Psychotropic Meds/PRN Use**	05/20/2022

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	ordered, and develop and implement behavioral interventions prior to use of a medication for 2 of 5 residents reviewed for unnecessary medications. (Resident 5 and Resident 32). Findings include: 1. The clinical record for Resident 5 was reviewed on 4/22/22 at 10:36 a.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance, major depressive disorder, and psychotic disorder with delusions. The physicians orders indicated to monitor and document the following behaviors every shift, as follows: invading others personal space, effective 2/23/22; agitation, effective 2/23/22; combative, effective 2/23/22; delusions, effective 2/23/22; refusal of care, effective 12/7/21; and wandering, effective 2/23/22. The April, 2022 MAR (medication administration record) indicated the monitoring and documenting of the following behaviors was not completed as ordered: invading others personal space on the night shift of 4/7/22 and the evening shift of 4/19/22; agitation on the night shift of 4/7/22, day shifts of 4/13/22, 4/16/22, and 4/19/22, and evening shift of 4/19/22; combative on the night shift of 4/7/22, day shifts of 4/13/22 and 4/16/22, and evening shift of 4/19/22; delusions on the night shift of 4/7/22, day shifts of 4/13/22 and 4/16/22, and evening shift of 4/19/22; refusal of care on the evening shifts of 4/1/22, 4/4/22, and 4/19/22 and the day shifts of 4/2/22 and 4/6/22; and wandering on the night shift of 4/7/22 and evening shift of 4/19/22. The physician's orders indicated for 250 mg of depakote sprinkles (mood		**1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** a. Resident 5 and 32 behavior monitoring orders and interventions were reviewed and ensured in place. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** **a.** All residents have the potential to be affected alleged deficient practice. **3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** a. DON/Designee conducted an audit of all resident's behavior monitoring and interventions. b. DON/Designee completed re-education with staff on behavior monitoring, interventions, medication administration, documentation. **4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** a. DON/Designee will conduct audits on behavior monitoring and interventions weekly x 4 weeks then monthly until substantial compliance has been maintained. b. Findings will be reported	

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	stabilizer/anticonvulsant medication) to be administered twice daily, effective 11/4/20; for 0.5 mg of risperdal (antipsychotic medication) to be administered at bedtime; and for 1 mg of risperdal to be administered in the morning. They indicated to monitor for and document side effects of the mood stabilizer/anticonvulsant medication every shift, effective 2/23/22, and to monitor for side effects of the antipsychotic medication every shift, effective 2/23/22. The April, 2022 MAR indicated the ordered monitoring and documenting of the mood stabilizer/anticonvulsant medication was not completed as follows: day shifts of 4/2/22, 4/13/22, and 4/16/22, evening shift of 4/19/22, and the night shift of 4/7/22. The ordered monitoring and documenting of the antipsychotic medication was not completed as follows: day shift of 4/16/22, the evening shift of 4/19/22, and the night shift of 4/7/22. An interview was conducted with the NC (Nurse Consultant) on 4/22/22 at 12:40 p.m. She indicated she was unsure why the behavior monitoring was not completed as ordered. The 2/23/22 9:49 a.m. activities note read, "On Friday 2/18/22 resident was being rude towards other residents in activities. Writer explained to resident that's not nice and we all need to get along resident stated she can do what she wants to do. Writer asked [name of Resident 5] to leave activities. On Monday 2/21/22 during activities residents stated to me the past weekend some of them were playing cards at the table on long-term dining room. Marlene took the resident [name of another resident] cookie that was in front of her. When [name of other resident] asked for her cookie back [name of Resident 5] told [name of		monthly at the QA/risk management meeting until such time substantial compliance has been maintained. **5.** DOC: 05/20/22	

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	other resident] she out [sic] her cookie in between her legs. [Name of other resident] told [name of Resident 5] I don't need it then. During activities on 2/22/22 residents were in the activities room writer walked by with a bag, [name of Resident 5] asked writer is that my stuff and writer said no is not. [Name of Resident 5] started getting upset being rude to the other residents writer asked [name of Resident 5] to leave and [name of Resident 5] said I will leave when I get ready. Writer asked [name of Resident 5] to leave again [name of Resident 5] turned her chair around and said no and then stood up grabbed writer arm and then hand and squeezed her nails in writer left hand skin. Then [name of Resident 5] hit writer in the left eye with a magazine and cursed at writer." The 3/16/22, 9:21 p.m. nurses note read, "CNA [Certified Nursing Assistant] and one resident saw her hit and kicked [room number of another resident,] patients separated and educated. Management noticed. will report to the next shift and keep monitoring." The 3/25/22, 3:05 p.m. nurse's note read, "I witnessed [name of Resident 5] throw a cup of punch in the CNA [name of CNA] face and she also hit him in the head with a plastic stand up sign holder." An interview was conducted with the SSD (Social Services Director) on 4/22/22 at 11:44 a.m. She indicated she was only aware of 1 or 2 incidents of resident to resident physically aggressive behaviors. She was unaware of her being physically aggressive with staff, as indicated in the nurse's and activities notes. She monitored behaviors by pulling behavior notes, not nurse's notes or activities notes, or reviewing the MAR. They probably needed to do some training to			

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document behaviors under behavior notes instead of activities. She knew nursing monitored behaviors in the MAR, but she did not monitor those. It was good to find out the behavior monitoring was in multiple places, so she didn't rely on behavior notes. If she had known about her behaviors during activities, she'd have followed up with her, talked to her, made sure everything was okay, see what happened, or try another intervention.

2. The clinical record for Resident 32 was reviewed on 4/20/22 at 3:13 p.m. Resident 32's diagnoses included, but not limited to, acute appendicitis with perforation, chronic obstructive pulmonary disease, emphysema, and anxiety. Resident 32's diagnoses list indicated, the anxiety was identified during his stay at the facility. Resident 32 was cognitively intact.

Resident 32 was re-admitted to the facility following a hospitalization on 4/12/22.

A physician's order placed on 4/13/22 indicated, to administer one 20 mg Prozac capsule once a day for panic attacks.

Resident 32's April Medication Administration Report (MAR) was reviewed on 4/20/21. It indicated, Resident 32 received the Prozac tablet on the following dates: 4/13/22, 4/14/22, 4/15/22, 4/16/22, 4/17/22, 4/18/22, 4/19/22, 4/20/22, and 4/21/22.

Resident 32's physician orders did not contain an order to monitor and document sign/symptoms of anxiety or to monitor and document the potential side effects related to the use of a psychotropic medication.

Resident 32's care plan dated 4/13/22 indicated, he

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	required supervision with activities of daily living and supervision of bed mobility related to anxiety. Resident 32's care plan did not address any non-pharmacological interventions to use prior to the administration of a psychotropic medication nor a care plan for anxiety. An interview with DON (Director of Nursing) was conducted on 4/20/22 at 10:21 a.m. DON indicated, Resident 32's care plan should have contained non-pharmacological interventions to use prior to use of anti-anxiety medication as well as monitoring and documentation of any adverse side effects. A Comprehensive Person-Centered Care Plan policy was received from DON on 4/20/22 at 10:52 a.m. It indicated, the care plan should include, but not limited to: identified problem areas; reflect treatment goals, timetables and objectives in measurable outcomes; aid in preventing or reducing decline in the resident's functional status and/or functional levels. Care plan interventions should address the underlying source(s) of the problem areas and not just addressing only symptoms or triggers. The resident's care plan should be reviewed and updated when there has been a significant change in the resident's condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay and at least quarterly, in conjunction with quarterly MDS (minimum data set) assessment. 3.1-48(a)(3) 3.1-48(b)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals			

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	Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview and record review, the facility failed to ensure medications stored in the medication carts had open dates on 1 of 2 medications observed. (Resident 32) Findings include: The clinical record for Resident 32 was reviewed on 4/22/22 at 10:00 a.m. The resident's diagnosis included, but was not limited to, chronic kidney disease. Resident 32 was admitted on 4/12/22. A physician order dated 4/13/22 indicated Resident 32 was to receive 50 mcg (micrograms) of	F 0761	F761 – Label/Store Drugs and Biologicals **1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** a. Resident 32 eye medication removed from med and flonse disposed of, new flonase bottle opened with date open placed on bottle. **2. How will the facility identify other residents having**	05/20/2022

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	flonase in both nostrils once a day. A physician order dated 4/13/22 indicated Resident 32 was to receive 2 drops in each eye every 2 hours. This order was discontinued on 4/19/22. An observation was made of the rehab medication cart with License Practical Nurse (LPN) 4 on 4/22/22 at 10:09 a.m. Resident 32's lubricating tears bottle had been used, and there was no open date observed. The resident's flonase was observed opened but there was no open date on it. At that time, LPN 4 indicated all medications stored in the medication cart should be labeled when the staff open the medication. Resident 32's lubricating had been discontinued a few days ago and should have been removed from the cart. An interview was conducted with the Assistant Director of Nursing (ADON) on 4/22/22 at 10:38 a.m. He indicated all meds stored in the medication carts should be dated with open dates. A labeling of medication containers policy was provided by the Assistant Director of Nursing (ADON) on 4/22/22 at 10:57 a.m. It indicated "...All medications in the facility are properly labeled in accordance with current state and federal guidelines and regulations...3. Labels for individual resident medications include all necessary information, such as: ..h. the expiration date when applicable..." 3.1-25(j)(k)(6)		**the potential to be affected by the same deficient practice?** **a.** All residents have the potential to be affected alleged deficient practice. **1.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** a. DON/Designee conducted an audit of date open stickers on medications. b. DON/Designee completed re-education with nursing staff on labeling/storage of medications. **1.How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** a. DON/Designee will audit date open stickers on medications weekly x 4 weeks then monthly until substantial compliance has been maintained. 1.Findings will be reported monthly at the QA/risk management meeting until such time substantial compliance has been maintained. **5.** DOC: 05/20/22	
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or			

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	obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.			
	Based on interview and record review, the facility failed to obtain STAT (immediately, without delay) labs, as ordered, for 1 of 2 residents reviewed for death and 1 of 2 residents reviewed for hospitalization (Resident 36 and Resident 15) Findings include: 1. The clinical record for Resident 36 was reviewed on 4/20/22 at 10:53 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease and Covid-19. She was admitted to the facility on 12/30/21. The 1/16/22 progress note read, "Resident tested positive for covid 19, resident moved immediately with N95 into red zone precautions, MD and family notified." The 1/18/22 NP (Nurse Practitioner) note, written by NP 18, NP read, "...seen for evaluation following positive COVID POC [point of care] test on 1/15/22. Patient is at high risk for poor outcomes d/t [due to] underlying comorbidities outlined in PMH to include long-Covid or patient mortality. VSS [vital signs stable] on baseline O2 [oxygen] today. Patient was started on Keflex last week for UTI [urinary tract infection,] Z-pak added following COVID diagnosis. Urinary symptoms have improved. Patient seen while resting in bed...She reports that she is feeling better today than yesterday, but still feels very tired. Lungs diminished with course rhonchi/wheezing	F 0770	F770 – Laboratory Services 1. **How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** a. Resident 36 has been discharged from the facility. b. Resident 15 lab orders were reconciled. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** **a.** All residents have the potential to be affected alleged deficient practice. **1.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** a. DON/Designee conducted an audit of stat lab orders. b. DON/Designee completed re-education with nursing staff on stat lab procedures. **1.How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** a. DON/Designee will conduct	05/20/2022

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	throughout....Bloodwork was not obtained last week as ordered for unclear reasons, request stat today. Medications, labs, and chart reviewed." There were no lab results in the clinical record referenced in the 1/18/22 NP note as not having been obtained last week for unclear reasons. The 1/21/22, 10:02 p.m. nurse's note read, "Resident alert to self with moderate to severe confusion. Severe tremors in all extremities. Unable to hold drink or use eating utensils. respirations 21 BP [blood pressure] =118/94 HR [heart rate] =100. Resident appears fearful. She doesn't know where she is and does not answer direct questions such as her DOB [date of birth.] Needs reassurance and coaching to help slow her breathing and calm her. Periods of calm are brief and she begins to panic again. Called on-call provider who ordered STAT CBC [complete blood count,] BMP [basic metabolic panel,] and UA [urinalysis.] Daughter of resident notified and states the she has noticed a decline in the resident's status. She also states her mother does have a history of anxiety. DON [Director of Nursing] also notified of resident's current status." There were no CBC, BMP, or UA results from the 1/21/22 NP note in Resident 36's clinical record. The 1/22/22, 6:45 p.m. nurse's note indicated Resident 36 was sent to the emergency room for further evaluation after a fall. The 1/22/22, 7:05 p.m. nurse's note read, "Resident transported to the hospital by EMS [emergency medical services.] An interview was conducted with the ADON		audits on stat labs weekly x 4 weeks then monthly until substantial compliance has been maintained. 1.Findings will be reported monthly at the QA/risk management meeting until such time substantial compliance has been maintained. 5. DOC: 05/20/22	

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(Assistant Director of Nursing) and the NC (Nurse Consultant) on 4/20/22 at 1:35 p.m. The NC indicated the STAT labs ordered on 1/21/22 should have been done. She reviewed lab results on her laptop and stated, "I don't see that the STAT labs were done." They'd been having a lot of issues with the lab, like them not coming to do STAT labs. If unable to obtain the labs, she'd have sent the resident out or notified the physician to see what they wanted to do.

An interview was conducted with NP 18 on 4/22/22 at 9:39 a.m. She indicated she couldn't recall if she was told about not being able to obtain the STAT labs on 1/21/22, but she knew the facility was having issues with the lab not showing up and was still having issues. Ideally, nursing would call and let her know and she could reorder them. She suggested reviewing the paging system records to see if the facility notified her about the inability to obtain labs.

The 1/22/22 paging system records were provided by the ADON on 4/22/22 at 10:47 a.m. It did not reference the STAT labs.

2. The clinical record for Resident 15 was reviewed on 4/19/22 at 9:30 a.m. The Resident's diagnosis included, but were not limited to, traumatic brain injury and epilepsy.

An Annual MDS (Minimum Data Set) Assessment, completed 2/25/22, indicated he had short- and long-term memory problems and severely impaired decision-making skills.

A health status note dated 1/19/22 at 1:55 a.m., indicated he was noted to have a slight, non-productive, cough. He was afebrile and was given cough medication. The physician and his

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power of attorney was notified.

A physician's order, dated 1/19/22, indicated a BMP (Basic Metabolic Panel), CBC (Complete Blood Count) and UA (Urinalysis) were to be completed STAT (right away) due to his cough and weakness

A health status note, dated 1/19/22 at 1:00 p.m., indicated a new order was received for STAT labs. A urine sample had been obtained and was awaiting pick up.

The clinical record did not contain any laboratory results for 1/19/22.

A physician's progress noted, dated 1/21/22 at 2:35 p.m., indicated he had been seen, at the request of the family, due to decreased mentation (mental activity) and dark urine. A STAT CMP, CBC, and UA were to be obtained.

Laboratory results for 1/21/22, indicated abnormal results as follows: elevated sodium level, low creatinine level, elevated BUN (Blood Urea Nitrogen)/ creatinine ration, elevated white blood cells, low hemoglobin, and low hematocrit. Urinalysis results indicated the urine color was amber and the clarity was turbid. There was blood and protein found in the urine and a culture was indicated.

The urine culture results were completed on 1/24/22 and indicated there was MRSA (Methicillin Resistance Staphylococcus Aureus) and Stenotrophomonas Maltephilia (type of bacteria).

A physician's progress note, dated 1/25/22 at 3:49 p.m., indicated that Bactrim (Antibiotic) was

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	started due to the bacteria present in the urinalysis and his water intake was to be increased for 72 hours due to mild hypernatremia (high sodium level). During an interview on 4/22/22 at 12:32 p.m., the NC (Nurse Consultant) indicated there were no laboratory results present in the clinical record for 1/19/22 and that STAT laboratory orders should be completed within 4 hours of being ordered. On 4/22/22 at 10:57 a.m., the Assistant Director of Nursing provided the Lab and Diagnostic Test Results Policy, revised 11/2018) which read "...Assessment and Recognition 1. The physician will identify, and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests. 3. The laboratory, diagnostic radiology provider, or other testing sources will report test results to the facility..." 3.1-49(a)			
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services;			

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	§483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.			
	Based on interview and record review, the facility failed to timely follow up on dental services for 1 of 3 residents reviewed for dental services. (Resident 32) Findings include: The clinical record for Resident 32 was reviewed on 4/20/22 at 3:13 p.m. Resident 32's diagnoses included, but not limited to, acute appendicitis	F 0791	**F791 – Routine/Emergency Dental Srvcs** 1. **How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** a. Resident 32 was seen by	05/20/2022

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	with perforation, chronic obstructive pulmonary disease, emphysema, and anxiety. Resident 32 was cognitively intact. An interview with Resident 32 was conducted on 4/19/22 at 10:42 a.m. Resident 32 indicated, he used to have dentures but, when he had returned from a hospitalization, his dentures were missing. He stated, the facility had arranged for him to see the dentist and they took dental impressions back in December 2021. He has not received his dentures to date nor had he heard anything about them. A social services note dated 12/14/2021 at 5:04 p.m. indicated, "Writer contacted [name, address and phone number of dentist] this date to request appointment for resident for new dentures. [sic]Scheduled appointment is Wednesday, 12/15/21, at 4:00 pm. [sic]Family will transport. Per ED[sic, Executive Director]/Administrator, this facility will assume cost of new dentures as original dentures were lost here". An interview with SSD (Social Services Director) was conducted on 4/20/22 at 10:49 a.m. SSD indicated, she was not the Director of Social Services when Resident 32 had gone to the dentist in December 2021 nor had She been made aware of Resident 32's dental issue or the need to follow up. A Consultants policy was received on 4/20/22 at 4:25 p.m. from Regional Director. The policy indicated, "Our facility may use as needed outside resources to furnish specific services to residents and to the facility...Consultant services may be utilized in the following areas:...Medical and dental services...Consultants provide the administrator with written, dated, and signed		dental services. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** a. All residents have the potential to be affected by this deficient practice. **3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** a. Facility is in the process of new contract with new ancillary services provider. b. SSD will refer any residents who have a need for dental services to an outside provider if current ancillary service provider unable to come. **4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** a. SSD will report schedule of ancillary services in morning meeting weekly x 4 weeks then monthly until substantial compliance has been maintained. b. Findings will be reported monthly at the QA/risk management meeting until such time substantial compliance has been maintained. 5. DOC: 05/20/22	

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	reports of each consultation visit. Such reports contain the consultant's: a. recommendations; b. plan for implementation of his/her recommendations; c. findings; and d. plan for continued assessments. 5. The facility retains the professional and administrative responsibility for all services provided by consultants." A Social Services policy was received on 4/20/22 at 4:25 p.m. from Regional Director. The policy indicated, "1. The Director of Social Services is a qualified social worker and is responsible for:...d. An adequate record system for obtaining, recording, and filing of social service data...4. The social services department is responsible for:...g. Maintaining appropriate documentation of referrals and providing social service data summaries to such agencies". 3.1-24(a)			