STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155417	A. BUILDING 00 B. WING	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT SCOTTSBURG	1100 N GARDNER AVE SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure survey. Survey dates: July 6, 7, 10, 11, and 12, 2023. Facility number: 000421 Provider Number: 155417 AIM number: 100288340 Census Bed Type: SNF/NF: 31 Total: 31 Census Payor Type: Medicare: 1 Medicaid: 24 Other: 6 Total: 31 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 19, 2023.	F 0000	This plan of correction constitutes the facility's written allegation of compliance for the deficiencies cited. The submission of the Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. Hickory Creek of Scottsburg would like to request a desk review. Please feel free to contact Rachel Colwell, if you need any additional information to support the desk review at 812-595-6125. Thank you for your consideration.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rachel Colwell		07/31/2023

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	(that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility	F 0580		08/11/2023

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	failed to notify the physician when a pulmonology consult was not made as ordered by the hospital discharging physician (Resident 12); a resident experienced low blood sugars outside the physician ordered parameters (Resident 19); and a resident experienced a change in condition which required hospitalization and ordered labs were not completed (Resident 2) for 3 of 13 residents reviewed for physician notification. Findings include: 1. The record for Resident 12 was reviewed on 7/10/23 at 8:34 a.m. The diagnoses included, but were not limited to, acute exacerbation of chronic obstructive pulmonary disease (COPD) with hypoxia, type 2 Diabetes Mellitus with diabetic polyneuropathy, peripheral vascular disease (PVD) and hypertensive heart disease with heart failure. The Quarterly Minimum Data Set (MDS) assessments, dated 3/3/23 and 6/20/23, indicated the resident was cognitively intact. A nurse's note, dated 2/18/23 at 9:22 p.m., indicated that while arguing with his roommate, Resident 12 became red in the face with slurred speech. A new physician's order was received to send him to the hospital. A nurse's note, dated 2/19/23 at 4:44 a.m., indicated the resident was transferred from the local hospital to another hospital to be admitted for syncope and exacerbation of COPD. The hospital discharge orders, dated 2/24/23, included, but were not limited to, keep the follow up appointments; follow up with the primary care physician in 1 week; and follow up with the (name		**F 580** **It is the standard of this facility to ensure that the physician is notified of changes.** 1.) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #12 had no negative outcome related to this alleged deficient practice. Resident NP canceled the pulmonary consult and the physician was notified. Resident # 2 had no negative outcome related to this alleged deficient practice. Resident's MD was notified of the resident's change of condition and no new orders were received. Resident # 19 had no negative outcome related to this alleged deficient practice. Resident's physician is being contacted when resident blood sugars are outside ordered parameters. 2.) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by this alleged deficient practice. All clinical staff will be in serviced	

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	of pulmonologist) in 2 to 3 weeks related to the final bronchi culture which grew escherichia coli ESBL (Extended Spectrum Beta Lactamase). The NP's (Nurse Practitioner) note, dated 2/27/23 at 12:16 a.m., indicated the resident was being evaluated after a hospital stay for COPD exacerbation with hypoxia. The hospital chest X-ray showed right lower lobe pneumonia and had required tapering doses of O2 (oxygen) ranging from 15 liters to 8 liters, and was then weaned down to 5 liters. An order was given for the resident to see the pulmonologist in 2 to 3 weeks. The NP's note, dated 2/28/23 at 8:09 a.m., indicated she had been notified over the weekend of the resident having desaturation and drowsiness. Orders were given for the resident to be transferred back to the hospital if not improved. He did not improve and EMS (Emergency Medical Services) was called. The resident initially refused to go, but then agreed to go to a different hospital, and refused to go when EMS arrived at the facility. An order was written again for the resident to follow up with the pulmonologist in 2 to 3 weeks. The NP's note, dated 3/2/23 at 8:45 a.m., indicated there was no nursing note of the pulmonary follow up documented. The NP again gave orders for the resident to follow up with the pulmonologist in 2 to 3 weeks. A nurse's note, dated 3/2/23 at 4:16 p.m., indicated the nurse attempted to contact the pulmonologist's office to schedule an appointment without success. A message was left for the office to return the call to the facility.		on the facility s Notification of Resident Change of Condition, Blood Glucose Monitoring policy, and to follow up with NP request for additional appointments on 08/03/23. DNS/Designee reviewed all resident medical record to ensure appointments were made as requested, Blood sugars are followed per MD order and to ensure residents MD have been notified for a change of condition. On 07/31/23 an audit of the past 30 days will be completed for all diabetic residents to ensure proper notification was made for all abnormal blood sugar readings. 3.) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? DNS or Designee will review the facility activity report during morning meeting and during Gemba rounds with the clinical IDT team. The DNS/Designee will verify if the physician has been notified of any medical status changes.	

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	The record lacked documentation indicating the physician had been notified that the facility was having difficulty contacting the pulmonologist's office to set up the ordered appointment. The record lacked documentation of the pulmonologist office having been contacted for an appointment until 7 weeks after the order was initially received after returning from the hospital. During an interview with the Director of Nursing (DON) on 7/10/23 at 10:50 a.m., she indicated the hospital notes only indicated for the resident to follow up with either his primary physician or the pulmonologist and that since the resident's primary physician saw him on 4/5/23 and indicated his breathing was fine, no pulmonologist follow up appointment was needed to be scheduled. A NP note, dated 4/18/23 at 8:56 a.m. and recorded as a late entry on 7/10/23 at 10:58 a.m., indicated the resident was being evaluated this day for follow up to his pneumonia. She indicated that although the resident was scheduled to go to the pulmonologist, he declined to go and told the staff and NP that he would not go because he had been in the hospital too long and was tired. The NP gave a new order to not follow up with pulmonary and that there was no need to reschedule. During an interview with the DON on 7/11/23 at 11:00 a.m., the DON indicated that when the NP saw the resident on 4/18/23, the resident had refused to go the pulmonary appointment. She then canceled the need for any further follow up by the pulmonologist. 2. The record for Resident 2 was reviewed on 7/6/23 at 11:37 a.m. The diagnoses included, but were not limited to, pneumonia, chronic respiratory failure with hypoxia, gastrostomy		4.) How the corrective action will be monitored to ensure that the deficient practice will not recur, i.e. what quality assurance program will be put into place? To ensure compliance the DNS/Designee will complete Appointments and Diabetic QAPI tool weekly x4 weeks, monthly x6 months and quarterly thereafter. The QAPI committee will determine the need for further review. If 100% is not achieved an action plan will be developed.	

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	status and gastro-esophageal reflux disease with esophagitis. The Quarterly MDS assessment, dated 5/22/23, indicated the resident was severely cognitively impaired. The resident required a feeding tube for nutrition. The care plan, dated 5/8/23, indicated the resident required enteral nutrition to meet nutrient needs related to chronic pneumonia evidenced by silent aspiration. The interventions included, but were not limited to, refer the resident to the RD (Registered Dietician) and physician as needed, treatment per physician order, and the resident was NPO (nothing by mouth). The care plan, dated 3/24/23 and last revised on 5/23/23, indicated the resident was at risk for aspiration related to enteral nutrition with use of a PEG (Percutaneous Endoscopic Gastrostomy) tube. The interventions included, but were not limited to, refer the resident to speech therapy as needed, assess the resident's vital signs and lung sounds as needed, report abnormal findings to the physician, document abnormal findings and notify the physician, and observe the resident for symptoms of aspiration and choking. The physician's order, dated 6/14/23, indicated the resident was to receive Resource 2.0 (nutritional supplements) every 6 hours via the gastric tube, flush with 120 ml (milliliter) of water before and after each bolus for a total of 477 ml. Staff were to elevate the resident's HOB (head of bed) 30 to 45 degrees at all times and perform oral care every shift. The NP note, dated 4/4/23 at 7:52 a.m., indicated a chest x-ray was to be done at the hospital if			

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	possible. The resident was to be straight catharized for a UA (urinalysis) and sent to the hospital stat (immediately). A CBC (Complete Blood Count) was to be repeated on Thursday. The nurse's note, dated 4/4/23 at 12:18 p.m., indicated a report was given to the hospital ER (Emergency Room) regarding a change in the resident's condition and decreased LOC (Level of Consciousness). The clinical record lacked documentation indicating the NP was notified for a change in condition, the UA was not collected for a stat order, and a CBC was not repeated. During an interview on 7/11/23 at 9:57 a.m., the NP indicated she had ordered a chest x-ray, UA stat and a CBC. She was aware of the resident going to the hospital for a chest x-ray and not for a change in condition. They should have let her know about the resident's change in condition and the labs should have been drawn. 3. The record for Resident 19 was reviewed on 7/10/23 at 10:10 a.m. The diagnosis included, but was not limited to, type 2 Diabetes Mellitus with hyperglycemia, The Significant Change MDS assessment, dated 5/6/23, indicated the resident was severely cognitively impaired. The care plan, dated 2/13/23 and last revised on 5/15/23, indicated the resident was at risk for adverse effects of hyperglycemia or hypoglycemia related to the use of glucose lowering medication and the diagnosis of diabetes mellitus. The interventions included, but were not limited, to document abnormal findings and notify the			

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	physician, observe for symptoms of hypoglycemia, observe for symptoms of hyperglycemia, diet as ordered and monitor intakes and offer replacements for 50% or less consumption, lab work and medications as ordered. The physician's order, dated 7/5/23, indicated the resident was to receive Basaglar KwikPen U-100 Insulin (insulin glargine) 30 units at bedtime subcutaneous. Notify the physician if the resident's blood sugar was less than 60 mg/dL mg (milligram per deciliter) or greater than 400. The vital signs record for blood sugars indicated the following: - On 6/18/23 at 5:02 a.m., the resident's blood sugar was low. - On 6/21/23 at 4:58 p.m., the resident's blood sugar was low. The clinical record lacked documentation indicating the physician was notified, treatment was provided, and the resident's blood sugar was rechecked. During an interview on 7/11/23 at 11:02 a.m., the NP indicated that if a resident had a low blood sugar reading, there were protocols in place for juice or something to be given, and if that didn't work then she should have been notified, and a change in insulin would be ordered. During an interview on 7/11/23 at 2:15 p.m., LPN (Licensed Practical Nurse) 5 indicated if a resident's blood sugar read low on the glucometer, she would retest the resident and use a different finger. She would do an assessment on the resident for any changes from their baseline. If the			

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	glucometer indicated the blood sugar was still low, she would give the resident some orange juice and a protein snack. She would notify the NP of the low blood sugar and retest the resident. During an interview on 7/12/23 at 8:39 a.m., the DON indicated she was aware of the lack of documentation of interventions and assessments by the nursing staff. The Policy and Procedure Blood Glucose Monitoring, dated 3/10 and revised on 2/15, provided on 7/11/23 at 2:30 p.m., by the DON included, but was not limited to, "...If the resident has not received specific blood glucose call parameters the physician will be notified of any blood sugar less than 70 or if the resident is having signs or symptoms of high or low blood sugar. The physician will be notified when the resident's blood sugar is outside the physician stated parameters or if the resident is experiencing signs and symptoms of high or low blood sugar. A resident with blood glucose below 70 requires an assessment for symptoms of hypoglycemia. Document assessment in nursing progress notes. Immediate treatment of hypoglycemia will be completed as follows if there is not a resident specific physician order. Blood glucose below 70 and resident is able to consume PO intake will receive 4 ounces of juice. Recheck blood glucose in 15 minutes and document. After 15 minutes proceed to the next step. If no symptoms of hypoglycemia and glucose is greater than 70 no further action is required. If symptomatic or blood sugar is less than 70 after 2 treatments, notify physician of resident status. Document MD notification and ongoing assessment and treatment. Blood glucose less than 70 and resident is unable to consume PO intake: Administer PRN IM or glucose as ordered. Recheck blood glucose			

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	in 15 minutes, document findings and current resident status and notify MD. If there is no PRN order notify MD immediately. Document notification, resident status and treatment interventions. Blood glucose results will be documented on the Capillary Blood Glucose Monitoring Tool or on the medication administration record." On 7/10/23 at 11:20 a.m., the Executive Director (ED) presented a copy of the facility's current policy titled "Resident Change of Condition Policy" dated effective 11/2018. Review of this included, but was not limited to, "Policy: It is the policy of this facility that all changes in resident condition will be communicated to the physician...and that appropriate, timely, and effective intervention takes place. Procedure:...2. Acute Medical Change: a. Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician. b. If unable to contact the attending physician or alternate physician in a timely manner, notify the Medical Director for medical intervention...d. All nursing actions/interventions will be documented in the medical record as soon as possible after resident needs have been met. 3. Non-Urgent Medical Change: a. All symptoms and unusual signs will be documented in the medical record and communicate to the attending physician promptly. Non-urgent changes are a minor change in physical and mental behavior, abnormal laboratory and x-ray results that are not life threatening. b. The nurse in charge is responsible for notification of the physician...prior to the end of assigned shift when a significant change in the resident's condition is noted. c. If unable to reach the physician..., all calls to the physician or exchanges...requesting callbacks will be			

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	documented. d. If the physician has not called back by the end of the shift, the oncoming nurse will be notified for follow up. e. If unable to contact the attending physician or alternate timely, the Medical Director will be notified for response and intervention for the resident change of condition. f. Document resident change of condition and response in the medical record. Documentation will include time and...physician response..." 3.1-5(a)(2) 3.1-5(a)(3)			
F 0690 SS=D 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, record review, and interview, the facility failed to ensure residents received the appropriate perineal care related to infection control guide lines to prevent urinary tract infections for 2 of 3 residents reviewed for bowel and bladder. (Residents 17 and 29) Findings include: 1. During an observation of incontinence care for Resident 17 on 7/12/23 at 10:37 a.m., CNAs (Certified Nurse Aides) 9 and 10 performed hand hygiene and applied gloves. The 2 basins were filled with warm water and the resident's brief was removed. A wet washcloth was obtained, and soap was added. CNA 10 used 6 swipes of the same area of the washcloth to clean the creases. The washcloth was folded and with 5 swipes of the same area of the washcloth she cleaned the penis with a back and forth motion down the shaft. She obtained another soapy washcloth and with 10 swipes of the same area of the washcloth she rinsed the penis and creases. The washcloth was folded and with 3 swipes of the same area of the washcloth she rinsed the creases. She folded the washcloth and with 4 swipes of the same area of the wipe she rinsed down the penis. She obtained a towel and with 7 swipes of the same area of the towel she dried the penis and creases.	F 0690	**F 690** **It is the standard of this facility to ensure that residents receive the appropriate perineal/catheter care related to infection control guidelines to prevent urinary infections.** 1.) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All clinical staff that provide perineal care/catheter care will be re-trained and inserviced by the DNS/ADNS on 08/03/23. Residents 17 and 29 are receiving perineal care per policy 2.) How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents that receive incontinent care have the potential	08/11/2023

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	The resident was rolled onto his right side. The wound dressing was removed. It was dated 7/11/23. CNA 10 obtained a wet washcloth and applied soap. Using 13 swipes of the same area of the washcloth she cleaned the resident's buttock and rectal area. She folded the washcloth and with 4 swipes of the same area of the washcloth she cleaned the scrotum and visible stool from the rectum. A new soapy washcloth was obtained and with 3 swipes of the same area of the washcloth she cleaned the buttocks and some stool was removed from the rectum. The washcloth was folded and with 3 swipes of the same area of the washcloth she cleaned the buttocks and the rectum area. The resident continued to have a bowel movement. A new soapy washcloth was obtained and with 4 swipes of the same area of the washcloth the stool was cleaned from the rectum. The washcloth was folded and with 2 swipes of the same area of the washcloth the stool was cleaned from the rectum. A new soapy washcloth was obtained and with 2 swipes of the same area of the washcloth the stool was cleaned from the rectum. The washcloth was folded and with 2 swipes of the same area of the washcloth the stool was cleaned from the rectum. The washcloth was folded and with 4 swipes of the same area of the washcloth she cleaned the stool from the rectum. A fresh wet washcloth was obtained and the rectal area was rinsed using 7 swipes of the same area of the washcloth. It was folded and with 4 swipes of the same area of the washcloth she rinsed the rectal area. She folded the washcloth and with 5 swipes of the same area of the washcloth she rinsed the rectal area. She obtained a towel and with 5 swipes of the same area of the towel she dried the rectal area. She folded the towel and with 2 swipes she dried the rectal area. She folded the towel and with 4 swipes of the same area of the towel she dried the rectal area.		to be affected by this alleged deficient practice. All residents who have catheters have the potential to be affected by this alleged deficient practice. All clinical staff will be in-serviced on the facilities Perineal Care and Catheter care policies on 08/03/23. All clinical staff will perform skills validation for Perineal Care and Catheter care that will be observed by the DNS/ADNS or designee on 08/03/23. Any staff who fail to comply with the points of the of the inservice will be further educated. 3.) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The DNS/ADNS or designee will monitor incontinence care through rounds each shift to ensure appropriate incontinence care is provided per protocol. Any areas of non compliance will require additional education. 4.) How the corrective actions will be monitored to ensure the deficient practice will not recur,	

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	The brief was applied. During an interview on 7/12/23 at 10:55 a.m., CNA 10 indicated she would clean the head of the penis first with using a front to back motion. She would rinse then dry the area. She would then clean the rectal area using a front the back motion, rinse, and then dry the area. She would use a clean area of the washcloth with each swipe. The record for Resident 17 was reviewed on 7/10/23 at 1:01 p.m. The diagnoses included, but were not limited to chronic kidney disease, BPH (benign prostatic hyperplasia) with lower urinary tract symptoms, dementia, personal history of UTIs (urinary tract infections), obstructive and reflux uropathy, retention of urine, and the need for assistance with personal care. The care plan, dated 7/13/22 and last revised on 5/30/23, indicated the resident was at risk for a UTI related to a history of recurrent UTIs, a history of a TURP (transurethral resection of the prostate) procedure, obstructive uropathy, a diagnosis of BPH, and urine retention. The interventions, dated 7/13/22, included but was not limited to assist with incontinence care. The Significant Change MDS (Minimum Data Set) assessment, dated 6/10/23 indicated the resident was severely cognitively impaired. The NP note, dated 7/6/23 at 8:21 a.m., indicated the resident was evaluated today for a UTI. The culture resulted from one of his recent emergency department visits with probable ESBL. He was started on ertapenem 1 gram daily for 7 days. The physician's order, dated 7/6/23, indicated to administer ertapenem 1 gram every 24 hours for 7		what quality assurance program will be put into place? To ensure compliance the DNS/ADNS or designee will implement a peri care/catheter care CQI audit tool weekly x 4 weeks, monthly x 6 months and quarterly thereafter. The CQI committee will determine need for further review. If 100% is not achieved an action plan will be developed.	

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	days until 7/12/23. 2. During an observation of catheter care for Resident 29 on 7/12/23 at 11:12 a.m., by CNA 10 and QMA (Qualified Medication Aide) 11, the catheter tubing was on the floor under the resident's wheelchair. Both staff performed hand hygiene and applied gloves. QMA 11 placed the catheter bag on the side of the bed. CNA 10 started to hang the catheter bag on her clothes and QMA 11 indicated to her to not hang it on her clothes. The resident was placed in the bed. The resident's pants were lowered, and CNA 10 obtained a wet washcloth. Using 3 swipes with the same area of the washcloth she rinsed the creases and the penis shaft. She folded the washcloth and with 5 swipes of the same area of the washcloth she rinsed the creases and penis with a back and forth motion. She folded the washcloth and with 4 swipes of the same area of the washcloth she rinsed the creases and groin. She obtained a soapy washcloth and with 7 swipes of the same area of the washcloth she cleaned the creases and the penis shaft using a back and forth motion. She folded the washcloth and with 6 swipes of the same area of the washcloth she cleaned the penis shaft. She did not clean the meatus of the penis. She obtained a fresh soapy washcloth and holding the tubing at the meatus she cleaned down the tubing. She folded the washcloth and with 3 swipes of the same area of the washcloth she cleaned the creases. She folded the washcloth and with 3 swipes of the same area of the washcloth she cleaned the shaft of the penis. She obtained a wet washcloth and the creases and penis were rinsed. She folded the washcloth and with 6 swipes of the same area of the washcloth she rinsed the creases and penis again. She obtained a dry towel and with 5 swipes of the same area of the towel the			

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	creases and penis were dried. She folded the towel and with 5 swipes of the same area of the towel she dried the area again. She folded the towel and dried the tip of the penis. She folded the towel and with 5 swipes of the same area of the towel she dried the tubing. The resident was rolled onto his left side and QMA 11 obtained a soapy washcloth. Using 2 swipes of the same area of the washcloth, using a circular motion, she cleaned the right buttock. She folded the washcloth and with 2 swipes of the same area of the washcloth, using a circular motion, she cleaned the left buttock back to front to the rectal area. She folded the washcloth and using 4 swipes of the same area of the washcloth she cleaned the rectal area. She obtained a new soapy washcloth she swiped the buttocks and rectal area 9 times with the same area of the washcloth going toward the scrotum. She obtained a new washcloth and using 3 swipes with the same area of the washcloth she cleaned the buttocks. She folded the washcloth and with 3 swipes of the same area she cleaned the buttocks. She obtained a new washcloth and with 3 swipes of the same area of the washcloth she cleaned the buttocks toward the scrotum. She folded the washcloth and with 3 swipes of the same area of the washcloth she cleaned the scrotum. The catheter bag was raised over the resident and held above the level of the bladder. The resident was dried using the same area for 4 swipes then folded, 3 swipes with the same area then folded, and 3 swipes of the same area over the rectal area. The resident was rolled onto his back and the brief was fastened. The resident's urine was a dark yellow and he indicated he had a burning stinging feeling. During an interview on 7/12/23 at 11:39 a.m., QMA 11 indicated for catheter and incontinence care, she would use a circular motion to clean around			

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	the penis and from the inside out. She would use a different area of the washcloth for each swipe. She would then clean the tubing. The resident would be rolled, and the backside would be cleaned. She used a circular motion from the outer area, then the inner. The bag doesn't go above the bladder and the tubing should not be pulled or stretched. The record for Resident 29 was reviewed on 7/10/23 at 10:15 a.m. The diagnoses included but were not limited to acute kidney failure with tubular necrosis, BPH, and obstructive and reflux uropathy. The care plan, dated 3/26/23, indicated the resident required an indwelling urinary catheter due to obstructive uropathy, BPH, and acute kidney failure with tubular necrosis. The interventions, dated 3/26/23, included, but were not limited to, do not allow tubing or any part of the drainage system to touch the floor, position the catheter bag below the level of the bladder, and provide assistance with catheter care. The Significant Change MDS assessment, dated 5/10/23 indicated the resident was moderately cognitively intact. The nurse's note, dated 5/23/23 at 7:47 a.m., indicated the resident's urine was yellow with sediment. The nurse's note, dated 6/10/23 at 3:50 p.m., indicated the resident required extensive assistance of 1 to 2 staff with toileting. A Foley catheter was in place for urinary retention. He was continent of bowel and staff provided peri care and Foley catheter care. The Catheter Care policy, last revised on May			

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	2023, was provided by the ED (Executive Director) on 7/12/23 at 12:46 p.m. The policy included, but was not limited to, " ... 10. Change the area of the washcloth or retrieve a new washcloth for consecutive passes along the catheter tubing. Do not rewipe the drainage tube ..." The Perineal Care with Disposable Wipes policy, last reviewed in March 2023, was provided by the Executive Director on 7/12/23 at 12:46 p.m. The policy included, but was not limited to, " ... Do not rewipe catheter ... 14. Wash tip of penis in circular motion, starting at urethra moving outward ... 15. Use a clean disposable wipe with each wipe. Do not rewipe area, unless using a clean disposable wipe. 16. Continue washing down the penis to the scrotum outward. 17. Gently pat dry area in same direction as washing ... 19. Clean anal area from front to back, using a clean disposable wipe. Do not rewipe area, unless using a clean disposable wipe ..." 3.1-41(a)(2)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and			

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	§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, interview and record review, the facility failed to ensure appropriate interventions were implemented to prevent aspiration for a resident with a g-tube (gastrointestinal tube) for 1 of 4 residents reviewed for g-tubes. (Resident 2) Findings include: The record for Resident 2 was reviewed on 7/6/23 at 11:37 a.m. The diagnoses included, but were not limited to, pneumonia, chronic respiratory failure with hypoxia, gastrostomy status and gastro-esophageal reflux disease with esophagitis. The Quarterly MDS (Minimum Data Set) assessment, dated 5/22/23, indicated the resident was severely cognitively impaired. The resident required a feeding tube for nutrition. The care plan, dated 5/23/23, indicated the resident required enteral nutrition to meet nutrient needs related to chronic pneumonia evidenced by silent aspiration. The interventions included, but were not limited to, The resident was to be referred to the RD (Registered Dietician) and physician as needed, treatment per physician order, and the resident was NPO (nothing by mouth). The care plan, dated 3/24/23 and last revised on	F 0693	**F 693** **It is the standard of this facility to ensure that all g-tube residents have appropriate interventions to prevent aspiration.** 1.) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. A physician's order for resident # 2 was added on 07/11/23 to check placement of tube. Check residual and hold feeding if residual is greater than 60 ml. Staff were educated on the importance of HOB elevated 30-45 degree. C.N.A assignment sheet revised to include HOB elevation. A sign was hung in resident #2 room stating that HOB must be elevated to 30-45 degree 2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action	08/11/2023

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	5/23/23, indicated the resident was at risk for aspiration related to enteral nutrition with use of a PEG (Percutaneous Endoscopic Gastrostomy) tube. The resident would be free from symptoms of aspiration. The interventions included, but were not limited to, refer the resident to speech therapy as needed, assess the resident's vital signs and lung sounds as needed, report abnormal findings to the physician, document abnormal findings and notify the physician, and observe the resident for symptoms of aspiration and choking. The physician order, dated 6/14/23, indicated the resident was to receive Resource 2.0 (nutritional supplements) every 6 hours via the gastric tube, flush with 120 ml (milliliter) of water before and after each bolus for total of 477 ml. Staff were to elevate the resident's HOB (head of bed) 30 to 45 degrees at all times and perform oral care every shift. The clinical record lacked documentation to indicated the nursing staff were checking for residual of the g-tube and lacked the documented residual amounts. The nurse's note, dated 4/21/23 at 3:25 p.m., indicated the resident received bolus feedings every 6 hours via his g-tube. The nurse's note, dated 5/9/23 at 3:01 p.m., indicated staff alerted the nurse that the resident had been vomiting. The resident was observed by the nurse and had light brownish or tan vomit on his clothing and bed, no active vomiting was observed. He was assisted onto his side; the HOB was elevated per protocol. The resident had removed his nasal cannula and his 02 (oxygen saturations) was 80 to 82% via NC (nasal cannula)		will be taken? All residents with G-tube placement have the potential to be affected by this alleged deficient practice. An audit on all G-tube residents was conducted on 07/24 to ensure they had orders to check residual and that they had the appropriate signage in their rooms. All clinical staff will be in-serviced on the facilities Enternal Feeding policy on 08/03/23. 3.) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? When a resident with a g-tube admits to the facility, the admitting nurse will review orders and ensure that the resident has an order to check the residual.. An audit on all G-Tube residents was conducted on 07/24 to ensure they had orders to check residual. The IDT team will complete the IDT admission review audit in the daily clinical meeting to verify all orders for new admissions have been put in.	

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	and remained at that level after his oxygen was reapplied. His heart rate was elevated in the 140s, and his lung sounds had wheezing present. Orders were received to send the resident to the hospital for evaluation and treatment. The nurse's note, dated 5/9/23 at 10:37 p.m., indicated the resident was admitted to the hospital for possible aspiration. The nurse's note, dated 5/18/23 at 7:44 a.m., indicated the resident was evaluated for abnormal breath sounds. The resident sounded "junky." He had been removing his supplemental oxygen and his 02 saturations were dropping. He was recently in the hospital with a diagnosis of pneumonia due to silent aspiration. He also had a history of COPD (Chronic Obstruction Pulmonary Disease) and chronic respiratory failure with hypoxia. The nurse's note, dated 6/25/23 at 12:00 p.m., indicated the nurse was called to the resident's room by the CNA (Certified Nursing Aide). He was observed to have emesis on his shirt and face. As staff were changing the resident, he began vomiting up a moderate amount of milk colored emesis with white clumps. The HOB was elevated throughout. The resident's lungs had expiratory wheezes and rhonchi. His O2 saturation was at 90% on 3L (liters) per nasal cannula. The NP (Nurse Practitoner) and DNS (Director of Nursing Services) were made aware of the findings and a new order was received to send the resident to the hospital for evaluation and treatment. During an observation on 7/6/23 at 11:37 a.m., the facility did not have signage posted indicating keep the head of the bed up 30 to 45 degrees at all times.		4.) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? To ensure compliance the DNS/Designee will complete a new admission G-Tube order CQI audit tool weekly x 4 weeks, monthly x 6 months and quarterly thereafter. The CQI committee will determine need for further review. If 100% is not achieved, an action plan will be developed.	

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During an interview on 7/11/23 at 8:49 a.m., the DON indicated the nursing staff should be checking residual for any resident that had a g-tube. That was the standard nursing protocol. She indicated she could not find any documentation indicating the nursing staff were checking and documenting the resident's residual.

During an interview on 7/11/23 at 9:57 a.m., NP 3 indicated Resident 2 came from another facility with a history of aspiration. She was not aware the facility was not checking the residual from the g-tube. It was a standard nursing practice for a g-tube.

The nurse's note, dated 7/11/23 at 5:07 a.m., indicated the resident was sent to the hospital for aspiration.

During an interview on 7/11/23 11:15 a.m., RN 4 indicated the resident was sent to the hospital that morning for aspiration. During shift report the night shift nurse reported Laboratory Technician 8 came to draw the resident's blood and lowered the resident's head of the bed flat to draw blood.

During an observation on 7/11/23 at 12:49 p.m., no signage was observed to be posted in the resident's room indicating to keep the head of the bed elevated 30 to 45 degrees at all times due to the g-tube feeding.

During an interview on 7/11/23 at 12:50 p.m., LPN 5 (Licensed Practical Nurse) indicated she would check a g-tube residual before and after feedings, before giving medications, changing feeding bags, or any time she did anything with the feedings. She would check the residual at least a

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	couple times her shift to make sure the feeding was doing okay. The residual was not documented in the clinical record. The resident's head of the bed should always be up at least 30 degrees. There would be no reason for the head of the bed to be lowered just to draw blood. The g-tube residual was checked but not documented in the clinical record. During an interview 7/11/23 at 1:12 p.m., LPN 6 indicated she was the nurse caring for the resident on the night shift. The lab technician came in that morning to draw the resident's blood for a CBC (Complete Blood Count). She wasn't sure how long the laboratory technician had been in the room. The labortary technician turned on the resident's call light and when she went to answer the light, she observed the resident's head of the bed was lowered in a flat position. She indicated the resident looked pale, so she called her DON and the resident was sent to the hospital for aspiration. During an interview on 7/12/23 at 8:39 a.m., the DON indicated she was aware of the lack of documentation of interventions by the nursing staff. During an interview on 7/12/23 at 9:00 a.m., laboratory technician 8 indicated when she entered the resident's room to draw his blood the resident had vomit on his clothing. The HOB was up 30 to 45 degrees. She did not observe HOB up at all times signage posted in the resident's room. She did not lower the resident's HOB. She turned on the resident's call light and the nursing staff came in. She informed them the resident had vomited. She was able to draw the labs and was in the resident's room for 4 minutes and then she left. While she was in the room, she did not see			

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	anyone lower the head of his bed and nursing staff was in the room. During an interview on 7/12/23 at 9:25 a.m., CNA 7 indicated she observed Laboratory Technician 8 enter the resident's room at approximately 1:00 a.m., to draw the resident's labs. After she was in there for a couple of minutes Laboratory Technician 8 turned on the resident's call light. When CNA 7 entered the resident's room she observed the HOB had been lowered. She did not observe Laboratory Technician 8 lower the HOB. CNA 7 indicated she had checked and repositioned the resident at 12:30 a.m., while doing her resident rounds. She specifically adjusted the resident's HOB and she was sure the HOB was up at a 30 to 45 degree. During an interview on 7/12/23 at 12:09 p.m., CNA 13 indicated she observed Laboratory Technician 8 lower the resident's HOB. She was sure the HOB up in the upright position because she and another CNA had made rounds at 12:30 a.m., and the resident was checked and repositioned then. The laboratory technician had turned the resident's call light on and indicated the resident had vomit on his gown. The CNAs elevated the HOB up to 30 degrees and provided patient care. During an observation on 7/12/23 at 10:41 a.m., RN 4 gathered her supplies for the resident g-tube feeding. She explained to the resident and proceeded to draw the privacy curtains. She washed her hands and donned gloves. She exposed the G-tube and checked for residual by aspirating stomach contents. the resident had 0 residual. She flushed the g-tube with 120 cc water, Resource 2.0 then flushed with 120 cc water after feeding. the resident tolerated the procedure well. She indicated she would document the residual			

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	155417	A. BUILDING 00 B. WING	07/12/2023

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	results on the MAR. If the residual was greater than 60 cc she would hold the feeding and notify the NP. The Policy and Procedure titled Enteral Therapy, dated 1/16, provided on 7/11/23 at 2:30 p.m., by the DON included, but was not limited to, "...The following orders should be obtained when enteral therapy is being implemented or changed: Type, size of the tube and route (PEG,GT, Nasogastric, J-tube) Site Care Type of formula Method of administration (gravity, bolus, pump) Flow rate or cycle schedule Amount and frequency of water flushes including medication administration flushes Gastric residual checked frequency with intervention Place verification frequency ...Placement of the enteral therapy tube (Gastric tube, PEG tube, Nasogastric tube, etc.) is to be assessed by the licensed nurse no less than once every shift and before any substance is administered through the tube. Gastric residual will be assessed per physician's order with appropriate interventions taken ..." 3.1-44(2)			
F 0727 SS=E Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.			

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	§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on record review and interview, the facility failed to schedule 8-hour RN coverage during the weekend day and night shifts for June and July 2023. This had the potential to affect all 31 residents residing in the facility. Findings include: On 7/6/23 between 9:30 a.m. and 2:30 p.m., the ED (Executive Director) provided a document indicating the facility had no staffing waivers. The June and July nursing schedule was reviewed on 7/11/23 at 9:02 a.m. 8-hour RN coverage was not documented on the following weekends: - On 6/3/23 no RN was scheduled for the day or night shift. - On 6/4/23 no RN was scheduled for the day or night shift. - On 6/10/23 no RN was scheduled for the day or night shift. - On 6/11/23 no RN was scheduled for the day or night shift. - On 6/17/23 no RN was scheduled for the day or night shift. - On 6/18/23 no RN was scheduled for the day or night shift. - On 6/24/23 no RN was scheduled for the day or night shift. - On 6/25/23 no RN was scheduled for the day or night shift. - On 7/1/23 no RN was scheduled for the day or night shift. - On 7/2/23 no RN was scheduled for the day or night shift.	F 0727	**F 727** 1.) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Facility is providing RN coverage during the weekend for day and night shift by hiring additional staff and by utilizing agency staff as needed. 2.) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected. RN staffing coverage was reviewed for the rest of the schedule with the DNS to ensure there was at least 8 consecutive hours a day for 7 days a week. All RN's, DNS, and ADNS were inserviced by the ED that there must be 8 consecutive hours a day for 7 days a week of Registered Nurse coverage and to ensure that they remain on the clock for the full 8 hours. 3.) What measures will be put into place or what systemic changes will be made to ensure	08/11/2023

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	- On 7/9/23 no RN was scheduled for the day or night shift. During an interview on 7/11/23 at 8:45 a.m., the DON (Director of Nursing) indicated she would come in on the weekends for a few hours and sometimes for 8 hours, it depended on who was in the building and what was going on. If there was an LPN (Licensed Practical Nurse) on shift for the weekend, she would work for 3 to 4 hours on average. During an interview on 7/11/23 at 1:43 p.m., the ED indicated the facility did not have a policy for 8-hour RN coverage. They followed the State guidelines for daily 8-hour RN coverage. During an interview on 7/12/23 at 2:15 p.m., CNA (Certified Nurse Aide) 9 indicated the DON would work on weekends if she was needed. She would sometimes stay a few hours, or she would stay all day if needed. During an exit conference interview on 7/12/23 at 1:12 p.m., the ED and DON indicated they could not locate any documentation of 8-hour RN coverage on the weekends over the last month. 3.1-17(b)(3)		that the deficient practice does not recur? DNS/Desginee will ensure RN staffing is available 8 consecutive hours a day for 7 days a week of RN coverage by reviewing the schedule and ensuring adequate staff is available. 4.)How the corrective action will be monitored to ensure that the deficient practice will not recur, i.e. what quality assurance program will be put into place? DNS/Designee will complete RN staffing CQI tool weekly X4 weeks and monthly X 6 months and quarterly thereafter. The CQI committee will determine need for further review. If 100% is not achieved an action plan will be developed.	