STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155809	A. BUILDING 00 B. WING	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREY STONE HEALTH & REHABILITATION CENTER	10445 DUPONT OAKS BLVD FORT WAYNE, IN 46845

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00414546, IN00413328 and IN00413298. Complaint IN00414546 - Federal/state deficiencies related to the allegations are cited at F 625. Complaint IN00413328- Federal/state deficiencies related to the allegations are cited at F 677 and F 692. ComplIn tiN00413298- No deficiencies realted to the allegations are cited. Survey dates: August 10, 11, 14, 15 and 16, 2023 Facility number: 012935 Provider number: 155809 AIM number: 201207690 Census Bed Type: SNF/NF: 80 SNF: 12 Total: 92 Census Payor Type: Medicare: 7 Medicaid: 69 Other: 16 Total: 92 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 21, 2023.	F 0000	September 1, 2023 Indiana State Department of Health Department of Health and Human Services Centers for Medicare & Medicaid Services To whom it may concern, Grey Stone Health and Rehabilitation, CMS Certification Number **155809** has received the 2567.. Enclosed is our Plan of Correction for all of the deficiencies we received during our Survey process. We ask that our Plan of Correction be reviewed and accepted as we strive to continue operating in compliance with CMS. We are also requesting desk review approval to place us back into compliance as quickly as possible. Thank you for your consideration in this matter. Sincerely, Eric Hunter, Administrator Grey Stone Health and Rehabilitation eric.hunter@saberhealth.com 260-494-2740	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eric Hunter	Administrator	09/01/2023

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

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F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review the facility failed to ensure assessment and consent for self-administration of medication was obtained prior to self-administration of medication for 1 of 8 residents reviewed (Resident 1). Findings include: During an observation and interview on 8/11/23 at 9:38 AM, a one-ounce clear plastic cup was observed on Resident 1's food tray filled about half full of pills and capsules. Resident 1 indicated staff did not always watch her take her medication because it took her a long time to take her medicine. Resident 1 indicated she did not wish to self-administer her medication and believed staff should watch her because she had difficulty at times due to gastroparesis. Resident 1's record was reviewed on 8/14/23 at 9:42 AM. Diagnoses included hemiplegia effecting left, non-dominant side, type 2 diabetes mellitus with unspecified complications, and gastroparesis. Resident 1's current annual Minimum Data Set (MDS) dated 7/7/23 indicated her BIMS (Basic Interview for Mental Status) score was 15 (cognitively intact). Resident 1's current care plan titled Resident has Potential for Nausea and Vomiting due to Gastroparesis indicated the resident had a	F 0554	F554 – Self Administration of Medication 1. What corrective action will be accomplished by those residents found to have been affected by the deficient practice? Resident #1 suffered no ill effects from the cited deficiency. 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? Current residents and new admissions that do not have an order to self-administer medications have the opportunity to be affected. The Director of Nursing or Assist and Director of Nursing will complete an audit utilizing the Medication Self Administration audit tool. This audit along with identified corrections will be completed on or before 9/22/23. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?	09/22/2023

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	problem of nausea and vomiting, with a goal date of 7/27/23 Interventions included administration of medications by facility staff. Physician orders dated 6/1/23 indicated Resident 1's fish oil 1200 mg capsule should be administered by staff. Orders dated 6/2/23 indicated Resident 1's anastrozole 1 mg tablet, aspirin 81 mg tablet, calcium carbonate with vitamin d 600-10 mg-mcg tablet, linaclotidine 290 mg capsule, loratadine 10 mg tablet, myrbetriq 50 mg tablet, florastor 250 mg capsule, and rytery 48.75-195 mg capsule should be administered by staff. Orders dated 6/7/23 indicated Resident 1's venlafaxine HCl ER 75 mg capsule should be administered by staff. Orders dated 6/8/23 indicated Resident 1's lotrel 10-40 mg capsule should be administered by staff. Orders dated 7/20/23 indicated Resident 1's buspirone HCl 10 mg tablet should be administered by staff. A medication self- administration assessment was not available for review. In an interview on 8/11/23 at 9:43 AM, Registered Nurse 21 indicated she was new to the facility and did not know which residents could self-administer their medication. She indicated she should have watched Resident 1 take her medication when she did not know for certain that she was able to self-administer. A current policy titled Self-Administration of Medication, last revised on 1/28/23, provided on 8/15/23 at 8:40 AM indicated a resident should express desire to self-administer medication and demonstrate the ability to do so safely prior to self-administering medications. 3.1-11		To prevent this from reoccurring the Director of Nursing or Assistant Director of Nursing will provide education to Licensed Nurses utilizing the General Dose Preparation and Medication Administration policy with an emphasis on observing the resident's consumption of the medications. This education will be completed on or before 9/22/23. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? To monitor and maintain ongoing compliance the Director of Nursing or Assistant Director of Nursing will complete weekly audits for 6 months utilizing the Medication Self Administration Audit Tool to ensure nurses remain in attendance while the residents consume their medications. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. By what date the systemic changes for each deficiency will be completed? All audits, in servicing, and systemic changes will be in effect by 9/22/22.	

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F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation, interview, and record	F 0583	F583 – Personal Privacy 1. What corrective action will	09/22/2023

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	review the facility failed to ensure privacy was maintained for 2 of 19 residents reviewed (Resident 1 and Resident 58). Findings include: 1. During an observation on 8/11/23 at 9:46 AM, Certified Nurse Aide (CNA) 23 walked into the room and began to converse with Resident 1. CNA 23 did not knock on the door or ask permission to come in prior to entering the room. Resident 1's record was reviewed on 8/14/23 at 9:42 AM. Diagnoses included hemiplegia effecting left, non-dominant side, type 2 diabetes mellitus with unspecified complications, and gastroparesis. Resident 1's current annual Minimum Data Set (MDS) dated 7/7/23 indicated her BIMS (Basic Interview for Mental Status) score was 15 (cognitively intact). A care plan titled resident has impaired vision with a goal date of 7/27/23 had an intervention of announcing self when entering Resident 1's space. 2. During an observation with Resident 58 and her husband on 8/11/23 at 10:36 AM, Central Supply 24 entered the room, indicated she had a question to ask Resident 58. Central Supply 24 did not knock on the door nor ask permission to come in prior to entering the room. Resident 58's record was reviewed on 8/11/23 at 11:10 AM Diagnoses included post-traumatic stress disorder (PTSD), anxiety disorder, and vascular dementia, unspecified severity, without behavioral disturbance.		be accomplished by those residents found to have been affected by the deficient practice? CNA # 23 will be educated by the Director of Nursing or Assistant Director of Nursing on the HIPPA Privacy policy as well as privacy related to entering resident rooms. This education will be completed on or before 9/22/23. Central Supply Clerk # 24 will be educated by the Director of Nursing or Assistant Director of Nursing on the HIPPA Privacy policy as well as privacy related to entering resident rooms. This education will be completed on or before 9/22/23. 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? Current residents and new admissions have the opportunity to be affected. The Administrator, Director of Nursing or Assist and Director of Nursing will complete an audit utilizing the Personal Privacy audit tool. This audit along with identified corrections will be completed on or before 9/22/23. 3. What measures will be put into place and what systemic	

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	A review of Resident 58's current quarterly Minimum Data Set (MDS) indicated her BIMS (Basic Interview for Mental Status) score was 7 (cognitively impaired). A review of Resident 58's current care plan titled Resident can show trauma, indicated the resident had a problem of PTSD with a goal date of 12/6/23. The care plan identified invasion of privacy as a trauma trigger. Interventions included knock before entering room and introduce self and reducing triggers such as invasion of privacy. In an interview on 8/14/23 at 12:34 PM, Registered Nurse 22 indicated staff should knock on doors and wait for a response before entering resident rooms to ensure privacy. In an interview on 8/15/23 at 11:33 AM, the Director of Nursing (DON) indicated the facility did not have a specific policy addressing knocking on doors, but staff was expected to knock on doors prior to entering. A current policy, undated, titled Federal Resident Rights and Facility Responsibilities provided by the DON on 8/15/23 at 1:50 PM indicated residents had the right to privacy during visits. 3-1(p)(5)		changes will be made to ensure that the deficient practice does not recur? Facility Staff will be educated on HIPPA Privacy policy as well as privacy related to entering resident rooms. This education will be completed by the Administrator, Director of Nursing, Department Manager or Assistant Director of Nursing on or before 9/22/23. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? To monitor and maintain ongoing compliance the Administrator or Director of Nursing will complete weekly audits for 6 months utilizing the Personal Privacy Audit Tool to ensure staff knock on the resident's door and wait for permission to enter a residents room. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. By what date the systemic changes for each deficiency will be completed? All audits, in servicing, and systemic changes will be in effect by 9/22/22.	

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F 0625 SS=E Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on interview and record review the facility failed to provide the resident with a written explanation of the Notice of Transfer or Discharge, Bed Hold Policy, and the Bed Hold Policy Notice within 24 hours of a hospital transfer for 4 of 19 residents reviewed. (Resident 14, Resident 1, Resident 8, and Resident T).	F 0625	F625 Bed Hold Policy 1. What corrective action will be accomplished by those residents found to have been affected by the deficient practice? Resident #1, 8 and 14 will receive a copy of the notice of transfer or	09/22/2023

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	Findings include: 1.Resident 14's record was reviewed on 08/14/23 at 1:45 PM. Diagnoses included cerebral infarction affecting left dominant side, hemiplegia, chronic kidney disease stage 3, anemia, atherosclerotic heart disease of native coronary artery without angina pectoris, and type 2 diabetes mellitus. A review of Resident 14's current quarterly Minimum Data Set (MDS) assessment indicated he was unable to complete the Basic Interview for Mental Status (BIMS) assessment but was able to recall staff names/faces and was in a nursing home; his cognitive skills for daily decision making were severely impaired. The MDS indicated the resident had no speech. A review of Resident 14's Notice of Transfer or Discharge form dated 4/13/23 was reviewed. The form had an unrecognizable signature with no date or time. The form did not indicate when the copy had been provided during the transfer process, mailed to the resident or resident representative. A review of Resident 14's Notice of Transfer or Discharge form dated 4/19/23 was reviewed. The form had an unrecognizable signature with no date or time. The form did not indicate when the copy had been provided during the transfer process, mailed to the resident or resident representative. A review of Resident 14's Notice of Transfer or Discharge form dated 6/6/23 was reviewed. The form had an unrecognizable signature with no date or time. The form did not indicate when the copy had been provided during the transfer		discharge form and bed hold policy on or before 9/22/23. Resident T no longer resides at the facility. 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? Current residents and new admissions who transfer to the hospital have the opportunity to be affected. The Social Services Director or Administrator will complete an audit back to August 1, 2023 of residents who transferred out to the hospital utilizing the Bed Hold/Transfer Documentation audit tool. This audit along with identified corrections will be completed on or before 9/22/23. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Administrative Staff and Licensed Nurses will be educated on the Resident Discharge and Transfer Letter Policy. This education will be completed by the Administrator on or before 9/22/23.	

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	process, mailed to the resident or resident representative. A review of Resident 14's progress notes, dated 4/11/23 through 6/8/23, did not contain any indication of resident or representative notification of the Notice of Transfer or Discharge form, the Bed Hold Policy, or Request for Hearing and Appeal Rights. 2. Resident 1's record was reviewed on 8/14/23 at 9:42 AM. Diagnoses included hemiplegia effecting left, non-dominant side, type 2 diabetes mellitus with unspecified complications, and gastroparesis. Resident 1's current annual Minimum Data Set (MDS) dated 7/7/23 indicated her BIMS (Basic Interview for Mental Status) score was 15 (cognitively intact). Progress notes dated 5/23/23 at 6:07 PM indicated Resident 1 experienced a decline in cognitive functioning, vital signs and she was sent to the hospital. A progress note dated 5/23/23 at 6:39 PM indicated Resident 1's son was notified of the transfer to the hospital. A bed hold policy was not discussed in any progress notes on 5/23/23 and 5/24/23. A review of a Notice of Transfer or Discharge dated 5/23/23 did not identify the date and time of family notification of the transfer, discharge, or the bed hold policy. 3. Resident 8's record was reviewed on 8/11/23 at 9:24 AM. Diagnoses included chronic kidney disease, stage 4, retention of urine, unspecified, and benign prostatic hyperplasia with lower urinary tract symptoms. Resident 8's current quarterly Minimum Data Set (MDS) dated 7/31/23 indicated his BIMS (Basic		4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? To monitor and maintain ongoing compliance the Administrator or Social Services Director o will complete weekly audits for 6 months utilizing the Bed Hold/Transfer Documentation audit tool to ensure the notice of transfer and bed hold policy are provided to the resident/representative within 24 hours of the transfer to the hospital. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. By what date the systemic changes for each deficiency will be completed? All audits, in servicing, and systemic changes will be in effect by 9/22/22.	

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	Interview for Mental Status) score was 14 (cognitively intact). Progress notes dated 6/20/23 at 12:24 PM indicated Resident 8 had been sent to the hospital for a change in level of consciousness. The progress note did not indicate the bed hold policy was discussed when the family was notified. A bed hold policy was not documented as discussed in any progress notes on 6/20/23 and 6/21/23. A Notice of Transfer or Discharge dated 6/20/23 did not identify the date and time of family notification of the transfer or discharge and bed hold policy. 3. Resident T's record was reviewed on 8/15/23 at 11:30 AM. Diagnoses included type 2 diabetes mellitus without complications, cognitive communication deficit and adult failure to thrive. Resident T's current annual Minimum Data Set (MDS) indicated her BIMS (Basic Interview for Mental Status) score was 6 (cognitively impaired). Progress notes dated 8/5/23 at 6:14 PM indicated Resident T's feeding tube had been pulled out and she was sent to the hospital for replacement. The progress note did not indicate the bed hold policy was discussed when the family was notified. A bed hold policy was not documented as discussed in any progress notes on 8/5/23 and 8/6/23. A review of a Notice of Transfer or Discharge dated 8/6/23 did not identify the date and time of family notification of the transfer, discharge and bed hold policy.			

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	In an Interview on 08/16/23 09:45 AM, the DON indicated upon transfer from the facility to another facility the nursing staff should ensure the resident, or their representative received a transfer/discharge notice within 24 hours signed and dated and that information would be documented in the chart by Social Services or designee. A current policy titled "Resident Discharge/Transfer Letter Policy, revised 4/19/23, provided by the DON on 8/15/23 at 2:45 PM indicated Social Services or designee would document in the chart all discharge/transfer reasons and any notices given to the resident or the guardian/sponsor. This citation is related to complaint IN00414546. 3.1-12(a)(25)(26)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview and record review the facility failed to ensure personal care was provided for 1 of 7 residents reviewed. (Resident K) Findings include: During a phone interview on 8/10/23 at 9:23 AM, Resident K's guardian indicated the resident had been admitted to the facility on 7/12/23. The guardian indicated they took the resident back home on 7/17/23 due to the resident not being provided with adequate care. The guardian	F 0677	F677 ADL Care for Dependent Residents 1. What corrective action will be accomplished by those residents found to have been affected by the deficient practice? Resident K no longer resides at the facility. 2. How other residents having	09/22/2023

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	indicated the resident had not received adequate personal care on Saturday 7/15/23 and Sunday 7/16/23. The guardian indicated over the weekend, Resident K had been left in bed all day with wet and soiled clothing, had not received oral care, had not been offered fluids, and had not been provided with a dinner meal on 7/16/23. The guardian indicated the resident's skin was excoriated due to their brief not being changed frequently enough. Resident K's record was reviewed on 8/14/23 at 10:20 AM. Diagnoses included ataxic (poor muscle control) cerebral palsy, expressive language disorder and cachexia (body wasting). A review of Resident K's current Discharge Minimum Data Set (MDS) indicated the resident had no memory problems. The MDS indicated the resident required extensive staff assistance for all activities of daily living (ADLs). A review of Resident K's current care plan for ADLs indicated the resident was at risk for self-care problems. Interventions included the provision of assistance with dressing, grooming, toileting, eating and oral care. A review of the resident's physician orders dated 7/12/23 indicated the resident was to be turned and repositioned while in bed every shift as tolerated. The physician orders indicated the resident was to be administered barrier cream every shift and as needed for incontinence episodes. A review of Resident K's ADL record dated July 2023 did not indicate the resident had been assisted with bed mobility on the following shifts: 7/13/23 10:00 PM to 6:00 AM		the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Current residents and new admissions who are dependent for care have the opportunity to be affected. The Director of Nursing or Assistant Director of Nursing will complete an audit utilizing the ADL Documentation audit tool to ensure ADL care is being provided and documented for dependent residents. This audit along with identified corrections will be completed on or before 9/22/23. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? To prevent this from reoccurring the Director of Nursing or Assistant Director of Nursing will provide education to Licensed Nurses and STNA's utilizing the ADL Documentation policy as well as the AM and PM care policies with an emphasis on providing ADL care and completing documentation of care. This education will be completed on or before 9/22/23. 4. How the corrective action	

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	7/14/23 10:00 PM to 6:00 AM 7/15/23 2:00 PM to 10:00 PM 7/15/23 10:00 PM to 6:00 AM 7/16/23 6:00 AM to 2:00 PM Resident K's ADL record dated July 2023 did not indicate the resident had been assisted with dressing on the following shifts: 7/15/23 2:00 PM to 10:00 PM 7/16/23 6:00 AM to 2:00 PM Resident K's ADL record dated July 2023 did not indicate the resident had been assisted with oral care or toileting on the following shifts: 7/13/23 10:00 PM to 6:00 AM 7/14/23 10:00 PM to 6:00 AM 7/15/23 2:00 PM to 10:00 PM 7/15/23 10:00 PM to 6:00 AM 7/16/23 6:00 AM to 2:00 PM Resident K's ADL record dated July 2023 did not indicate the resident's skin condition had been monitored or that barrier cream had been applied on the following shifts: 7/13/23 10:00 PM to 6:00 AM 7/14/23 10:00 PM to 6:00 AM 7/15/23 2:00 PM to 10:00 PM 7/15/23 10:00 PM to 6:00 AM 7/16/23 6:00 AM to 2:00 PM Progress notes dated 7/17/23 at 2:02 PM related to a care plan meeting indicated Resident K's family had requested the resident to be assisted out of bed daily, to be provided personal care, to be provided an explanation before and during care procedures, and to be assisted to the dining room. In an interview on 8/16/23 at 11:53 AM the Administrator indicated they were aware of Resident K's report of not been provided with		will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? To monitor and maintain ongoing compliance the Director of Nursing or Assistant Director of Nursing will complete weekly audits for 6 months utilizing the ADL Documentation audit tool to ensure dependent residents are receiving ADL care and documentation is completed. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. By what date the systemic changes for each deficiency will be completed? All audits, in servicing, and systemic changes will be in effect by 9/22/22.	

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	personal care. The Administrator indicated they were unaware of blank documentation related to personal care. In an interview on 8/16/23 at 12:03 PM the Administrator indicated the facility nursing management team had reported Resident K had been out of the facility on 7/15/23 and 7/16/23. The Administrator indicated the resident being out of the facility explained the blank documentation related to personal care. The Administrator indicated they were unaware of the documentation process related to residents being out of the facility. In a confidential staff interview on 8/16/23, direct care staff indicated the resident was out of the building for a few hours on 7/15/23, but was returned to the facility in the afternoon. A current policy dated 9/1/22 indicated morning care would be provided daily. Some procedures of morning care included explaining morning care to the resident, oral care, toileting, and dressing. A current policy dated 6/15/20 indicated evening care would be provided daily. Some procedures of evening care included explaining evening care to the resident, oral care, toileting, dressing for bed, and offering fluids. A current policy dated 8/12/20 indicated ADLs would bed documented every shift. The policy indicated the nurse would review the ADL record before the end of the shift to ensure completion of care before staff depart. This citation is related to complaint IN00413328. 3.1-38(a)(3)			

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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 ensure nursing assessments were performed when indicated for 2 of 19 residents reviewed. (Resident 1, and Resident 18) Findings include: During an observation and interview on 8/11/23 at 9:38 AM Resident 1 indicated she had gone to the hospital the previous weekend after a flare up of gastroparesis. Resident 1's record was reviewed on 8/14/23 at 9:42 AM. Diagnoses included hemiplegia effecting left, non-dominant side, type 2 diabetes mellitus with unspecified complications, and gastroparesis. A review of Resident 1's current annual Minimum Data Set (MDS) dated 7/7/23 indicated her BIMS (Basic Interview for Mental Status) score was 15 (cognitively intact). A review of Resident 1's current care plan titled Resident has Potential for Nausea and Vomiting due to Gastroparesis indicated the resident had a	F 0684	F684 Quality of Care 1. What corrective action will be accomplished by those residents found to have been affected by the deficient practice? Resident # 1 suffered no ill effects related to the nausea not being assessed and documented. Resident # 18 suffered no ill effects related to related to his wrist not being assessed and documented. 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? Current residents and new admissions who have a change in condition have the opportunity to be affected. Utilizing the Change in Condition Audit tool the Director of Nursing or Assistant Director of Nursing will review resident documentation during the clinical	09/22/2023

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	problem of nausea and vomiting, with a goal date of 7/27/23 Interventions included monitoring for weakness and unsteadiness and assessing and documenting emesis. A review of a medication administration note dated 8/3/23 at 9:43 AM indicated Resident 1 refused her morning medications and breakfast due to nausea, and the nurse had been notified. A medication administration note dated 8/3/23 at 12:54 PM indicated Resident 1 refused all medications and lunch due to nausea, and the nurse had been notified. A medication administration note dated 8/3/23 at 5:29 PM indicated Resident 1 requested medication for nausea and after nurse notification, Ondansetron 8 mg was provided. A medication administration note dated 8/3/23 at 6:28 PM indicated Resident 1 refused all medications due to nausea, and the nurse had been notified. A medication administration note dated 8/3/23 at 9:40 PM indicated Ondansetron 8 mg was given for nausea. A medication administration note dated 8/4/23 at 5:54 AM indicated Ondansetron 8 mg was given for nausea. A medication administration note dated 8/4/23 at 1:15 PM indicated Resident 1 refused all medications. A medication administration note dated 8/4/23 at 9:25 PM indicated Resident 1 refused all medications due to nausea.		meetings Monday – Friday to identify residents with a change in condition and ensure assessments are documented as appropriate. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? To prevent this from reoccurring the Director of Nursing or Assistant Director of Nursing will provide education to Licensed Nurses utilizing the Change in Condition policy with an emphasis on providing assessing and documenting residents noted with a change in condition. This education will be completed on or before 9/22/23. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? To monitor and maintain ongoing compliance the Director of Nursing or Assistant Director of Nursing will complete weekly audits for 6 months utilizing the Change in Condition audit tool to ensure residents with a change in	

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	A triage note dated 8/4/23 with no time noted was electronically signed by Nurse Practitioner (NP) 25 on 8/14/23 at 6:03 PM. The note indicated NP 25 was notified of nausea and vomiting that morning and the use of ondansetron. NP 25 indicated nursing was to continue to monitor. No physical assessment was recorded. A progress note dated 8/5/23 at 9:24 AM indicated Resident 1 experienced abdominal pain, behavioral symptoms, and nausea/vomiting pain, uncontrolled, and went to the hospital. A review of progress notes and nursing assessments between 8/2/23 at the onset of nausea and the 8/5/23 departure to the hospital did not indicate any nursing assessments were performed. In an interview on 8/15/23 at 10:20 AM, the Director of Nursing (DON) indicated upon a Qualified Medicine Aide notification of nausea, the nurse should see the resident and inquire about the symptoms. A nurse should check for abdominal distention and bowel sounds. She indicated assessment could vary with chronic conditions. In an interview on 8/16/23 at 12:09 PM, Resident 1 indicated she had flare ups of gastroparesis that required intravenous medication in the hospital setting and she felt as if her episode prior to the 8/5/23 hospitalization was on such a level. Resident 1 indicated she called her gastrointestinal specialist's office herself on 8/4/23 and they advised her to go to the hospital. Resident 1 indicated she notified the Assistant Director of Nursing (ADON) 20 and she said she could not send her due to not having a		condition had an assessment and documentation completed. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. By what date the systemic changes for each deficiency will be completed? All audits, in servicing, and systemic changes will be in effect by 9/22/22.	

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	physician's order. Resident 1 indicated she asked ADON 20 to contact the doctor and she did not hear back from her for the rest of the day. Resident 1 indicated her daughter transported her to the hospital on 8/5/23 as she did not feel enough was being done at the facility. In an interview on 8/16/23 at 8/16/23 at 12:20 PM, the ADON 20 indicated she spoke to Resident 1's son on 8/5/23 and told him intravenous medications could be administered in the building and there was no need to go to the hospital. The ADON 20 denied performing any assessments on Resident 1 that day, and no further orders for interventions were received. A current policy titled Resident Change in Condition Policy last revised 7/2/21 provided by the Director of Nursing on 8/14/23 at 3:40 PM indicated the licensed nurse should recognize and intervene in the event of a change in the resident's condition. 2. During an observation and interview on 8/11/23 at 1:35 PM Resident 18 had a partial cast on his right hand wrapped with ace wrap. Resident 18 indicated he had carpal tunnel surgery the week before. Resident 18's record was reviewed on 8/16/23 at 10:44 AM. Diagnoses included end stage renal disease, type 2 diabetes mellitus with chronic kidney disease, and carpal tunnel syndrome, bilateral upper limbs. A review of Resident 18's current quarterly Minimum Data Set (MDS) dated 7/20/23 indicated his BIMS (Basic Interview for Mental Status) score was 15 (cognitively intact).			

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	A care plan addressing Resident 18's carpal tunnel syndrome and surgery was not available for review at the time of exit. A review of physician orders dated 8/1/23 indicated staff should call on 8/1/23 to obtain the surgery time for the surgery scheduled on 8/4/23. In an interview on 8/16/23 at 11:05 am, Resident 18 indicated he had surgery on 8/4/23 and only one nurse on one occasion had looked at his wrist and asked him if he could move his fingers and if he felt any pain or tingling since. A review of a post procedure note dated 8/4/23 at 4:18 PM indicated Resident 18 had a right sided carpal tunnel release surgery performed. A review of a monthly nurses note dated 8/10/23 at 6:06 PM indicated Resident 18 had dull pain of the right wrist, intermittent, rated 3 on a scale of 1-10 with 10 with 1 meaning very little pain, and 10 meaning excruciating pain. The note indicated an incision was present, but a dressing was to remain in place until he returned to the orthopedic office on 8/17/23. No further progress notes regarding assessment of circulation, sensation, movement, or pain were available for review. In an interview on 8/16/23 at 1:08 PM, the DON indicated the facility did not have a specific policy addressing assessments after a surgery, but indicated the resident should have been assessed for circulation, sensation, movement, and pain. 3.1-37(a)			

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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 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 record review and interview, the facility failed to ensure indwelling catheter care and maintenance was provided for 2 of 3 residents	F 0690	F690 – Catheter 1. What corrective action will be accomplished by those	09/22/2023

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	reviewed for urinary catheter. (Resident 39 and Resident 194). Findings include: 1. Resident 39's record was reviewed on 08/14/23 09:44 PM. Diagnoses included neuromuscular dysfunction of bladder, cerebral infarction, chronic kidney disease, dependence on renal dialysis, and type 2 diabetes mellitus with complications. Resident 39 's current quarterly Minimum Data Set (MDS) assessment indicated their Basic Interview for Mental Status (BIMS) score was 13 (cognitively intact). The MDS indicated the resident had an indwelling catheter. Resident 39's current care plan titled "Alteration of Elimination" indicated the resident had a problem of neuromuscular dysfunction of the bladder and foley catheter use, with a goal the resident would be free of complications from her foley catheter. Interventions included to ensure the foley bag was covered with a dignity bag, irrigate as ordered, provide catheter care as ordered, empty the foley catheter bag every shift, and keep the foley catheter bag below the level of the bladder. Resident 39's physician order dated 9/8/22 at 7:30 PM indicated the staff would change the foley catheter every thirty days at bedtime. An order dated 7/13/23 at 11:00 PM indicated the staff would check the catheter for placement every shift. An order dated 2/19/23 at 2:00 PM indicated the staff would flush the foley catheter with 60 milliliters of water every shift for foley catheter maintenance. An order dated 12/27/21 at 2:00 PM indicated staff would document foley output		residents found to have been affected by the deficient practice? Resident # 39 suffered no ill effects related to not receiving catheter care per physicians orders. Resident # 194 suffered no ill effects related to not receiving catheter care per physicians orders. 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? Current residents and new admissions who utilize a urinary catheter have the opportunity to be affected. Utilizing the Urinary Catheter Audit tool, the Director of Nursing or Assistant Director of Nursing will review residents who have a urinary catheter to ensure physicians orders for care of the catheter are in place and being documented as appropriate. This audit along with identified corrections will be completed on or before 9/22/23. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?	

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	every shift. An order dated 2/19/23 at 2:00 PM indicated the staff would ensure the resident had a foley catheter size 18 French with a 30-milliliter balloon every shift. A physician order dated 2/27/21 at 2:00 PM indicated the staff would ensure the foley catheter bag was covered every shift. A physician order dated 2/27/21 at 2:00 PM indicated staff would provide foley catheter care every shift. A physician order dated 12/27/21 at 2:00 PM indicated the staff would ensure the foley catheter was to continuous drainage every shift. Resident 39's Treatment Administration Record (TAR) dated 7/1/23 to 7/31/23 and 8/1/23 to 8/13/23 indicated the following: - Staff changed the resident's foley catheter at bedtime on 7/6/23 but failed to change the foley catheter in thirty days on 8/5/23. - Staff failed to check the catheter placement every shift on: 6:00 AM 7/25/23, 8/10/23 2:00 PM 7/17/23, 7/27/23, 7/28/23 11:00 PM 8/11/23 - Staff failed to flush the foley catheter with 60 milliliters of water for foley catheter maintenance on: 6:00 AM 7/15/23, 7/29/23 - Staff failed to document foley output every shift on: 6:00 AM 7/3/23, 7/12/23, 7/13/23, 7/14/23, 7/17/23, 7/25/23, 7/28/23, 7/31/23, 8/10/23, 8/13/23 2:00 PM 7/3/23, 7/9/23, 7/17/23, 7/24/23, 7/27/23, 7/28/23 11:00 PM 7/3/23, 7/9/23, 7/17/23, 7/24/23, 7/27/23, 7/28/23, 8/11/23 - Staff failed to ensure the resident had a foley		To prevent this from reoccurring the Director of Nursing or Assistant Director of Nursing will provide education to Licensed Nurses utilizing the Indwelling urinary catheter care procedure as well as the Intake and Output policy. This education will be completed on or before 9/22/23. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? To monitor and maintain ongoing compliance the Director of Nursing or Assistant Director of Nursing will complete weekly audits for 6 months utilizing the Urinary Catheter Audit Tool to ensure residents with urinary catheters to ensure physicians orders for care of the catheter are in place and being documented as appropriate. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. By what date the systemic changes for each deficiency will be completed? All results will be taken to the monthly QAPI meeting for review	

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	catheter size 18 French with a 30-milliliter balloon every shift on: 6:00 AM 7/25/23, 8/10/23 2:00 PM 7/3/23, 7/17/23, 7/27/23, 7/28/23 11:00 PM 8/11/23 - Staff failed to ensure the resident's foley catheter bag was covered every shift on: 6:00 AM 7/25/23, 8/10/23 2:00 PM 7/3/23, 7/17/23, 7/27/23, 7/28/23 11:00 PM 8/11/23 - Staff failed to ensure they provided foley catheter care every shift on: 6:00 AM 7/25/23, 8/10/23 2:00 PM 7/3/23, 7/17/23, 7/27/23, 7/28/23 11:00 PM 8/11/23 - Staff failed to ensure the foley catheter was to continuous drainage every shift on: 6:00 AM 7/25/23, 8/10/23 2:00 PM 7/3/23, 7/17/23, 7/27/23, 7/28/23 11:00 PM 8/11/23 2. Resident 194's record was reviewed on 08/15/23 at 12:09 PM. Diagnoses included obstructive and reflux uropathy, hydronephrosis, urinary tract infection, and a profound intellectual disability. A review of Resident 194's current admission MDS assessment indicated her BIMS score was 5 (severe impairment). A review of Resident 194's current care plan indicated the resident required a urinary catheter due to obstructive and reflux uropathy, urinary tract infections and hydronephrosis with a goal she would be free of complications from her foley catheter. Interventions included: administer peri-care, change catheter and draining system per		and recommendations	

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	155809	A. BUILDING 00 B. WING	08/16/2023

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	physician orders, ensure foley bag is covered, maintain drainage bag below the bladder level, and flush with 60 milliliters of normal saline for blockage. A review of Resident 194's physician order dated 8/2//22 at 2:00 PM indicated the staff would check placement every shift. A physician order dated 8/2/23 at 6:00 AM indicated staff would document the resident had a foley catheter size 16 French with a 30 ml balloon every shift, staff would record the resident's foley catheter output every shift, staff would ensure the foley catheter was to continuous drainage every shift, the staff would ensure the resident received foley catheter care every shift, the staff would ensure the foley catheter bag was covered every shift. A review of Resident 194's TAR dated 8/2/23 to 8/13/23 indicated the following: staff failed to check the catheter placement every shift on: 6:00 AM 8/4/23, 8/10/23, 8/11/23 11:00 PM 8/11/23 - The staff failed the document the resident had a foley catheter size 16 French with a 30 ml balloon every shift on: 6:00 AM 8/4/23, 8/10/23, 8/11/23 11:00 PM 8/11/23 - The staff failed to document the resident's foley catheter output every shift on: 6:00 AM 8/4/23, 8/10/23, 8/11/23 11:00 PM 8/11/23 -Tthe staff failed to ensure the resident's foley catheter was to continuous drainage every shift on: 6:00 AM 8/4/23, 8/10/23, 8/11/23 11:00 PM 8/11/23			

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	- The staff failed to ensure the resident received foley catheter care every shift on: 6:00 AM 8/4/23, 8/10/23, 8/11/23 11:00 PM 8/11/23 - The staff failed to ensure the foley catheter bag was covered every shift on: 6:00 AM 8/4/23, 8/10/23, 8/11/23 11:00 PM 8/11/23 In an interview on 08/15/23 at 10:20 AM, the DON indicated documentation was absent for various physician orders on Resident 39 and 194's catheter care and maintenance, catheter outputs, and Resident 39's catheter change should had been completed. Policies were requested for following medical doctor's orders and failure to document foley catheter: changing, flushing, bag being covered, catheter care, to hang to continuous drainage, and output recording. A current policy titled "Intake and Output (I&O) Policy", revised 8/12/18, provided by the DON on 8/15/23 at 2:30 PM indicated output would be recorded for residents with indwelling urinary catheters. A current policy titled " Urinary Catheterization and Removal Procedure (Female)", revised 1/5/23, provided by the DON on 8/15/23 at 2:30 PM contained no information related to the survey. No further policies concerning catheter documentation was provided prior to survey exit. State Rule does not apply			
F 0692 SS=D	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance			

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Bldg. 00	§483.25(g) Assisted nutrition and hydration. (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)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review the facility failed to ensure adequate nutrition for 1 of 7 residents reviewed. (Resident K) Findings include: During a phone interview on 8/10/23 at 9:23 AM, Resident K's guardian indicated the resident had been admitted to the facility on 7/12/23. The guardian indicated they took the resident back home on 7/17/23 due to the resident not receiving meal trays. The guardian indicated they had a meeting with facility staff on 7/17/23 at approximately 2:00 PM. The guardian indicated an agreement was made to assist the resident to the dining room for meals. The guardian indicated they returned to the facility on 7/17/23 at 5:40 PM	F 0692	F692 – Nutrition 1. What corrective action will be accomplished by those residents found to have been affected by the deficient practice? Resident K no longer resides at the facility. 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? Current residents and new admissions who require extensive	09/22/2023

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	and observed Resident K in their room. The Guardian indicated the resident had not been assisted to the dining room and had not been provided with a meal. Resident K's record was reviewed on 8/14/23 at 10:20 AM. Diagnoses included ataxic (poor muscle control) cerebral palsy, expressive language disorder and cachexia (body wasting). A review of Resident K's current Discharge Minimum Data Set (MDS) indicated the resident had no memory problems. The MDS indicated the resident required extensive staff assistance for eating. A review of Resident K's current care plan for nutrition indicated the resident was at risk of nutritional problems and the resident required extensive assistance with meals. Interventions included serving the resident the prescribed diet and recording meal intake daily. A review of progress notes dated 7/17/23 at 2:02 PM indicated the Resident K's family was okay with the resident eating in the dining room. A progress note dated 7/17/23 at 7:30 PM by the Director of Nursing (DON) indicated Resident K's family was upset the resident was not taken to the dining room and had not received a meal tray. The progress note indicated the DON had been aware of the resident's choice to eat all meals in the dining room. A review of Resident K's nutrition record dated July 2023 did not indicate the resident had received eating assistance for the following meals: breakfast on 7/16/23 lunch on 7/16/23		assistance for meals have the opportunity to be affected. The Director of Nursing or Assistant Director of Nursing will complete an audit utilizing the Nutrition Documentation audit tool to ensure eating assistance is being provided and documented for residents who require extensive assistance with meals. This audit along with identified corrections will be completed on or before 9/22/23. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? To prevent this from reoccurring the Director of Nursing or Assistant Director of Nursing will provide education to Licensed Nurses and STNA's utilizing the ADL Documentation policy with an emphasis on providing assistance with meals completing required documentation. This education will be completed on or before 9/22/23. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? To monitor and maintain ongoing	

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	Resident K's record did not indicate they had received a meal for the following meals: breakfast on 7/16/23 lunch on 7/16/23 Resident K's record did not indicate the resident had received fluid intake on the following shifts: 7/15/23 from 2:00 PM until 10:00 PM 7/16/23 from 6:00 AM until 2:00 PM. In an interview on 8/16/23 at 11:53 AM the Administrator indicated they were aware of Resident K's report of not receiving meals and fluids. The Administrator indicated they were unaware of blank documentation related to meal and fluid intake records. In an interview on 8/16/23 at 12:03 PM the Administrator indicated the facility nursing management team had reported Resident K had been out of the facility on 7/15/23 and 7/16/23. The Administrator indicated the resident being out of the facility explained the blank documentation related to meal and fluid intake. The Administrator was made aware Resident K's record did not reflect they had been out of the facility on 7/15/23 and 7/16/23. The Administrator indicated they were unaware of the process of documentation related to residents being out of the facility. In an interview on 8/16/23 at 12:17 PM the Assistant Director of Nursing (ADON 20) indicated Resident K's actual intake records were not visible to writer due to the resident having been discharged. ADON 20 provided individual pages of Resident K's meal intake records. ADON 20 did not provide documentation for the		compliance the Director of Nursing or Assistant Director of Nursing will complete weekly audits for 6 months utilizing the Nutrition Documentation audit tool to ensure residents who require extensive assistance with eating is being provided and documented as required. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. By what date the systemic changes for each deficiency will be completed? All audits, in servicing, and systemic changes will be in effect by 9/22/22.	

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	following meals: breakfast on 7/16/23 lunch on 7/16/23 A current policy dated 9/21/20 indicated meals would be distributed promptly with supervision as needed by nursing staff. The policy indicated the nursing staff would notify dietary services in writing of residents who chose to eat in their rooms. This citation is related to complaint IN00413328. 3.1-46			