STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KOKOMO HEALTHCARE CENTER	429 W LINCOLN RD KOKOMO, IN 46902

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00380972 and IN00386947. Complaint IN00380972 - Substantiated. Federal/State deficiencies related to the allegations are cited at F602. Complaint IN00386947 - Substantiated. Federal/State deficiencies related to the allegations are cited at F842. Unrelated deficiencies are cited at F684. Survey dates: August 1, 2 and 3, 2022 Facility number: 000127 Provider number: 155222 AIM number: 100291430 Census bed type: SNF/NF: 65 Total: 65 Census payor type: Medicare: 7 Medicaid: 54 Other: 4 Total: 65 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on August 12, 2022.	F 0000	**Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law.** **The facility cordially requests paper compliance regarding alleged deficient practices.**	
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12			

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

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

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	The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Based on observation, interview and record review, the facility failed to ensure residents' narcotic medications were kept safe and secure during their admissions for 2 of 3 residents being reviewed for misappropriation of residents' property and exploitation (Residents B and D). Findings include: During an entrance interview, on 8/1/22 at 3:48 p.m., the Executive Director (ED) indicated she started as the newly hired ED the last week of June 2022. She indicated she knew very little about a nurse being accused of switching Ibuprofen (a non-narcotic pain medication, which relieved pain by decreasing inflammation) for Hydrocodone (a narcotic pain medication.) At that time, the ED looked for a reportable for the allegation of Hydrocodone being replaced with Ibuprofen, but she was unable to locate a reportable for the allegation. She was not the ED during that time frame, but she had heard bits and pieces about the incident after being hired. The staff member who was supposedly involved with the incident was not currently working at the facility due to being on medical leave. 1. During an interview, on 8/2/22 at 3:41 p.m., Resident B indicated during the months from April 2022 through May 13, 2022, whenever LPN 7 worked, LPN 7 switched out her Hydrocodone for Ibuprofen. Resident B indicated she got to the	F 0602	Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident B still resides at the facility and has not been harmed by the alleged practice. The facility conducted a medication reconciliation with the narcotics any discrepancies were reported to MD and family. Resident B states she has had no further concerns with receiving pain medication. Resident D no longer resides at the facility. The LPN was placed on Medical Leave and is currently receiving treatment at a Drug Rehabilitation Center and has not worked. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents whom are prescribed narcotics have the potential to be affected. No other residents were found to be affected by the alleged deficient practice. The facility conducted a medication reconciliation with the narcotics and no discrepancies were reported. Measures put in place and	09/05/2022

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	point when LPN 7 worked the evening shift, she did not request her PRN (as needed) dose of Hydrocodone. She also refused to take her routine scheduled dose at 6:00 p.m., because she knew LPN 7 would bring her an Ibuprofen instead of her Hydrocodone. Resident B did not want to give LPN 7 any other opportunities to "steal" her pain pills or another resident's Ibuprofen. She did not have an order for the Ibuprofen, so Resident B assumed LPN 7 was "stealing" those off another resident, but she was unable to indicate, which resident's Ibuprofen was being used. Resident B spoke to LPN 7 regarding her giving the Ibuprofen instead of Hydrocodone to her, but LPN 7 denied "switching" out the medication. On one occasion when she was sitting by the medication cart waiting for her mediations, she observed LPN 7 take all her medications from the regular drawer, but she did not get into the narcotic drawer to retrieve her Hydrocodone, which was locked up. She confronted LPN 7 about her not getting her Hydrocodone out of the narcotic drawer and was told by LPN 7 she did get her Hydrocodone out of the locked drawer. On the evening shift, of 5/10/22, LPN 7 again gave Resident B a pill, which did not look like her Hydrocodone. When she asked LPN 7 what the white pill was, she was told it was her Hydrocodone. The resident was unsure of the name of the medication she had been receiving, so she looked the medication up on her phone and discovered she had been receiving an 800 mg (milligram) tablet of Ibuprofen (which she did not have an order for), instead of her Hydrocodone. At that time, Resident B was observed retrieving something from the top drawer of her nightstand. The resident had a large white oblong pill with IBU and 800 under the IBU stamped on the pill, in her hand. On 5/10/22, she had seven of these		systemic changes made to ensure the alleged deficient practice does not recur: The DON/Designee will complete education with all staff utilizing the Indiana Abuse, Neglect, and Misappropriation of Property policy. The DON/Designee will educate all licensed nurses and QMAs on the Medication Controlled Drugs Security Policy and procedure to ensure the alleged deficient practice does not recur. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The DON/Designee will conduct an audit by observation of medication administration to 5 residents per week for 4 weeks, 3 residents per week for 4 weeks, then 1 resident per week for 4 months to ensure narcotic medications have been received per MD order. The DON/Designee will observe shift to shift narcotic count on random shifts 5 times per week for 4 weeks then, 3 times per week for 4 weeks, then 1 time per week for 4 months to ensure narcotics are kept safely stored and secured. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.	

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	tablets saved in her drawer. She gave one tablet to LPN 3 the morning of 5/11/22, and informed her of what LPN 7 had done with her Hydrocodone. She kept one of the pills as "evidence" to show what pills LPN 7 had been giving her in place of her Hydrocodone and she threw the rest of them away. LPN 3 told the resident she would report her concerns regarding the "switching" of the two drugs to the Director of Nursing (DON) and Resident B gave her the one of the Ibuprofen pills. Resident B indicated Resident D also had issues with LPN 7 "switching" his Hydrocodone out for another medication. She was unsure of how long the "theft" of his pain medications had went on. Resident B indicated the previous Interim ED and previous Human Resource Director (HRD) came down to her room later that day on 5/13/22, to talk to her regarding LPN 7, the controlled substance and Ibuprofen. The previous Interim ED indicated the "switching" of controlled substances had not been reported to him prior to that morning and he was going to have to get the previous DON involved. The resident indicated the previous DON supposedly already knew about the allegation at least two days prior to that date, which was 5/11/22, because LPN 3 reported it to her as well as took the Ibuprofen pill to her. On the evening, of 5/13/22, after the previous ED and HRD spoke to Resident B regarding the "switching" of her Hydrocodone with Ibuprofen, she decided she was going to confront LPN 7 about the medication. That evening during the medication pass, another resident (Resident D) who also had problems with LPN 7 "switching" out his Hydrocodone for another medication, was sitting next to the nurses' cart waiting to get his medication. LPN 7 had given her the Ibuprofen in place of the Hydrocodone again, so Resident B			

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	went to the nurse's cart at the nurses' station. She told LPN 7, as she held the white pill in her hand out towards LPN 7, the pill she had given her for her Hydrocodone was not the correct medication and she wanted what was due to her. LPN 7 opened the narcotic drawer, at that time, and got one of her Hydrocodone's out of the drawer and gave it to Resident B. Resident B indicated LPN 7 was suspended for three days (she was not sure of the date) after Resident D reported his medication being "stolen". After her suspension, she was brought back to work. Then, after Resident B reported her medications being "stolen," LPN 7 gave her two weeks' notice and she no longer worked at the facility. The reportable and investigation into the diversion of drugs for Residents B was requested from the ED on 8/3/22 at 10:45 a.m. The ED indicated when asked if LPN 7 was on a medical leave as she originally said on the first day of the survey, she indicated LPN 7 she was on medical leave while being treated at a Drug Rehabilitation Center. The record for Resident B was reviewed on 8/3/22 at 2:01 p.m. Diagnoses included, but were not limited to, Type 2 diabetes mellitus, acute cystitis, hypertension, lymphedema, major depressive disorder and anxiety disorder. The resident's quarterly MDS (Minimum Data Set) assessment, dated 4/20/22, indicated her BIMS (Brief Interview Mental Status) score was 15, which indicated she was cognitively intact. Resident B had a care plan for the problem of acute and chronic pain and inflammation, arthritis			

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	and fibromyalgia. The interventions included, but were not limited to, observe for pain every shift and provide medication as the physician had ordered. Resident B's EMAR (Electronic Medication Administration Record), dated 4/1/22-4/30/22, included, but were not limited to, the following orders: a. Hydrocodone-Acetaminophen Tablet 7.5-325 mg (milligrams), give one tablet by mouth every 12 hours as needed for pain. Resident B took a total of 6 doses from 4/1/22 to 4/9/22. A total of 1 of 2 evening doses were documented as administered by LPN 7 on the evening shift from 4/1/22-4/9/22. b. Hydrocodone-Acetaminophen Tablet 7.5-325 mg, give one tablet by mouth every 12 hours as needed for pain. Resident B took a total of 12 doses during the month of April. A total of 3 of 4 evening doses were documented as administered by LPN 7 on the evening shift during the month of April. Resident B's EMAR (Electronic Medication Administration Record), dated 5/1/22-5/31/22, included, but was not limited to, the following orders: a. Hydrocodone-Acetaminophen Tablet 7.5-325 mg, give one tablet by mouth every 12 hours as needed for pain. Resident B took a total of 6 doses during the period of 5/1/22 to 5/9/22. A total of 1 of 2 evening doses were documented as administered by LPN 7 on the evening shift from 5/9/22 to 5/31/22. b. Hydrocodone/Acetaminophen tablet 7.5 mg-325 mg, take one tablet by mouth four times a day for pain. Scheduled to be administered at 12:00 a.m., 6:00			

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	a.m., 12:00 p.m., 6:00 p.m. Resident B took a total of 23 doses from 5/9/22 to 5/31/22 on the evening shift. A total of 15 of the 23 doses were documented as administered by LPN 7 on the evening shift from 5/9/22 to 5/31/22. Resident B's EMAR for the months of April and May 2022, lacked an order for Ibuprofen 800 mg. During a phone interview, on 8/3/22 at 2:30 p.m., Resident D indicated on 5/13/22, on the evening shift, he sat at the nurses' cart waiting on his medication to be administered by LPN 7. Resident B came up to LPN 7 with a white oblong pill in her hand. The resident told LPN 7 to give her what was due to her. LPN 7 opened the narcotic drawer and pulled out a card and got the pill off the card and gave it to Resident B. She let the resident keep the original white pill she had in her hand. During an interview, on 8/3/22 at 3:25 p.m., LPN 3 indicated she could not remember the exact date of the incident. She had worked a night shift and when she came on duty Resident B handed her a white tablet, which she recognized as being an Ibuprofen tablet. Resident B told her LPN 7 had been "switching" this pill out for her Hydrocodones since sometime in April and when she confronted LPN 7 regarding her doing this and she denied it. LPN 3 reported the incident and gave the Ibuprofen pill to the previous DON the next morning before she got off work. She was not asked to write a statement and as far as she knew, Resident B reported the incident to the previous ED, the previous DON did not. LPN 3 did not believe any investigation transpired from the incident. LPN 7 no longer worked for the facility and had accepted a job at another facility. On 8/3/22 at 5:13 p.m., the following information			

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	was provided as the only information the ED could locate regarding Resident B and her Hydrocodone being replaced with an Ibuprofen tablet: A document, titled "Employee Corrective Action Form," dated 5/17/22, indicated the previous DON gave LPN 7 the document. The Subject of Discipline included, but were not limited to, the following disciplines: Performance/Policy Violation, indicate policy (Medication Administration five rights) Safety/Carelessness (Wrong Medication) Falsification of Documentation (Signed out Narcotic) The Violation Statement indicated a resident asked for a pain pill, but was given an Ibuprofen instead of the Narcotic pain medication prescribed to the resident. The Narcotic medication looked similar to the Ibuprofen. LPN 7 documented on the narcotic sign out sheet and signed out the narcotic as being administered. The resident had to correct LPN 7. 2. During a phone interview, on 8/3/22 at 2:30 p.m., Resident D indicated starting sometime in April 2022, LPN 7 started trying to get him to "believe" his acid reflux pill was his Percocet 10 mg pain medication. She tried to get him to "believe" this on four separate occasions, so she could "steal" his Percocet 10 mg pills. There was two times in one shift, two days in a row, LPN 7 indicated he did not have any Percocet 10 mg available in the narcotic drawer and it was too early to order it from the pharmacy, so he had to do without his pain medication. He indicated LPN 7 telling him he did not have pain medication was beginning to happen more frequently, so one day when LPN 7 told him he did not have any pain			

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	meds left and it was too early to order them from the pharmacy he summonsed the previous ED to his room. The resident spoke to the previous ED regarding why he thought he was running out of his Percocet 10 mg tablets for pain. Resident D "believed" LPN 7 was "stealing" his Percocet 10 mg pain pills and using them for herself. After speaking to the previous ED regarding his concerns, the previous ED wrote out his statement for him and he signed it and gave it to the previous ED, who indicated he would start an investigation, but he never heard anything back from anyone about his pain medication. The previous ED went to the nurses station to check into why Resident D did not have any pain medication. The previous ED had the nurse get the resident's Percocet 10 mg out of the EDK and take it to him. Resident D's record was reviewed on 8/3/22 at 2:42 p.m. Diagnoses included, but were not limited to, chronic pain, rhabdomyolysis, major depressive disorder, and chronic kidney disease. The resident's quarterly MDS (Minimum Data Set) assessment, dated 4/20/22, indicated his BIMS (Brief Interview Mental Status) score was 15, which indicated he was cognitively intact. Resident D's EMAR (Electronic Medication Administration Record), dated 4/1/22-4/30/22, included, but were not limited to, the following orders: a. Oxycodone-Acetaminophen Tablet 10-325 mg, give one tablet by mouth three times a day. Resident D took a total of 82 doses during the period of 4/1/22 to 4/27/22. A total of 14 of the 27 evening doses were documented as administered by LPN 7 on the evening shift from 4/1/22 to			

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	4/27/22. Resident D took a total of 11 doses during the period of 4/27/22 to 4/30/22. A total of 2 of the 5 evening doses were documented as administered by LPN 7 on the evening shift from 4/27/22 to 4/30/22. Resident D's EMAR (Electronic Medication Administration Record), dated 5/1/22-5/31/22, included, but were not limited to, the following orders: a. Oxycodone-Acetaminophen Tablet 10-325 mg, give one tablet by mouth every six hours as needed for pain. Resident D took a total of 31 doses during the period of 5/1/22 to 5/18/22. A total of 3 of the 18 evening doses were documented as administered by LPN 7 on the evening shift from 5/1/22 to 5/18/22. b. Oxycodone-Acetaminophen Tablet 10-325 mg, give one tablet by mouth every six hours as needed for pain. Resident D took a total of 10 doses during the period of 5/18/22 to 5/25/22. A total of 7 of the 10 evening doses were documented as administered by LPN 7 on the evening shift from 5/18/22 to 5/25/22. c. Oxycodone-Acetaminophen Tablet 10-325 mg, give one tablet by mouth every six hours as needed for pain. Resident D took a total of 31 doses during the period of 5/26/22 to 5/31/22. A total of 2 of the 18 evening doses were documented as administered by LPN 7 on the evening shift from 5/26/22 to 5/31/22. On 8/3/22 at 5:13 p.m., the ED indicated she did not know anything about Resident D not getting four doses of his Hydrocodone and that information being reported to the previous ED with a statement being written to explain			

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	everything which happened about the incident. A current policy, titled "INDIANA Abuse & Neglect & Misappropriation of Property," dated with a revised date of 10/27/2021 and provided by the ED on 8/2/22 at 3:30 p.m., indicated "...Misappropriation of resident funds or property: In Indiana, the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's property or money without the resident's consent. Resident's property includes all resident' possessions, regardless of their apparent value since it may hold intrinsic value to the resident. This includes any medication dispensed in the name of a resident. This does not include medications from an EDK that have not been charged to the resident...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the resident. It is the intent of this facility to prevent the abuse, mistreatment, or neglect of residents or the misappropriation of their property, corporal punishment and/or involuntary seclusion and to provide guidance to direct staff to manage any concerns or allegations of abuse, neglect or misappropriation of their property...In the event an allegation is made, the facility will take measures to protect residents from harm during an investigation. Accurate and timely reporting of incidents, both alleged and substantiated, will be sent to officials in accordance with the state law. If the alleged violation is verified, appropriate corrective action will be taken by the facility...III. Prevention...4. An employee who is alleged or accused of being a party to abuse, neglect, misappropriation of property will be immediately removed from the area(s) of resident care, interviewed by facility leadership for a written statement and not left alone...5. After completing the statement(s), the			

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	employee(s) will be asked to vacate the facility until further investigation of the incident is completed. a. The employee(s) will be notified of the findings of the investigation. b. Appropriate measures will be taken with the employees(s) post investigation including but not limited to: i. Returning to work including no change in regular pay during off time. ii. Additional education and training. iii. Disciplinary action if appropriate including termination following facility HR [Human Resources] termination policies and guidance...V. Investigation of Incidents: 1. In the event a situation is identified as abuse, neglect or misappropriation, an investigation by the executive leadership will immediately follow-up. a. The Director of Nursing (DON) and Executive Director (ED) receives reports of resident incidences. The Executive Director determines when an investigation is required and directs the investigation. b. The resident's safety is the first consideration. The following steps will be followed as appropriate...d. In the event the alleged perpetrator is a staff member that staff member will be removed from areas of resident living and interviewed by nurse on duty. i. The staff member will be escorted off of the premises by another staff member. II. The accused staff member will be suspended, by the Executive Director or designee, pending the outcome of the investigation the incident. III. The staff member will be considered innocent of any accusation unless prove otherwise by the formal investigation and continue to receive regularly scheduled pay while on suspension. iv. Removing the staff member serves to protect...g. Documentation of the facts and findings will be completed in each resident medical record...i. Notify the physicians of each resident. j. Notify the resident representative...A Suspected Abuse: a. Neglect or Misappropriation Investigation			

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	155222	A. BUILDING 00 B. WING	08/03/2022

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	report will be initiated by the Director of Nursing or Designee. b. Initial findings will be reported to the Executive Director, the physician (except in the case of misappropriation of funds/property) and the resident representative. c. The Executive Director, Director of Nursing or designee will report immediately to the appropriate agencies and document the time and date of that report on the investigation form. d. Statements will be obtained from staff related to the incident, including victim, person reporting incident, accused perpetrator and witnesses. This statement should be in writing, signed and dated at the time it was written...All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury...6. If a covered individual suspects that a crime has been committed, that individual is obligated to contact the state Agent and the local police department...." A current policy, titled "Medication Controlled Drugs and Security," dated with a revised date of 7/25/2018, provided by the ED on 8/2/22 at 3:30 p.m., indicated "...Definitions: Schedule Drugs or Controlled drugs: also known as 'narcotics'-Drugs that have been classified by a Schedule of 1-5 by the Drug Enforcement Administration (DEA) according to their potential for abuse, misuse, and ability to create dependence including physical and psychological dependence. Policy...Narcotics, scheduled or controlled drugs are medications that pose a high risk for addiction when improperly taken and are known to depress the respiratory system which, if taken inappropriately could lead to overdose up to and including			

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	death...The purpose of this policy is to provide direction of the nurse regarding processes of operation for the administration and control of narcotics, depressants, and stimulant drugs and to provide maximum safety for residents and nursing personnel. Procedure:..1. Controlled drug distribution is for use of residents only a. Residents may not 'share' or 'borrow' medications...d. Drug diversion will be treated as misappropriation of Resident Property and the Board of Nursing will be notified as appropriate for known drug diversions or suspected drug diversion after careful review and evidence collection...." A current policy, titled "Medication Administration," dated with a revised date of 12/14/2017, provided by the ED on 8/2/22 at 3:30 p.m., indicated "...Definitions: MAR: Medication Administration Record-the legal documentation for medication administration. PRN: use on an 'as needed' basis within the parameter. Policy...The purpose of this policy is to provide guidance for general medication administration to be provided by personnel recognized by legally able to administer. Procedures: 1. General Procedures: a. Administer medication only as prescribed by the provider...Observe the 'five rights' in giving each medication...the right medication...Do not share or 'borrow' medication from others...PRN medications will have a reason documented for giving and the effectiveness of the drug...IV. Documentation: a. Documentation of medication will be current for medication administration. b. Documentation of medications will follow accepted standards of nursing practice. This Federal tag relates to Complaint IN00380972. 3.1-28(c)			

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	3.1-28(d)			
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 physician appointments with a specialist were scheduled and transportation was set up to ensure the resident was evaluated by these physicians for 1 of 1 resident being reviewed for quality of treatment and care (Resident B). Finding includes: During an interview, on 8/2/22 at 3:41 p.m., Resident B was observed with a copy of her physician's "Order Recap Report," which she indicated she received the copy of last evening. Her concern was she had several physician consultation appointments, which had been ordered by the facilities' Nurse Practitioner (NP), but had never been followed through on as far as getting her an appointment or if there was an appointment made, she was never taken to the appointment. She had complaints of diarrhea since October 2021, but had not seen a Gastroenterologist (a physician who specialized in diseases of the gastrointestinal tract). She indicated she was concerned because she was on Methotrexate (a medication used to treat	F 0684	Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The facility obtained an appointment for GI and Neurology. The facility has faxed all required information to Rheumatology to secure appointment times. Facility is awaiting call back with appointment date from physician. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Any resident whom has referrals for appointments with Specialists have the potential to be affected. The facility will review orders for all residents within last 90 days and validate that resident attended appointment if there are any discrepancies the appointment will be rescheduled. Measures put in place and systemic changes made to ensure the alleged deficient practice does	09/05/2022

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	inflammation from autoimmune diseases) and Hydroxychloroquine (a medication used to treat inflammation from autoimmune diseases), but had not seen a Rheumatologist (a physician who specialized in treating patients with autoimmune diseases) since she was admitted on 7/29/21. She had an accident, which caused her to have a neuropathy over her lower half of her body prior to being admitted to the facility. If she had continued to get therapy and seen a Neurologist, since she was admitted to the facility, she may have been doing better than she was now, but she did not believe she would ever improve from where her health status was as of this date. She had spoken to different staff members including the NP, the previous DON and ED, but nothing had gotten accomplished and she had not gotten to these specialists appointments. The record for Resident B was reviewed on 8/3/22 at 2:01 p.m. Diagnoses included, but were not limited to, Type 2 diabetes mellitus, acute cystitis, hypertension, lymphedema, major depressive disorder and anxiety disorder. The resident's quarterly MDS (Minimum Data Set) assessment, dated 4/20/22, indicated her BIMS (Brief Interview Mental Status) score was 15, which indicated she was cognitively intact. Resident B had a care plan for the problem of diarrhea. The interventions included, but were not limited to, administer medications as the physician prescribed them and dietary consult for recommendations and teaching. The physician's Order Recap Report, dated 10/1/21-8/31/22, included, but were not limited to, the following orders: (All the following orders remained active orders from the date they were		not recur: The IDT will bring all new admission charts to daily clinical meeting and review chart for follow up appointments needed with Specialist. Any appointment that needs scheduled will be scheduled and transportation arranged and placed on appointment calendar on nursing unit. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The DON/Designee will conduct an audit of 5 residents per week for 8 weeks, then 3 residents per week for 8 weeks, then 1 resident weekly for 8 weeks and compliance is achieved and all referrals to Specialist have an appointment made and resident attends. Any discrepancy will result in appointment being rescheduled and MD/family notified. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.	

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	written by the NP (Nurse Practitioner) as of the date of the exit conference 8/3/22.) 10/15/21, Referral for (Name of Rheumatologist). 3/23/22, Identify Gastroenterologists and schedule a follow up with them due to calculi in the gall bladder and hepatomegaly with fatty infiltration. 5/9/22, Please identify and schedule appointment with Gastroenterologist due to diarrhea. 5/9/22, Please identify and schedule appointment with Rheumatologist (takes Methotrexate and Hydroxychloroquine) 6/1/22, Schedule appointment with (Name of Gastroenterologist) due/to excessive diarrhea 6/20/22, Referral for resident to see (Name of Gastroenterologist) for excessive diarrhea 7/28/22, Consult Neurologist (a physician who specialized in treating patients with nerve disorders) for sign/symptoms of Fibromyalgia Progress Notes were reviewed, which included, but were not limited to, the following information from each individual progress note: On 4/27/22, A physician's progress note indicated the resident was complaining of generalized pain and diarrhea. On 5/9/22, A physician's progress note indicated the resident was seen to follow-up on her continued complaints of generalized complaints of pain and diarrhea. Her pain medications were adjusted, but they were not working very well. The plan was to identify and schedule			

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	appointments with the Rheumatologists due to taking Methotrexate and Hydroxychloroquine and the Gastroenterologist due to diarrhea. On 6/1/22 at 2:10 p.m., a nurses note indicated the facility received a new order to schedule an appointment with (Name of Gastroenterologist) for excessive diarrhea. The nurse had to leave a message at (Name of Gastroenterologist's) office. The office was to call back to have the appointment scheduled. If the office had not called back in a day or two, the nurse needed to follow-up with another call to the physician's office to schedule the appointment. The nurse on Resident B's hall was alerted (Name of Gastroenterologist) was to call back to schedule her appointment. On 6/3/22, A physician's progress note indicated the resident was seen for a follow-up visit for complaints of diarrhea and she had continued to complain of diarrhea. She also complained of Malians and extremity weakness. She complained of deficits in some of her life activities with her social and interpersonal functioning. The physician plan for the resident was to please identify and schedule an appointment with Gastroenterologist due to diarrhea. On 7/28/22, A physician's progress note indicated during a physician visit a concern was brought up regarding having a flare up with signs and symptoms of fibromyalgia (severe joint pain in specific pressure trigger areas). She complained of deficits in some of her life activities for social and interpersonal functioning. Resident had a diagnosis of fibromyalgia and generalized muscle weakness. The plan was to consult a neurologist for signs and symptoms of fibromyalgia.			

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	During a phone interview, on 8/3/22 at 5:11 p.m., Nurse Practitioner (NP) 9 was asked about Resident B's active physician consultation appointments she had ordered for her concerning symptoms the resident had voiced dating back to 10/21/21, regarding diarrhea, taking Methotrexate (a drug used to treat cancer, which can be taken to treat autoimmune diseases) and she had not seen a Rheumatologist since she had been admitted to the facility on 7/29/21. NP 9 indicated an active order was a current order. She indicated the orders dating back to 10/21/22 and 3/23/2022, were her longest standing orders for physician consultations appointments and were ordered during the time COVID-19 hit and most physicians were not accepting new patients in their office. She also indicated Resident B's referral appointments to the GI (Gastroenterologist) (there had been four of them) was for complaints of diarrhea. Her diarrhea had stopped at some point, so she did not need to go to the Gastroenterologist for those appointments, but NP 9 failed to write a discontinued order for them. She had no understanding of why the resident had not made it to those appointments already. As far as she knew, she had went to those appointments with the specific specialist physician names. The staff are now working on an appointment for a GI physician for complaints of diarrhea. 3.1-37(a)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in			

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	accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.			

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	§483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on interview and record review, the facility failed to maintain medical records which were complete and accurate as indicated by documentation for a resident who wanted to choose his therapy time for 1 of 3 residents reviewed for choice of therapy time (Resident C). Finding includes: A Confidential interview was conducted during the course of the survey. The Confidential Interviewee indicated the resident residing at the facility was admitted to the facility for rehabilitation. The therapists would come into the resident's room at 9:00 a.m., and the resident would decline to have therapy at that time of the morning because the resident was not a morning	F 0842	Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident C no longer resides at the facility. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents who receive therapy have the potential to be affected. The facility will interview all residents currently participating in therapy services to identify schedule preferences and will make changes to regimen to meet resident preference.	09/05/2022

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	person. The Confidential Interviewee asked the therapists to come in the afternoon, so the resident would not continually decline therapy services, but the therapists declined to come in the afternoon. The record for Resident C was reviewed on 8/2/22 at 4:15 p.m. Diagnoses included, but were not limited to, hypertension, cognitive communication deficit, rhabdomyolysis, Alzheimer's disease, chronic kidney disease stage 3, Type 2 diabetes mellitus and morbid (severe) obesity due to excess calories. The therapy notes were reviewed, which indicated the resident refused to attend therapy. When he refused it was due to not wanting to go in the mornings. The therapists lacked documentation they offered him another time frame later in the mornings or afternoons. The therapists did often complete therapy with Resident C throughout the mornings and afternoon. During an interview, on 8/2/22 at 2:34 p.m., Physical Therapy Assistant (PTA) 6 indicated Resident C was not very motivated to do his therapy. He talked with one of the resident's daughter and she came in to talk with PTA 10 about the resident refusing therapy and not wanting to be up in the chair. PTA 6 indicated all the resident's therapist offered different times of the day (morning, early and late afternoon). Sometimes he had to be seen in the morning if he had a progress report due to the doctor by the evaluating therapists. They tried to see him later in the day because he did not want to be seen in the morning. His daughter would be on the phone trying to get him to participate in the afternoon sessions of therapy and she came in one time to try to get him to go to therapy. Resident C would		Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Therapy department any new admission to therapy services and develop a schedule based on resident preference. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The Therapy Director/Designee will conduct audits of 5 residents per week for 4 weeks, then 3 residents for 4 weeks, then 1 resident for 4 months to ensure residents are receiving therapy per preference. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.	

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	be agreeable to go to therapy as long as his daughter was here, but as soon as she left he wanted back into bed and he would not participate in therapy. On 5/25/22, his daughter was present during the therapy education and goals of therapy. PTA 6 indicated they offered Resident C so many different times to come to therapy. If he refused, they would go back at least three times to try to get him to come to therapy. The therapists did not typically document the times they attempted to get the resident to therapy or every time a therapist discussed something with a family member. We should have documented the attempts we made to show we tried to get the resident to come to therapy and kept the family up to date. This Federal tag relates to Complaint IN00386947 3.1-50(a)(2)			