

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155787	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/09/2024
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NAME OF PROVIDER OR SUPPLIER INDIANA VETERANS HOME	STREET ADDRESS, CITY, STATE, ZIP COD 3851 N RIVER RD WEST LAFAYETTE, IN 47906
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00429556, IN00432213, IN00435458, IN00438643, IN00439998, IN00441727, IN00441751 and IN00448381.</p> <p>Complaint IN00429556 - No deficiencies related to the allegation are cited.</p> <p>Complaint IN00432213 - No deficiencies related to the allegation are cited.</p> <p>Complaint IN00435458 - No deficiencies related to the allegation are cited.</p> <p>Complaint IN00438643 - No deficiencies related to the allegation are cited.</p> <p>Complaint IN00439998 - No deficiencies related to the allegation are cited.</p> <p>Complaint IN00441727 - No deficiencies related to the allegation are cited.</p> <p>Complaint IN00441751 - No deficiencies related to the allegation are cited.</p> <p>Complaint IN00448381 - Federal/State deficiencies related to the allegations are cited at F689.</p> <p>Survey dates: December 2, 3, 4, 5, 6 and 9, 2024.</p> <p>Facility number: 001134 Provider number: 155787 AIM number: 200817200</p> <p>Census Bed Type:</p>	F 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure Survey dated December 9, 2024. Please accept this plan of correction as the Indiana Veterans' Home credible allegation of compliance. Indiana Veterans' Home respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Amy Gibson	TITLE Superintendent	(X6) DATE 12/23/2024
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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 0684 SS=D Bldg. 00	<p>SNF/NF: 115 Total: 115</p> <p>Census Payor Type: Medicare: 1 Medicaid: 55 Other: 59 Total: 115</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review was completed on December 13, 2024.</p> <p>483.25 Quality of Care</p> <p>Based on observation, interview and record review, the facility failed to ensure the physician was notified when blood sugar readings were in the call parameter range and to hold medications per the physician ordered parameters for 3 of 3 residents reviewed for quality of care. (Resident 93, 35 and 108)</p> <p>Findings include:</p> <p>1. The clinical record for Resident 93 was reviewed on 12/4/24 at 9:43 a.m. The diagnoses included, but were not limited to, diabetes mellitus, atrophy of the kidney, and hypothyroidism.</p> <p>A current care plan, with a start date of 8/1/24, indicated the resident was at risk of complications related to diabetes and to notify the physician or Nurse Practitioner (NP) as needed.</p> <p>A physician's order, with a start date of 10/2/24, indicated to check blood sugars in the morning</p>	F 0684	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Nurse who did not notify provider of low blood sugar for resident 93 provided education on notifications.</p> <p>Nurse who did not notify provider of low pulse for resident 35 no longer employed by facility.</p> <p>Nurse who did not notify provider of elevated blood sugar for resident 108 provided education on notifications.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>All diabetic residents with call</p>	01/07/2025

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	<p>and at night and to call the physician if the blood sugar was below 60 or above 350.</p> <p>The electronic medical record indicated, on 10/7/24, the morning blood sugar was 57.</p> <p>A progress note, dated 10/7/24 at 6:08 a.m., indicated the blood sugar this morning was 57. The resident was given chocolate milk and a Nutri grain bar. When the resident was rechecked the blood sugar was 67 and the resident was working on another chocolate milk.</p> <p>There was no documentation to indicate the physician was notified of the low blood sugar reading.</p> <p>During an interview, on 12/5/24 at 3:30 p.m., Nursing Supervisor 4 indicated she could not find the low blood sugar notification in the chart. There should be an "event" opened when they notify the physician of an out-of-range blood sugar.</p> <p>During an interview, on 12/5/24 at 3:33 p.m., Dementia Care Director 3 indicated the low blood sugar notification was not in the resident's chart.</p> <p>During an interview, on 12/9/24 at 10:16 a.m., the Director of Nursing (DON) indicated they did not have a policy for following physician's orders.2. The clinical record for Resident 35 was reviewed on 12/5/24 at 2:55 p.m. The diagnoses included, but were not limited to, congestive heart failure, hypertension, and atrial fibrillation.</p> <p>a. A physician's order indicated to give Digoxin (a medication used to treat heart failure) 125 mcg (microgram) and to hold the medication if the apical pulse was less than 60.</p>		<p>parameters have the potential to be affected by the alleged deficient practice. Education to be provided to nursing staff on appropriate provider notification of blood sugars by 1/7/2025.</p> <p>All residents with call parameters for blood pressure or heart rate have the potential to be affected by the alleged deficient practice. Education to be provided to nursing staff on appropriate provider notification of blood pressure or heart rate by 1/7/2025.</p> <p>What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur</p> <p>Nursing staff to be educated on provider notification of blood sugars by 1/7/2025. An audit of resident blood sugars for 5 residents per day 5 days per week for 4 weeks, 5 residents 1 day per week for 4 weeks, and 5 residents 1 day per month for 4 months to be completed to ensure notification for any blood sugars outside of parameters.</p> <p>Nursing staff to be educated on provider notification of pulse call parameters by 1/7/2025. An audit of resident pulse outside of call parameters for 5 residents per day 5 days per week for 4 weeks, 5 residents 1 day per week for 4 weeks, and 5 residents 1 day per month for 4 months to be completed to ensure notification</p>	

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	<p>A review of the MAR (Medication Administration Record) indicated Digoxin was administered when the apical pulse was below the hold parameters per the physician's order on the following dates:</p> <ol style="list-style-type: none"> 1. On 4/21/24, with a heart rate of 59. 2. On 4/29/24, with a heart rate of 58. 3. On 5/14/24, with a heart rate of 56 <p>b. A physician's order indicated to give Lisinopril (a medication used to treat high blood pressure) 2.5 mg (milligrams) and to hold the medication if the systolic blood pressure was less than 105.</p> <p>A review of the MAR indicated Lisinopril was administered when the systolic blood pressure was below the hold parameters per the physician's order on the following dates:</p> <ol style="list-style-type: none"> 1. On 1/8/24, with a systolic blood pressure of 101. 2. On 1/16/24, with a systolic blood pressure of 102. 3. On 3/21/24, with a systolic blood pressure of 91. 4. On 4/20/24, with a systolic blood pressure of 99. 5. On 4/24/24, with a systolic blood pressure of 98. 6. On 6/20/24, with a systolic blood pressure of 97. 7. On 6/30/24, with a systolic blood pressure of 102. 8. On 7/3/24, with a systolic blood pressure of 94. 9. On 7/9/24, with a systolic blood pressure of 101. 10. On 7/27/24, with a systolic blood pressure of 81. 11. On 7/31/24, with a systolic blood pressure of 103. 12. On 10/25/24, with a systolic blood pressure of 100. 13. On 11/3/24, with a systolic blood pressure of 103. 14. On 11/14/24, with a systolic blood pressure of 104. 		<p>for any pulse outside of parameters. Results from audits will be brought to QAPI for review monthly for a minimum of 6 months. QAPI will determine need for further audits. By what date the systemic changes for each deficiency will be completed: Date of compliance 1/7/2025.</p>	

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	<p>During an interview, on 12/9/24 at 10:39 a.m., LPN 2 indicated medications would be held if the resident's vital signs were below the physician ordered hold parameters.</p> <p>During an interview, on 12/9/24 at 9:51 a.m., the DON (Director of Nursing) indicated a medication should not be given below a physician's hold parameter. The medications were administered below the hold parameters on the dates listed above.</p> <p>During an interview, on 12/9/24 at 10:36 a.m., the DON indicated the facility did not have a policy about following physician's orders. 3. The clinical record for Resident 108 was reviewed on 12/4/24 at 12:12 p.m. The diagnoses included, but were not limited to, dementia, chronic kidney disease stage 2, type 2 diabetes mellitus with hypoglycemia without coma and hyperglycemia, anxiety disorder, Alzheimer's disease, depression, irritability, and anger.</p> <p>A physician's order, dated 5/28/24, indicated special instructions were if the blood sugar reading was greater than 340 to give Novolog U-100 insulin 12 units and call the MD.</p> <p>The electronic medical record indicated the following blood sugars were elevated and the physician needed notified: On 10/17/24 at 11:32 a.m., the blood sugar reading was 350. On 10/18/24 at 3:37 p.m., the blood sugar reading was 362.</p> <p>The clinical record did not include any documentation of physician notifications for the blood sugars greater than 340 on 10/17/24 or 10/18/24.</p>			

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F 0689 SS=D Bldg. 00	<p>During an interview, on 12/5/24 at 3:32 p.m., the Dementia Care Director 3 indicated he could not find any documentation the physician was notified of the elevated blood sugar readings on the dates of 10/17/24 or 10/18/24.</p> <p>During an interview, on 12/9/24 at 1:44 p.m., LPN 7 indicated the nurse should notify the nurse practitioner for any blood sugar which was above or below the the ordered parameters if it occurred during normal daytime hours. They would call the telemedicine physician if it was during off hours, weekends, or a holiday. The nurse should document the call and the physician's response in the electronic medical record.</p> <p>A current facility policy, titled "Physician Contact," dated as reviewed on 9/2023 and received from the Administrator on 12/9/24 at 10:15 a.m., indicated "...The following symptoms/signs...that require immediate notification are...blood sugars...that are outside or exceed the specific call orders for care...."</p> <p>A current facility policy, titled "Liberalized Medication Pass," and received from the Director of Nursing on 12/9/24 at 10:15 a.m., indicated "...The policy of this facility is to administer medications in a safe manner...."</p> <p>3.1-37(a)</p> <p>483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices</p> <p>Based on observation, interview and record review, the facility failed to ensure staff did not leave a resident unsupervised in a multi-sensory room for longer than 30 minutes per the facility</p>	F 0689	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	01/07/2025

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	<p>policy, to ensure the resident had a call light or a way to summon staff while in the multi-sensory room, and failed to ensure staff did not leave the resident lying on a fall mat on the floor for an extended period of time for 1 of 6 residents reviewed for supervision. (Resident J)</p> <p>Finding includes:</p> <p>The clinical record for Resident J was reviewed on 12/5/24 at 11:32 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy, violent behavior, primary insomnia, Alzheimer's disease, anxiety disorder, malignant neoplasm of prostate, frequency of micturition, history of falling, pain, and dementia with psychotic disturbance, mood disturbance, anxiety, and agitation.</p> <p>A significant change Minimum Data Set (MDS) assessment, dated 10/21/24, indicated the resident required moderate assistance to move from lying to sitting on the side of his bed, to come to a standing position from sitting in a chair, and to transfer from his wheelchair to bed.</p> <p>1a. During an observation, on 12/3/24 at 11:01 a.m., the "Snoezelin Room" door was locked and only accessible by a staff member key. The window on the door was covered and the room inside could not be viewed. The blinds on the side window next to the door were open. The rough outline of the bean bag chair could be seen when placing your face right up against the window. The white blanket could be seen with the blue light on. Other items in the room could not be viewed. No sounds could be heard from outside of the room. Once the door was opened, the sound machine which had been playing could easily be heard. The room was dim and lit with</p>		<p>practice?</p> <p>Policy for multi-sensory room reviewed and updated to reflect time-period of resident preference. Door to multi-sensory room to remain open while room is occupied with bell available to call for staff when needed. Resident J's careplan updated to reflect preference of lying on floor mat to sleep and at other times, at will.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>All residents who utilize the multi-sensory room have the potential to be affected by the alleged deficient practice, currently only Resident J utilizes the room. Education to be provided to nursing staff who provide care on Memory Care Unit on updated policy by 1/7/2025. All residents with fall mats have the potential to be affected by the alleged deficient practice. Education to be provided to nursing staff on appropriate use of fall mats by 1/7/2025.</p> <p>What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur</p> <p>Nursing staff to be educated on multi-sensory room policy by 1/7/2025. An audit of residents</p>	

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	<p>only the blue light. Large objects could be seen but smaller items were still difficult to view. There was a messaging recliner in the room which could not be seen from the window. No call light could be seen.</p> <p>A comprehensive care plan, with a start date of 7/23/24, indicated the resident was to be offered the opportunity to spend time in the sensory room in the bean bag chair.</p> <p>A comprehensive care plan, with a start date of 9/4/24, indicated to assist the resident to the Snoezelen room as needed for calming and redirection.</p> <p>A comprehensive care plan, with a start date of 10/21/24, indicated the resident was to be monitored while in the sensory room by a staff member.</p> <p>A 15-minute checks document, dated 11/11/24, indicated the resident was in the Snoezelin room from 2:30 p.m. until 5:30 p.m.</p> <p>A 15-minute checks document, dated 11/12/24, indicated the resident was in the Snoezelin room from 12:15 p.m. until 4:30 p.m.</p> <p>A 15-minute checks document, dated 11/14/24, indicated the resident was in the Snoezelin room from 1:15 p.m. until 4:30 p.m.</p> <p>A 15-minute checks document, dated 11/15/24, indicated the resident was not in the Snoezelin room at all the entire day. However, a nursing progress note at 1:18 p.m. indicated the resident was taken to the Snoezelin room where he attempted to hit the staff and stayed in the room for a short time.</p>		<p>utilizing multisensory room to be completed 5 residents per day 5 days per week for 4 weeks, 5 residents 1 day per week for 4 weeks, and 5 residents 1 day per month for 4 months.</p> <p>Nursing staff to be educated on proper fall mat use by 1/7/2025.</p> <p>An audit of residents utilizing fall mats 5 residents per day 5 days per week for 4 weeks, 5 residents 1 day per week for 4 weeks, and 5 residents 1 day per month for 4 months to be completed to appropriate use of fall mat.</p> <p>Results from audits will be brought to QAPI for review monthly for a minimum of 6 months. QAPI will determine need for further audits.</p> <p>By what date the systemic changes for each deficiency will be completed: Date of compliance 1/7/2025.</p>	

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	<p>A 15-minute checks document, dated 11/22/24, indicated the resident was in the Snoezelin room from 2:15 p.m. until 9:30 p.m. However, a nursing progress note indicated the resident was sleeping in the Snoezelin room at the beginning of the midnight shift until the nurse woke the resident up at about 11:00 p.m., to administer his bedtime medications. Then, the resident was taken to his room.</p> <p>A 15-minute checks document, dated 11/23/24, indicated the resident was in the Snoezelin room from 12:45 p.m. until 4:00 p.m.</p> <p>A 15-minute checks document, dated 11/30/24, indicated the resident was in the Snoezelin room from 2:15 p.m. until 5:00 p.m. A nursing progress note, at 6:47 p.m., indicated the resident opted to relax in the Snoezelin room.</p> <p>During an interview, on 12/3/24 at 11:01 a.m., CNA 8 indicated the facility did not like doors to be propped open, so the door was shut when a resident was in the Snoezelin room. It was difficult to hear sounds inside the room when the door was shut, and you were outside of the room. She tried to stay in the room with the resident when she could but not everyone stayed in the room and sometimes, they were busy and could not stay the entire time. There was no call light in the room. She indicated it was hard to hear when you were out in the hallway, but you could look in the window to check on things. She did not think the resident could get out of the bean bag chair on his own.</p> <p>During an interview, on 12/3/24 at 4:24 p.m., CNA 9 indicated Resident J was on every 15-minute checks which were recorded on papers in a binder</p>			

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	<p>at the nurse's station. When the resident was in the Snoezelin room, the staff took turns staying in or near the room as much as they could and recorded his location on the paper in the binder.</p> <p>During an interview, on 12/6/24 at 11:22 a.m., CNA 10 indicated Resident J was currently the only resident which used the Snoezelin room, and he was on every 15-minute checks. There was no call light, but staff could look in through the observation window to check on him. They tried to leave him alone if he was sleeping and not fidgeting. She did not stay with the resident. Sometimes, he slept in there during the day for a few hours. She did not think he could get out of the bean bag chair on his own.</p> <p>During an interview, on 12/9/24 at 1:38 p.m., QMA 6 indicated the staff had supervised Resident J more closely the first few times the resident was in the room by propping the door open for the 15-minute checks, but now someone was just checking on him by looking through the window as they walked by the room for the 15-minute checks. She did not think he could get out of the bean bag chair on his own.</p> <p>During an interview, on 12/9/24 at 1:52 p.m., the Dementia Care Director 3 indicated the term supervision meant watching and being present with a resident.</p> <p>During an interview, on 12/9/24 at 2:44 p.m., the Administrator indicated the staff were not following the current policy for the Snoezelin room or the care plan for the resident. There was not a call light, but there was a bell in the Snoezelin room.</p> <p>During all interviews with the nursing staff who</p>			

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	<p>provided care to the resident, no staff member indicated there was a bell or any way for the resident to call for staff while he was in the Snoezelin room. Every staff member indicated the resident did not have a means to call for help other than when the staff checked on him.</p> <p>A current facility policy, titled "Multi-Sensory Room," dated as revised on 2/2018 and received from the Administrator on 12/6/24 at 1:45 p.m., indicated "...The Multi-Sensory Room ("MSR") (also referred to as a "Snoezelen" room) is a therapeutic environment created for the express purpose of delivering high levels of stimuli to patients in the memory care units...Residents must be supervised when visiting the MSR...the resident's time in the MSR should be limited to thirty (30) minutes...."</p> <p>1b. During an observation, on 12/3/24 at 2:05 p.m., Resident J's room had a regular mattress on a low bed frame with a large red mat on the floor right next to the bed.</p> <p>A comprehensive care plan, with a start date of 7/23/24, indicated the resident was at risk for falls. The interventions included, but were not limited to, 8/23/24, resident was to have a raised edge mattress.</p> <p>Resident J's bed was observed to have a regular mattress and not a raised edge mattress.</p> <p>A comprehensive care plan, with a start date of 10/21/24, indicated the resident had a history of aggressive behaviors and would slide himself out of his Broda chair. He had a large red mat at his bedside. The interventions included, but were not limited to, 10/21/24, ensure the resident was checked on frequently while having "mat time"</p>			

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NAME OF PROVIDER OR SUPPLIER INDIANA VETERANS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3851 N RIVER RD WEST LAFAYETTE, IN 47906
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	<p>and to offer to get him up when checking on him.</p> <p>The care plan did not clarify what "mat time" meant or if the resident was too be left to sleep on the red fall mat beside his bed for long periods.</p> <p>A 15-minute checks document, dated 11/11/24, indicated the resident was lying on the red mat from 12:15 a.m. until 4:45 a.m. The documentation indicated the resident had been on the mat since 8:00 p.m.</p> <p>A nursing progress note, dated 11/12/24 at 2:13 a.m., indicated the resident had napped in his chair periodically at the beginning of the shift before bedtime. He attempted to slide out of the chair at different times. The resident was taken to bed per his usual bedtime, slept briefly, tried to get out of bed, and yelled for help as usual.</p> <p>A 15-minute checks document, dated 11/12/24, indicated the resident was on the red mat from 9:45 p.m. until 12:00 a.m. According to the 15-minute checks document, dated 11/13/24, the resident remained on the mat until 3:45 a.m.</p> <p>A 15-minute checks document, dated 12/3/24, indicated the resident was on the red fall mat next to his bed from 12:15 a.m. until 6:45 a.m. and again from 9:15 p.m. until 12:00 a.m.</p> <p>A nursing progress note, dated 12/3/24 at 3:08 a.m., indicated the resident had been restless and calling out to staff for most of the night. After making several attempts to get out of bed by himself, he rolled onto the mat and kept attempting to pull himself under the low bed frame.</p> <p>A 15-minute checks document, dated 12/4/24,</p>			

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	<p>indicated the resident was on the red fall mat from 12:15 a.m. until 6:00 a.m.</p> <p>A nursing progress note, dated 12/4/24 at 3:56 a.m., indicated the resident slept on and off through the night and had been cooperative with care.</p> <p>The progress note did not include the reason the resident was on the mat instead of in the bed from 9:15 p.m. on 12/3/24 until 6:00 a.m. on 12/4/24.</p> <p>During an interview on 12/6/24 at 11:22 a.m., CNA 10 indicated the staff tried to leave Resident J alone if he was sleeping and not fidgeting.</p> <p>During an interview, on 12/9/24 at 2:44 p.m., the Administrator indicated the resident should not be sleeping long hours on the fall mat on his floor instead of his pressure relieving mattress.</p> <p>A current facility policy, titled "Fall Prevention and Investigation," dated as last revised 12/2021 and provided by the Administrator on 12/9/24 and 2:57 p.m., indicated "...unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred...."</p> <p>A current facility policy, titled Resident Rights," not dated and provided by the Administrator on 12/9/24 and 2:57 p.m., indicated "...The resident has a right to a dignified existence...facility must protect and promote the rights of each resident...facility must care for its residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his/her individuality...."</p> <p>This citation relates to Complaint IN00448381.</p>			

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F 0695 SS=D Bldg. 00	<p>3.1-45(a)(2)</p> <p>483.25(i) Respiratory/Tracheostomy Care and Suctioning</p> <p>Based on observation, interview and record review, the facility failed to ensure the correct amount of oxygen was administered to 1 of 2 residents reviewed for respiratory care. (Resident 64)</p> <p>Finding includes:</p> <p>During an observation, on 12/2/24 at 12:35 p.m., Resident 64 was sitting at a table in the common area in his reclining wheelchair. He was wearing oxygen administered via a portable oxygen tank hanging on the back of his wheelchair at a rate of 3 liters per minute (L).</p> <p>During an observation, on 12/3/24 at 4:19 p.m., the resident was sitting in his wheelchair with the portable oxygen tank turned off and hanging on the back of his wheelchair. There was no oxygen tubing present. The resident was not receiving any supplemental oxygen.</p> <p>During an observation, on 12/4/24 at 11:53 a.m., the resident was coloring with the staff in the common area with the portable oxygen tank on the back of his wheelchair delivering oxygen at 1.5 liters per minute. At 12:05 p.m., CNA 8 pushed Resident 64 in his wheelchair to another table for lunch with the portable tank hanging on the back of the wheelchair still set at 1.5 liters per minute.</p> <p>The clinical record for Resident 64 was reviewed on 12/4/24 at 1:11 p.m. The diagnoses included, but were not limited to, cardiac arrhythmia</p>	F 0695	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident 64 oxygen tank adjusted to correct liter flow. Nursing and respiratory staff educated on appropriate liter flow for resident.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>All residents receiving oxygen therapy have the potential to be affected by the alleged deficient practice. Education to be provided to nursing staff and respiratory staff on following oxygen orders by 1/7/2025.</p> <p>What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur</p> <p>Nursing and respiratory staff to be educated on following oxygen orders by 1/7/2025. An audit of residents receiving oxygen at correct liter flow for 5 residents per day 5 days per week for 4 weeks, 5 residents 1 day per week for 4 weeks, and 5 residents 1 day per</p>	01/07/2025
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	<p>(problem with the heart's rhythm or rate), essential primary hypertension, pain, anoxic brain damage, dementia, anemia, mood disorder with depressive features, other seizures, and psychotic disorder with delusions.</p> <p>A physician's order, dated 6/14/24, indicated to administer oxygen at 2 liters per minute during the day.</p> <p>A current care plan, dated as last reviewed on 11/27/24, included a problem of being at risk for shortness of breath, dyspnea (difficulty breathing), and respiratory distress related to a disorder of the diaphragm. An approach, with a start date of 9/3/24, indicated to administer oxygen as ordered.</p> <p>A recent Minimum Data Set (MDS) quarterly assessment, dated 9/2/24, indicated the resident received supplemental oxygen with shortness of breath or trouble breathing with exertion, at rest, and when lying flat.</p> <p>During an interview, on 12/4/24 at 12:42 p.m., LPN 11 indicated the portable tank was delivering 1.5 liters per minute of oxygen and the resident should be on 2 liters per minute. LPN 11 turned the portable tank dial to deliver 2 liters per minute of oxygen to the resident.</p> <p>A current policy, titled "Oxygen Therapy," with no review date and received from the Administrator on 12/5/24 at 12:30 p.m., indicated "...Physician's order is necessary for the administration of oxygen...set flow rate as ordered by the physician...."</p> <p>3.1-47(a)(6)</p>		<p>month for 4 months to be completed to ensure notification for any blood sugars outside of parameters.</p> <p>Results from audits will be brought to QAPI for review monthly for a minimum of 6 months. QAPI will determine need for further audits.</p> <p>By what date the systemic changes for each deficiency will be completed: Date of compliance 1/7/2025</p>	

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F 0880 SS=D Bldg. 00	<p>483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control</p> <p>Based on observation, interview and record review, the facility failed to wear PPE (personal protective equipment) into an enhanced barrier precaution (EBP) room for 1 of 4 residents reviewed for transmission-based precautions. (Resident 39)</p> <p>Finding includes:</p> <p>During an observation, on 12/4/24 at 2:04 p.m., Register Nurse (RN) 13 entered Resident 39's room to administer medication. The resident had a gastrostomy tube (a tube surgically inserted into the stomach to provide medication and nutrition) and was in isolation for enhanced barrier precautions. RN 13 did not put on an isolation gown to give the medication via gastrostomy tube.</p> <p>The clinical record for Resident 39 was reviewed on 12/4/24 at 11:28 a.m. The diagnoses included, but were not limited to, Huntington's disease (a disorder which damages brain cells), dysphagia (difficulty swallowing) and abnormal weight loss.</p> <p>A physician's order, dated 12/1/24, indicated the resident was in Enhanced Barrier Precautions.</p> <p>During an interview, on 12/4/24 at 2:39 p.m., RN 13 indicated the resident was not in isolation. The nurse then read the sign on the resident's door and indicated she should have worn a gown.</p> <p>During an interview, on 12/4/24 at 2:40 p.m., the Nursing Supervisor 12 indicated when a resident was in EBP the staff were supposed to wear a gown and gloves. They needed to wear both</p>	F 0880	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Nurse who did not follow enhanced barrier precautions provided education.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>All residents with enhanced barrier precautions have the potential to be affected by the alleged deficient practice. Education to be provided to all staff on enhanced barrier precautions by 1/7/2025.</p> <p>What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur</p> <p>Education to be provided to all staff on enhanced barrier precautions by 1/7/2025. An audit of residents receiving care requiring enhanced barrier precautions for 5 residents per day 5 days per week for 4 weeks, 5 residents 1 day per week for 4 weeks, and 5 residents 1 day per month for 4 months to be completed to ensure precautions are followed.</p> <p>Results from audits will be brought</p>	01/07/2025
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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	<p>when giving gastrostomy tube medications.</p> <p>A current facility policy, titled "Enhanced Barrier Precaution," dated 6/24 and provided by the Assistant Director of Nursing (ADON) on 12/6/24 at 3:00 p.m., indicated "...Enhanced Barrier Precautions: All residents with any of the following: Wounds...feeding tube, regardless of MDRO colonization status...Required PPE...Gloves and gown prior to the high contact care activity...."</p> <p>3.1-18(b) 3.1-18(l)</p>		<p>to QAPI for review monthly for a minimum of 6 months. QAPI will determine need for further audits. By what date the systemic changes for each deficiency will be completed: Date of compliance 1/7/2025.</p>		