STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155419	A. BUILDING 00 B. WING	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT CRAWFORDSVILLE	817 N WHITLOCK AVE CRAWFORDSVILLE, IN 47933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 6, 7, 8, 9, and 10, 2023 Facility number: 000533 Provider number: 155419 AIM number: 100267230 Census Bed Type: SNF/NF: 28 Total: 28 Census Payor Type: Medicare: 6 Medicaid: 19 Other: 3 Total: 28 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 22, 2023.	F 0000	This provider respectfully requests that this requests a desk review in lieu of a post survey review on or after March 31, 2023. Please feel free to contact Jeremiah Johnson, if you need any additional information to support the desk review at 317-473-0239. Thank you for your consideration.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status			

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

Jeremiah Johnson | Executive Director | 04/03/2023

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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	(that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on observation, record review, and	F 0580	What corrective action(s) will be	03/31/2023

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	interview, the facility failed to notify the family/responsible party of the resident's gradual dose reduction of an antipsychotic medication recommended by pharmacy for 1of 5 residents reviewed for unnecessary medications (Resident 181). Findings Include: On 3/6/2023 at 2:30 p.m., Resident 181 was observed outside of his room speaking with staff. Resident indicated to staff he wanted the code to "get out of here." On 3/9/2023 at 11:48 a.m., Resident 181 was observed ambulating in hallway wandering around looking into different rooms. Resident 181's record was reviewed on 3/8/2023 at 2:30 p.m. The profile indicated the resident's diagnoses included, but were not limited to, Heart failure (a condition in which the heart doesn't blood pump as well as it should), Type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), Dementia (a condition characterized by progressive or persistent loss of intellectual functioning) in other diseases classified elsewhere, mild with anxiety (a feeling of worry, nervousness, or unease), and Paroxysmal atrial fibrillation (an irregular and often very rapid heart rhythm that causes poor blood flow). An admission Minimum Data Set (MDS) assessment, dated 2/19/2023, indicated the resident had moderate cognitive deficit and received antipsychotic (used to treat a range of psychotic disorders) and antidepressant (used to treat depressive symptoms) medications.		accomplished for those residents found to have been affected by the deficient practice; Resident 181's family contacted to discuss communication preferences and practices - Care Plan Meeting Held GDR failed prior to Survey date, medication previously addressed 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;All Residents who have responsible parties and experience change in condition have potential to be effected. Notification review of medication changes in the past week for all residents Nurses found to have missing communication will be educated on expectations What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Education to all nurses of notification expectations Communication of Change audits added to administrative Meeting How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; andChange of Condition QAPI to be completed weekly x4 monthly x6 What date the systemic changes	

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	A care plan, dated 2/27/2023, indicated the resident received psychotropic medication, antidepressant, and antipsychotic. Interventions included, but were not limited to, administer medications as ordered, observe for effectiveness, and pharmacist to review medications routinely. A care plan, dated 02/21/2023 and revised on 03/06/2023, indicated the resident was at risk for elopement due to resident having a diagnosis of dementia and requesting a secured key code to get outside. Interventions included, but were not limited to, wander guard placed on left leg per physician order, all facility exits secured with key code pad, and provide one on one (1:1) attention and conversation as needed. A pharmacy recommendation, dated 02/14/2023, recommended to attempt a gradual dose reduction (GDR) of olanzapine (antipsychotic medication) to 2.5 milligrams (mg) every hs (bedtime) from 5 mg every hs. The record lacked documentation that family was notified of recommendation. A physician order dated 02/17/2023, indicated to change olanzapine from 5 mg every hs to 2.5 mg every hs. The March 2023 MAR (medication administration record) indicated Resident 181 received the olanzapine 2.5 mg dose on 02/18/2023, 02/19/2023, 02/20/2023, and 02/21/2023. Review of progress note, dated 02/17/2023 at 7:23 p.m., indicated the psychiatric NP (nurse practitioner) was in the facility on that date. A new order was obtained to discontinue olanzapine 5 mg and start olanzapine 2.5 mg orally (by mouth) every hs. Review of progress note, dated 02/18/2023 at 3:06 p.m., indicated resident had increased confusion		for each deficiency will be completed. Friday, March 31, 2023	

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	and was pointing down the hallway asking for assistance to his car in the ditch so that he could go home. Review of progress note, dated 02/21/2023 at 12:06 a.m., indicated resident was confused and exit seeking. Resident 181 had been in several different rooms searching for a way to get out. Review of progress note, dated 02/21/2023 at 1:18 a.m., indicated resident continued to exit seek, threatened to bust the doors down, and taunted staff to call the law and have him arrested. Review of progress note, dated 02/21/2023 at 5:32 a.m., indicated resident had been up the entire night wandering the halls and exit seeking. Continued to enter other residents' room. Resident became very frustrated and verbally abusive to staff. Review of progress note, dated 02/21/2023 at 10:44 a.m., indicated resident had been up all night wandering the hallways looking for staff in residents' rooms. Resident would become verbally aggressive and threatening. IDT (interdisciplinary team and consists of members from different disciplines working collaboratively to set goals and make decisions) met and in agreement was a failed gradual dose reduction of his olanzapine medication. Review of progress note, dated 02/21/2023 at 12:37 p.m., indicated the nurse notified resident's wife of the decrease in antipsychotic medication. Review of progress note, dated 02/22/2023 at 7:52 a.m., indicated the resident has had increased behaviors since medication had been decreased and the family was concerned.			

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	Review of progress note, dated 02/22/2023 at 2:15 p.m., indicated the NP was in the facility and increased the olanzapine back to 5 mg orally every hs. During a family interview, on 03/10/23 at 09:53 a.m., Resident 181's family member indicated they were not informed of the physician order to decrease the olanzapine medication until days later. The family had noticed the resident was having increased behaviors when they came to visit him at the facility. The family member indicated they would not have approved of the decrease in medication if they were made aware of it in a timely manner. During an interview, on 3/10/2023 at 10:57 a.m., LPN 6 indicated the family should be notified immediately of any new order or change of condition. If the family did not answer, they would leave them a message for them to return their call. On 3/10/2023 at 12:12 p.m., the Executive Director provided a document, with a revised date of 11/2018, titled, "Resident Change of Condition Policy", and indicated it was the policy currently being used by the facility. The policy indicated, " ...3b. the nurse in charge is responsible for notification of family/responsible party prior to end of assigned shift when a significant change in the resident's condition is noted ...." 3.1-5(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including			

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	tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to properly clean and store nebulizer (small machine that turns liquid medication into a mist that can be easily inhaled) and oxygen equipment for 3 of 4 residents reviewed for respiratory care (Residents 21, 1, and 16). Findings include: 1a. On 3/6/2023 at 1:53 p.m., Resident 21's nebulizer tubing and equipment was observed to be in a clear plastic bag and was unlabeled and not dated. The clear plastic bag was hanging from the nebulizer machine. On 3/7/2023 at 11:01 a.m., Resident 21's nebulizer tubing and equipment including mouthpiece was observed to be out of the bag sitting next to the nebulizer machine. No date noted to be on the tubing. Resident was resting in her recliner resting. The clear plastic bag for nebulizer observed to be on the floor next to side table. On 3/7/2023 at 12:00 p.m., Resident 21's nebulizer tubing and equipment including mouthpiece was observed to be out of the bag sitting next to machine. Resident was resting in her recliner. On 3/7/2023 at 12:59 p.m., Resident 21's nebulizer tubing and equipment including mouthpiece was	F 0695	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 1, 16, 21's Respiratory equipment sanitized, stored correctly, cleaned/replaced 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;Every Resident receiving respiratory therapy is has potential to be effected Facility wide audit of Respiratory Equipment cleanliness What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Staff training on respiratory equipment safety & sanitation Skills validations completed for nursing staff How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; andRespiratory	03/31/2023

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	observed to be out of the bag sitting next to machine. Resident was sitting up in wheelchair eating lunch. Clear plastic bag for nebulizer tubing was on the floor next to recliner. On 03/07/2023 at 1:56 p.m., Resident 21'a nebulizer tubing and equipment including mouthpiece was observed to be out of the bag sitting next to machine. There was a clear liquid noted to be in the chamber of the nebulizer equipment. On the floor next to the resident's recliner was an empty clear plastic bag that was unlabeled and not dated. A second clear plastic bag was observed to be on the window ledge that contained the word "Nebulizer" on the bag with the resident's name on it and it was dated 12/4/2022. On 03/08/23 at 1:40 p.m., Resident 21's nebulizer tubing and equipment was observed to be inside a clear plastic bag that was unlabeled and not dated hanging on the nebulizer machine. No date noted to be on the nebulizer tubing. A clear liquid was noted to be inside the chamber of the nebulizer equipment. 1b. During an observation on 3/06/23 at 10:25 a.m., Resident 21 was observed sitting in her recliner receiving supplemental oxygen per a nasal cannula from an oxygen concentrator on the floor. A nebulizer machine was observed on a table next to the recliner, the mouthpiece and tubing were observed to be out of a bag next to the machine. On 3/8/23 at 11:48 a.m., Licensed Practical Nurse (LPN) 5 was observed entering the resident room to administer a nebulizer aerosol treatment to Resident 21. The nurse removed a mouthpiece from a bag hanging from the side of a bedside stand, poured medication into the nebulizer cup, turned on the nebulizer machine, and stood with the resident as she received her treatment. The		Care QAPI to be completed weekly X4 monthly x6 Oxygen Therapy QAPI to be completed Weeklyx4 Monthlyx6 What date the systemic changes for each deficiency will be completed. Friday, March 31, 2023	

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	nurse was then observed to turn off the nebulizer machine and place the mouthpiece back into the bag hanging from the bedside stand. The nurse was not observed to wash or rinse the remaining medication from the mouthpiece. A second observation of Resident 21's nebulizer mouthpiece on 3/08/23 at 1:42 p.m., indicated small amounts of liquid medication remained in the nebulizer cup. On 3/09/23 at 8:46 a.m., Resident 21's nebulizer mouthpiece and tubing were observed to be inside a clear plastic bag hanging from the bedside stand, the mouthpiece was observed to still contain liquid inside the nebulizer cup. On 3/09/23 at 11:44 a.m., Resident 21 was observed sitting in a wheelchair in her room after LPN 6 was observed giving her a nebulizer treatment. The nebulizer mouthpiece was observed inside a clear plastic bag on the side of a bedside stand, small amounts of liquid medication remained in the nebulizer cup. Resident 21 indicated staff changed the mouthpiece weekly, and the resident cleaned off the outside of the mouthpiece with alcohol preps. To her knowledge, no one took the mouthpiece apart and rinsed out the excess medication from the nebulizer cup after each treatment. Resident 21's record was reviewed on 3/09/23 at 8:58 a.m. Diagnoses on Resident 21's profile included, but were not limited to, chronic COPD (chronic obstructive pulmonary disease - a group of lung diseases that block airflow and make it difficult to breath) and chronic respiratory failure (develops when the lungs can't get enough oxygen into the blood). Physician's orders for Resident 21 indicated, a. On 8/9/22 change nebulizer tubing/set on			

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	Sunday 6:00 p.m. - 6:00 a.m. b. On 1/19/23 ipratropium-albuterol solution (bronchodilators used to treat and prevent wheezing and shortness of breath) for nebulization 0.5 mg (milligrams)/3 mg) per 3 ml (milliliter) give 1 vial three times a day at 6:00 a.m., 12:00 p.m., and 6:00 p.m. and as needed. A quarterly MDS (Minimum Data Set) assessment (part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), completed on 2/5/23, assessed the resident as receiving oxygen therapy. A care plans for Resident 21 indicated she was at risk for impaired gas exchange related to COPD with exacerbation with shortness of breath while lying flat, patient to have head of bed elevated. The goal was for the resident to have adequate respiratory functions as evidenced by decreased or absence of dyspnea (shortness of breath), improved breath sounds, decreased or absence of shortness of breath, and improved oximetry (non-invasive method for monitoring oxygen saturation) results. Approaches included oxygen at 3 L (liters), elevate head of bed for shortness of breath when lying flat, monitor the resident, and administer medications as ordered. An In-Service Class Attendance Record, dated 9/12/22 at 2:00 p.m., subject(s) oxygen application, tubing in bags, and observations, indicated 13 staff members signed as having received the education. On 3/10/23 at 1:50 p.m., the Executive Director (ED) provided a Respiratory Care: Competency Assessment Form: Aerosolized Medication Nebulizer Treatment, undated, and indicated the			

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	process was the one currently being used by the facility. The competency indicated, "Verify physician's order. Obtain all necessary equipment and supplies ...Attach one end of the tubing to the nebulizer and the other end to the compressor or oxygen source. Remove the nebulizer top, place prescribed medication into the cup, then secure the top back onto the nebulizer. Attach mouthpiece, aerosol mask, or trach mask to the nebulizer [use the reservoir tubing on the t-piece when using a mouthpiece for better medication delivery] ...Once the treatment is complete, place the nebulizer in a plastic bag with the resident's name and date. Change out nebulizer weekly per facility policy ..." How to Clean a Nebulizer - American Lung Association (11/17/22) at www.lung.org was retrieved from the American Lung Association website. The guidance indicated cleaning a nebulizer was important to prevent the spread of germs and keep individuals from getting sick. It was recommended to wash the parts of the nebulizer after each use, including the mouthpiece or mask, top piece, and medicine cup per manufacturer's instructions. After rinsing, the mouthpiece or mask, top piece, and medication cup were to be left to air-dry in a cool, dry place. 2. During the initial observation, on 3/6/23 at 2:35 p.m., Resident 16 was lying in his bed with his supplemental oxygen (O2) being administered via nasal canula (NC-a medical device to provide supplemental oxygen therapy to people who have lower oxygen levels). The resident's O2 concentrator (a medical device that provides supplemental oxygen) was observed to be dust covered. The humidification bottle (a sealed bottle of water inserted into a breathing circuit to add moisture to the breathing gases for administration) was not dated. A nebulizer (an			

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	electrically powered machine that turns liquid medication into a mist so that it can be breathed directly into the lungs through a face mask or mouthpiece) and tubing were observed in a bag which was dated 2/23/23. During a random observation, on 3/7/23 at 2:18 p.m., the resident was lying in his bed with his NC in place. The O2 concentrator was observed to be set to administer his O2 at 3 liters (L). The resident's O2 concentrator was observed to be dust covered. The humidification bottle was not dated. A O2 tubing bag, attached to the concentrator, was dated 2/23/23. The nebulizer mask was observed in a bag dated 2/23/23, and noted to have brown debris inside of the mask, near where it would be placed on the resident's mouth. During a random observation of the resident's room, on 3/8/23 at 10:55 a.m., the resident was not in the room. The O2 concentrator was turned off. The O2 concentrator was observed to be dust covered. The nebulizer mask appeared to have been changed to a new mask. No debris noted on the mask. No date noted on the bag which contained the nebulizer. The humidification bottle on the O2 concentrator was not dated. During a random observation, of the resident's room, on 3/8/23 at 11:56 a.m., the resident was not in the room. The O2 concentrator was turned off. The O2 concentrator was observed to be dust covered. The O2 NC tubing was in a bag, dated 2/23/23, hanging on the back of the concentrator. The tubing was observed to have clear fluid drops in the tubing. None of the clear fluid was noted on the inside of the bag where the tubing was placed. During a random observation on, 3/8/23 at 12:00			

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	155419	A. BUILDING 00 B. WING	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT CRAWFORDSVILLE	817 N WHITLOCK AVE CRAWFORDSVILLE, IN 47933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	p.m., the resident was sitting in the dining room. The resident's supplemental O2 was being administered through a portable O2 tank. The O2 tank was set at 3 L and was being administered via NC. The NC was noted to be out of the nostrils to the left side of his nose. During a random observation, on 3/9/23 at 10:15 a.m., the resident was lying in bed with his O2 NC in place. The nebulizer tubing and mask were in an undated bag. The inside of nebulizer mask was observed to be soiled with a dust like debris and oily residue. The tubing, mask, and nebulizer chamber were dry. At the same time, the resident indicated the nurse puts the mask on and takes it off for him. Resident 16's record was reviewed on 3/8/23 at 1:50 p.m. The profile indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD-a group of diseases that cause airflow blockage and breathing-related problems). An annual Minimum Data Set (MDS-part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) assessment, dated 11/11/22, indicated the resident had severe cognitive deficit, was short of breath (SOB) when lying flat, and required supplemental O2. A care plan, dated 10/13/21, indicated the resident required supplemental O2 due to his diagnosis of COPD. Interventions included, but were not limited to, administer O2 per physician's order at 2 L per NC. A physician's order, dated 8/24/21, indicated change oxygen tubing and humidity. Clean			

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	concentrator and filter. Once A Day on Sunday. A physician's order, dated 10/13/21, indicated O2 at 2 L per NC continuously. A physician's order, dated 10/13/21, indicated change oxygen tubing and water canister (humidification bottle) every week on Sunday night shift. Label tubing with date and initials. A physician's order, dated 1/7/23, indicated ipratropium-albuterol solution (a medication used to help control the symptoms of lung diseases, such as asthma, chronic bronchitis, and emphysema) for nebulization; 0.5 milligrams (mg)-3 mg (2.5 mg base)/3 milliliters (mL). 1 vial inhalation two times a day. 3. During the initial observation, on 3/6/23 at 10:24 a.m., Resident 1 was lying in bed with supplemental oxygen (O2) being administered by nasal canula (NC-a medical device to provide supplemental oxygen therapy to people who have lower oxygen levels). The resident's O2 concentrator (a medical device that provides supplemental oxygen) was set at 2.5 liters (L). The date on O2 tubing bag was 2/23/23, and the date on the humidification bottle (a sealed bottle of water inserted into a breathing circuit to add moisture to the breathing gases for administration) was 3/5/23. During a random observation, on 3/7/23 at 10:00 a.m., the resident was lying in bed with O2 being administered at 2.5 L by NC. The date on O2 tubing bag was 2/23/23, and the date on the humidification bottle was 3/5/23. During a random observation, on 3/8/23 at 10:41 a.m., the resident was lying in bed with O2 being			

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	administered at 2.5 L by NC. The date on O2 tubing bag was 2/23/23, and the date on the humidification bottle was 3/5/23. During a random observation, on 3/9/23 at 10:00 a.m., the resident was lying in bed with O2 being administered at 2.5 L by NC. The date on O2 tubing bag was 2/23/23, and the date on the humidification bottle was 3/5/23. Resident 1's record was reviewed on 3/9/23 at 1:15 p.m. The profile indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD-a group of diseases that cause airflow blockage and breathing-related problems) and congestive heart failure (CHF-occurs when the heart muscle doesn't pump blood as well as it should). A quarterly Minimum Data Set (MDS-part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) assessment, dated 12/9/22, indicated the resident had moderate cognitive deficit, was short of breath (SOB) when lying flat, and required supplemental O2. A care plan, dated 10/13/21, indicated the resident required O2 per NC continuously related to his diagnosis of CHF and COPD. Interventions included, but were not limited to, administer O2 per physician's order order and staff to change O2 tubing and water canister (humidification bottle) every week on Sunday night shift. Label tubing with date and initials. A physician's order, dated 2/17/21, indicated O2 at 3 liters (L) per NC continuously. A physician's order, dated 12/10/22, indicated			

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	change O2 tubing and humidification bottle, clean concentrator and filter, once daily on Sunday. During an interview, on 3/10/23 at 11:57 a.m., Licensed Practical Nurse (LPN) 6 indicated, there were 4 or 5 residents who had orders for oxygen, and 2 who received nebulizer treatments. The residents must have a physician's order for oxygen use and for nebulizer treatments. Nebulizer hand piece and oxygen masks were replaced with new units weekly, and placed back into storage bags. Both oxygen and nebulizer equipment had physician's orders to be changed weekly on Sunday night shift, and to be documented in the medication administration record (MAR) in electronic medical record (EMR). Equipment should be dated when changed. If equipment was soiled in any way in between scheduled change dates the nurse would be responsible for cleaning it or changing the soiled piece of equipment. Cleaning of the nebulizer or oxygen concentrators should be cleaning at the same time the tubing, masks and bottles, to include the filter as needed. During an interview, on 3/10/23 at 12:05 p.m., LPN 6 indicated, the process for nebulizer treatments were, there must be a physician's order for medication. The resident's vital signs (respirations, oxygen saturations, listen to breath/lung sounds) should be completed. The medication would then be placed into the nebulizer hand piece. Hand the nebulizer to resident to hold. Mid way through the procedure, recheck vitals and breath sounds. When finished help resident place nebulizer in bag, and recheck vitals. On 3/10/23 at 1:50 p.m., the Executive Director (ED) provided an undated document, titled, "Oxygen Therapy and Devices," and indicated it			

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	was the policy currently being used by the facility. The policy indicated, "...Definition of Oxygen: 1) Oxygen is a drug which must be ordered by a physician...Initiation of Oxygen: 1) Verify physician order...7) Apply device to the patient with appropriate liter flow...Oxygen Devices: 1) Nasal Canula...e. Change out weekly and PRN (as needed). f. Place in a labeled bag when not in use...." 3.1-47(a)(6)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure medications and blood sugars had	F 0757	What corrective action(s) will be accomplished for those residents	03/31/2023

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	been documented as administered and obtained, and they failed to ensure physician documentation addressing pharmacy recommendations for 2 of 5 residents reviewed for unnecessary medications (Residents 18 and 26). Findings include: 1. Resident 18's record was reviewed on 3/8/2023 at 10:49 a.m. The profile indicated the resident's diagnoses included, but were not limited to, Type 2 diabetes mellitus with diabetic neuropathy (a type of nerve damage caused by long term high blood sugar levels), phantom limb syndrome with pain (pain in the part of limb that is no longer there), chronic kidney disease stage 2 (mild damage to your kidneys), and unspecified atrial fibrillation (an irregular and often very rapid heart rhythm that can lead to blood clots in the heart). A quarterly Minimum Data Set (MDS) assessment, dated 2/4/2023, indicated the resident had moderate cognitive deficit and received routine insulin medications. A care plan, dated 1/14/2020, indicated the resident received insulin medication related to her diagnoses of diabetes. Interventions included, but were not limited to, blood sugar checks as ordered by physician, medication administered as ordered by physician. Review of the resident's March 2023 medication administration records (MARs) indicated the following: A physician's order, dated 12/5/2022, indicated Insulin glargine (insulin medication) 10 units, by subcutaneous (under the skin) injection at 9:00 p.m. daily. The March 2023 MAR lacked		found to have been affected by the deficient practice; Resident 18's orders clarified and expectations communicated with Nursing staff Resident 26's order reviewed and clarified by physician 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;All residents have potential to be effected Facility wide audit of missing med administration documentation Audit of Pharmacy Recs for Physician Rationale What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Agency orientation for new Agency staff on documentation Review of Medication Administration documentation added to daily administrative meeting Medication Administration Skills validation done for all Nurses How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; andMatrix Maintenance QAPI weekly X4 monthly X6 What date the systemic changes for each deficiency will be completed. Friday, March 31,	

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	documentation of the medication having been administered at 9:00 p.m. on 3/3/2023. The record lacked documentation of resident refusal. A physician's order, dated 7/12/2022, indicated Accu check (blood sugar level) to be obtained twice daily at 6:00 a.m. and 8:00 p.m. March 2023 MAR lacked documentation of the blood sugar level was obtained at 8:00 p.m. on 3/3/2023, 3/4/2023, and 3/5/2023. The record lacked documentation of resident refusal. The resident's MAR indicated her blood sugars were running high at bedtime. On 3/1/2023 her blood sugar was 294, on 3/2/2023 was 292, on 3/6/2023 was 347, and on 3/7/2023 was 243. During an interview, on 3/8/2023 at 10:49 a.m., Licensed Practical Nurse (LPN) 5 indicated Resident 18 was on insulin injections. The resident received injections in the morning and at bedtime. During an interview, on 3/8/2023 at 11:53 a.m., Resident 18 indicated the staff often forget to check her blood sugar at bedtime. During an interview, on 3/8/2023 at 1:53 p.m., the Assistant Director of Nursing Services (ADNS) indicated she had noticed there were holes in the Resident 18's MAR. She further indicated it was an agency nurse that had worked the weekend. She was sure the nurse obtained the blood sugar and gave the insulin because she "pre-sets" her medication for her shift, she just forgot to sign it off. The ADNS indicated she had called the agency to see if the nurse could finish her documentation. On 3/9/2023 at 2:53 p.m., the Executive Director		2023	

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	(ED) provided a document with a revised date of 1/1/2013, titled, "6.0 General Dose Preparation and Medication Administration," and indicated it was the policy currently being used by the facility. The policy indicated, " ...6.1 Document necessary medication administration/treatment information when medications are opened, when medications are given, injection site of a medication, if medications are refused. PRN medications ...on appropriate forms ...." 2. Resident 26's record was reviewed on 3/8/23 at 10:07 a.m. The profile indicated the resident's diagnoses included, but were not limited to, atherosclerotic heart disease (the buildup of fats, cholesterol and other substances in and on the artery walls) and peripheral vascular disease (a slow and progressive circulation disorder). A quarterly Minimum Data Set (MDS-part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) assessment, dated 2/8/23, indicated the resident had severe cognitive deficit. The assessment lacked documentation of an anticoagulant medication (substance that hinders the clotting of blood) having been administered. A physician's order, dated 5/29/22, indicated aspirin tablet (ASA-a drug that reduces pain, fever, inflammation, and blood clotting) chewable, 81 milligrams (mg), by mouth daily. A physician's order, dated 11/10/22, indicated enoxaparin (an anticoagulant that helps prevent the formation of blood clots) syringe, 40 mg/0.4 milliliters (mL), subcutaneous (SQ-beneath, or under, all the layers of the skin), every evening for 10 days, then discontinue. For post Covid therapy.			

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	A pharmacy recommendation, dated 11/16/22, indicated the resident received ASA and enoxaparin. Recommended to consider holding the resident's ASA until the enoxaparin was no longer needed. The physician declined the recommendation. The recommendation lacked documentation of the physician's rationale to decline the recommendation. The document had been signed and dated by the physician on 11/20/22. During an interview, on 3/8/23 at 12:09 p.m., the acting Director of Nursing Services (DNS) indicated the physician was responsible for documenting a written rationale for any declined pharmacy recommendations. She was not sure why the document lacked the physician's written rationale. On 3/10/23 at 2:30 p.m., the Executive Director (ED) provided a document, dated 10/2018, titled, "Medication Regimen Reviews and Pharmacy Recommendations," and indicated it was the policy currently being used by the facility. The policy indicated,"...Medication Regimen Review...The consultant pharmacist recommendations will be reviewed by the Director of Nursing and the attending physician will be notified promptly of any recommendations...Pharmacy recommendations should be reviewed with follow up by the physician...." 3.1-48(a)(1)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements.			

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	The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure proper handwashing for 1 of 2 kitchen observations. Findings include: The initial kitchen observation was conducted, on 3/6/23 at 10:07 a.m., with the Culinary & Nutritional Manager (Manager). On 3/6/23 at 10:09 a.m., the Manager was observed to washed hands for less than 20 seconds and touch the faucet handles, without paper towels, when turning off the water. On 3/6/23 at 10:13 a.m., the Manager was observed to wash his hands a second time. He again was observed to washed hands for less	F 0812	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No Residents Effected 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;All residents have potential to be effected Skills validation of all staff on Hand Washing to identify any deficient practices What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not	03/31/2023

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	than 20 seconds and touch the faucet handles, without paper towels, when turning off the water. During an interview, on 3/6/23 at 10:24 a.m., the Manager indicated he knew better than not to use the paper towel to turn off the faucet and was unsure how long he had washed his hands for. On 3/7/23 at 11:40 a.m., the Executive Director provided a document, with a revision date of July 2022, titled, "Hand Hygiene," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure Steps: Hand Hygiene with soap and water (handwashing)...6. Vigorously rub hands for at least 20 seconds...10. Use paper towel to turn off faucet...." 3.1-21(a)(3)		recur; Updated Signage at all handwashing station Education to all staff on Handwashing procedures How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; andCulinary Handwashing QAPI Weekly x4 Monthly x6 Hand Hygiene Program QAPI Weekly x4 Monthly x6 Hand Hygiene Observation tool Weekly x4 Monthly x6 What date the systemic changes for each deficiency will be completed. Friday, March 31, 2023	