STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	04/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	1000 ELIZABETH DR VALPARAISO, IN 46383

(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 the Investigation of Complaint IN00406256. Complaint IN00406256 - Federal/state deficiencies related to the allegations are cited at F656, F684, F692 and F740. Survey dates: April 18 & April 21, 2023 Facility number: 000078 Provider number: 155158 AIM number: 100289310 Census Bed Type: SNF/NF: 61 Total: 61 Census Payor Type: Medicare: 6 Medicaid: 47 Other: 8 Total: 61 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/25/23.	F 0000	The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exits or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusion set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of Appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tami Adams	Executive director	05/10/2023

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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			the facility. This facility respectfully requests consideration of paper compliance for the cited deficiencies	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and			

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	desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on record review and interview, the facility failed to develop and implement a person-centered care plan for a resident, related to self harming behaviors, for 1 of 3 residents reviewed for care plans. (Resident B) Finding includes: Resident B's record was reviewed on 4/18/23 at 9:24 a.m. The diagnoses included, but were not limited to, cerebral palsy, epilepsy, and cerebrospinal fluid drainage device (shunt) (drain excess fluid from the brain). The admission date into the facility was 12/7/21. An Admission Progress Note, dated 12/7/21 at 2:25 p.m., indicated a behavior of pulling her hair and biting her fingers. The Care Plans, dated 12/23/21, indicated a behavior of pulling at her hair and pulling on her feeding tube. The Nurses' Progress Notes from 2/16/23 through	F 0656	F 656 Development/Implement Comprehensive Care Plans **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** 1. Resident B no longer resides at facility **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:** **2**. Other residents have the potential to be affected therefore SSD completed an in house audit of residents with behaviors to assure current and accurate behaviors are care planned with appropriate interventions in place by date of compliance. Any issues identified will be corrected immediately	05/11/2023

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	2/24/23 indicated several observed behaviors of yelling out, biting of the arms and hands, hitting self in the head, and sticking fingers down her throat. Cross reference F740. There were no Care Plans developed and implemented for the behaviors of yelling out, biting of the arms and hands, hitting self in the head, and sticking fingers down her throat. During an interview on 4/18/23 at 11:14 a.m., the Administrator indicated not all behaviors had a care plan developed and implemented. This Federal tag relates to Complaint IN00406256. 3.1-35(a)		**What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** 3. SSD and MDS will be educated by the ED by the date of compliance on accurate and current behavior care plans, the expectations and assure current behaviors being addressed and interventions in place to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** 4. ED/Designee will review 5 records weekly of residents with behaviors to assure care plan updated and accurate, and interventions in place as well on care plan and Kardex. Monitoring will continue x 6 months. Audits will be presented to QAPI monthly and QAPI will determine the need for further audits.	
F 0684 SS=G 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.			

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	Based on record review and interview, the facility failed to ensure residents received treatment and care in accordance with professional standards for 2 of 3 residents reviewed for quality of care, related to not obtaining a neurological consult for a cerebrospinal shunt assessment for a resident experiencing increased seizures and behaviors resulting in the resident being transferred to the hospital after a Grand Mal seizure and found to have a malfunctioning shunt in the brain a which then required emergency surgery and not following up timely on laboratory results which required changes in the resident's seizure medications. (Resident B) The facility also failed to monitor blood sugar levels and administer insulin as ordered by the Physician. (Resident D) Findings include: 1. Resident B's closed record was reviewed on 4/18/23 at 9:24 a.m. The diagnoses included, but were not limited to, cerebral palsy, epilepsy, and cerebrospinal fluid drainage device (shunt, used to drain excess fluid from the brain). The admission date into the facility was 12/7/21. An Annual Minimum Data Set (MDS) assessment, dated 12/13/22, indicated long and short term memory problems, no behaviors, dependent on staff for all activities of daily living, required a feeding tube, which supplied 51% or more of calories and over 501 cc's of fluids. a. A Care Plan, dated 3/29/22, indicated seizure precautions were required. The interventions included seizure medications would be administered as ordered, seizure activity would be reported to the Charge Nurse, Facility Management, and the Physician and would be	F 0684	F 684 Quality of Care **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** **1.**. Resident B and D no longer reside in facility. **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:** 2. Other residents have the potential to be affected therefore an In house audit will be completed on residents with a shunt and insulins and Blood sugars by Nursing management by date of compliance. Any issues noted will be addressed immediately. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** 3. Education will be provided to licensed nursing staff on shunts, follow up requirements, including neurological consults, monitoring of changes in condition of residents with shunts, response by MD for abnormal labs, admission orders, and clarification of MD orders, calling MD and not faxing for emergent situations and clarifying admission orders, how to write and complete insulins orders, sliding scales and Blood	05/11/2023

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	followed up as indicated. The Nurses' Progress Notes indicated the following: There were behaviors of restlessness, hollering, biting at arms and hands on 2/16/23 at 1:41 a.m. and 2/16/23 at 10:47 a.m. On 2/17/23 at 2:42 p.m., the behaviors of scratching self, disconnecting the feeding tube, and sticking her fingers down her throat were present. On 2/18/23 at 6:41 a.m., the behaviors of restlessness, intermittent yelling out and biting of hands were present. The biting of the hands continued per the Nursing Progress Note on 2/18/23 at 1:50 p.m. On 2/20/23 at 4:32 a.m., high pitched noises and banging were heard in the resident's room. She was observed having a grand mal seizure and was immediately turned to the side. She had uncontrolled fluttering of the eyes and jerking movements of the body for 3 1/2 to 4 minutes. On 2/24/23 at 3:45 p.m., she was found having tonic/clonic seizures continually (Grand Mal) and the Emergency Management System (EMS) was notified for transfer to the Emergency Room. A Care Plan Conference was held with the Co-Guardian on 2/17/23. It was reported the resident was "doing well". The Co-Guardian had asked that the functioning of the shunt be checked and was informed a Neurologist would need to be notified.		sugar checks correctly. This education will completed by DON/Designee to licensed nursing staff by date of compliance. No Nurse will work after date of compliance if not completed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** 4. Admission and readmission orders will be validated by 2 nurses ongoing. Orders will be reviewed again by nursing management the next morning in clinical meeting Monday thru Friday. On call nurse will validate on weekends and holidays. Audits will be presented to QAPI monthly.	

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	There was no documentation that indicated the Primary Care Physician and/or a Neurologist was notified for the request of the shunt to checked for proper functioning. A Neurosurgeon's Surgery Note, dated 2/25/23, indicated the resident had shunt dependent hydrocephalus and had been having increased seizure activity with increased behaviors. The shunt was found disconnected to the shunt catheter and the brain imaging revealed enlarged ventricles. This had been considered a neurosurgical emergency and an emergent cerebral spinal fluid (CSF) diversion was indicated. There had been no CSF flow through the old catheter and the CSF was noted around the catheter. There had been a slight adherence of the catheter and once out, a large amount of CSF fluid flowed out of the catheter tract. The final diagnosis indicated a longstanding VP (ventriculoperitoneal) shunt with VP shunt malfunction. A Hospital Discharge Summary, dated 2/26/23, indicated a CT scan of the head showed asymmetry of the lateral ventricle and a shuntogram series showed the shunt drain was disconnected. Emergency surgery was completed by the Neurosurgeon and the resident developed intraventricular hemorrhage and an external ventricular drain that assisted with the drainage was placed. She was intubated and transferred to the Intensive Care Unit (ICU). The CT of the head indicated intraventricular hemorrhage post revision of the ventriculostomy drainage system. She was transferred to a Neurology ICU at another hospital. During an interview on 4/18/23 at 11:45 a.m., the Director of Nursing (DON) indicated the Primary			

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	Care Physician and/or Neurologist had not been notified as requested for the status of the shunt to be checked. b. The Physician ordered Tegretol and Lamictal (antiseizure medications) levels and a comprehensive metabolic panel laboratory test on 2/20/23 at 6:11 a.m. for Resident B due to an increase in seizure activity. A Nurse's Progress Note, dated 2/21/23 at 2:03 p.m., indicated the results of the laboratory tests ordered were still pending. A Nurse's Progress Note, dated 2/22/23 at 7:39 a.m., indicated the results of the laboratory test was communicated to the Physician. The Lamictal level was low at 3 (normal 3-15), the sodium level was high at 152 (normal 138-147), carbon dioxide high at 33 (20-30), glucose 118 (70-110), BUN (kidney function) 22 (5-20), and SGOT (liver function) AST 42 (9-35). The facility was waiting on a response from the Physician. There was no documentation that indicated the Physician responded or follow up with the Physician was completed in response to the abnormal laboratory test results. Documentation on the bottom of the laboratory results, dated 2/23/22 (sic -2023), indicated orders were received and noted. A Physician's Order to increase the Lamictal from 100 milligrams twice a day to 150 milligrams twice a day was written at 2 p.m. on 2/23/23. The Nurse's Progress Notes, dated On 2/24/23 at 3:45 p.m., indicated a Grand Mal seizure and she was transferred to the hospital Emergency Room			

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	by EMS. During an interview on 4/18/23 at 1:46 p.m., the DON indicated the results of the laboratory tests arrived at the facility on 2/22/23 at 7:39 a.m. and the Physician was made aware of the results by fax. The orders were texted to her on 2/23/23 at 8:31 a.m. The Physician indicated he had sent the orders to the facility per fax on 2/22/23. There were no orders documented on 2/22/23. There was a delay in starting the increased dosage of Lamictal. 2. Resident D's record was reviewed on 4/18/23 at 2:17 p.m. The diagnoses included, but were not limited to, anoxic brain damage, tube feeding, and diabetes mellitus. The admission date was 1/31/23. An Admission MDS assessment, indicated the cognition status was not able to be assessed, was dependent on staff for all activities of daily living, required a feeding tube, which supplied 51% or more of calories and over 501 cc's of fluids. The Care Plans, dated 1/31/23, indicated a feeding tube was present and was unable to consume food by mouth (NPO). The intervention indicated the feeding was going to be provided as ordered by the Physician. The resident had diabetes mellitus and blood sugars would be completed and medication administered per Physician's Orders. An Admission Nurse's Progress Note, dated 1/31/23 at 6:33 p.m., indicated the resident had arrived at the facility, was NPO and had a feeding tube in place for nutrition. There was no documentation the Physician had been notified for admission and/or clarification of			

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	admission orders. The Admission Physician's Orders for Resident D, dated 1/31/23, indicated Lispro insulin was to be administered 0-12 units every 6 hours for high blood sugars. The Hospital Medication Record, dated 1/25/23 through 1/31/23, indicated a sliding scale (amount given based on blood sugar level) of Lispro insulin to be given every 6 hours after the blood sugar was completed. The Physician's Order was transcribed on 1/31/23 as Lispro Insulin per sliding scale with amounts per blood sugar level to be given every 6 hours as needed, not on a schedule, for diabetes. The MAR's, dated 1/2023 and 2/2023, indicated the blood sugars and Lispro were to be completed as needed (prn) every 6 hours. There was no blood sugar level check completed from admission on 1/31/23 until the time of transfer to the Emergency Room on 2/4/23. A Physician's Progress Note, dated 2/1/23 at 7:39 a.m., indicated an insulin sliding scale was used and no blood sugar level had been obtained yet. A Nurse's Progress Note, dated 2/3/23 at 1:36 a.m., indicated a diagnosis of hyperglycemia and an insulin sliding scale was used after a glucose check every 6 hours. The resident was receiving prednisone, which might have contributed to the hyperglycemia. The DON indicated on 4/18/23 at 3:08 p.m., all admission orders should have been clarified with the Physician and she was unable to find			

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documentation the orders were clarified. At 3:42 p.m., she indicated there were no blood sugar levels obtained until 2/4/23 prior to being transferred to the Emergency Room.

During an interview on 4/21/23 at 8:33 a.m., the DON indicated she had spoken with LPN 1 (Admission Nurse). LPN 1 could not remember everything, but remembered she had faxed the orders to the Physician. She had not called the Physician. She had reported to the oncoming nurse the orders needed to be clarified.

A signed and undated statement from LPN 1 indicated the medications were entered into the computer and another nurse reviewed the orders. The discharge medication list was sent to the Physician's office for review and she reported to the oncoming nurse to clarify the orders given from the hospital.

During an interview on 4/21/23 at 8:51 a.m., LPN 2 (oncoming nurse) indicated she had not spoken to the Physician and everything had been completed on the admission already when she came in to work. She was informed the water flush order needed to be clarified. She had not clarified the water flush and had passed it on to the day shift nurse to clarify.

During an interview with LPN 1 on 4/21/23 at 10:59 a.m., she indicated she had faxed the orders to the Physician's Office for clarification. The Physician was not in the office in the evening and she would normally call the Physician, but knew he was going to be in the building the next morning and could clarify the orders then. She informed the Night Shift Nurse the orders needed to be clarified. The prn sliding scale for the insulin was written from the admission paperwork. Every order

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	written was from the hospital paperwork. It was difficult to remember everything, however, due to the amount of time that had passed. This Federal tag relates to Complaint IN00406256. 3.1-37(a)			
F 0692 SS=G Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to provide sufficient fluid intake to maintain proper hydration and health related to lack of timely follow up on laboratory results which required changes in the feeding tube water flushes and failure to clarify and implement correct Physician's admission orders which contributed to	F 0692	F 692 Nutrition/Hydration Status Maintenance **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** 1. Resident B and D no longer	05/11/2023

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	the residents being admitted/readmitted into the hospital with severe dehydration for 2 of 3 residents reviewed for quality of care. (Residents B & D) Findings include: 1. Resident B's closed record was reviewed on 4/18/23 at 9:24 a.m. The diagnoses included, but were not limited to, cerebral palsy, epilepsy, and cerebrospinal fluid drainage device (shunt, used to drain excess fluid from the brain). The admission date into the facility was 12/7/21. An Annual Minimum Data Set (MDS) assessment, dated 12/13/22, indicated long and short term memory problems, no behaviors, dependent on staff for all activities of daily living, required a feeding tube, which supplied 51% or more of calories and over 501 cc's of fluids. The Physician ordered Tegretol and Lamictal (antiseizure medications) levels and a comprehensive metabolic panel laboratory test on 2/20/23 at 6:11 a.m. due to an increase in seizure activity. A Nurse's Progress Note, dated 2/21/23 at 2:03 p.m., indicated the results of the laboratory tests ordered were still pending. A Nurse's Progress Note, dated 2/22/23 at 7:39 a.m., indicated the results of the laboratory test was communicated to the Physician. The sodium level was high at 152 (normal 138-147), carbon dioxide high at 33 (20-30), glucose 118 (70-110), BUN (kidney function) 22 (5-20), and SGOT (liver function) AST 42 (9-35). The facility was waiting on a response from the Physician.		resides at facility. **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:** 2. Other residents have the potential to be affected therefore an In House audit has been completed on residents with feeding tubes to assure orders accurate, labs completed per order and timely follow up with labs in place. Any issues identified will be corrected and audit will be completed by nursing management and by date of compliance. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** 3. Education will be provided to licensed nursing on clarifying and validating admission orders as well as any new orders with 2 nurses ongoing to ensure accuracy of orders. Education will include timely follow up from MD on labs as well. This will be completed by date of compliance by nursing management. No nurse will work if education not completed by date of compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** 4. Nursing management will	

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	There was no documentation that indicated the Physician responded or follow up with the Physician was completed in response to the laboratory test results. Documentation on the bottom of the laboratory results, dated 2/23/22 (sic -2023), indicated orders were received and noted. A Physician's Order, dated 2/23/23, indicated the water flushes for the feeding tube were to be increased from 244 cubic centimeters (cc's) every 4 hours to 300 cc's every 4 hours. The Nurse's Progress Notes, dated 2/24/23 at 3:45 p.m., indicated a Grand Mal seizure and she was transferred to the hospital Emergency Room by EMS. The Emergency Room Physician Notes, dated 2/24/23 at 6:15 p.m., indicated a critical sodium level at 171 and a high BUN of 64. She had a seizure in the Emergency Room. The diagnoses included, sepsis likely due to a urinary tract infection and possible left lower lobe pneumonia, seizure disorder, and severe hypernatremia likely due to severe dehydration. During an interview on 4/18/23 at 1:46 p.m., the DON indicated the results of the laboratory tests arrived at the facility on 2/22/23 at 7:39 a.m. and the Physician was made aware of the results by fax. The orders were texted to her on 2/23/23 at 8:31 a.m. The Physician indicated he had sent the orders to the facility per fax on 2/22/23. There were no orders documented on 2/22/23. There was a delay in starting the increased dosage of Lamictal and the increase in the water flush. 2. Resident D's record was reviewed on 4/18/23 at		validate orders, admission, readmission, new orders daily Monday thru Friday and assure labs ordered have been completed, MD notified and timely response from MD in place. Nurse on call will review new admissions, readmissions, and lab orders on weekends and holidays. Audits will be present to QAPI monthly x 6 months and QAPI will determine the need for further audits.	

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	2:17 p.m. The diagnoses included, but were not limited to, anoxic brain damage, tube feeding, and diabetes mellitus. The admission date was 1/31/23. An Admission MDS assessment, indicated the cognition status was not able to be assessed, was dependent on staff for all activities of daily living, required a feeding tube, which supplied 51% or more of calories and over 501 cc's of fluids. The Care Plans, dated 1/31/23, indicated a feeding tube was present and was unable to consume food by mouth (NPO). The intervention indicated the feeding was going to be provided as ordered by the Physician. The resident had diabetes mellitus and blood sugars would be completed and medication administered per Physician's Orders. An Admission Nurse's Progress Note, dated 1/31/23 at 6:33 p.m., indicated the resident had arrived at the facility, was NPO and had a feeding tube in place for nutrition. There was no documentation the Physician had been notified for admission and/or clarification of admission orders. A Hospital Dietary Order, dated 1/14/23, indicated a NPO diet with tube feeding of Glucerna 1.5 continuous at 47 cc's per hour with a water flush of 30 cc's every 6 hours. The current feeding amount met the caloric and protein needs of the patient. The free water flush was to be increased to 175 cc's every 6 hours to better meet the patient's fluid needs. The After Visit Summary Physician's Orders (Admission Orders), dated 1/31/23, indicated diet instructions of Glucerna at 47 cc's per hour with a			

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	water flush of 175 cc's every 6 hours. The order did not indicate Glucerna 1.5 was to be administered. The Facility Physician's Orders, indicated an order on 1/31/23 for 230 cc's of water to be provided every hour per feeding pump. The Medication Administration Record (MAR), dated 1/2023, indicated this was transcribed on 1/31/23 at 3:34 p.m. then it was discontinued at 8:35 p.m. The times the order was scheduled for were 5 a.m., 8 a.m., 12 p.m., 3 p.m., 7 p.m., 10 p.m. and was documented as completed at 7 p.m. Other Physician's Orders, dated 1/31/23, indicated 30 cc's of water was to be provided per the feeding pump every hour and another order indicated Glucerna 1.5 at 47 cc/hour per pump with a flush with 30 cc's water every 6 hours. The MAR's dated 1/2023 and 2/2023, indicated both orders were being followed. There was no documentation of the amount of fluid intake per shift to determine how much fluids were being administered. A Nurse's Progress Note, dated 2/1/23 at 7:23 a.m., indicated the Physician visited the resident. There was no documentation of a clarification of the feeding type and water flush per the feeding tube. The Interdisciplinary Team (IDT) Notes, dated 2/1/23 at 11:09 a.m., indicated she received Glucerna 1.5 at 47 cc's and hour with scheduled water flushes. There was no clarification of the amount of water flushes she received or the type of feeding she was to receive.			

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	A Nurse's Progress Note, dated 2/3/23 at 1:36 a.m., indicated Glucerna 1.5 was being administered at 47 cc's per hour with a 30 cc's of water flush every 6 hours. A Nurse's Progress Note, dated 2/4/23 at 11:10 a.m., indicated around 10:30 a.m. she was diaphoretic and hyperpneic (fast breathing), blood pressure 74/46, pulse 110, blood sugar 203. The lung sounds were congested in the bilateral upper fields. The nebulizer treatment per Physician Orders was administered. The Physician was notified and the resident was transferred to the Emergency Room. The Emergency Room Physician's Notes, dated 2/4/23, indicated the differential diagnosis included dehydration and electrolyte imbalance. Sodium was elevated at 162 with a potassium of 6.3 and the BUN was 33. The white blood cells were high at 21.5. The impression and plan indicated the diagnoses of hypoxia, sepsis, and pneumonia. During an interview on 4/18/23 at 3:27 p.m., the DON indicated the water flush was 30 cc's every 6 hours and the Hospital Dietician had recommended to increase the water to 175 cc/hour. She indicated the dietary orders on the admission indicated Glucerna not Glucerna 1.5. During an interview on 4/21/23 at 8:51 a.m., LPN 2 (night shift nurse) indicated she had not spoken to the Physician and everything had been completed on the admission when she came in to work. She was informed the water flush order needed clarified. She had not clarified the water flush and had passed it on to the day shift nurse to clarify.			

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	During an interview with LPN 1 on 4/21/23 at 10:59 a.m., she indicated she had faxed the orders to the Physician's Office for clarification. The Physician was not in the office in the evening and she would normally call the Physician, but knew he was going to be in the building the next morning and could clarify the orders then. She informed the Night Shift Nurse the orders needed to be clarified. She indicated she had seen the water flush for the feeding tube to be 30 cc's every 6 hours on the paperwork. She had not seen the order for 175 cc's of water flush every 6 hours. Every order written was from the hospital paperwork. It was difficult to remember everything, however, due to the amount of time that had passed. This Federal tag relates to Complaint IN00406256. 3.1-46			
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on record review and interview, the facility failed to provide the necessary behavioral health care and services related to not consulting the Physician or Psychiatric services for increased	F 0740	F 740 Behavioral Health Services **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	05/11/2023

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	behaviors due to self-harming behaviors for 1 of 3 residents reviewed for quality of care. (Resident B) Finding includes: Resident B's closed record was reviewed on 4/18/23 at 9:24 a.m. The diagnoses included, but were not limited to, cerebral palsy, epilepsy, and cerebrospinal fluid drainage device (shunt, used to drain excess fluid from the brain). The admission date into the facility was 12/7/21. An Annual Minimum Data Set (MDS) assessment, dated 12/13/22, indicated long and short term memory problems, no behaviors, dependent on staff for all activities of daily living, required a feeding tube, which supplied 51% or more of calories and over 501 cc's of fluids. An Admission Progress Note for Resident B, dated 12/7/21 at 2:25 p.m., indicated a behavior of pulling hair and biting of the fingers and baby oil was to be applied to the hair to assist with reducing the behavior of pulling the hair out. The Care Plans, dated 12/23/21, indicated a behavior of pulling at her hair and pulling on her feeding tube. The Nurses' Progress Notes, dated 2/1/23 through 2/15/23, indicated no behaviors were present. The Nurses' Progress Notes, starting on 2/16/23, indicated the following: On 2/16/23 at 1:41 a.m., behaviors of restlessness, biting self, and hollering were present. Socks were placed on the arms and were immediately removed by the resident. The Physician's Office was		**practice?** 1. Resident B no longer resides in the facility. **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:** 2. Other residents have the potential to be affected therefore an In House audit will be completed by the SSD by date of compliance on residents with increasing or changed behaviors last 30 days to assure MD and or Psychiatric services have been notified. Any issues identified will be corrected immediately. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** 3. Education will be provided by the ED to SSD/MDS and DON/Designee will educate licensed nursing on reporting behaviors, including changes, and increased frequency and appropriate documentation in the clinical record including updating the care plan and Kardex. Notification should include MD and or Psy services as well as POA/responsible party. This education will be completed by date of compliance and no nurse will work if education not completed by date of compliance. **How the corrective action(s)**	

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	notified of the "agitation" and a 1 centimeter by 1 centimeter abrasion from biting herself on the right lower arm by fax. On 2/16/23 at 6:36 a.m., the Co-Guardian was notified of the restlessness, the abrasion to the right lower arm, and the Physician had been notified by fax. On 2/16/23 at 10:47 a.m., she was yelling out and continued to bite herself during the morning. There was a distressed look on her face. An as needed ibuprofen was administered, she was repositioned, and incontinent care was given. She was not biting herself at the time of the note and the facility was waiting on a response from the Physician from the faxed communication from 1:41 a.m. On 2/16/23 at 8:51 p.m., the abrasion on the right lower arm was cleansed, an antibiotic ointment was applied and a dressing was used to cover the area. A Physician's Order, dated 2/16/23 at 9 p.m., indicated the right lower arm was to be cleansed, patted dry, an antibiotic ointment was to be administered, and the area was to covered with a dressing daily until the area healed. There was no documentation on 2/16/23 the Physician had been notified of the continued behaviors or follow up to the fax sent at 1:41 a.m. During an interview on 4/18/23 at 11:28 a.m., the DON indicated the Physician had been notified on 2/16/23 at 1:41 a.m. and she was unable to locate any follow up to the fax until the order was written on 2/16/23 at 9 p.m.		**will be monitored to ensure the deficient practice will not recur:** 4. DON/Designee/SSD will validate clinical records of residents with changes in behaviors or increased frequency to assure appropriate notification has occurred timely and any new orders have been implemented accurately x 6 months. Audits will be presented to QAPI monthly and QAPI will determine the need for further audits.	

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	A Nurse's Progress Note, dated 2/17/23 at 2:42 p.m., indicated the resident had behaviors of scratching herself, disconnecting the feeding tube, and had been sticking her fingers down her throat. A text had been received from the Physician to contact Psychiatric Services. A Nurse's Progress Note, dated 2/17/23 at 8:55 p.m., indicated minimal yelling out during the evening shift after Tylenol was administered. A Nurse's Progress Note,dated 2/18/23 at 6:41 a.m., indicated intermittent yelling out during the night shift and was biting her hands. A Nurse's Progress Note, dated 2/18/23 at 1:50 p.m., indicated there had been occasional moaning and yelling out and she continued to bite herself. There was no documentation on 2/17/23 through 2/21/23 that indicated the facility's Psychiatric Services had been notified of the Physician's Order per text on 2/17/23 at 2:42 p.m.. A Psychiatry Progress Note, dated 2/21/23, indicated there were no recent reports of new or worsening behaviors. She recently had a seizure and was anxious before the seizure, which could be cause of an aura. There were no symptoms of anxiety, no agitation, physical or verbal aggression observed or reported. She appeared calm. A Nurse's Progress Note, dated 2/21/23 at 4:03 p.m., indicated she continued to bite her hands and remained restless. There was scabbing to the bilateral arms. On 2/22/23 at 7:43 a.m., a Nurse's Progress Note indicated the she had been awake the entire night			

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	shift, was biting both arms, smacking herself in the head, and the yelling continued. Tubi grips (special skin covering) had been placed on the arms and the resident would remove them. On 2/23/23 at 8:07 a.m., a Nurse's Progress Note indicated the yelling out, biting hands and arms, and hitting herself in the head continued. Ibuprofen was administered and the behaviors were unchanged. On 2/23/23 at 10:24 p.m., a Nurse's Progress Note indicated she displayed more restlessness and had signs and symptoms of pain. Ibuprofen was administered with minimal relief. She continued to attempt to bite her arms and hands and was observed hitting herself. She was redirected and attempts were made to soothe and distract were successful for short periods of time. On 2/23/23 at 11:37 a.m., the Nurse's Progress Note indicated she would sometimes hit herself and would bite her arms. Ibuprofen was administered with positive results. The DON indicated on 4/18/23 at 11:28 a.m., she was unable to find documentation the facility's Psychiatric Services were notified of the Physician's Order on 2/17/23. The Psychiatric Nurse Practitioner was also interviewed and he indicated the visit on 2/21/23 was a regular scheduled visit. No one from the facility had contacted him on 2/17/23 and no one had reported new and/or worsening behaviors, and if they had, the medications would have been reviewed with possible changes. The resident was calm at the time of his visit. On 4/18/23 at 1:22 p.m., the Social Service Director indicated she had informed the Psychiatry Nurse			

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	Practitioner of the increased behaviors on 2/21/23. She indicated there was no documentation that indicated the Psychiatric Nurse Practitioner was notified. This Federal tag relates to Complaint IN00406256. 3.1-37(a) 3.1-43(a)(1)			