STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 00 B. WING	03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREEN HOUSE COTTAGES OF CARMEL	616 GREEN HOUSE WAY CARMEL, IN 46032

(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 Complaints IN00336426, IN00336591, IN00337934, IN00343992, IN00344146, IN00345639, IN00346154, IN00346532, IN00348218, IN00348726 and IN00348744. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00336426 - Substantiated. Federal/State deficiencies related to the allegations are cited at F563, F580, F609, F610, F732, F759 and F842. Complaint IN00336591 - Substantiated. Federal/State deficiencies related to the allegations are cited at F563, F580, F609, F610 and F732. Complaint IN00337934 - Substantiated. Federal/State deficiencies related to the allegations are cited at F609, F610 and F842. Complaint IN00343992 - Substantiated. Federal/State deficiencies related to the allegations are cited at F679 and F732. Complaint IN00344146 - Substantiated. Federal/State deficiencies related to the allegations are cited at F732. Complaint IN00345639 - Substantiated. Federal/State deficiencies related to the allegations are cited at F609 and F610. Complaint IN00346154 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission of agreement by this facility or Management Group of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. The facility respectfully requests paper compliance.	

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

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

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	Complaint IN00346532 - Substantiated. Federal/State deficiencies related to the allegations are cited at F679 and F732. Complaint IN00348218 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580, F679, F692 and F732. Complaint IN00348726 - Substantiated. Federal/State deficiencies related to the allegations are cited at F732. Complaint IN00348744 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580 and F692. Survey dates: March 1, 2, 3, 4 and 5, 2021 Facility number: 013753 Provider number: 155846 AIM number: 201362150 Census Bed Type: SNF/NF: 52 Total: 52 Census Payor Type: Medicare: 4 Medicaid: 31 Other: 17 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on March 15, 2021.			
F 0563 SS=D Bldg. 00	483.10(f)(4)(ii)-(v) Right to Receive/Deny Visitors §483.10(f)(4) The resident has a right to			

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	receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation.			
	Based on interview and record review, the facility failed to provide family members visitation with a resident during end of life for 1 of 5 residents reviewed for visitation rights. (Resident F) Finding includes: During a telephone interview, on 03/01/21 at 10:45	F 0563	F 563 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** It is the practice of this facility to follow the CDC and ISDOH	04/04/2021

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	a.m., Resident F's niece indicated she and her sister requested to visit in the weeks leading up to the resident's death but were denied. They were Catholic and wanted to say rosary with her. The Hospice nurse offered to coordinate a visit when the Hospice staff took the resident off all medications except comfort medications. The facility told the Hospice nurse they would contact the family. Resident F's niece became emotional when she indicated the facility did not call them and the family was not able to visit before the resident died. During a telephone interview, on 03/05/21 at 11:33 a.m., the Administrator of Resident F's Hospice service indicated Resident F was on their services from 03/10/20 to 8/14/20. During a telehealth (virtual) visit on 08/13/20, the Hospice nurse offered to call Resident F's family to let them know the resident was transitioning (actively dying) and to coordinate in-room visit(s). The facility's previous Director of Nurses (DON) told the Hospice nurse the facility had rules regarding visitation and the DON wanted to call the family. The resident passed the next day. The family informed the Hospice service they were not made aware the resident was transitioning and they did not have an opportunity to visit the resident before she died. During an interview, on 03/05/21 at 11:50 a.m., Registered Nurse (RN) 20 indicated she remembered Resident F was "going downhill." On 08/13/20, the resident's nurse reported to the DON the family should come visit. The next day, 08/14/20, at the morning staff meeting, a second nurse indicated she felt the resident was dying and the family should be notified and be able to visit. The DON told them she would assess the resident after the meeting. If she felt the resident		guidelines on visitation during the COVID pandemic. Resident F no longer resides in the facility. The facility does allow compassionate care visits as in the end of life. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** All residents have the potential to be affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** All staff will be in-serviced on the policy and procedure on visitation. All staff will be update as changes occur during the COVID -19 pandemic. Any staff who fail to comply with the information delivered at the in-service will be further educated and/or progressively disciplined as indicated. The current DON and Administrator are aware of the visitation guidelines and follow them. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. shat quality assurance program will be put into place:** This deficient finding will be monitored by the DON/designee during the clinical meeting Mon-Fri	

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	was actively dying, she would contact the family. The DON got busy and did not see the resident. After lunch, on 08/14/20, RN 20 got a call from the resident's Certified Nurse Aide asking RN 20 to come see the resident. When RN 20 got there, Resident F had passed. When RN 20 let the previous DON know the resident had passed, the look on her face was immediate remorse. The DON had not contacted the family. Regretfully, the nurse who notified the family was blunt. She told them "Your Aunt died." The family was extremely upset. Resident F's medical record was reviewed on 03/05/21 at 10:45 a.m. Her diagnoses included, but were not limited to, Alzheimer's disease, major depressive disorder and heart disease. Resident F's two nieces were listed as emergency contacts. Resident F's quarterly Minimum Data Set assessment, dated 06/25/20, indicated the resident had severe cognitive impairment. Resident F's Social Services Note, dated 07/27/20, indicated "...Writer facilitated a phone care conference today with the [Hospice] Administrator, Nurse and Social Worker, along with the IDT [interdisciplinary team], elder's daughter, niece and the IDT. Plan of care reviewed. Family and Hospice staff inquired about the visitation policy and Writer directed them to administration...." Resident F's Health Status Note, dated 08/13/20 at 1:19 p.m., indicated "...[Nurse from Hospice Service] face time with elder. Elder is not eating or drinking or taking PO [by mouth] medication...New orders: discontinue all PO		using an audit tool. Will monitor for any declines in the Elders condition, if the has a decline family will be notified and ask if they would like a visit. Audit 5 days a week x 3 months then monthly x 3 months. The results of the audit will be reviewed at the monthly quality assurance meeting. The QAPI program will review, update, and make changes as needed for sustaining substantial compliance for no less than 6 months. **The date the systemic changes will be completed**: April 4, 2021	

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	medication, except comfort medication...Hospice nurse will reach out to DON for request for hospice face-to-face visit and for Family to face visit during this transition...." Resident F's Health Status Note, dated 08/13/20 at 1:50 p.m., indicated "...DON notified of Hospice face time call and orders...." Resident F's Health Status Note, dated 08/14/20 at 4:01 p.m., indicated "...At 13:50 [1:50 p.m.] today this nurse was called to confirm that elder's [resident's] respirations had ceased...[Hospice] nurse was on site at the time, POA [power of attorney] was contacted, staff respectfully prepared and positioned the elder for family viewing...." Resident F's Hospice Care Coordination Note, dated 07/13/20, indicated "...SW [Social Worker] updated [family member] regarding DON had called hospice and advised of their plan to allow family visitation for 14 days and then allow RNCM [Registered Nurse Care Manager] to come in if there are no occurrences of COVID-19...." Resident F's Hospice Care Coordination Note, dated 08/10/20, indicated "...Return call received from [family member] who is very upset with the facility in regards to visitor restrictions. [Family member] indicated that outdoor visits have been stopped and she feels there has been favoritism amongst who gets to visit their loved ones, etc...." Resident F's Hospice Care Coordination Note, dated 08/13/20, indicated "...Spoke to clinical director [DON] regarding allowing hospice to visit building with patient now early transitioning. [DON] approved 3x [three times a] week until further decline. [DON] will reach out to family to			

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	arrange bedside scheduled visits...." During an interview, on 03/05/21 at 2:53 p.m., the ED indicated the policy "Supporting the Family when an Elder is Dying," was their current policy for compassionate care visits. They followed policy except when restricted by the Centers for Medicare and Medicaid Services (CMS) or State guidance related to COVID-19 visitation restrictions. A current facility policy, titled "Supporting the Family when an Elder is Dying," dated 2016 and provided by the ED on 03/05/21, indicated "...Policy: The household team will provide support to family members of elder's before and after the death of an elder...Procedure: 1. When it is determined that an elder is in need of end of life care, the household team will develop a plan to support the elder's family while the elder is dying, at the time of death and after the death occurs...e. If family members desire, provide opportunities for them to assist in providing care to their loved one as appropriate...." The CMS guidance, titled "Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes," dated 03/15/20 and current at the time of Resident F's death (Reference QSO-20-14-NH), indicated "...Facilities should restrict visitation of all visitors and non-essential health care personnel, except for certain compassionate care situations, such as an end-of-life situation. In those cases, visitors will be limited to a specific room only...." The Indiana State Department of Health Long Term Care Newsletter, Issue 2020-04, dated 03/15/20, indicated "...All facilities should restrict visitation of all visitors and non-essential			

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	healthcare personnel. The only exception for visitors is for compassionate care situations, as in end of life...." This Federal tag relates to Complaints IN00336426 and IN00336591. 3.1-8(b)(7)			
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 (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			

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	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 interview and record review, the facility failed to notify a resident's representatives of a significant change in physical status and need to alter treatment for 1 of 5 residents reviewed for a change of condition. (Resident F) Finding includes: During a telephone interview, on 03/01/21 at 10:45 a.m., Resident F's niece indicated she and her sister never received a call letting them know the resident was dying or was told by the facility the Hospice nurse had decided to take the resident off her medications. The facility told the Hospice nurse they would contact the family. Resident F's niece became emotional when she indicated the facility did not call them and the family was not able to visit before the resident died.	F 0580	**F580** ="" span="">It is the practice of this facility to notify the resident or POA with a significant change in physical status and need to alter treatment. Resident F no longer resides in facility. ="" span="">
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="" span="">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..
="" span=""> | 04/04/2021 |

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	During a telephone interview, on 03/05/21 at 11:33 a.m., the Administrator of Resident F's Hospice service indicated Resident F was on their services from 03/10/20 to 8/14/20. On 08/13/20 via a teleheath (virtual) visit, the Hospice nurse assessed the resident and determined she was transitioning to actively dying and was unable to swallow. She obtained an order to discontinue all medications administered by mouth. The Hospice nurse offered to call Resident F's family to let them know of the change of condition and treatment and to coordinate an in-room visit. The facility's previous Director of Nurses (DON) said they had rules and she wanted to call the family. The patient passed the next day while the Hospice nurse was at the facility admitting another resident. Hospice was contacted by the family and was informed they were not notified of the transition or change of orders. They were extremely upset. During an interview, on 03/05/21 at 11:50 a.m., Registered Nurse (RN) 20 indicated she remembered Resident F was "going downhill." On 08/13/20, the resident's nurse reported to the DON the resident was dying and the family should come visit. The next day, 08/14/20, at the morning staff meeting, a second nurse indicated she felt the resident was dying and the family should be notified and be able to visit. The DON told them, she would assess the resident after the meeting. If she felt the resident was actively dying, she would contact the family. The DON got busy and did not see the resident. After lunch, on 08/14/20, RN 20 got a call from the resident's Certified Nurse Aide asking RN 20 to come see the resident. When RN 20 got there, Resident F had passed. When RN 20 let the previous DON know the resident had passed, the look on her face was immediate remorse. The DON had not contacted		=" " span="">All residents have the potential to be affected. =" " span="">"> =" " span="">What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. =" " span="">"> =" " span="">Nurses will be in-serviced on the Change of Condition policy and procedure. =" " span="">Any staff who fail to comply with the information delivered at the in-service will be further educated and/or progressively disciplined as indicated. =" " span="">"> =" " span="">How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance prgram will be put into place; and =" " span="">"> =" " span="">This deficient finding will be monitored by the director of nursing/ designee through observation, clinical meeting Mon-Fri using an audit tool. The results of the audit will be reviewed at the monthly quality assurance meeting. The QAPI program will review update, and make changes	

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	the family. Regretfully, the nurse who notified the family was blunt. She told them "Your Aunt died." The family was extremely upset. Resident F's medical record was reviewed on 03/05/21 at 10:45 a.m. Her diagnoses included, but were not limited to, Alzheimer's disease, major depressive disorder and heart disease. Resident F's two nieces were listed as emergency contacts. Resident F's quarterly Minimum Data Set assessment, dated 06/25/20, indicated the resident had severe cognitive impairment. Resident F's Health Status Note, dated 08/13/20 at 1:19 p.m., indicated "...[Nurse from Hospice Service] face time with elder. Elder is not eating or drinking or taking PO [by mouth] medication...New orders: discontinue all PO medication, except comfort medication...Hospice nurse will reach out to DON for request for hospice face-to-face visit, and for Family to face visit during this transition...." Resident F's Health Status Note, dated 08/13/20 at 1:50 p.m., indicated "...DON notified of Hospice face time call and orders...." Resident F's physician orders reflected the following orders were discontinued on 08/13/20: a. whole milk with meals for weight loss prevention b. evening snack c. Two, 400-unit cholecalciferol capsules in the morning for vitamin D deficiency d. One, 0.5 milligram (mg) clonazepam twice a day for anxiety disorder e. One, 100 mg gabapentin capsule 3 times a day		as needed for sustaining substantial compliance for no less than 6 month. ="" span="">"> Systemic changes will be completed: April 4, 2021 ="" span="">"> **span="">"> **span="">"">="" span="">"> **span="">"> **span="">">	

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	for neuropathy (nerve pain) f. One, 25 mg promethazine hydrochloride tablet every 6 hours as needed for nausea and vomiting g. 30 milliliters (ml) of Milk of Magnesia suspension as needed for constipation at bedtime if no bowel movement in 3 days h. One, 60 mg duloxetine hydrochloride capsule in the morning for neuropathy i. One, 100 mg tablet of docusate sodium in the morning for constipation related to irritable bowel syndrome j. One, 20 mg tablet of famotidine in the morning for indigestion k. 650 mg of acetaminophen extended release tablet every 8 hours as needed for mild pain l. One, 75 mg clopidogrel bisulfate tablet in the morning for heart failure. Resident F's Hospice Physician Order, signed by the Registered Nurse Case Manager (RNCM) on 08/13/20 at 1:40 p.m., indicated "...DC [discontinue] all PO MEDS [medications administered by mouth], Patient transitioning, not swallowing...." Resident F's Health Status Note, dated 08/14/20 at 4:01 p.m., indicated "...At 13:50 [1:50 p.m.] today this nurse was called to confirm that elder's [resident's] respirations had ceased...[Hospice] nurse was on site at the time, POA was contacted, staff respectfully prepared and positioned the elder for family viewing...." A current facility policy, titled "Notification of a Significant Change of Condition," dated 2016 and provided by the Executive Director on 03/05/21, indicated "...A household licensed nurse responsible for the elder's [resident's] care will inform the elder, the elder's legal representative and/or interested family member when a			

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	155846	A. BUILDING 00 B. WING	03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	significant change in treatment has been ordered by the physician...." This Federal tag relates to Complaints IN00336426 and IN00336591, IN00346154, IN00348218, and IN00348744. 3.1-5(a)(2) 3.1-5(a)(3)			
F 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within			

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	5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure alleged violations of abuse, neglect or misappropriation was reported to the State Survey Agency for 1 of 3 residents reviewed for abuse. (Resident D) Finding includes: During an interview, on 03/01/21 at 2:58 p.m., when asked if anyone had hurt her, Resident D indicated "oh yes." There was an aide who would come in her room, in the middle of the night, and go through her drawers and then through her things in the bathroom. Resident D eventually told her not to come into her room again. Resident D indicated the person was a thief, but the resident was unable to say what the woman allegedly took. Then one night, again, in the middle of the night, she heard the same aide having a temper tantrum right outside her door because the resident wouldn't let her in. They had to give the aide a sedative. The person was moved to another cottage, which Resident D was thrilled about. During a telephone interview, on 03/04/21 at 7:00 p.m., Licensed Practical Nurse (LPN) 17 indicated she worked on Sunday night, 08/23/20, from 7:00 p.m. until 7:00 a.m. on Monday morning, 08/24/20. At about 4:00 a.m. to 5:00 a.m., she went into Resident D's room to draw blood for a laboratory test. The resident started yelling and screaming and saying, "you're not going to draw my blood." So, LPN 17 walked out of the room and asked another nurse to draw her blood. LPN 17 usually only worked on weekends, but she was asked to attend a mandatory training on abuse prohibition	F 0609	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident D suffered no ill effects due to this alleged deficient practice. 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 the potential to be affected. What measures will be put into place and what systemic changes will be made to ensure that the Deficient practice does not recur; There was a change in administration the current Administrator and DON knows importance of reporting abuse allegation to proper people. 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; The Administrator/designee will monitor/audit residents medical records weekly times 4 weeks, then biweekly for 2 months, then monthly for 3 months to ensure all allegation is properly/timely report to the ISDH. The results of the audit will be reviewed at the monthly quality assurance	04/04/2021

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	that Wednesday. This was the first time she heard there was an allegation against her. The next thing LPN 17 knew, she was being suspended because Resident D said LPN 17 would not give her pain medication. LPN 17 was terminated, effective 08/31/20, because the statement LPN 17 gave did not coincide with what other staff members reported of the alleged incident. During an interview, 03/05/21 at 9:38 a.m., Registered Nurse (RN) 20 indicated she remembered a day nurse, who no longer worked at the facility, had reported Resident D complained LPN 17 was too rough with her during a transfer one night. A second staff member, who also no longer worked at the facility, also reported Resident D alleged LPN 17 was too rough. The two staff members who reported the allegation were the staff members who came in during the day following the night shift LPN 17 had just worked. They reported the allegation on the morning of 08/24/20. Resident D's family also indicated they were going to report the allegation to the Ombudsman. RN 20 thought the Staff Development Coordinator at the time helped with the investigation, but RN 20 did not know what she did. Resident D's medical record was reviewed on 03/01/21 at 10:02 a.m. Her diagnoses included, but were not limited to, low back pain, dementia, cognitive communication deficit, age related debility, and vitamin B12, vitamin D and magnesium deficiency. Resident D's health status note documented by LPN 17, dated Monday, 08/24/20, at 6:32 am., indicated "...Lab: BMP [basic metabolic panel] drawn this morning; awaiting pick-up from lab...."		meeting. Changes may be established to the auditing process, based upon the results of audits. Compliance Date: April 4, 2021	

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	During an interview, on 03/05/21 at 9:48 a.m., the Human Resource (HR) manager indicated the last time LPN 17 worked at the facility was 08/24/20, but she was called in for a 30-minute mandatory training on 08/26/20. The HR manager sat in on the termination notice to LPN 17. She did not remember what reason LPN 17 was given for the termination. During an interview, on 03/05/21 at 9:15 a.m., the Executive Director (ED) indicated Resident D's allegation of abuse transpired before she, the current Director of Nurses and current Staff Development Coordinator started working at the facility. The ED looked at the State Survey Agency's (SSA) portal, the facility's medical records, the facility's administrative offices, and LPN 17's personnel file. She could not find documentation the allegation was investigated or reported to the SSA. A current facility policy, titled "Prevention of Elder Abuse, Neglect and Misappropriation of Elder Property Policy," dated 2016 and provided by the ED on 03/05/21, indicated "...When staff...suspect a crime has occurred against a resident at [the facility], they must report the incident to SSA and local law enforcement...." This Federal tag relates to complaints IN00336426, IN00336591, IN00337934 and IN00345639. 3.1-28(c)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:			

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	§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure alleged violations of abuse, neglect or misappropriation was thoroughly investigated for 1 of 3 residents reviewed for abuse. (Resident D) Finding includes: During an interview, on 03/01/21 at 2:58 p.m., when asked if anyone had hurt her, Resident D indicated "oh yes." There was an aide who would come in her room, in the middle of the night, and go through her drawers and then through her things in the bathroom. Resident D eventually told her not to come into her room again. Resident D indicated the person was a thief, but the resident was unable to say what the woman allegedly took. Then one night, again, in the middle of the night, she heard the same aide having a temper tantrum right outside her door because the resident wouldn't let her in. They had to give the aide a sedative. The person was moved to another cottage, which Resident D was thrilled about.	F 0610	F 610 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident D suffered no ill effects due to this alleged deficient practice. 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 the potential to be affected. What measures will be put into place and what systemic changes will be made to ensure that the Deficient practice does not recur; There was a change in administration the current Administrator and DON knows importance of investigating allegation abuse.	04/04/2021

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	During a telephone interview, on 03/04/21 at 7:00 p.m., Licensed Practical Nurse (LPN) 17 indicated she worked from 7:00 p.m. on Sunday night, 08/23/20, to 7:00 a.m. on Monday morning, 08/24/20. At about 4:00 a.m. to 5:00 a.m. she went into Resident D's room to draw blood for a laboratory test. The resident started yelling and screaming and saying, "you're not going to draw my blood." So, LPN 17 walked out of the room and asked another nurse to draw her blood. LPN 17 usually only worked on weekends, but she was asked to attend mandatory training on abuse prohibition that Wednesday. That was the first time she heard there was an allegation against her. The next thing LPN knew, she was being suspended because Resident D said LPN 17 would not give her pain medication. LPN 17 was terminated effective 08/31/20 because the statement LPN 17 gave did not coincide with what other staff members reported of the alleged incident. During an interview, 03/05/21 at 9:38 a.m., Registered Nurse (RN) 20 indicated she remembered a day nurse, who no longer worked at the facility, had reported Resident D complained LPN 17 was too rough with her during a transfer one night. A second staff member, who also no longer worked at the facility, also reported Resident D alleged LPN 17 was too rough. The two staff members who reported the allegation were the staff members who came in during the day following the night shift LPN 17 had just worked. They reported the allegation on the morning of 08/24/20. Resident D's family also indicated they were going to report the allegation to the Ombudsman. RN 20 thought the Staff Development Coordinator at the time helped with the investigation, but RN 20 did not know what she did.		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; The Administrator/designee will monitor/audit any reported concerns to ensure investigation is done if needed. 4 x weeks, then biweekly for 2 months, then monthly for 3 months to ensure all allegation are properly investigated. The results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based upon the results of audits. Compliance Date: April 4, 2021	

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	During an interview, on 03/05/21 at 9:48 a.m., the Human Resource (HR) manager indicated the last time LPN 17 worked at the facility was 08/24/20, but she was called in for a 30-minute mandatory training on 08/26/20. The HR manager sat in on the termination notice to LPN 17. She did not remember what reason LPN 17 was given for the termination. During an interview, on 03/05/21 at 9:15 a.m., the Executive Director (ED) indicated Resident D's allegation of abuse transpired before she, the current Director of Nurses and current Staff Development Coordinator started working at the facility. The ED looked at the State Survey Agency's (SSA) portal, the facility's medical records, the facility's administrative offices, and LPN 17's personnel file. She could not find documentation the allegation was investigated. LPN 17's personnel file was reviewed on 03/03/21. There was no evidence of an investigation, suspension, or reason for termination. There was also no evidence the facility performed reference checks prior to her employment in April 2020. The "Telephone Reference Check" form was undated and had a line drawn across the form. During an interview, on 03/04/21 at 4:55 p.m., the Executive Director (ED) indicated she did could not find reference checks for LPN 17 and did not know why the reference check form was not completed. A current facility policy, titled "Investigating Elder [Resident] Abuse and Neglect," dated 2016 and provided by the ED on 03/05/21, indicated "...1. In the event an incident that meets or has potential to meet one of the definitions stated in			

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	the policy on abuse or neglect of an elder is reported to an executive director or designee, an investigation of the incident will be commenced immediately...13. Within five days of the incident, the executive director or designee will review the information from the investigation and prepare a written report that will include the following: a. A list of findings. b. Summary of conclusions of the investigation...15. The abuse, neglect and misappropriation of elder property investigation form will be completed by the executive director or designee and filed with the written report found in item 13 of the executive director's office...." A current facility policy, titled "Preventing Elder Abuse, Neglect and Misappropriation of Elder Property," dated 2016 and provided by the ED on 03/05/21, indicated "...Previous and current employers will be contacted for references prior to the decision to employ...." This Federal tag relates to complaints IN00336426, IN00336591, IN00337934, and IN00345639. 3.1-28(d)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.			

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	Based on observation, interview and record review, the facility failed to provide activities based on the comprehensive assessments and preferences for 3 of 3 residents reviewed for activities. (Residents G, L and U) Finding includes: 1. During an observation, in Cottage 3, on 03/01/21 at 3:50 p.m., Resident G was sitting in a recliner chair in the common lounge area. Resident G was picking at her clothing and staring out into the room. The television was turned on and tuned to the Cartoon Network. Four additional residents were sitting in the immediate area with their eyes closed. No other activity was observed in the room. A February 2021 Activity calendar was laying on a shelf in the dining room of the cottage. During an observation, on 03/02/21 at 10:20 a.m., Resident G was sitting in a reclining lounge chair, with the footrest up, in the common lounge area of Cottage 3. Six additional residents were sitting in the immediate area with their eyes closed. Resident G had her eyes closed but, using her index finger and thumb, was picking at her clothing and the material on the arm of the chair. The television was on and tuned to the Cartoon Channel. No other activities were observed in the area. The February 2021 Activity calendar remained on a shelf in the dining room of the cottage. During an observation, on 03/03/21 at 11:10 a.m., Resident G was sitting on a couch in the common lounge area in Cottage 3. Five additional residents were in the lounge area. Three residents had their eyes closed and the remaining two residents were looking around the room. Star Trek was playing on the television. Resident G was sitting on the	F 0679	F679 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. It is the practice of this provider to ensure that based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support elders in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each elder, encouraging both independence and interaction to the community, 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 elders have the potential to be affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. The Activity Director will supply any materials needed for the daily activity list on calendar. The Shabazz wilt be in serviced on Activity calendar. Any staff who fail to comply with the information delivered at the in-service will be further educated and/or progressively disciplined as	04/04/2021

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	edge of the couch and looked around the room but did not engage with the television or other residents sitting in the immediate area. No other activity was observed. The March 2021 Activity calendar, posted in the Cottage, indicated an activity of "Daily Chronicles" was scheduled for 11:00 a.m. on this date. During an observation, on 03/04/21 at 10:00 a.m., Resident G was sitting in a recliner chair in the common lounge area of Cottage 3. Five additional residents, sitting in wheelchairs and upholstered chairs, were in the immediate area. One additional resident was sleeping on a sofa. The television was turned on and an unknown channel was playing. Resident G was awake and looking around the room. The resident was not observed to be engaged with the television or other residents. No other activity was observed. The March 2021 Activity calendar indicated a "Balloon Toss" was scheduled for 10:00 a.m. on this date. During an interview in Cottage 3, on 03/04/21 at 10:10 a.m., Certified Nurse Aide (CNA) 3 and CNA 4 indicated they were unaware they were responsible for conducting activities in the cottages. When questioned regarding what kind of activity "daily chronicles" was, CNA 3 and CNA 4 both indicated they did not know. During an observation, on 03/05/21 at 10:01 a.m., Resident G was sitting in an upholstered armchair in the common lounge area in Cottage 3 with a lap blanket draped over her legs. The resident picked up the blanket and turned it over and over in her hands, investigating the seams and corners. CNA 14 walked over to Resident G and attempted to take the blanket out of her hands. Resident G swatted at the CNA's hands preventing her from taking the blanket.		indicated. Activities education will be emphasized during new hire orientation for all 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; and This deficient finding will be monitored by the life enrichment director through observation, interview, and audit tools. An Activity monitoring tool will be utilized weekly x 2 months then, monthly x 4 months. The results of the audit will be reviewed at the monthly QA meet. Any concerns will have been addressed upon discovery, The systemic changes will be completed. April 4, 2021	

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	The record for Resident G was reviewed on 03/02/21 at 3:30 p.m. Diagnoses included, but were not limited to, Alzheimer's Disease, bipolar disorder and glaucoma. The resident's MDS (Minimum Data Set) assessment, dated 2/12/21, indicated the resident was "severely impaired" in cognitive skills of daily decision making. Resident G's plan of care, dated 2/12/21, identified the problem of "...dependent on staff...for meeting emotional, intellectual, physical and social needs...." The goal for this identified problem was "...will attend/participate passively or actively in group actively 3-5 times weekly." Interventions included, but were not limited to, "...Elder benefits from working with her hands...." Progress notes in the clinical record indicated the following: "02/04/21...enjoyed visiting with daughter this morning in person. Elder also played with her fidget apron...." "02/11/21...Elder had an in person visit with a family member this morning. Elder enjoyed feeling her fidget lap apron...." "02/18/21...Elder enjoyed feeling her sensory apron while visiting with her daughter this morning for an in person visit...." During an interview, on 03/05/21 at 10:01 a.m., CNA 14 indicated she did not know the resident had an activity apron but indicated the resident "likes to fidget with her hands." Upon request, the CNA went to Resident G's room and searched the			

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GREEN HOUSE COTTAGES OF CARMEL	616 GREEN HOUSE WAY CARMEL, IN 46032

(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
	closet and dresser for an activity apron without success. When questioned regarding activities in Cottage 3, CNA 14 indicated the Activity Director "does it." The CNA indicated she was unaware she was responsible for conducting activities in the cottage. 2. During an observation in Cottage 3, on 03/01/21 at 3:50 p.m., Resident U was laying on the sofa with eyes closed in the common lounge area. Four additional residents were in the immediate area and the television was turned on to the Cartoon Channel. The February 2021 Activity calendar was laying on a shelf in the dining room. During an observation, on 03/02/21 at 10:20 a.m., Resident U was in Cottage 3, sitting on the sofa, at times rocking back and forth, with her hands folded in front of her in a praying position. Her eyes were closed. Six additional residents were sitting in the immediate area with their eyes closed. The television was on the Cartoon Channel. No other activities were observed in the area and the February 2021 calendar remained on the shelf in the dining room of the cottage. During an observation in Cottage 3, on 03/03/21 at 11:10 a.m., Resident U was sitting on the sofa in the common lounge area. The television was turned on and Star Trek was playing. Five additional residents were sitting in the immediate area. Resident U was not observed to be engaged with the television or other residents in the immediate area. A March 2021 Activity calendar, now posted for Cottage 3, indicated "Daily Chronicles" was scheduled at 11:00 a.m. During an observation, on 03/04/21 at 10:00 a.m. in Cottage 3, Resident U was laying on the sofa with her eyes closed. The resident was dressed in			

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	street clothing and covered by a blanket. Six additional residents were sitting the common lounge area. Three of the residents had their eyes closed. The television was on and was playing the Animal Channel. The March 2021 Activity calendar indicated "Balloon Toss" was scheduled for 10:00 a.m. on this date. No activities were observed at this time. During observation in Cottage 3, on 03/05/21 at 10:12 a.m., Resident U was laying diagonally across her bed with eyes closed. The March 2021 Activity calendar indicated "Exercise and Stretch" was scheduled at 10:00 a.m. on this date. The record for Resident U was reviewed on 03/04/21 at 2:00 p.m. Diagnoses included, but were not limited to, Alzheimer's Disease, dementia, mood disorder, anxiety disorder and major depressive disorder. The resident's MDS assessment, dated 01/21/21, indicated the resident had severely impaired cognitive skills for daily decision making. Resident U's plan of care, dated 01/21/21, contained an identified problem "...needs staff assistance in order to divert energy and attention...." The goal for this problem indicated "...will be able to participate in a variety of activities that interests me for 30 minutes each day 7 times a week..." Interventions included, but were not limited to, "...Divert attention by offering different activities the elder enjoys such as arts and crafts, puzzles and games. Offer safe props materials that might be associated with days-end activities such as setting the table, folding clothes or household chores. Provide opportunities elder to work with her hands such as sorting, matching games, puzzles, folding laundry, or simple			

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	household chores...." The plan of care identified an additional problem of "...dependent on staff...for meeting emotional, intellectual, physical, and social needs r/t [related to] dementia. I enjoy individual and group activities but requite invitation from staff to participate." A goal for this identified problem indicated "...will attend/participate in activities of choice 3-5 times weekly." Interventions included, but were not limited to, "...enjoys arts and crafts, games and puzzles...Provide a program of activities that is of interest and empowers the elder by encouraging/allowing choice, self-expression and responsibility...." 3. During an observation in Cottage 4, on 03/02/21 at 11:00 a.m., Resident L was laying in the recliner with the foot raised, in the common lounge area. The resident's eyes were closed and the resident was covered with a blanket. Two additional, unidentified residents, also with eyes closed, were sitting in wheelchairs in the immediate area. The television was on with the Animal Channel playing. An Activity calendar, for the month of February 2021 was laying on a shelf above the fireplace. During an observation, on 03/04/21 at 10:25 a.m. in Cottage 4, Resident L was lying in a recliner with the foot up and the resident's eyes were closed. Two additional residents, with eyes closed, were sitting in wheelchairs in the lounge area. The television was turned on and tuned to the Animal Channel. The March 2021 calendar was observed to be laying on a shelf in the lounge area. According to the schedule for 03/04/21, a "Balloon Toss" was scheduled at 10:00 a.m. and "Daily Chronicles" were scheduled for 11:00 a.m. CNA 8 and CNA 9, present in the lounge area, on			

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	03/04/21 at 10:30 a.m., were interviewed regarding activities in Cottage 4. Both CNAs indicated they were unaware they were responsible for resident activities in the cottage and neither CNA could explain what "Daily Chronicles" was. The record for Resident L was reviewed on 03/03/21 at 3:00 p.m. Diagnoses included, but were not limited to, Alzheimer's Disease, dementia, psychotic disorder with delusions, anxiety disorder and major depressive disorder. The resident's MDS assessment, dated 12/07/20, indicated the resident had a BIMS (Brief Interview for Mental Status Assessment) score of "3", indicating the resident had severely impaired cognitive skills. Resident L's plan of care contained an identified problem of "...dependent on staff to meet my social, emotional, intellectual, and physical needs r/t dementia and I require encouragement to participate in activities with set up assistance...." with a goal of "...will participate in activities of choice 3-5 times a week..." Interventions included, but were not limited to, "...Assist elder with set up of individual activities or activities in a group setting. Escort elder to and from activity functions...enjoys the following television Shows: Wheel of Fortune, Let's Make a Deal, Price is Right and Judge Judy...previously enjoy [sic] playing card game [sic] such as euchre and Gin Rummy. Elder enjoys Yahtzee...Encourage activity participation and invite elder to scheduled activities...." During interview, on 03/02/21 at 3:15 p.m., the Life Enrichment Director (LED) indicated she scheduled the Activity calendar and delivered the calendar to the cottages, along with items required			

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	to conduct the activities. The LED indicated it was the responsibility of the CNA at each cottage to conduct daily activities for the residents. During an interview, on 03/05/21 at 3:00 p.m., the ED indicated it was the responsibility of the CNA in each cottage to conduct activities on the daily basis, according to the Activity calendar developed by the LED. The ED indicated performance of activities was reflected in the job description of each CNA and discussed at the time of their employment. A current facility polity, titled "Life Enrichment Policy," dated 2016 and received from the Executive Director (ED) on 03/04/21 at 3:00 p.m., indicated "...The goal of the Life Enrichment Programs is to find ways to assist each elder to continue to experience personal growth and to maintain those activities that give them pleasure now and in the past. Enhancing the lives of elders is integral to the mission of this community...." The job description of the CNA was requested and received from the ED on 3/4/21 at 12:25 p.m. The job description indicated "Essential Functions" of the CNAs included the following: "1. Provides quality nursing care to elders in an environment that promotes their rights, dignity, freedom of choice and individuality as illustrated by the following: a. Provides individualized attention, which encourages each elder's ability to maintain or attain the highest practical, physical, mental and psychosocial well-being... p. Provides and initiates activities and functions for elder's psycho-social well-being...." This Federal tag relates to Complaints IN00343992, IN00346532 and IN00348218.			

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	3.1-33(c)			
F 0692 SS=D 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 interview and record review, the facility failed to ensure a resident receiving nutrition by a feeding tube maintained acceptable parameters of nutritional status when the facility failed to weigh the resident as ordered and to accurately document nutrition intakes for 1 of 2 residents reviewed for nutrition. (Resident P) Finding includes: The record for Resident P was reviewed on 03/04/21 at 12:50 p.m. Diagnoses included, but were not limited to, ataxia (loss of full control of	F 0692	F 692 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident P had no significant weight changes in 30/90/180 days. Her weights and feeding order were reviewed and updated as needed. How other residents having the potential to be affected by the	04/04/2021

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	bodily movement), dysphagia (difficulty swallowing), aphasia (inability to understand or express speech), dementia, Vitamin B and D deficiencies and heart disease. Resident P's physician order, dated 10/19/17 and active through 01/13/21, indicated "Monthly weight starting on the first and ending on the first of every month." Resident P's weight records reflected the following: On 07/01/20, she weighed 133.2 lbs (pounds). On 08/01/20, she weighed 132.2 lbs On 09/01/20, she weighed 132.2 lbs. On 10/01/21, she weighed 129.8 lbs. On 11/05/20, she weighed 135.6 lbs. No weight was recorded in December 2020. On 01/03/21, she weighed 113.6 lbs. Resident P's weight record documented her weight on 01/03/21 represented a 14.7 percent, 19.6 lb weight loss over 180 days (since 07/01/20); and a 16.2 percent, 22 lb weight loss since her last weight on 11/05/20. Resident P's Health Status Note, dated 01/02/21, indicated the assessment on 01/02/21 was based on the resident's weight on 11/05/20 and did not identify the resident was not weighed in December 2020. "...Resident most recent weight of 136# [pounds] which indicates no significant weight changes x [in] 30/90/180 days. Resident UBW [usual body weight] ~ [is approximately]130s#. Resident continues on hospice caseload. Resident is NPO [nothing by mouth] and receives Osmolite 1.2 250 ml [milliliters] 5x per day to provide 1500 kcal [calories], 69 grams protein, 1026 ml free water,		same deficient practice will be identified and what corrective action(s) will be taken. All Residents receiving nutrition by a feeding tube have the potential to be affected. What measures will be put into place and what systemic changes will be made to ensure that the Deficient practice does not recur; Nurses will be in-serviced on ensuring the monthly weights are done and documented and that the weights are used to maintain acceptable parameters of nutrition for resident receiving nutrition by a feeding tube. 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; DON/designee will monitor/audit weekly and monthly weights to ensure they are being done and documented for no less than 6 months. The results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based upon the results of audits. Compliance Date: April 4, 2021	

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	and 850 ml flush (85 ml flush before and after each tube feeding). Resident needs 1342-1708 kcal, 49-61 g [grams] protein, 1342 ml fluid. Resident receives total of 1875 ml fluid which is adequate to meet needs. Resident with no new labs. Needs are met through feeding at this time. No new recommendations. Will continue to monitor...." A continued review of Resident P's progress notes indicated the weight loss was not identified and interventions were not put in place to prevent further weight loss until 01/13/21. Resident P's Registered Dietician Note, dated 01/13/21, indicated "...Elder [Resident] triggering for 15.2% loss x 180 days. Elder receives Osmolite 1.2 250 ml 5x per day. Elder previously had not triggered for weight loss this last month...Resident needs increased due to needing weight gain at this time; 1530-1785 kcal, 51-62 grams of protein, 1530 ml. Recommend d/c [discontinue] current tube feeding, d/c Isosource- start Osmolite 1.5 @ 65 ml/hr [milliliters per hour] x 18 hours to provide 1755 ml, 73 grams of protein, and 892 ml free water...Overnight feeding to provide consistent feeding, increased calories, and adequate nutrition to promote weight gain...." Resident P's quarterly Minimum Data Set (MDS) assessment, dated 01/06/21, documented she had severe cognitive impairment, required total dependence by one staff person for nourishment intake, received nutrition by a feeding tube, was 67 inches tall, and weighed 113 pounds. The MDS did not identify the resident lost 5 percent or more of her weight in the last month. During an interview, on 03/04/21 at 3:28 p.m., the MDS Coordinator indicated it was her signature on 01/12/21 in Section K (Swallowing/Nutrition			

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	Status) of Resident P's MDS reflecting no weight loss. The documented Assessment Reference Date (ARD) on the assessment, on 01/06/21, which would have been three days after she was weighed on 01/03/21. The MDS should have reflected the weight loss from 135.6 on 11/05/20 to 113.6 on 01/03/21. Had they correctly documented the weight loss in Section K of the MDS, it would have triggered a care plan for actual weight loss, rather than a risk for weight loss. Resident P's Care Plan, updated on 11/21/18, indicated "...I had a Peg tube placed [percutaneous endoscopic gastrostomy, feeding tube placed into the stomach]. I have a swallowing problem r/t [related to] dysphagia...I have the potential for unintentional weight loss r/t DX [related to diagnosis] of depression and anxiety...I am receiving 100% of my nutrition via enteral nutrition [tube feeding]...." Interventions included, but were not limited to, "...Administer my artificial nutrition support as ordered...Monitor weights as ordered." The care plan was not updated to reflect the resident had experienced actual weight loss. Resident P's electronic Medication and Treatment administration records (MAR and TAR), for 12/01/20 through 12/31/20, reflected the following: From 12/01/20 to 12/06/20, the nurses documented on an order, dated 09/06/20 and discontinued on 12/06/20, "Enteral Feed Order four times a day...Isosource 1.5 cal is delivered...." The TAR did not reflect how many milliliters were given with each administration. From 12/24/20 to 12/31/20, the nurses documented on an order, dated 12/17/20 through 12/24/20, they administered 250 ml of Isosource 1.5 cal four times			

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	a day at 8:00 a.m., 1:00 p.m., 4:00 p.m. and 9:00 p.m., except for 4:00 p.m. on 12/29/20 to 4:00 p.m. on 12/30/20. Resident P's Health Status Report, dated 12/29/20 at 5:20 p.m., documented the resident's feeding tube was dislodged and the resident was sent to the hospital. A Health Status Report, dated 12/31/20 at 3:24 p.m., documented the resident returned to the facility. During the same dates as the previous order for tube feedings four times a day, 12/24/20 through 12/31/20, the nurses also documented they administered 250 ml of Osmolite 1.2 five times a day at 8:00 a.m., 11:00 a.m., 2:00 p.m., 5:00 p.m., and 9:00 p.m., including on 12/29/20 to 12/30/20 when the resident was not in the facility. During an interview, on 03/04/21 at 3:10 p.m., the Registered Dietitian (RD) indicated she was not the RD during the time of Resident P's weight loss in December 2020. There was no difference between Isosource and Osmolite feeding solution other than they were different brand names. The December 2020 TAR documented Resident P received nine feedings a day from 12/24/20 to 12/31/20 because her tube feedings were documented on two orders: one for Isosource four times day and one for Osmolite five times a day "until Isosource is delivered." That would never have been done. It was an error in documentation. The RD could not tell how much nutrition the resident received in December 2020. During the same interview, on 03/04/21 at 3:10 a.m., the RD indicated after Resident P's weight loss in December 2020, the RD calculated Resident P's caloric needs based on the goal to gain weight. Based on her weight, etc., she required 25-30			

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	kcal/kg for weight maintenance and 30-35 kcal/kg for weight gain. They changed her Osmolite solution to 65 ml/hr over 6 hours to provide 30-35 kcal/kg for weight gain. The RD also consulted with the Nurse Practitioner (NP) because the resident was previously on bolus feedings (intermittent) and was losing weight. The NP and RD agreed to try continuous. The resident has tolerated it well and had gained weight. The resident was currently weighed weekly to monitor her weight gain. The resident did not have skin breakdown. No laboratory studies were ordered because the resident was on Hospice and Hospice services limited laboratory studies. Resident P's most recently documented weight, dated 03/01/21, was 119.8 pounds. A current facility policy, titled "Weighing of Elders," dated 01/05/21 and provided by the Executive Director on 03/05/21, indicated "...Policy: Elders are weighed per physician orders. Procedure: 1. Follow Physician Order for scheduled weighing of Elder or monthly...." This Federal tag relates to Complaint IN00348744 and IN00348218. 3.1-46(a)(1)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of			

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	licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation, interview and record review, the facility failed to post the nurse staffing data in 5 of 5 resident-occupied cottages (Cottages 1 through 5). Finding includes: During an observation, on 03/04/21 at 11:45 a.m., a white board in the library of Cottage 1 contained the nurse staffing data for 08/27/20. Continued	F 0732	**F 732** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The nurse staffing data was posted in all 5 Cottages. **How other residents having the potential to be affected by the**	04/04/2021

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	observations, on 03/04/21 from 11:47 to 11:53 a.m., revealed the white boards in the libraries of Cottages 2, 4, and 5 containing the nurse staffing data were dated 08/27/20. The whiteboard in the library of Cottage 3 describing the nurse staffing data was dated 08/26/20. Cottage 6 was unoccupied. During an interview, on 03/04/21 at 12:10 p.m., in Cottage 5, the Executive Director (ED) indicated there was no other posting of nurse staffing data in Cottage 5 other than the one posted in the library, dated 08/27/20. In-house visits were being conducted in the cottage libraries. Because there was no common entrance to the community, and residents/family members entered the facility at individual cottages, the nurse staffing data was expected to be posted in the libraries of each individual cottage. The postings should be updated daily for the residents and their families to see. It was the responsibility of the Staffing Coordinator to update the postings daily. During an interview, on 03/05/21 at 3:34 p.m., the Staffing Coordinator indicated she started working at the facility in November 2020. She was not aware her job responsibilities included updating the postings of the nurse staffing data until it was explained to her today. A current facility policy, titled "Posting Household Staffing Form," dated 2016 and provided by the ED on 03/05/21, indicated "...Policy: The team member will ensure that the number of registered nurses, licensed practical nurses and Shahbazim [certified nurse aides] scheduled for each day is posted at the entrance to the community. Procedure: 1. At the end of each shift the director of nursing or designee will calculate the number of full time equivalent (FTE)		**same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the Deficient practice does not recur;** In-serviced the staffing coordinator on ensuring the daily staffing data is posted in all 5 Cottages. **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;** SDC/designee will audit each Cottage 5 days a week x 4 weeks, then 4 days a week x 2 months, then 3 days a week for 3 months. The results of the audit will be reviewed at the monthly quality assurance meeting. The QAPI program will review, update, and make changes as needed for sustaining substantial compliance for no less than 6 months. **Compliance Date:** April 4, 2021	

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	155846	A. BUILDING 00 B. WING	03/05/2021

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	for the following types of nursing team members that provided direct care to elders on that shift. A. Registered Nurses, B. Licensed Practical Nurses, ac. Shahbazim. 2. The calculated FTE will be recorded on daily nurse staffing form required by the Federal government ...4. The form will be posted at the main entrances to the community and be accessible to elders [residents], family members and others in the public...." This Federal tag relates to Complaints IN00336426, IN00336591, IN00343992, IN00344146, IN00346532, IN00348218, and IN00348726.			
F 0759 SS=E Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5 percent based on medication errors observed during 5 of 36 opportunities for errors during random medication administration observations, resulting in a medication error rate of 13.8 percent (Residents D and Q). Finding includes: 1. During a random medication administration observation, on 03/02/21 at 8:01 a.m., Licensed Practical Nurse (LPN) 5 administered 14 pills to Resident D. She did not administer a 500-200 milligram (mg) tablet of Calcium and Vitamin D. Resident D's record was reviewed on 03/02/21 at 2:22 p.m. Diagnoses included, but were not limited	F 0759	F 759 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. There were no negative outcomes for residents D and Q. The two staff members were educated. **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 elders have the potential to be affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	04/04/2021

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	to, vitamin D deficiency and age-related osteoporosis. Resident D's quarterly Minimum Data Set (MDS) assessment, dated 01/25/21, reflected the resident had a moderate cognitive impairment. Resident D's physician's order, dated 04/24/19, indicated Calcium 500+D Tablet 500-200 mg unit (Calcium Carb-Cholecalciferol). Give 1 tablet by mouth in the morning related to age-related osteoporosis without current pathological fracture. It was scheduled to be administered "upon rising." During an interview, on 03/02/21 at 3:23 p.m., LPN 5 indicated she did not give the Calcium 500+D tablet to Resident D and the medication was not in her medication cart for Resident D. 2. During a random medication administration observation, on 03/02/21 at 8:41 a.m., Qualified Medication Aide (QMA) 10 administered 14 pills to Resident Q. She did not administer two 500 mg tablets of Acetaminophen, one 5 mg tablet of Linagliptin (anti-diabetic medication) and administered only one 4 mg tablet of Glimepiride (anti-diabetic medication). During an interview, on 03/02/21 at 8:41 a.m., QMA 10 indicated she was administering one 4 mg tablet of Glimepiride to Resident Q. Resident Q's record was reviewed on 03/02/21 at 2:34 p.m. Diagnoses included, but were not limited to, chronic pain and type 2 diabetes mellitus with diabetic polyneuropathy (damage to multiple nerves) and kidney damage. Resident Q's quarterly MDS assessment, dated		**practice does not recur.** In-service nursing staff on policy and procedure on medication pass. **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; and** DON/designee will monitor med passes on 5 Elders by observation using an audit tool 5 days a week x 4 weeks, then weekly x 4 weeks, then monthly x 4 months. The results of the audit will be reviewed at the monthly Q A meet. Any concerns will have been addressed upon discovery. The systemic changes will be completed. April 4, 2021	

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	01/08/21, reflected she was cognitively intact. Resident Q's physician's order, dated 10/19/20, indicated Acetaminophen Tablet 500 mg. Give 2 tablets by mouth three times a day related to other chronic pain. It was scheduled to be administered at 8:00 a.m., 2:00 p.m. and 8:00 p.m. Resident Q's physician's order, dated 08/10/20, indicated Linagliptin tablet 5 mg. Give 1 tablet by mouth in the morning for diabetes related to type 2 diabetes mellitus with diabetic polyneuropathy. It was scheduled to be administered "upon rising." Resident Q's physician's order, dated 12/30/19, indicated Glimepiride tablet 4 mg. Give 2 tablets by mouth one time a day for type 2 diabetes mellitus with diabetic polyneuropathy. It was scheduled to be administered at 9:00 a.m. During an interview, on 03/02/21 at 8:34 a.m., QMA 10 indicated she did not have Resident Q's Acetaminophen because it was not in her medication cart to administer. She would let Resident Q's nurse, LPN 16, know the resident did not have her Acetaminophen. During an interview, on 03/02/21 at 3:51 p.m., with QMA 10, LPN 16 and the Director of Nurses (DON), QMA 10 indicated she did not give Resident Q her morning Acetaminophen on 03/02/21. LPN 16 indicated QMA 10 did not tell her Resident Q did not have Acetaminophen and LPN 16 did not administer it. The DON indicated the medication should have been pulled from the Emergency Drug Kit and administered to the resident until the medication arrived from the pharmacy.			

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	During an interview, on 03/02/21 at 4:00 p.m., with QMA 10 and the DON, QMA 10 indicated she did not administer Linagliptin to Resident Q because the resident did not have Linagliptin in her medication cart to administer to Resident Q. The DON indicated they would need to call the physician to let him know the resident missed a dose. During an interview, on 03/03/21 at 9:15 a.m., the Executive Director (ED) and DON indicated Resident Q's Linagliptin and Acetaminophen should have been administered on the morning of 03/02/21. They were not administered, even though QMA 10 charted she gave it. Resident Q's most recent glycated hemoglobin level (Glyco-HGBA1C, diagnostic test for long-term management of diabetes), dated 07/23/20, was 8.2 percent, with a reference range of 4.1 to 6.1 percent. Her mean glucose (eaG) was 189 milligrams per deciliter (mg/dl), with a reference range of 70 to 120 mg/dl. 3. During an interview, on 03/02/21 at 9:40 a.m., LPN 16 indicated Resident Q's blood glucose level at 8:00 a.m., before breakfast, was 214 mg/dl. The LPN was not able to administer the insulin before breakfast because she had to go to another Cottage to administer insulin and the resident ate breakfast earlier than she usually did. By the time the LPN returned from the other cottage, Resident Q had already eating breakfast. She did not want to administer the insulin at the common dining table where Resident Q was at breakfast because it would not be private, so she was waiting for the resident to return to her room. The LPN indicated she would recheck Resident Q's blood sugar when the resident returned to her room because the resident had eaten.			

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	During an observation, on 03/02/21 at 9:40 a.m., LPN 16 checked Resident Q's blood sugar and indicated it was 372 mg/dl. Using a Lisbro KwikPen (pre-filled insulin injection device), the LPN rechecked the resident's orders, primed the pen with 2 units of insulin, and then dialed the dosage to 36 units. LPN 16 indicated the resident's dose was 26 units plus 10 units based on sliding scale orders. During the continued observation, on 03/02/21 at 10:00 a.m., LPN 16 walked into Resident Q's room and indicated she was administering 36 units of Humalog insulin based on the resident's blood sugar of 372 mg/dl. This writer suggested she contact her DON before administering the medication. During an interview, on 03/02/21 at 10:03 a.m., the DON indicated to LPN 16 she should not give the insulin to Resident Q based on the blood sugar of 372 because it will "bottom her out." The order was in anticipation the resident will eat after receiving the insulin, but she had already eaten. The insulin should be administered based on the pre-meal blood sugar of 214 mg/dl, 30 units. Resident Q's physician's order, dated 01/10/20, indicated "Humalog Solution 100 unit/ml [milliliter] (Insulin Lispro). Inject 26 units subcutaneously [injected under the skin] before meals for diabetes related to type 2 diabetes mellitus with diabetic polyneuropathy." An additional physician's order, dated 05/16/18, indicated "Humalog Solution 100 unit/ml (Insulin Lispro). Inject as per sliding scale: if 151-200 = 2 units; 201-250 = 4 units; 251-300 = 6 units; 301-350 = 8 units; 351-400 = 10 units." Both orders were scheduled to be administered at 8:00 a.m., 12:00 noon, and 5:00 p.m.			

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	A current facility policy, titled "Administering Medication," dated December 2012 and received from the Executive Director on 03/03/21 at 3:40 p.m., indicated "...3. Medications will be administered in accordance with the orders, including any required time frame...." This Federal tag relates to Complaint IN00336426. 3.1-48(c)(1)			
F 0842 SS=E Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident			

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	representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and			

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	(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on observation, record review and interview, the facility failed to ensure medical records were complete and accurate for 1 of 2 residents receiving nutrition by feeding tube (Resident P) and 2 of 8 residents reviewed for medication administration (Residents Q and B). Finding includes: 1. Resident P's medical record was reviewed on 03/04/21 at 12:50 p.m. Diagnoses included, but were not limited to, ataxia (loss of full control of bodily movement), dysphagia (difficulty swallowing), aphasia (inability to understand or express speech), dementia, Vitamin B and D deficiencies and heart disease. Resident P's quarterly Minimum Data Set (MDS) assessment, dated 01/06/21, documented she had severe cognitive impairment, required total dependence by one staff person for nourishment intake, received nutrition by a feeding tube, was 67 inches tall and weighed 113 pounds. Resident P's Care Plan, updated on 11/21/18, indicated "...I had a Peg tube placed [percutaneous endoscopic gastrostomy, feeding tube placed into the stomach]. I have a swallowing problem r/t [related to] dysphagia...I have the potential for unintentional weight loss r/t DX [related to diagnosis] of depression and anxiety...I am receiving 100% of my nutrition via enteral nutrition [tube feeding]...." Interventions included, but were not limited to, administer the artificial nutrition support as ordered. Resident P's electronic Medication and Treatment administration records (MAR and TAR), for	F 0842	F 842 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident P's chart was audited correction made as needed. The 2 staff member passing medication to Resident B and Q was educated. **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 elders have the potential to be affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** In-service nursing staff on when they pass medication if there are duplicate order notify nursing management for clarification, but do not sign both orders. Give you give a medication you are to sign off, do not sign off any medication you did not give, sign the medication off as per our policy. **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; and**	04/05/2021

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	12/01/20 through 12/31/20, reflected the following: From 12/01/20 to 12/06/20, the nurses documented on an order dated 09/06/20 and discontinued on 12/06/20, "Enteral Feed Order four times a day...Isosource 1.5 cal is delivered." The TAR did not reflect how many milliliters were given with each administration. From 12/24/20 to 12/31/20, the nurses documented on an order dated 12/17/20 through 12/24/20, they administered 250 ml of Isosource 1.5 cal four times a day at 8:00 a.m., 1:00 p.m., 4:00 p.m. and 9:00 p.m., except for 4:00 p.m. on 12/29/20 to 4:00 p.m. on 12/30/20 at 4:00 p.m. Resident P's Health Status Report, dated 12/29/20 at 5:20 p.m., documented the resident's feeding tube was dislodged and the resident was sent to the hospital. A Health Status Report, dated 12/31/20 at 3:24 p.m., documented the resident returned to the facility. During the same dates as the previous order for tube feedings four times a day, 12/24/20 through 12/31/20, the nurses also documented they administered 250 ml of Osmolite 1.2 five times a day at 8:00 a.m., 11:00 a.m., 2:00 p.m., 5:00 p.m., and 9:00 p.m., including on 12/29/20 to 12/30/20 when the resident was not in the facility. During an interview, on 03/04/21 at 3:10 p.m., the Registered Dietitian (RD) indicated there was no difference between Isosource and Osmolite feeding solution other than they were different brand names. The December 2020 TAR documented Resident P received nine feedings a day from 12/24/20 to 12/31/20 because her tube feedings were documented on two orders: one for Isosource four times day and one for Osmolite		All resident receiving nutrition by feeding tubes charts will be audited and corrected as needed. DON/designee will monitor med passes 5 days a week x 4 weeks, then weekly x 4 weeks, then monthly x 4 months. The results of the audit will be reviewed at the monthly Q A meet. Any concerns will have been addressed upon discovery; the systemic changes will be completed. **Compliance Date:** April 4, 2021	

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	five times a day "until Isosource is delivered." That would never have been done. It was an error in documentation. The RD could not tell how much nutrition the nurses administered to Resident P in December 2020. 2. During a random medication administration observation, on 03/02/21 at 8:41 a.m., Qualified Medication Aide (QMA) 10 administered 14 pills to Resident Q. She did not administer 2, 500 mg tablets of Acetaminophen; and did not administer 1, 5 mg tablet of Linagliptin (anti-diabetic medication). Resident Q's record was reviewed on 03/02/21 at 2:34 p.m. Diagnoses included, but were not limited to, chronic pain, hypertension (high blood pressure), seasonal allergic rhinitis, macular degeneration (blurred vision in the center of the visual field), and type 2 diabetes mellitus with diabetic polyneuropathy (damage to multiple nerves) and kidney damage. Resident Q's quarterly MDS assessment, dated 01/08/21, reflected she was cognitively intact. Resident Q's physician's order, dated 10/19/20, indicated "Acetaminophen Tablet 500 mg [milligrams]. Give 2 tablets by mouth three times a day related to other chronic pain." It was scheduled to be administered at 8:00 a.m., 2:00 p.m. and 8:00 p.m. Resident Q's physician's order, dated 08/10/20, indicated "Linagliptin tablet 5 mg. Give 1 tablet by mouth in the morning for diabetes related to type 2 diabetes mellitus with diabetic polyneuropathy." It was scheduled to be administered "upon rising."			

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	During an interview, on 03/02/21 at 8:34 am., QMA 10 indicated she did not have Resident Q's Acetaminophen because it was not in her medication cart to administer. She would let Resident Q's nurse, Licensed Practical Nurse (LPN) 16, know the resident did not have her Acetaminophen and document it was in transit from pharmacy. Resident Q's March 2021 MAR was reviewed on 03/02/21 at 2:35 p.m. QMA 10's initials with a checkmark at the dose due on 03/02/21 at 8:00 a.m. for the resident's two 500 mg tablets of acetaminophen was documented. The grid "Chart Code" reflected: "checkmark = administered." QMA 10's initials were also documented with a checkmark for the resident's 5 mg table of Linagliptin due on 03/02/21 "upon rising." During an interview, on 03/02/21 at 3:51 p.m., with QMA 10, LPN 16 and the Director of Nurses (DON), QMA 10 indicated she did not give Resident Q her morning Acetaminophen on 03/02/21. QMA 10 denied she documented giving the pill because she would not have documented the medication was in transit from pharmacy and documented she administered it. During an interview, on 03/02/21 at 4:00 p.m., with QMA 10 and the DON, QMA 10 indicated she did not administer Linagliptin to Resident Q because the resident did not have Linagliptin in her medication cart to administer to Resident Q. She indicated she did not document she administered the medication. During an interview, on 03/03/21 at 9:15 a.m., the Executive Director (ED) and DON indicated Resident Q's Linagliptin and Acetaminophen should have been administered on the morning of			

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	155846	A. BUILDING 00 B. WING	03/05/2021

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	03/02/21. They were not administered, even though documentation reflected QMA 10 charted she gave it. During a random medication administration observation, on 03/02/21 at 8:41 a.m., Qualified Medication Aide (QMA) 10 administered one 25 mg tablet of carvedilol (Coreg, beta-blocker used to treat high blood pressure). She was not observed to take the resident's blood pressure. Resident Q's physician order, dated 06/08/18, indicated "Carvedilol tablet 25 mg, give 1 tablet by mouth two times a day for hypertension related to essential (primary) hypertension. Hold and notify MD [physician] for systolic BP [blood pressure] 100 or less." Resident Q's March 2021 MAR was reviewed on 03/02/21 at 2:35 p.m. It reflected LPN 16's initials with a checkmark at the 25 mg dose of carvedilol due on 03/02/21 "upon rising" and the resident's blood pressure was taken at that time. During an interview, on 03/03/21 at 9:15 a.m., the Executive Director (ED) and Director of Nursing (DON) indicated QMA 10 failed to document giving the carvedilol when she administered it, at 8:40 a.m. on 03/02/21. LPN 16 only took Resident Q's blood pressure and heart rate for the carvedilol at 10:53 a.m. on 03/02/21. She did not administer the medication. It appeared as if LPN 16 administered it because the system assumed whoever took the blood pressure also administered the medication and provided only one place to document both. Since QMA 10 had not documented administering the medication, it appeared as if LPN 16 administered it when she documented the vital signs.			

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	During a random medication administration observation, on 03/02/21 at 8:59 a.m., QMA 10 prepared to administer carboxymethylcellulose sodium (artificial tears) eye drops and fluticasone propionate (corticosteroid to relieve allergy symptoms) nose spray to Resident Q. Resident Q was sitting at the common dining table. The resident indicated she wanted to wait until she finished her breakfast before getting her eye drops and nose spray. QMA 10 returned the medications to the medication cart. During another random medication administration observation, on 03/02/21 at 9:40 a.m., LPN 16 administered one drop of carboxymethylcellulose sodium in each of Resident Q's eyes and one spray of fluticasone propionate 50 microgram (mcg) in each of Resident Q's nostrils. Resident Q's physician order, dated 03/12/20, indicated "Refresh Tears Solution (carboxymethylcellulose sodium). Instill 1 drop in both eyes four times a day related to unspecified macular degeneration." Resident Q's physician order, dated 01/22/20, indicated "fluticasone propionate suspension 50 mcg/act. 1 spray in each nostril two times a day for congestion related to other seasonal allergic rhinitis." It was scheduled for 8:00 a.m. and 8:00 p.m. Resident Q's March 2021 MAR was reviewed on 03/02/21 at 2:35 p.m. It reflected QMA 10's initials with a checkmark for the administration of carboxymethylcellulose sodium eye drops dose "upon rising" and fluticasone propionate nose spray dose due at 8:00 a.m. on 03/02/21. During an interview, on 03/03/21 at 9:15 a.m., the			

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	ED and DON indicated Resident Q's fluticasone nose spray and eye drops were administered by LPN 16, but documented as given by QMA 10. QMA 10 had pulled the medications and documented she gave them but had to go to another cottage. QMA 10 asked LPN 16 to administer them. LPN 16 administered them but did not document on them because QMA 10 already did. However, LPN 16 could have and should have removed QMA 10's initials and documented she gave the medications. 3. Resident B's medical record was reviewed on 03/01/21 at 9:38 a.m. Diagnoses included, but were not limited to, bipolar disorder, hyperlipidemia (high cholesterol), heart disease, gastro-esophageal reflux disease (GERD) and hypothyroidism. The resident's admission summary note, dated 07/26/20, documented she arrived from the hospital at approximately 3:00 p.m. All medications were ordered from the pharmacy as STAT (immediate) orders except medications which could be found in the emergency drug kit. Resident B's admission MDS assessment, dated 08/02/21, documented she was cognitively intact. Resident B's MAR for 07/01/20 through 07/31/20, indicated orders for medications from a prior admission, with start dates from 05/06/20 and 05/07/20, were not discontinued until the day of or after her most recent admission on 07/26/20. There were blank areas on the MAR for 07/26/20 and 07/27/20, of the following medications, so it was not possible to audit whether the resident received duplicate doses or missed doses on 07/26/20 and 07/27/20.			

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	Resident B's hospital discharge orders, dated 07/26/26, indicated "Aspirin 81 oral delayed release tablet. 1 tab(s) [tablet] orally once a day (in the morning)." The area on Resident B's July 2020 MAR for the 8:00 a.m. dose on 07/27/20 was blank. Resident B's hospital discharge orders, dated 07/26/20, indicated "lamotrigine [used to treat bipolar disorder] 200 mg oral tablet, 0.5 mg tab(s) orally once a day (in the morning)." The area on Resident B's July 2020 MAR for the 9:00 a.m. dose on 07/27/20 was blank. Resident B's hospital discharge orders, dated 07/26/20, indicated "fenofibrate [to treat hyperlipidemia] 54 mg oral tablet. 1 tab(s) orally once a day (in the morning)." The area on the resident's July 2020 MAR for the morning dose of 07/27/20 was blank. Resident B's hospital discharge orders, dated 07/26/20, indicated "metroprolol succinate [used to treat high blood pressure] 25 mg oral tablet, extended release. 1 tablet orally once a day (in the morning)." The area on Resident B's July 2020 MAR for the 9:00 a.m. dose on 07/27/20 was blank. Resident B's hospital discharge orders, dated 07/26/20, indicated "pantoprazole [used to treat GERD] 40 mg oral delayed release tablet. 1 tab(s) orally once a day (in the morning)." The area on Resident B's July 2020 MAR for the 9:00 a.m. dose on 07/27/20 was blank. Resident B's hospital discharge orders, dated 07/26/20, indicated "Synthroid 0.1 mg oral tablet. 1 tab(s) orally once a day (in the morning.)" The area on Resident B's July 2020 MAR for the morning dose on 07/27/20 was blank.			

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	Resident B's hospital discharge orders, dated 07/26/20, indicated "quetiapine [used to treat bipolar disorder and anxiety] 50 mg oral tablet. 1 tab(s) orally once a day (at bedtime)." The area on Resident B's July 2020 MAR for the bedtime dose on 07/26/20 was blank. During an interview, on 03/04/21 at 9:50 a.m., the DON and Staff Development Coordinator (SDC) indicated they reviewed Resident B's orders and MARs. They determined Resident B was previously a resident at the facility from 05/06/20 to 06/20/21. It appeared the orders which were active when she discharged on 06/20/21 did not get discontinued, so they were active on the day of admission on 07/26/20. When a medication was held for any reason (e.g., not received from pharmacy, resident refused, etc.), the nurse should document it was held and why. An area on the MAR should not be blank. A current facility policy, titled "Administering Medication," received from the Executive Director on 03/03/21 at 3:40 p.m., indicated "...3. Medications will be administered in accordance with the orders, including any required time frame...18. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug dose. 19. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones...." This Federal tag relates to Complaints IN00336426 and IN00337934. 3.1-50(a)(1) 3.1-50(a)(2)			

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