STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00438092, IN00439247, IN00439634, IN00437908, IN00438994, and IN00438111. Complaint IN00438092 - Federal/state deficiencies related to the allegations are cited at F690 and F580. Complaint IN00439247 - No deficiencies related to the allegations are cited. Complaint IN00439634 - No deficiencies related to the allegations are cited. Complaint IN00437908 - No deficiencies related to the allegations are cited. Complaint IN00438994 - Federal/state deficiencies related to the allegations are cited at F657 and F842. Complaint IN00438111 - Federal/state deficiencies related to the allegations are cited at F578 and F684. Survey dates: July 30, 31, and August 1, 2024. Facility number: 012534 Provider number: 155792 AIM number: 201028420 Census Bed Type: SNF/NF: 118 SNF: 9 Total: 127 Census Payor Type:	F 0000	August 22, 2024 Ms. Brenda Buroker Director of Long Term Care 2 North Meridian St. Indianapolis, IN 46204 Re: Survey Event ID F7T711 Dear Ms. Buroker: Please find attached my Plan of Correction for the deficiencies cited during this Complaint Survey. I am respectfully requesting paper compliance. If you have any questions, please feel free to contact me. Sincerely, Karsen Rauch, HFA Administrator Countryside Meadows – Avon, IN.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karsen Rauch	HFA	08/22/2024

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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	Medicare: 6 Medicaid: 89 Other: 32 Total: 127 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 14, 2024.			
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that			

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	the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on interview and record review, the facility failed to ensure a resident, (Resident E) received treatments and services in accordance with his guardian's wishes. This deficient practice had the potential to effect 1 of 3 residents reviewed for quality of care. Findings include: During an interview on 8/1/24 at 12:11 p.m., Resident E's guardian indicated, she had received a call from Nurse Practitioner, (NP) on 6/14/24 who indicated, Resident E had not eaten or drank anything and had been sleeping more than usual. The guardian asked the NP, did she believe this change in his condition was related to the progression of his dementia, or could there be something else going on. The NP told the guardian, she did believe the decline was related to his dementia. The NP asked the family about changing his code status from a Full Code, too a Do-Not Resuscitate (DNR). Because the guardian lived out of state, she told the NP she wanted her brother to go visit Resident E first, before she made a decision about changing his code status,	F 0578	Plan of Correction **F578 Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident E's advanced directive was corrected and updated per Guardian's directive. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. ·A code status audit was	08/22/2024

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	however, during a care plan meeting on June 27th, the guardian was informed, her brother had been asked and signed a DNR POST form which the guardian had not agreed to. The guardian indicated, no one was authorized to sign off, and/or make treatment changing decision about Resident E's care except for her. The guardian indicated, she was upset to learn that her brother had been asked to sign the DNR, and that his overall treatment plan and goals had been changed to palliative care without her knowledge or consent. During an interview on 8/1/24 at 12:58 p.m., Resident E's son indicated, his sister was Resident E's guardian, but she lived out of state, so he was often asked to visit Resident E on her behalf to check on his condition. He indicated, there was some confusion on the part of the facility and Resident E's DNR was presented to him under the assumption that his dementia had gotten worse and that he was at the end of his life, "basically, he was getting ready to pass." Resident E's son indicated, the NP brough him a DNR form and said it was OK for him to sign it. Resident E's son indicated he regretted signing the form, because it was presented to him as already approved by the guardian. On 7/31/24 at 10:00 a.m., Resident E's medical record was reviewed. He was a long-term care resident who resided on the secured memory care unit with diagnoses which included, but were not limited to, Parkinson's disease a chronic, progressive brain disorder that affects the body's motor and non-motor systems) Alzheimer's disease (a degenerative brain disease which affects memory and cognition), Peripheral vascular disease (a		completed by Social Services on all residents to ensure code status matches their care plan and post form is in place and signed by the correct person. ·An in-service will be completed with social services staff to ensure they are confirming advanced directive forms are signed by the required/responsible party for each resident. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·Following audit and education, the social services team will stay diligent on ensuring any updated code status forms are signed by the responsible parties. **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 SSD/ED will be responsible for the completion of an Advanced Directives Audit Tool/Log. This log will be kept and updated upon a change in any resident's code status. This log will be kept for 6 months. The Advanced Directives Audit Tool/Log will be reviewed	

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	progressive disorder that occurs when blood vessels outside of the heart or brain narrow, block, or spasm) and Atherosclerosis (the thickening or hardening of the arteries caused by a buildup of plaque in the inner lining of an artery). Resident E had a physician's order to be a full code which had been initiated 3/28/24, but was discontinued on 6/19/24. A POST form dated 6/18/24, changed his code status from a full code to a DNR with comfort measures. The POST was signed by Resident E's son and the NP. A document titled, "Permanent Guardianship," dated 12/3/2020 indicated, " ...grated [name of Resident E's guardian] the authority to administer the permanent guardianship of the Person and Estate of [Resident E's name]. Said guardian shall have all of the authority of permanent guardianship under I.C. 29-3-7-3 ...." A Social Service care plan meeting and documentation progress note dated 6/17/24 at 10:29 a.m., indicated, Resident E had a legal guardian who requested the resident remain a full code. A NP progress note dated 6/18/24 at NP 1:43 p.m., indicated, Resident E was " ...seen today in f/u [follow up] for hypernatremia. Labs reviewed and sodium remains elevated at 155 and creatinine up to 2.0. He is resting in bed with SQ button in place. He previously discontinued his Midline. Daughter called to discuss resident declining condition with poor PO [by mouth] intakes and labs. Daughter states that her father was previously a DNR with comfort care. Son in		monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	building. Reviewed POST form and signed DNR comfort measures. Discussed declining condition with poor PO intakes. He has the same wishes as his sister. Both agree on palliative care with comfort focused care." The NP gave new orders at that time to DC the SQ button and added morphine (a narcotic pain medication) and lorazepam (an anti-anxiety medication) as needed. A nursing progress note dated 6/18/24 at 9:49 p.m., indicated, Resident E's son (an not his guardian) had been notified of the new orders to DC all labs, doppler, and was placed on palliative care with morphine and lorazepam as needed. Cross reference F684. This citation relates to Complaint IN00438111. 3.1-4(l)(4)			
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			

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	consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on interview and record review, the facility failed to ensure the family/representative for a resident, (Resident F) was notified of a change in condition related to an acute urinary tract infection (UTI) which resulted in urosepsis-associated acute kidney injury/failure, (SA-AKI) and had a systemic inflammatory	F 0580	Plan of Correction **F580 Notify Changes (Injury/Decline/Room, etc.)** **What corrective action(s) will be accomplished for those residents found to have been**	08/22/2024

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	response (SIRS) for 1 of 3 residents reviewed for quality of care. Findings include: During a confidential interview, it was indicated, Resident F's family member received a phone call on the day he passed away which was 5/31/24. The facility wanted to confirm Resident F's Do-Not-Resuscitate (DNR) orders because he had an infection and experienced a change in condition. The facility asked if the family member wanted Resident F to be sent to the hospital. The family member did want Resident F to be sent out and had been unaware that Resident F was being treated for an infection and that his condition had worsened so severely. Resident F had a history of infections and they could get bad fast. When the family member arrived to the facility, there was an ambulance at the door. When the family member got to Resident F's room, EMS and the facility nurse said there was nothing more they could do, and he took his last breaths moments after the family walked into the room. The family member indicated they were shocked and in denial that this had happened so quickly and did not understand why they had not been made aware of the infection in the first place. On 7/30/24 at 10:55 a.m., Resident F's medical record was reviewed. He was a long-term care resident with diagnoses which included, but were not limited to, history of a cerebral infarction (stroke, bleeding in the brain) which resulted in left side hemiplegia and hemiparesis, (similar conditions that cause weakness on one side of the body), Alzheimer's disease (a degenerative brain disease with affects memory and cognition) and he required the use of a suprapubic catheter (a surgically created connection between the		**affected by the deficient practice?** ·Resident F no longer resides at the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. ·An all-nursing staff in-service was completed on the necessity of family notification upon a resident change in condition. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·Following education, a Family Notification Audit Tool will be kept by DNS/Designee and will be completed in morning meeting daily for 4 weeks and weekly for 4 weeks after. ·The audit tool will be completed for the previous day to ensure the family/responsible party was notified of any changes of condition and a progress note was placed in the resident's record. **How the corrective action (s)**	

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	urinary bladder and the skin through the abdominal cavity used to drain urine from the bladder in individuals with obstruction of normal urinary flow) related to neuromuscular dysfunction of the bladder. Resident F had a Physician's Scope of Treatment (POST) form dated 4/16/2020. The POST form gave instruction for Resident F to be a DNR if "the patient had no pulse AND was not breathing," and also specified his wishes for main treatment goals were to give, "full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advance airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs." Resident F had a care plan, initiated on 11/1/2012, which indicated he was in the facility for long term placement. Interventions for this plan of care included, but were not limited to, "encourage family/friends to stay involved in resident care." A STAT (immediate) New Order Documentation/Temporary Care plan was initiated on 5/24/24 at 3:13 p.m. Notification to the family/representative was not noted as completed until 5/31/24 at 12:22 p.m. Resident F's condition continued to decline over the weekend of May 25th-26th with critical lab results and acute SIRS related bruising. Cross Reference F690. The record lacked documentation, and documentation and/or evidence was not provided		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DNS/Designee will be responsible for the completion of the Family Notification Audit Tool daily for 4 weeks and weekly for 4 weeks after. The Advanced Directives Audit Tool/Log will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	before the time of exit, to indicated Resident F's family had been notified of his acute change of condition. On 7/31/24 at 9:00 a.m., the DON provided a copy of current facility policy titled, "Resident Change of Condition," revised, 11/2018. The policy indicated, "It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place ...1. Life Threatening Change: the licensed nurse will notify the family/representative party of resident change of condition and document in the medical record ...2. Acute Medical Change: any acute or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician ... the responsible party will be notified that there has been a change in the resident's condition and what steps are being taken ... Non-Urgent Medical Change: ... the nurse in charge is responsible for notification of physician and family/representative party prior to end of assigned shift when a significant change in the resident's condition is noted. If unable to reach the physician or family/representative party, all calls to physician's or exchanges and family/representative party requesting callbacks will be documented in the medical record ...." This citation relates to Complaint IN00438092. 3.1-5(a)(2)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan			

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	must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on record review and interview, the facility failed to update a skin care plan for a resident with skin breakdown for 1 of 3 residents reviewed for care plans (Resident D). Findings include: On 7/31/24 at 12:13 p.m., a record review was conducted for Resident D. He had the following diagnoses which included, but were not limited to, cerebral infarction (stroke), Parkinson's disease, and diabetes mellitus.	F 0657	**F657 Care Plan Timing and Revision** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Skin care plan for resident D is updated with personalized/effective interventions. **How will you identify other residents having the potential**	08/22/2024

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	Resident D had a skin event, dated 7/17/24, indicating he had skin breakdown to his coccyx measuring 1.0 centimeters (cm) by (x) 1.0 cm x 1.0 cm. Resident D's care plan, dated 6/14/24, indicated resident was at risk for skin breakdown related to decreased mobility, incontinence, friction/shearing, and related to diagnoses of CVA (Cerebral Vascular Accident) with left sided hemiplegia (paralysis), adult failure to thrive, aphasia (loss of ability to understand or express speech, caused by brain damage), and HLD (hyperlipidemia). On 8/1/24 3:20 p.m., during an interview with the Director of Nursing Services (DNS), she indicated an event was a care plan that was good for at least seven days, after that the care plan should be updated. A policy titled, "IDT (Interdisciplinary Team) Comprehensive Care Plan Policy," dated 8/2023, was provided by the MDS (Minimum Data Set) Coordinator on 8/1/24 at 3:27 p.m. It indicated, " ...Care plan problems, goals, and interventions must be reviewed and revised by the interdisciplinary team periodically and following completion of each MDS assessment ...." This citation relates to Complaint IN00438994. 3.1-35(c)(1)		**to be affected by the same deficient practice and what corrective action will be taken?** All residents with skin breakdown have the potential to be affected by the alleged deficient practice. All residents with skin breakdown will be reviewed by DNS/designee to ensure care plans are in place. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Daily audit of physician orders and medical record documentation will be completed by MDSC/designee to ensure that care plans are updated with personalized interventions based on identified risk factors. In-servicing will be completed by ED/designee with IDT by 8/22/24 related to updating care plans within 7 days after completion of the comprehensive assessment. **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 MDSC/designee will be responsible for the completion of a Care Plan Updating QA Tool for six months with audits being completed once weekly for one	

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			month, and then monthly for 5 months by a nurse manager or designee. The Care Plan Updating QA Tool QA Tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure a resident's legal guardian participated and agreed to the changes in the resident's plan of care and treatment for 1 of 3 residents reviewed for quality of care (Resident E). Findings include: During an interview on 8/1/24 at 12:11 p.m., Resident E's guardian indicated, she had received a call from Nurse Practitioner, (NP) on 6/14/24 who indicated Resident E had not eaten or drank anything and had been sleeping more than usual.	F 0684	Plan of Correction **F684 Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident E's advanced directive was corrected and updated per Guardian's directive.	08/22/2024

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	The NP told the guardian, she did believe the decline was related to his dementia. The NP asked the family about changing his code status from a Full Code, too a Do-Not Resuscitate (DNR). The guardian lived out of state and told the NP she wanted her brother to go visit Resident E before the guardian made a decision about changing the resident's code status. The guardian indicated her brother went to visit Resident E on June 16th. Resident E had been awake, alert, and took food and drink when assisted by the family. The guardian indicated the family requested staff to sit with Resident E to assist him with meals due to his dementia. The guardian indicated she did not hear anything back after that and assumed everything was going well or back to baseline. On June 26th, the guardian received a call back from the NP who told her Resident E's right big toe had turned "black and had an odor," which meant the toe was "dead." The NP informed the guardian she had placed a referral for a vascular surgeon and ordered a doppler ultrasound. The NP indicated it would be approximately 2 weeks to a month before the vascular doctor could see Resident E. The guardian indicated, "that was unacceptable." On June 27th, the guardian indicated she called the facility back and told them to have a doctor's appointment and a care plan meeting scheduled so they could discuss and review Resident E's condition. A care plan meeting was scheduled for that afternoon, and a vascular doctor's appointment was set for June 28th. During the care plan meeting, the guardian was informed, her brother had been asked and signed a DNR form and Resident E's overall treatment plan and goals had been changed to palliative care without her knowledge or consent. The guardian indicated no one was authorized to sign off, and/or make treatment changes or decisions about Resident E's care.		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** In-servicing will be completed by ED/designee with IDT by 8/22/24 related to the information in the 2567 and the necessity of including the resident's legal guardian in any changes to the plan of care or treatment. · A code status audit was completed by Social Services on all residents to ensure code status matches their care plan and post form is in place and signed by the correct person. **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?** SSD/designee will make sure that resident's legal guardian or representative is included in and	

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	During an interview on 8/1/24 at 12:58 p.m., Resident E's son indicated his sister was Resident E's guardian, but she lived out of state. So he was often asked to visit Resident E on her behalf to check on his condition. He indicated there was some confusion on the part of the facility and Resident E's DNR was presented to him under the assumption that his dementia had gotten worse and that he was at the end of his life, "basically, he was getting ready to pass." Resident E's son indicated the NP brought him a DNR form and said it was "OK" for him to sign it. Resident E's son indicated the form was presented to him as already approved by the guardian. On 7/31/24 at 10:00 a.m., Resident E's medical record was reviewed. He was a long-term care resident who resided on the secured memory care unit with diagnoses which included, but were not limited to, Parkinson's disease (a chronic, progressive brain disorder that affects the body's motor and non-motor systems), Alzheimer's disease (a degenerative brain disease which affects memory and cognition), peripheral vascular disease (a progressive disorder that occurs when blood vessels outside of the heart or brain narrow, block, or spasm), and atherosclerosis (the thickening or hardening of the arteries caused by a buildup of plaque in the inner lining of an artery). A document titled, "Permanent Guardianship," dated 12/3/2020, indicated, " ...granted [name of Resident E's guardian] the authority to administer the permanent guardianship of the Person and Estate of [Resident E's name]. Said guardian shall have all of the authority of permanent guardianship under I.C. 29-3-7-3 ...."		agreeable to all plan of care and treatment changes. A Care Plan Meeting Audit will be completed weekly for 8 weeks. This audit will outline every care plan from that week and if any changes were made, they are to ensure that the responsible party is agreeable and aware to all changes. The Care Plan Meeting Audit Tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	Resident E had a physician's order to be a full code had been initiated 3/28/24 and was discontinued on 6/19/24. A Social Service care plan meeting and documentation progress note, dated 6/17/24 at 10:29 a.m., indicated Resident E had a legal guardian who requested the resident remain a full code. A nursing progress note, dated 6/18/24 at 2:31 p.m., indicated Resident E was started on the D5W fluid via a subcutaneous (SQ) button, (a site where a healthcare provider inserts a small needle under the skin to administer fluids). Resident E tolerated the fluids well. A NP progress note, dated 6/18/24 at 3:20 p.m., indicated, Resident E was seen for, "...hypernatremia [a condition where the sodium concentration in the blood is too high]. Labs reviewed on Friday and Na [sodium] was elevated at 155. New orders were given for midline and D5W [a type of intravenous (IV) fluid]. He pulled out his midline and did not receive the fluids ... his R [right] great toenail is bleeding and likely bumped on something ..." The NP gave new orders to discontinue (DC) his Lasix (a diuretic medication) and re-insert a midline for fluids. An interdisciplinary team (IDT) progress note, dated 6/18/24, indicated a new skin injury had been noted to Resident E's right great toe. The root-cause determination was Resident E, "...is in weakened state and while ambulating stubbed toe. Currently resting in bed since injury. New interventions initiated: Lab tests ordered and IV fluids ordered to determine reason for weakness and support hydration ...."			

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	A NP progress note, dated 6/18/24 at NP 1:43 p.m., indicated, Resident E was " ...seen today in f/u [follow up] for hypernatremia. Labs reviewed and sodium remains elevated at 155 and creatinine up to 2.0. He is resting in bed with SQ button in place. He previously discontinued his Midline. Daughter called to discuss resident declining condition with poor PO [by mouth] intakes and labs. Daughter states that her father was previously a DNR with comfort care. Son in building. Reviewed POST form and signed DNR comfort measures. Discussed declining condition with poor PO intakes. He has the same wishes as his sister. Both agree on palliative care with comfort focused care." The NP gave new orders at that time to DC the SQ button and added morphine (a narcotic pain medication) and lorazepam (an anti-anxiety medication) as needed. A Physician's Order for Scope of Treatment (POST) form, dated 6/18/24, changed his code status from a full code to a DNR with comfort measures. The POST was signed by Resident E's son and the NP. A new order for a doppler ultrasound was conducted on 6/18/24 and results were available the same day at 4:22 p.m. The doppler indicated, " ...Right common femoral artery and infrapopliteal arterial stenosis." The doppler results also recommended, " ...further examination recommended such as additional imaging modalities ...." A nursing progress note dated 6/18/24 at 9:49 p.m., indicated, Resident E's son (and not his guardian) had been notified of the new orders to DC all labs, doppler, and was placed on palliative care with morphine and lorazepam as needed.			

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	Cross reference F578. This citation relates to Complaint IN00438111. 3.1-37(a)			
F 0690 SS=G Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of			

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	bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to ensure lab specimens were obtained immediately with symptoms of urinary tract infection and laboratory results were reviewed in a timely manner for a resident with an indwelling urinary catheter to prevent urinary tract infection for 1 of 3 residents reviewed for quality of care (Resident F). This deficient practice resulted in a delay of treatment and the resident developed urosepsis with acute kidney failure with a systemic inflammatory response syndrome (SIRS) and died. Findings include: During a confidential interview, it was indicated Resident F's family member received a phone call on 5/31/24. The facility wanted to confirm Resident F's Do-Not-Resuscitate (DNR) orders because he had an infection and experienced a change in condition. The family member wanted Resident F to be sent out to the hospital, had been unaware that Resident F was being treated for an infection, and that his condition had worsened so severely. Resident F had a history of infections. When the family member arrived to the facility, there was an ambulance at the front door. EMS and the facility nurse said there was nothing more they could do for Resident F, and the resident took his last breaths moments after the family walked into the room. On 7/30/24 at 10:55 a.m., Resident F's medical record was reviewed. He was a long-term care resident with diagnoses which included, but were not limited to, history of a cerebral infarction (stroke, bleeding in the brain) which resulted in	F 0690	**F690 Bowel/Bladder, Incontinence, Catheter, UTI** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident F has expired **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. ·A 1x audit completed to ensure residents with STAT labs were received and reviewed in a timely manner with MD/NP notification. ·Licensed nursing personnel will be in-serviced by 8/22/24 by the DNS/designee on timeliness of STAT labs, MD/NP notification, and treatment **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·Licensed nursing personnel will be in-serviced by 8/22/24 by the DNS/designee on timeliness of STAT labs, notification, and treatment ·DNS or designee will review all STAT lab orders daily to ensure	08/22/2024

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	left side hemiplegia and hemiparesis, (similar conditions that cause weakness on one side of the body), Alzheimer's disease (a degenerative brain disease with affects memory and cognition) and he required the use of a suprapubic catheter (a surgically created connection between the urinary bladder and the skin through the abdominal cavity used to drain urine from the bladder in individuals with obstruction of normal urinary flow) related to neuromuscular dysfunction of the bladder. Resident F had a Physician's Scope of Treatment (POST) form dated 4/16/2020. The POST form gave instruction for Resident F to be a DNR if "the patient had no pulse AND was not breathing," and also specified his wishes for main treatment goals were to give, "full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advance airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs." Resident F had a care plan, initiated 6/25/2020, which indicated he required the use of a suprapubic catheter related to his diagnosis of neurogenic bladder. Interventions for this plan of care included, but were not limited to, "report complications/UTI: acute confusion, bladder spasms, low back/flank pain, malaise, nausea, emesis, chills, fever, foul odor, concentrated urine, blood in urine ...staff to record urinary output in milliliters ...." Resident F had a care plan, initiated 10/4/2021, which indicated he had the potential for pain related to his diagnoses which included, but was		completed timely and MD/NP notified for any new orders. **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?** ·To ensure compliance the DNS/Designee will complete a Change of Condition QA audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The Change of Condition QA tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	not limited to, back pain. Interventions for this plan of care included, but were not limited to, "Notify MD [Medical Doctor] if pain is unrelieved and/or worsening." On 5/22/24 at 11:04 a.m., Resident F's Medication Administration Record (MAR) indicated he complained of back pain on a scale of 7 out of 10. An "as needed" (PRN) physician order for 500 milligrams (mg) of extra-strength Tylenol was administered and effective until 4:39 p.m., when he complained of increased pain at a level 9 out of 10. A second dose of his PRN Tylenol was administered. There was no documentation on the MAR, progress notes, or within the resident's electronic record that the physician was notified of resident's worsening pain. On 5/23/24 at 3:12 p.m., Resident F's MAR indicated he complained of pain at a level 9 out of 10 and his PRN Tylenol was administered. There was no documentation on the MAR, progress notes, or within the resident's electronic record that the physician was notified of resident's continued back pain. A Nurse Practitioner (NP) progress note, dated 5/24/24 at 4:09 p.m., indicated nursing staff requested the NP visit due to increased confusion. "... seen today for confusion. He has a history of dementia with acute worsening of confusion. He is seen today, sitting up in his wheelchair. Nursing noted increased confusion over night. He asked what time dinner was after he just finished dinner. They also noted purulent drainage around SP cath [suprapubic catheter]. On exam, he is awake but drowsy in his wheelchair. He has a low grade temp of 99.3. Other VSS [vital signs stable]. He denies SP [suprapubic] pain but does endorse CVA			

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	tenderness [Costovertebral angle- CVA tenderness often indicates kidney pathology]. His SP cath has purulent sediment noted in the tubing ..." The NP ordered STAT (an task that is to be completed immediately. The standard time for STAT lab results is 90 minutes, or one hour or less from specimen receipt) for a CBC (Complete metabolic panel), BMP (Basic Metabolic Panel), and urinalysis. A Lab requisition form, dated 5/24/24, with a timestamp that was not visible, indicated Resident F's urine sample had been collected at 4:00 p.m. The requisition did not indicate or specify STAT status. At the bottom of the requisition, "Lab Use Only" indicated the urine sample was not collected by the lab until 5/25/24 at 7:33 a.m. A nursing progress note, dated 5/24/24 at 4:00 p.m., indicated, "collected urine specimen for STAT UA C&S [urinalysis with culture and sensitivity] stored in lab refrigerator for pick up." During an interview on 7/30/24 at 2:00 p.m., the Director of Nursing (DON) indicated the facility did not have a policy or procedure related to lab services/STAT lab services. On 7/31/24 at 1:33 p.m., the Senior Vice President (SVP) of Customer Service for the contracted Lab Service company provided a copy of the Lab's timeline of events for the Resident F's STAT lab order as follows: a. Order for STAT labs was received on 5/24/24 at 2:54 p.m. b. On 5/24/24 at 7:03 p.m., a Lab Associate called the facility to notify them, a Lab Technician would not be available until the next morning and made a note, "nurse didn't answer page." c. On 5/45/24 results of the CBC were faxed at			

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	10:41 a.m., the BMP results were faxed at 11:42 a.m., and the UA results were faxed at 10:49 a.m. On 7/31/24 at 9:00 a.m., the DON provided a copy of Resident F's urinalysis lab results. The results were dated 5/25/24 at 8:27 a.m. and were positive for signs of infection as the urine was cloudy and orange with white blood cell (WBC) clumps, many bacteria and a large amount of Leukocytes were present. The results were initialed by the NP as reviewed on 5/25. On 7/31/24 at 9:00 a.m., the DON provided a copy of Resident F's C&S results. The results were reported 5/27/24 at 10:39 a.m. and indicated the presence of Proteus mirabilis (a gram-negative bacterium that is a common cause of catheter-associated urinary tract infections). During an interview on 7/31/24 at 10:24 a.m., the NP indicated she received the urinalysis results at home over the holiday weekend and decided to wait for the C&S before she ordered a treatment because he had a history of frequent infections. The NP indicated she did not remember what time she received the urinalysis or the C&S results. Resident F's electronic record including, but not limited to, vital signs, and progress notes, lacked documentation of a set of vital signs or resident assessment over the weekend on 5/25/24 or 5/26/24. Resident F's electronic record including, but not limited to, events, documents, and progress notes, lacked documentation of assessment/monitoring of his suprapubic catheter (SP cath) insertion cite and/or tubing/drainage system after signs of an infection had been noted on 5/24/24.			

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	A nursing progress note, dated 5/27/24 at 11:26 p.m., indicated at 4:00 p.m., "Resident called for help in a very faint voice, resident panting, cyanotic [bluish-purplish discoloration] lips and legs, cold clammy all extremities, bloody urine noted in urine bag. Temperature: 101.5, unable to get BP [blood pressure] and O2 [oxygen] saturation. Placed on 2 L [liters] O2 via nasal cannula ...." Eventually obtained BP of 113/68, pulse of 124, O2 sat of 99% at 2L O2 via nasal cannula. DON and on call NP notified. On 7/30/24 at 12:47 p.m., the DON provided a copy of the On-Call Provider correspondence which indicated the following: On 5/27/24 at 4:25 p.m., the facility nurse messaged the On-Call Provider to report Resident F's change in condition and indicated, " ...last week he started to have confusion and back pain. Pus and redness noted on SP cath insertion site, cloudy urine, now it's bloody, redness on SP region ..." The NP responded (with no timestamp noted) and indicated to administer Rocephin (antibiotic) 1 gram (gm) IM (intramuscular) now and place a peripherally inserted central catheter (PICC) to administer Vancomycin (antibiotic) 1 gm now then to have the pharmacy determine the dose time for additional Vancomycin over the next 7 days. The provider ordered STAT labs for diagnosis of sepsis. Nursing was to administer Tylenol 650 milligrams (mg) every 4 hours and as needed (PRN) ibuprofen 400 mg every 6 hours for fever. Once temps trended down vital signs were to be obtained every 4 hours for 24 hours. Additional orders included a chest x-ray after PICC placement. The facility nurse responded (with no timestamp notes), "phlebotomist was not able to put PICC but she was able to put a midline [a long, flexible tube inserted into a vein in the upper arm to administer medication or fluids into the			

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	bloodstream], I will give Vancomycin IV now." At 7:49 p.m., the facility nurse responded, " ...we ran out [Vancomycin] in the EDK [Emergency Drug Kit], I called pharmacy to expedite vancomycin one time 1 gram IV." At 8:01 p.m., the facility nurse notified the On-Call Provider, "Vancomycin came, he is now much better after Rocephin ..." A nursing progress note, dated 5/28/24 at 1:15 p.m., indicated the results of the chest x-ray concluded no abnormalities, infiltrate or effusion. An NP Progress note, dated 5/28/24 at 3:38 p.m., indicated Resident F was, " ...seen today for AKI [Acute Kidney Injury] and SIRS [Systemic Inflammatory Response Syndrome]. He was seen Friday for AMS [altered mental status] at which time, labs were ordered. Labs reviewed ... Yesterday, on call provider was called after nurse noted hematuria, increased weakness, low grade temp and tachycardia. On call provider ordered Rocephin IM x 1 and Vancomycin. After discussion with pharmacy, vanc [vancomycin] had to be discontinued because of elevated creatinine and dosing being every 72 hours. He is seen today, resting in his bed. He is awake, confused and agitated. He does report that he has not been feeling well. He remains tachycardic but is afebrile on exam. His SP cath is draining dark, brown urine with purulent drainage at SP site. He is 97% [02 saturation] on room air with no reported hypoxia, cough or dyspnea. He has a RUE [right upper extremity] midline in place. He meets SIRS criteria with fever and tachycardia. Likely urinary source, however culture is <100,000. He has a history of Proteus UTI as well as EColi with ESBL. Will start rocephin and if no improvement will transition to Merrem ..." The NP ordered to start IV fluids and a renal ultrasound.			

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	On 5/28/24 at 5:20 a.m., Resident F had bloodwork drawn for a CMP and the results were reported on 5/28/24 at 1:46 p.m. His Creatine level rose from 4.6 to 6.7 and his BUN level was elevated at 94. A nursing progress note, dated 5/29/24 at 10:45 a.m., indicated Resident F, " ...continues on second liter of IVFs [intravenous fluids] per MD order ..." On 5/29/24 at 5:10 a.m., Resident F had bloodwork drawn for a BMP and the results were reported on 5/29/24 at 1:57 p.m. His BUN level rose and was now critically high at 102. A nursing progress note, dated 5/29/24 at 2:50 p.m., indicated, " ...Received call from lab regarding critical high urea nitrogen 102. On call NP notified, NP ordered additional 1L NaCl 0.9% 100ml/hr, and repeat BMP in AM. Lab request placed, resident completed 2 L NaCl 0.9%. Hooked additional 1 L NaCl 0.9% 100 ml/hr ...." A nursing progress note, dated 5/30/24 at 2:07 p.m., indicated, an ultrasound technician had been unable to complete a renal ultrasound due to unable to obtain clear imaging and the NP was notified. A late nursing progress note, created, 5/31/24 at 3:54 p.m., and set as effective for 5/30/24 at 8:30 p.m. indicated, Resident's SP cath was changed per order and a 22 French catheter was inserted. Resident tolerated the change well and urine output flowing with ease. On 5/30/24 at 8:26 a.m., Resident F had bloodwork drawn for a CMP and the results were reported on 5/30/24 at 1:12 p.m. His BUN and Creatine levels remained elevated. His BUN was still critically			

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	high at 101. A nursing progress note, dated, 5/31/24 at 6:14 a.m., indicated during morning care the Certified Nursing Aide (CNA) called the nurse into room to show the discoloration to Resident F's left side of abdominal area. The area was hard to touch. The resident did not complain of pain when touched. Resident's name was put in the doctor's binder to be reviewed. During an interview on 7/31/24 at 9:00 a.m., the DON provided the "Doctor's Binder" for review. She indicated the binder was an internal tool used by the nurses to put notes and concerns related to resident conditions, so that when the MD or NP came in, they would look through the Doctor's Binder to review and see residents as needed. The DON looked for notes related to Resident F from May, 2024, but was unable to locate any. When the DON contacted the NP, the NP indicated she threw the old pages away after the resident's had been seen. A nursing progress note, dated 5/31/24 at 8:10 a.m., indicated a second nurse was notified by a CNA " ...that resident had a large hematoma to side of ABD [abdomen], writer assessed area and it was hard to touch, resident did not c/o pain ...Vital signs were within normal limits. The NP was informed of findings. NP had seen him during the week, and would see him "this morning." On 5/31/24 at 4:20 a.m., Resident F had bloodwork drawn for a BMP and the results were reported on 5/31/24 at 12:05 p.m. His BUN was even more elevated and critically high at 105. Resident F's electronic record lacked documentation, and no documentation or			

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	evidence was provided by the DON, NP, or any facility staff before exit, to indicate his increased and critically high BUN level had been reviewed. During an interview on 7/31/24 at 10:24 a.m., the NP could not recall if there was a note on her Doctor's Binder. The NP had seen Resident F on the morning of 5/31/24 and saw the discolored area. The NP described the discoloration as a large bruise that was tender to touch, but at that time he had been eating breakfast so she told him she would come back later in the day to see him again. The NP indicated the bruising could be a symptom of worsening SIRS, but the NP still felt comfortable treating Resident F in-house. The NP indicated she had been asked to come back around lunch time, to re-assess and check on Resident F as he had another change of condition. The NP indicated when she saw him, "he was not well." They called Resident F's family member and reviewed his code status as a DNR, but also asked if the family would like him sent to the ER. The Family member did want him sent out. By the time EMS got to the facility, they determined due to Resident F's DNR status, he was "too far gone" and there was nothing more they could do except let him "pass away." On 7/31/24 at 9:00 a.m., the DON provided a copy of the lab contract. The document was titled, "American Senior Communities, L.L.C. Service Agreement," Service Agreement: Clinical Laboratory Services which was dated 11/1/2017. The contract indicated, " ...Vendor will provide Lab Services to ASC Locations in accordance with each ASC Location's policies ...Vendor provides STAT (life threatening situation) services 24 hours per day, 365 days per year. Laboratory STAT testing will be reported within four (4) hours ... Vendor shall respond to an ASC			

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	Location's request for STAT Services within 30 minutes and notify ASC Location of the time that Vendor will arrive ... Critical and STAT results will be phoned to the ASC Location as soon as they are available ...." The contract did not indicate/specify a timeframe and/or a minimum number of attempts to contact the facility for Critical/STAT labs. According to the Lab Contract specifications, Resident F's urine specimen should have been picked up, processed and reported by 5/24/24 at 8:00 p.m. but was not picked up until more than 11 hours later. The facility did not have a policy for the Lab Service to indicate/specify a timeframe and/or a minimum number of attempts should be required to report Critical/STAT labs, and/or have facility nursing staff follow up on Critical/STAT labs. On 7/31/24 at 9:00 a.m., the DON provided a copy of current facility policy titled, "Resident Change of Condition," revised 11/2018. The policy indicated, "It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place ...1. Life Threatening Change: the licensed nurse will notify the family/representative party of resident change of condition and document in the medical record ...2. Acute Medical Change: any acute or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician ... the responsible party will be notified that there has been a change in the resident's condition and what steps are being taken ... Non-Urgent Medical Change: ... the nurse in charge is responsible for notification of physician and family/representative party prior to end of			

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	assigned shift when a significant change in the resident's condition is noted. If unable to reach the physician or family/representative party, all calls to physician's or exchanges and family/representative party requesting callbacks will be documented in the medical record ... the licensed nurse responsible for the resident will continue assessment and documentation in the medical record every shift until the resident's condition has stabilized ...." This citation relates to Complaint IN00438092. 3.1-41(a)(2)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in 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,			

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	regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §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			

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	determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on observations, record review, and interviews, the facility failed to document the results of glucometer (blood sugar) results for 1 of 3 residents reviewed for quality of care (Resident D). Findings include: On 7/31/24 at 12:13 p.m., a record review was conducted for Resident D. He had the following diagnoses which included but were not limited to cerebral infarction (stroke), Parkinson's disease, and diabetes mellitus. He had a physician order, updated on 7/23/24, to obtain blood sugar every 6 hours and to notify the physician if results are below 70 or greater than 400. His Medication Administration Record (MAR) for June and July 2024 had missing documentation of the results for the following dates/times: a.) 7/14/24 at 8:00 a.m. b.) 7/30/24 at 6:00 a.m. c.) 6/20/24 at 8:00 a.m. d.) 6/19/24 at 8:00 a.m. e.) 6/17/24 at 8:00 a.m. During an interview with the Director of Nursing Services (DNS), she indicated they had gotten away from running reports to see what was omitted from the day before. A policy titled;, "Blood Glucose Monitoring," dated 2/2015, was provided by the Minimum Data	F 0842	Plan of Correction **F842 Resident Records – Identifiable Information** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident D's medical record ran daily for missed administration. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** In-servicing will be completed by ED/designee with IDT by 8/22/24 related to following orders and ensuring proper	08/22/2024

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	Set (MDS) Coordinator on 8/1/24 at 3:27 p.m. It indicated, "...Blood glucose results will be documented on the capillary blood glucose monitoring tool or on the medication administration record (MAR) ...." This citation relates to Complaint IN00438994. 3.1-3(o) 3.1-3(r)		documentation is in the resident's medical record. ·A Blood Glucose Monitoring report will be ran and reviewed for omissions in MAR during morning meeting for the previous day(s). **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 DNS/Designee will be responsible for the completion of the Blood Glucose Monitoring Audit Tool for 6 weeks and ongoing after that. The Advanced Directives Audit Tool/Log will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	