STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155166	A. BUILDING 00 B. WING	07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALPARAISO CARE & REHABILITATION	606 WALL STREET VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00408762 and IN00412950. Complaint IN00408762 - No deficiencies related to the allegations are cited. Complaint IN00412950 - No deficiencies related to the allegations are cited. Survey dates: July 10, 11, 12, 13, and 14, 2023. Facility number: 000083 Provider number: 155166 AIM number: 100289670 Census Bed Type: SNF/NF: 116 Total: 116 Census Payor Type: Medicare: 4 Medicaid: 103 Other: 9 Total: 116 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 7/18/23.	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation. This provider respectfully requests a desk review for compliance on or after 7/14/23.	
F 0640 SS=A Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing requirement-			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nathan Wolf	Executive Director	08/03/2023

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

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	§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's			

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	transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. Based on record review and interview, the facility failed to transmit a Minimum Data Set (MDS) assessment in the required time frame for 1 of 27 MDS assessments reviewed. (Resident 29) Finding includes: The Resident Assessment Task MDS tracking data indicated Resident 29's last MDS assessment was over 120 days old. Record review for Resident 29 was completed on 7/11/23 at 1:59 p.m. The resident had passed away in the facility on 3/28/23. The Quarterly MDS assessment, dated 2/20/23, was the last assessment completed for the resident. There was no Death in Facility entry. Interview with the MDS Nurse on 7/12/23 at 3:32 p.m., indicated she should have transmitted a Death in Facility tracking for the resident and she would enter one now.	F 0640	What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 29 has been discharged from facility as of 3/28/23; no further corrective action is possible. 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 impacted by this deficient practice. All residents that have passed away at facility since 3/28/23 have been audited to ensure Death at Facility assessment has been completed and submitted timely.	08/09/2023

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			What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: ED/designee to re-educate MDS nurse on or before 8/9/23 regarding the requirement to complete and submit a Death at Facility assessment timely when a resident passes away at facility. 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: Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “RAI Process” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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			By what date the systemic changes will be completed: 8/9/2022	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-			

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	(A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on record review and interview, the facility failed to ensure a Care Plan was developed for a resident who received an antidepressant medication for 1 of 24 residents reviewed for Care Plan development. (Resident 64) Finding includes: Resident 64's record was reviewed on 7/11/23 at 1:46 p.m. Diagnoses included, but were not limited to, chronic respiratory failure with hypoxia and Diabetes Mellitus. The resident was ventilator dependent. The Admission Minimum Data Set (MDS) assessment, dated 5/29/23, indicated the resident took antidepressant medication 7 of 7 days during the assessment period. The current Physician's Orders indicated the resident took Trazodone (an antidepressant), 50 milligrams, every 12 hours.	F 0656	What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: It is the practice of the facility to ensure all residents have a comprehensive person-centered care plan consistent with the goals and preferences. The care plan for Resident 64 has been reviewed and updated to include a care plan for psychotropic medications. 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	08/09/2023

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	The record lacked a Care Plan for antidepressant medications. Interview with the MDS nurse on 7/12/23 at 2:18 p.m., indicated there should be a Care Plan in place for the antidepressant and there was not. She would implement it at that time. 3.1-35(a)		be impacted by this deficient practice. An audit of all residents Comprehensive Care Plans related psychotropic medications will be completed and updated appropriately. Comprehensive Care Plan meetings will be held to ensure care plans are consistent with the goals and preferences. All residents receiving antidepressant medication care plans were reviewed to ensure care plan addressed the antidepressant medication. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Comprehensive Care Plan reviews will be completed for all residents who receive antidepressant medication upon Admissions and quarterly thereafter and any change in condition involving the prescription of antidepressant medication. DNS/designee will re-educate clinical staff on initiation of care plans for residents receiving antidepressant medications. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what	

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			quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Comprehensive Care Plan Review” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 8/9/23	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical			

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	condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure pressure offloading boots were in place as ordered for 1 of 4 residents reviewed for pressure ulcers. (Resident 90) Finding includes: On 7/10/23 at 10:19 a.m., Resident 90 was observed lying in bed watching television. There were no pressure offloading boots in place to his feet. On 7/12/23 at 10:35 a.m., Resident 90 was observed lying in bed with his eyes closed. No pressure offloading boots were in place to his feet. The boots were on the empty bed on the other side of the room. Two CNAs entered the room to assist the resident with getting out of bed. On 7/12/23 at 11:23 a.m. Resident 90 was observed seated in his Broda chair in the Main Dining Room. The pressure offloading boots were not in place to his feet. Resident 90's record was reviewed on 7/11/23 at 2:33 p.m. Diagnoses included, but were not limited to, dementia, congestive heart failure, and anemia. The Significant Change MDS (Minimum Data Set) assessment, dated 6/27/23, indicated the resident	F 0686	It is the practice of this facility to ensure residents receive care consistent with professional standards of practice to prevent pressure ulcers. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Offloading boots were put into place per physician orders for resident 90. Resident profile was reviewed to ensure offloading boots are included in interventions. 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 by this deficient practice. An audit of resident's skin preventative measures will be completed to ensure items are in place per physician's orders.	08/09/2023

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	was not cognitively intact, was at risk for pressure ulcers, and had a current pressure ulcer. The resident had a current care plan for a pressure ulcer to the right heel. The interventions included, bilateral heel boots as tolerated. The Physician's Order Summary, dated 7/2023, indicated an order for bilateral heel boots as tolerated. Interview with the Director of Nursing (DON) on 7/12/23 at 1:26 p.m., indicated the resident should have had his boots in place. 3.1-40(a)(2)		What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Nursing will be re-educated related to pressure ulcer prevention. DNS/Designee will round daily to ensure pressure offloading boots are in place per physician order. 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: Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “wounds and skin management” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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			By what date the systemic changes will be completed: 8/9/23	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure a resident was supervised and orders were obtained for an electronic cigarette for 1 of 1 residents reviewed for smoking. (Resident 44) Finding includes: On 7/11/23 at 10:20 a.m. Resident 44 was observed in bed with an electronic cigarette at his bedside. On 7/11/23 at 1:40 p.m. Resident 44 was observed sitting up in his bed smoking his e-cigarette. Interview with the resident at this time indicated that he bought his own refills for his electronic cigarettes and his family would bring them to him. The record for Resident 44 was reviewed on 7/12/23 at 1:17 p.m. Diagnoses included, but were not limited to, muscular dystrophy, chronic obstructive pulmonary disease (restrictive airway), and depression.	F 0689	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 ensure that the resident environment remains free from hazards and has supervision and devices to prevent accidents. The orders, care Plan and intervention for Resident 44 were updated to address electronic cigarettes. 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	08/09/2023

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	The Quarterly Minimum Data Set (MDS) assessment, dated 6/27/23, indicated the resident was cognitively intact. Staff assistance was needed for mobility, transfers and toileting with supervision for eating. A Care Plan, updated on 6/30/23, indicated the resident has a history of of attempting to smoke in the facility. Approaches were to offer a nicotine patch and assist in finding a smoke friendly long term care community per request. There was no care plan for electronic cigarette use. There was no Physician's Order for electronic cigarette use. There was no smoking assessment completed for the resident. Interview with the DON (Director of Nursing) on 7/12/23 at 1:45 p.m., indicated a resident required a Physician's Order for electronic cigarette use. Continued Interview with the DON on 7/12/12 at 1:54 p.m., indicated the resident was not an approved electronic cigarette user and they were not aware the resident was in possession of an electronic cigarette. Interview with the Administrator on 7/12/23 at 2:48 p.m., indicated he had spoken with the resident and confiscated the electronic cigarette. A policy, titled "Electronic Cigarettes", updated June 2022, indicated "...if the resident is appropriate for the use of an electronic cigarette based on cognitive ability, hand eye coordination		be affected by this finding. A facility audit of all residents will be done to ensure the facility is aware of residents using electronic cigarettes, MD orders are received, and residents are assessed for using electronic cigarettes by DNS/designee on or before 8/9/23. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The DNS/designee will in-service Nursing department on resident electronic cigarette usage on or before 8/9/23. ED/Designee will ensure any resident who uses electronic cigarettes will be assessed and MD order received. 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: Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the	

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	and vision using the Electronic Cigarette Safety Assessment. The physician will be notified with the results of the assessment and a physician's order will be obtained..." 3.1-45(a)(1)		QAPI Audit tool "Smoking" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 8/9/23	
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, record review and interview, the facility failed to care for a PICC line (peripherally inserted central catheter, intravenous catheter placed into the peripheral veins of the upper arm) in accordance with professional standards of practice, related to flushing the PICC line and changing the PICC site dressings for 1 of 1 resident reviewed for intravenous care. (Resident 90) Finding includes: On 7/10/23 at 10:19 a.m., Resident 90 was	F 0694	It is the practice of this facility to ensure that resident IV access sites are maintained consistent with professional standards of practice and in accordance with physician orders. Resident 90's PICC line was discontinued per physician order on 7/10/23. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	08/09/2023

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	observed lying in bed watching television. There was a PICC line in place to his right upper arm. It was covered with a wrap and the date on the site dressing was unable to be seen. Resident 90's record was reviewed on 7/11/23 at 2:33 p.m. Diagnoses included, but were not limited to, dementia, congestive heart failure, and anemia. The Significant Change MDS (Minimum Data Set) assessment, dated 6/27/23, indicated the resident was not cognitively intact and had received IV (intravenous) medications. A Physician's Order, dated 6/22/23, indicated new PICC line to the right arm. A Physician's Order, dated 6/20/23 and discontinued on 6/22/23, indicated piperacillin tazobactam (Zosyn, an antibiotic) 3.375 g (grams) every 8 hours IV. A Progress Note, dated 6/20/23 at 3:06 p.m., indicated the resident was readmitted to the facility and had an IV catheter in place to the right wrist. A Progress Note, dated 6/22/23 at 4:58 a.m., indicated the resident had pulled out his IV catheter and an order was submitted to have a PICC line inserted. A Progress Note, dated 6/22/23 at 2:45 p.m., indicated a new PICC line had been placed to the resident's right arm and antibiotic therapy continued. A Progress Note, dated 7/10/23 at 4:46 p.m., indicated the PICC line to the right upper arm had been discontinued and removed.		action(s) will be taken: All residents have the potential to be affected by this finding. An audit for all residents with IV access will be completed by 8/9/23 to ensure that orders are in place for flushing IV catheters and changing dressings. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The DNS/designee will in-service Nursing department on residents receiving parenteral fluids, including PICC lines, on or before 8/9/23. DNS/Designee will observe PICC lines to ensure dressings are changed and to ensure PICC lines are flushed per protocol and daily. 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: Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI).	

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	The Medication Administration Records (MAR) and Treatment Administration Records (TAR), dated 6/2023 and 7/2023, lacked documentation any IV or PICC flushes had been administered or PICC site dressing changes had been completed from 6/20/23 through 7/10/23. Interview with the Director of Nursing (DON) on 7/13/23 at 10:03 a.m., indicated she was unable to find any documentation of the flushes or site dressing changes. A facility policy, titled "Peripherally Inserted Central Catheter (PICC) Management Guidelines," received as current, indicated, "...5. Dressing and securement device is to be changed every 7 days or PRN (as needed) using sterile technique...7. If ordered by prescriber an unused catheter should be flushed at least daily with 3 ml (milliliters) of Heparin flush solution..." A facility policy, titled "Flush Orders for Vascular Access Devices," received as current, indicated, "...Peripherally Inserted Central Catheter (PICC) non valved, flush with normal saline-10 ml before and after IV medication administration followed by Heparin 10 units/ml-5 ml. Maintenance flush each lumen every 12 hours..." 3.1-47(a)(2)		The DNS/designee will be responsible for completing the QAPI Audit tool “Parenteral Therapy” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. By what date the systemic changes will be completed: 8/9/23	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.			

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	Based on record review and interview, the facility failed to ensure residents with pain were assessed and monitored related to lack of non-pharmacological pain interventions, pain was not assessed for severity or location, and parameters were not in place for use of pain medication for 2 of 2 residents reviewed for pain. (Residents 64 and 28) Findings include: 1. Resident 64's record was reviewed on 7/11/23 at 1:46 p.m. Diagnoses included, but were not limited to, chronic respiratory failure with hypoxia, sacrum pressure ulcers, neuropathy and Diabetes Mellitus. The resident was ventilator dependent. The Admission Minimum Data Set (MDS) assessment, dated 5/29/23, indicated the resident had received an opioid medication 5 of 7 days during the assessment period. The resident's cognitive status was unable to be assessed and he was dependent on two staff for bed mobility and transfers. A current Physician's Order indicated to give Norco (an opioid pain medication), 5 milligrams(mg)/325 mg, every 4 hours as needed for pain. A current Physician's Order indicated to give Tylenol, 650 mg, every 6 hours as needed for fever or pain. The July 2023 Medication Administration Record (MAR) indicated the resident received Tylenol once for pain. There was no indication where the pain was or the severity of the pain. The July 2023 MAR indicated the resident	F 0697	It is the practice of this facility to ensure that pain management is provided to residents consistent with professional standards of practice. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Current pain medication regimen for resident 64 has been reviewed for accuracy, including nonpharmacological interventions, pain severity, pain location and medication parameters. 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 other residents have the potential to be affected by this deficient practice. DNS/Designee will audit all residents with orders for pain management to include nonpharmacological interventions, pain severity, pain location and medication parameters. What measures will be put into place or what systemic changes will be made to ensure that the	08/09/2023

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	received Norco 16 times. There was no severity of the pain documented with any Norco administrations. Non-pharmacological interventions were documented as refused on 7/2/23, no other administration indicated non-pharmacological interventions were given or attempted. 3 of the 16 administrations indicated back pain, 2 of the 16 indicated general pain, the remaining had no pain location indicated. The current Pain Care Plan indicated the resident was at risk for pain, interventions included to offer non pharmacological interventions such as rest, shower, back rub or reposition. Interview with the DON, on 7/12/23 at 1:05 p.m., indicated there was a space on the MAR to document where the pain was and they were going to add a space for the pain severity. She indicated she understood the concern with lack of documentation and indication for use. 2. The record for Resident 28 was reviewed on 7/12/23 at 3:24 p.m. Diagnoses included, but were not limited to, metabolic encephalopathy (imbalance in the brain), atrial fibrillation (irregular heart beat), gastroesophageal reflux disease (acid reflux), hypertension (high blood pressure), neurogenic bladder (loss of bladder function), diabetes, arthritis, peritoneal abscess (abdominal wound), anxiety, weakness and depression. The Significant Change Minimum Data Set (MDS) assessment, dated 6/14/23, indicated the resident was impaired in decision making. The resident required extensive assistance with 2 person physical assist for bed mobility and was a total assist for transfers and bathing. A Care Plan, updated 7/9/23 at 2:23 p.m., indicated the resident had an abdominal abscess infection,		deficient practice does not recur: DNS/Designee will educate all nursing staff on nonpharmacological interventions prior to pain medication administration. DNS/Designee will review residents pain medication orders to ensure the order includes severity, location, and medication parameters for administration of pain medication. This will be monitored daily by running the EMAR compliance report. 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: Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Pain management” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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	and sepsis. Approach was to administer medications as ordered. A Care Plan, updated 7/9/23 at 2:23 p.m., indicated the resident was at risk for pain related to arthritis, weakness, limited mobility, and depression. Approaches were to notify the physician if pain was unrelieved, or worsening, and observe for non verbal signs of pain. A Physician's Order, dated 6/8/23, indicated the resident be given hydrocodone-acetaminophen (a narcotic pain medication) 5-325 mg (milligrams) every 6 hours as needed for pain. The hydrocodone-acetaminophen order did not have a pain assessment indicator as when to administer the medication. The Medication Administration Records (MAR), dated 6/2023 and 7/2023, indicated the resident received hydrocodone-acetaminophen 5-325 mg for pain on the following dates: June 16th, 23rd, 24th, 25th, 26th, 27th, 28th, 29th, & 30th. July 2nd, 6th, 7th, 9th, 11th, & 13th. The MAR, dated 7/2023, indicated on 7/9/23 the resident was reported to have pain 8/10 and on 7/11/23 the resident was reported to have pain 7/10. There was lack of any other pain scale rating or assessment prior to the hydrocodone-acetaminophen administration. Interview with LPN 1 on 7/14/23 at 8:31 a.m., indicated that she would determine the resident's pain by using a pain scale before giving the resident medication. They did not need to chart the pain rating, but were to follow up with the effectiveness.		By what date the systemic changes will be completed: 8/9/23	

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	Interview with DON (Director of Nursing) on 7/14/23 at 8:48 a.m., indicated they were working with their electronic computer charting system to update the orders to include pain rating in the documentation. The "Pain Management Policy", was received from the Director of Nursing (DON), on 7/13/23 at 10:08 a.m., indicated, "...1. Residents are assessed for pain on admission, weekly, and during medication administration as outlined below...Ongoing nursing assessments can also be documented in matrix progress notes or matrix vitals..." The policy also indicated, "...Physician orders for pain medications will be prescribed based upon the resident's intensity of pain, for example: Tylenol for mild to moderate pain, Vicodin (opioid) for severe to very severe pain...." 3.1-37(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or			

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	§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure each resident's medication regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being, related to ensuring a pain medication was available and given as ordered by the Physician for 1 of 5 residents reviewed for unnecessary medications. (Resident 86) Finding includes: Resident 86's record was reviewed on 7/14/23 at 9:46 a.m. Diagnoses included, but were not limited to, spinal stenosis (narrowing of the spine), hypertension (high blood pressure), heart failure, diabetes, depression, low back pain, gout, difficulty walking, and muscle weakness. The Annual Minimum Data Set (MDS) assessment, dated 5/31/23, indicated the resident was cognitively intact. A Physician's Progress Note, dated 7/6/23 at 5:08 p.m., indicated the resident's chief complaint was neck pain. Assessment indicated he had failed 1 spinal injection and was to go back for another treatment shortly. Assessment plan for neck pain included, biofreeze as needed and scheduled Percocet. A Physician's Order, dated 11/3/22, indicated to	F 0757	What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 86 had current medication regimen reviewed by physician. No new orders or adjustments suggested. 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 impacted by this deficient practice. An audit will be completed to identify anyone on narcotic pain medication and ensure medications are available to be administered per physician order. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:	08/09/2023

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	give oxycodone-acetaminophen (Percocet, a narcotic pain medication) 10-325 mg (milligrams) every 4 hours. The Medication Administration Record (MAR), dated 6/2023, indicated the Percocet had not been given as ordered on the following dates and times: - 6/17/23 at 2 p.m., 6 p.m., and 10 p.m. - 6/18/23 at 2 a.m., 6 a.m. and 2 p.m. Interview with the DON on 7/14/23 11:57 a.m., indicated that the oxycodone was on hold, not because they were waiting on pharmacy to deliver the medication, but because they needed a refill on the prescription from the Physician. They do carry oxycodone-acetaminophen 10-325 mg in their EDK (emergency drug kit) but still needed a current prescription to obtain it. Continued interview with the DON on 7/14/23 at 2:12 p.m., indicated they checked every Wednesday, before the weekend, to ensure no one needed a refill on medications. It was the nurse's responsibility to call for a refill order if a resident was out. She was unable to provide documentation of when the Physician was notified for a prescription refill or if follow up had been completed. She had just spoken with the Physician and he indicated it was his fault, "he forgot". 3.1-48(a)(3)		DNS/designee will in-service nursing staff regarding the need for timely requesting of narcotic scripts, as well as the process for reporting any narcotic scripts that are unavailable to be obtained from physician. DNS/Designee will review the residents pain medication to ensure MD orders are followed and medication is available per order by reviewing the daily narcotic log. 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: Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Narcotic Scripts” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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			By what date the systemic changes will be completed: 8/9/23	
F 0759 SS=D 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% for 1 of 7 residents observed during medication pass. Two errors were observed during 27 opportunities for errors during medication administration. This resulted in a medication error rate of 7.41%. (Resident 91) Finding includes: On 7/14/23 at 8:04 a.m., QMA 1 was observed preparing medications for Resident 91. She prepared 6 pills and 1 liquid medication and administered them to the resident. The resident's medications were reconciled on 7/14/23 at 8:25 a.m. The July 2023 Medication Administration Record indicated the resident was to receive potassium, 20 milliequivilants daily and Restasis eye drops, 1 drop in each eye, twice daily. Both medications had been signed out as given during the observed medication pass with QMA 1, however they had not been observed as given. Interview with the QMA, on 7/14/23 at 10:55 a.m., indicated she had missed the potassium. She indicated she gave the eye drops later that	F 0759	It is the practice of this facility to ensure residents are free from any significant medication errors. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Residents 91 were assessed for any adverse reactions with none found. MD was notified of medication errors with no new orders received. 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 impacted by this deficient practice. QMA 1 was immediately in- on medication administration.	08/09/2023

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	morning, but she was unable to locate the eye drops in the medication cart. 3.1-48(c)(1)		What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: DNS/designee will in-service all nurses and QMA's on medication administration on or before 8/9/2023 with skills validations. 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: Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool "medication errors" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. By what date the systemic	

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			changes will be completed: 8/9/2022	