STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155826	A. BUILDING 00 B. WING	02/03/2023

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EVERGREEN CROSSING AND THE LOFTS	5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00397088, IN00398676, IN00398951, IN00399180, IN00399593, IN00400347, IN00400616, IN00400628, IN00400636, and IN00400296. Complaint IN00397088- Unsubstaniated. Complaint IN00398676- Unsubstantiated. Complaint IN00398951- Substantiated. Federal/State deficiencies related to the allegations are cited at F755. Complaint IN00399180- Substantiated. Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00399593- Unsubstantiated. Complaint IN00400347- Substantiated. Federal/State deficiencies related to the allegations are cited at F755. Complaint IN00400616- Unsubstantiated. Complaint IN00400628- Unsubstantiated. Complaint IN00400636- Substantiated. Federal/State deficiencies related to the allegations are cited at F755. Complaint IN00400296- Substantiated. Federal/State deficiencies related to the allegations are cited at F656 and F695.	F 0000		

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

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

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	Survey dates: January 26, 27, 30, 31, Feburary 1, 2, and 3, 2023. Facility number: 013280 Provider number: 155826 AIM number: 201270670 Census Bed Type: SNF/NF: 87 Total: 87 Census Payor Type: Medicare: 10 Medicaid: 71 Other: 6 Total: 87 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 16, 2023.			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure the PASRR (Pre-Admission Screening and Resident Review) Level II (comprehensive mental health evaluation) was recorded correctly in the Minimum Data Set (MDS) assessment for 1 of 5 residents reviewed for MDS accuracy (Resident 56). Findings include: On 1/27/23 at 12:42 p.m., the Minimum Data Set Coordinator (MDSC) indicated Resident 56's annual Minimum Data Set (MDS) assessment,	F 0641	F641 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: No residents were harmed by the alleged deficient practice. The MDS coordinator reviewed MDS for Resident 56 on 1/27/23 and corrected the error for PASRR and resubmitted the MDS. Identification of other residents	03/07/2023

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	dated 10/1/22, was reported in error. The resident had a Pre-Admission Screening and Resident Review (PASRR) assessment, and the MDS reported the Level II was not completed. On 1/27/23 at 1:00 p.m., the MDSC provided documentation of the MDS PASRR error corrected and resubmitted. On 2/1/23 at 10:30 a.m., Resident 56's medical record was reviewed. Her diagnoses included, but were not limited to, generalized anxiety disorder (condition that caused fear, feelings of being overwhelmed, and worry), major depressive disorder (condition that caused long-term loss of pleasure and interest in life), hallucinations (experiences involving the perception of something not present), and schizophrenia (condition that caused disruption of thought processes, perceptions, emotional responsiveness, and social interactions). A care plan, dated 10/26/21, indicated she had a Level II due to her diagnosis of schizophrenia. The goal was to follow the Level II recommendations until the next review date. A medication care plan, dated 10/26/21, indicated she used anti-psychotic medications, and an intervention was to provide anti-psychotic medication per the medical provider's orders. A medication care plan, dated 10/26/21, indicated she used anti-depressant medication, and an intervention was to provide anti-depressant medication per the medical provider's orders. A current policy was provided by the Administrator, on 2/3/23 at 1:07 p.m., from the CMS's (Centers for Medicaid and Medicare) RAI		having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents who require a Level II have the potential to be affected. The MDS coordinator audited all residents who required a Level II and corrected any discrepancies and resubmitted the MDS. Care plans were updated to reflect changes. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The Regional Resident Care Coordinator(R2C2) provided education to the facility MDS nurse and Social Services Director using the RAI manual on 2/8/22 with emphasis on coding MDS pertaining to Level II. Social Services will complete the Level II coding on MDS. How the corrective measures will be monitored to ensure the alleged deficient practice does not reoccur: R2C2/ Designee will conduct audits of the MDS to ensure Level II are accurately coded for 3 residents per week for 4 weeks, then 1 resident per week for 8 weeks, then 1 resident per month for 3 months. Any discrepancies will be corrected and education provided immediately. The results of the audit observations will be reported, reviewed and trended for	

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	(Resident Assessment Instrument) Version 3.0 Manual. A review of the document indicated, " ...The RAI process has multiple regulatory requirements. Federal regulations ...require that ...the assessment accurately reflects the resident's status ...The assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts ...." 3.1-31(d)		compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation	
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			

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	the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and 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 interview and record review, the facility failed to ensure a person centered care plan was developed and implemented for 1 of 3 residents reviewed for respiratory (Resident F). Findings include: On 1/30/23 at 11:51 a.m., Resident F's medical record was reviewed. The resident was admitted to the facility on 10/4/22. The diagnoses included, but were not limited to end stage renal disease, hypertensive heart and chronic kidney disease with heart failure and stage 5 renal disease, diabetes, heart failure and epilepsy. A copy of Resident F's Oxygen Therapy care plan was provided by the Regional Director of Clinical Services on 2/1/23 at 11:47 a.m.	F 0656	F656 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident F has discharged from the facility. No residents were harmed by the alleged deficient practice. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents that require oxygen therapy have the potential to be affected. The facility reviewed care plans for all residents requiring oxygen and updated any care plan to include flow rate, route and diagnosis.	03/07/2023

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	The care plan, dated 10/11/22, indicated, "(Name of Resident F) has Oxygen Therapy." The goal indicated "Resident will have no s/sx [signs and symptoms] of poor oxygen absorption through the review date." The review date was listed as 2/5/23. The interventions were: "[left blank] L [liters] by [left blank] route for Hypoxia & [left blank] DX [diagnoses], Give medications as ordered by physician. Monitor/document side effects and effectiveness. Monitor for s/sx of respiratory distress and report to MD PRN: Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, Skin color. Resident non-compliant with 02 at times will continue praise when in compliance." During an interview, on 2/1/23 at 8:36 a.m., the Divisional Risk Strategist indicated the care plan should have been person centered without blanks in the text. On 2/1/23 at 9:51 a.m., the Administrator provided a current, undated, policy, titled "Plan of care Overview." This policy indicated "...for the purpose of this policy the Plan of Care, also Care Plan is written treatment provided for a resident that is resident-focused and provides for optimal personalized care...Care plan documents are resident specific/resident focused...." This Federal regulation relates to Complaint IN00400296. 3.1-35(a) 3.1-35(d)(2)(B)		Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Education was provided to all licensed nurses utilizing the policy for Plan of care overview with emphasis on updating care plan for oxygen therapy specific to flow rates, route of delivery and diagnosis. How the corrective measures will be monitored to ensure the alleged deficient practice does not reoccur: DON/Designee will conduct audits of care plans for residents who require oxygen therapy to ensure flow rate, route of delivery, and diagnosis are updated as needed for 3 residents per week for 4 weeks and then 1 resident per week for 8 weeks, then 1 resident per month for 3 months. Any discrepancies will be immediately corrected and education will be provided as needed. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation	

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F 0657 SS=E 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 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 observation, interview and record review, the facility failed to ensure comprehensive care plans were created, implemented, and revised in a timely manner for 4 of 18 residents reviewed for care plans, (Residents D, 41, E and 73). Findings include: 1. On 1/27/23 at 8:30 a.m., Resident D's medical	F 0657	F657 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: No residents were found to be harmed by the alleged deficient practice. Resident D no longer resides at the facility. Resident 41 care plan has been	03/07/2023

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	record was reviewed. Resident D had been admitted to the facility on 10/28/22 after an acute hospital stay. A hospital discharge report dated 10/28/22 indicated Resident D had been treated for breakthrough seizures which resulted in a fall with a hematoma (A pool of mostly clotted blood that forms in an organ, tissue, or body space) to his forehead. Upon admission, Resident D had diagnoses which included, but were not limited to, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (stroke) which affected his right/dominant side, epilepsy, unsteadiness on his feet, and anxiety. An admission nursing evaluation, which also included the 48-hour baseline care plan, was dated 10/28/23. The baseline care plan indicated Resident D had experienced a fall within the previous 30 days but did not make a note of his head injury. Interventions from the baseline care plan were as follows; Ensure resident was wearing appropriate non-skid footwear, refer to therapy, place call bell within reach, room to be well let and free of clutter, assist with ADLs (activities of daily living), bed in lowest position, and remind resident to call for assistance. Further, the baseline care plan indicated bed assist bars were in place. An admission fall risk assessment, dated 10/28/22, indicated Resident D was at risk for falls and gave instructions to proceed to the care plan. Resident D's active, resolved, and cancelled comprehensive care plans were reviewed. A fall		updated to reflect his preference of NO PORK, Language line number, and primary language of Arabic. Resident E was unable to be identified due to being part of a complaint survey. Resident 73 care plan was reviewed and updated to reflect necessary interventions for fall prevention. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents whom have fallen, had a change in pain medications, require the use of language line or have religious/cultural food preferences have the potential to be affected. The facility completed an audit of all residents whom have fallen in the last 30 days to ensure appropriate fall interventions have been updated on the plan of care. Any resident whom did not have an intervention in place was re-assessed and intervention was added. The facility completed an audit of all residents who require the use of a language line for communication and updated the plan of care if needed. The facility completed an audit of all residents for religious/cultural food preferences and anyone identified had their plan of care updated to reflect the preference. Measures put in place and systemic changes made to ensure the alleged deficient practice does	

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	risk care plan was not initiated until 1/2/23 and only included the following two interventions: PT/OT (physical and occupational therapy) evaluation and treat, as needed, and send to ER (emergency room) to eval and treat. An ADL care plan was not initiated until 1/3/23, which indicated Resident D had an ADL self-care performance deficit and required assistance with his ADLs related to weakness. ADL interventions were listed for bed mobility, eating, toileting and transfers, but lacked specific, person-centered details and were left blank. His assistance levels were documented as follows: a. Resident requires _____ assistance with bed mobility b. Resident requires _____ assistance with eating c. Resident requires _____ assistance with toileting d. Resident requires _____ assistance with transfers Resident D's care plan lacked documentation of his bowel/bladder status, level or frequency of incontinence, and/or his use of and preference for a urinal at his bedside. Further, Resident D's care plans lacked documentation that he had a vagal nerve stimulator placed as preventative equipment to treat his epilepsy and seizure disorder, which also placed him at a greater risk for falls. Cross reference F684. 2. On 1/26/23 at 12:46 p.m., Resident 41 was initially observed. Upon attempt to interview him, he responded with very limited English words, and shook his head "no," as he indicated, "no		not recur: Education was provided to all licensed nurses by DON/Designee utilizing the policy for “Plan of care overview” with emphasis on updating care plan for fall interventions, food preferences, pain medications changes, and language barrier needs. How the corrective measures will be monitored to ensure the alleged deficient practice does not reoccur: The DON/Designee will conduct audits of 3 resident care plans per week for 4 weeks, then 1 resident care plan per week for 8 weeks, then 1 resident per month for 3 months to ensure fall interventions, food preferences, pain medications changes and interventions for language barriers are updated. Any discrepancies will be immediately corrected and education will be provided as needed. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation	

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	English, Arabic only." Using a language interpreter line, an interview was conducted with Resident 41 on 1/31/23 at 9:39 a.m. Through the interpreter Resident 41 indicated he did not like the food and often did not eat lunch or dinner because the meat was not right. Resident 41 was Muslim and did not eat pork, but it was often sent to him anyway. Resident 41 indicated he had not talked to anyone about a care plan, and that staff were often quick with him because they could not understand him. During an interview on 1/31/23 at 9:57 a.m., Licensed Practical Nurses (LPN) 18 and 22 indicated they had not used the language line before, but the number was posted in his room. Neither LPN 18 or 22 were aware of what type of snacks he liked to eat at night because they did not understand him, and they did not know he preferred not to be sent pork. Resident 41's comprehensive care plans were reviewed and lacked revision to include person-centered details that he did not eat pork or spoke Arabic. Although there was a care plan for Resident 41 being at risk for communication issues which advised to "use the language line" posted in his room, the number for the service was not included on the plan of care in case the paper fell down or was lost. 3. On 1/30/23 at 9:00 a.m., Resident E's medical record was reviewed. He was a long-term care resident who admitted on 5/20/22 with diagnoses, which included, but were not limited to, peripheral vascular disease and amputation of his right leg. He had physician's order for Oxycodone 10 milligrams (mg) as needed every 4 hours, which			

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	was discontinued on 1/20/23 when the order was change from as needed, to scheduled and was still active at the time of the review. A comprehensive care plan for Pain was not initiated until 8/9/22, (approximately 3 months after his admission). Further, the care plan only included one intervention, to, "Administer non-pharmacological interventions (repositioning, diversion activities, snacks and fluids, ice / heat, music therapy, relaxation techniques, imagery). Resident E's care plan lacked revisions to include the administration of narcotic pain medications, even after the prescriptions had been changed from as needed to scheduled. 4. On 1/31/23 at 2:53 p.m., Resident 73's medical record was reviewed. The diagnoses included, but was not limited to congestive heart failure, acute kidney failure and anemia. A nurses' note, dated 12/22/2 at 8:14 a.m., indicated, "Writer called to resident's room. Resident reported self-fall. Husband at bed side. Resident stated she was having pain to left side. Pain medication ordered. Upon further assessment resident noted to have increased pain. Advised NP [Nurse Practitioner]. New orders to send to [Name of local Hospital] for further evaluation. MD and family aware." On 12/22/22 at 2:01 p.m., a nurses' note indicated, "Hospital follow up: Spoke to pt's [patient's] ER [emergency room] nurse at [Name of Local Hospital]. Per charge nurse, pt broke 4 ribs and she is being admitted for pain management. Head CT [cat scan] WNL [within normal limits]. ER nurse will call for any changes in condition." On 1/31/23 at 3:48 p.m., the Regional Director of			

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	Clinical Services provided a copy of Resident 73's current fall care plan, with dates. The care plan, initiated 11/23/22, indicated, Resident 73 was at risk for falls related to weakness. The goal was revised on 1/6/23, with a target date of 4/6/23, it indicated Resident 73 would not sustain major injury related to falls through review date. The interventions, dated 11/23/22, were: Ensure resident was wearing appropriate non-skid footwear. Ensure resident's room was free of accident hazards. Ensure that the bed locks were engaged. Place call bell within reach, remind resident to call for assistance. Provide adequate lighting at night. Provide assuasive devices as needed. An intervention, initiated post fall, on 12/22/22, indicated, "Send to ER [emergency room] for eval [evaluation]." No other interventions had been added for fall prevention, post fall with injury. On 2/1/23 at 8:36 a.m., during an interview, the Divisional Risk Strategist indicated the care plan should have had fall interventions added. On 2/1/23 at 9:51 a.m., the Administrator provided a current, undated, policy titled, "Plan of care Overview." This policy indicated, "...for the purpose of this policy the Plan of Care, also Care Plan is written treatment provided for a resident that is resident-focused and provides for optimal personalized care...Care plan documents are resident specific/resident focused...." 3.1-35(c)(1)			

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	3.1-35(c)(2) 3.1-35(d)(2)(B)			
F 0684 SS=G Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure a resident who was at high risk for falls had a timely treatment after a fall which resulted in actual harm when staff continued to transfer him in and out of bed, he was taken to participate in therapy, and his mobile x-ray was canceled after no physician's order could be provided to the x-ray technician for 1 of 3 residents reviewed for falls (Resident D). Findings include: During a phone interview on 1/27/23 at 11:05 a.m., Resident D's family member indicated an e-mail grievance had been sent to the facility Administrator on 1/10/23 regarding a delay in treatment for Resident D after a fall. According to the family member, they called to check in on Resident D on 12/31/22 and he complained of pain at that time. It wasn't until 1/3/23 when x-ray results were received and revealed a broken hip that the family member was notified of the fall and a new order had been given to send him to the hospital. The family member indicated Resident D had complained of pain for several days and	F 0684	F684 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident D no longer resides in the facility. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents who are high risk for falls and have had a fall have the potential to be affected. The facility reviewed the care plans and interventions for these residents to ensure care plan is appropriate and interventions are in place. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Education was provided to all nursing staff utilizing the Fall prevention and Management policy with emphasis on obtaining and	03/07/2023

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	wondered why he had not been sent out earlier. The staff just said, Resident D had refused to go to the hospital, which was odd, because when the family member spoke to him, Resident D indicated he was in pain and waiting for treatment. If the facility had called sooner, the family member indicated they would have been able to convince him to go to the hospital. When the family member was notified of the fall, they were told he fell from his bed after reaching for his urinal which he was accustomed to using, so the family member wondered why it was out of reach. Further, the family member complained that the bed controls had not worked, so there was no way to know if his bed was lowered. Often when the family member visited, his bed was at regular height. The family member indicated one of Resident D's friends came to visit him and noted he was in pain and complained that it was taking too long to get help. The family member also wondered if his several room moves contributed to his confusion and fall. He was originally put in a room upstairs, then he was told he needed to move rooms for new residents, but he would be put in a bigger room. He was moved a third time to a room at the end of the hall, where the service lights weren't working so he had to call out for help a lot. During a phone interview on 1/31/23 at 2:00 p.m., a former co-worker and close friend indicated she visited Resident D on afternoon of New Year's Eve, 12/32/23. When she arrived, he was sitting up in a chair and complained of pain, so she did not visit for long. She asked what happened, and he indicated he fell. She asked if he was still getting physical therapy and he said, yes- they took him down earlier. A nurse came in the room, and she told her that Resident D was complaining of pain because he fell he and wanted to get back in bed. When asked about Resident D's bed position, the		transcribing diagnostic physician orders, ensuring testing is completed in a timely manner, and what to do if pain occurs post fall. How the corrective measures will be monitored to ensure the alleged deficient does not re-occur: The DON/Designee will conduct audits to ensure all orders for diagnostic services needed post fall are transcribed in the medical record and timely completion of testing is achieved, and if pain is present that therapy is held. The audits will be conducted as follows 5 residents per week for 4 weeks then 3 residents per week for 4 weeks then 1 resident per week for 4 months. Any discrepancies will be immediately corrected and education provided. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation Facility IDR being request to dispute the scope and severity of this tag.	

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	friend indicated it was a regular bed, not too high and not too low. Resident D's friend indicated the resident was not one to complain much, but he was uncomfortable enough that he asked for pain medicine. On 1/31/23 at 2:32 p.m., a phone interview was conducted with Resident D, who no longer resided in the facility. Resident D indicated he did remember being at Evergreen and that he fell out of bed. He indicated, "I fell out of bed, I just rolled over and fell out, it didn't feel good at all, and it hurt for days. I think I was sleeping and just rolled over." He did not remember how he got off the floor or back in bed. He indicated he was at another facility still rehabilitating from the fall. On 1/27/23 at 8:30 a.m., Resident D's medical record was reviewed. Resident D had been admitted to the facility on 10/28/22 after an acute hospital stay. A hospital discharge report, dated 10/28/22, indicated Resident D had been treated for breakthrough seizures which resulted in a fall with a hematoma (A pool of mostly clotted blood that forms in an organ, tissue, or body space) to his forehead. A physical therapy note on the discharge report indicated, "some confusion, but pleasant ...Sat [on the] edge of bed with assist of 1 today but [unable] to tolerate transfer to stand, stating his right leg felt too weak and 'I will fall.' He is considered a high fall risk currently due to his dependent mobility level and poor safety awareness ...." Upon admission to Evergreen, Resident D had diagnoses which included, but were not limited to hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body)			

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	following cerebral infarction (stroke) which affected his right/dominant side, epilepsy, unsteadiness on his feet and anxiety. An admission nursing evaluation, which also included the 48-hour baseline care plan, was dated 10/28/23. The baseline care plan indicated Resident D had experienced a fall within the previous 30 days but did not make a note of his head injury. Interventions from the baseline care plan were as follows; Ensure resident was wearing appropriate non-skid footwear, refer to therapy, place call bell within reach, room to be well let and free of clutter, assist with ADLs (activities of daily living), bed in lowest position, remind resident to call for assistance. Further, the baseline care plan indicated bed assist bars were in place. An admission fall risk assessment, dated 10/28/22, indicated Resident D was at risk for falls and gave instructions to proceed to the care plan. Resident D's care plans lacked documentation that he had a vagal nerve stimulator placed as preventative equipment to treat his epilepsy and seizure disorder, which also placed him at a greater risk for falls. Resident D's care plan lacked documentation of his bowel/bladder status, level or frequency of incontinence, and/or his use of and preference for a urinal at his bedside. A Nurse Practitioner (NP) progress note, dated 11/8/22 at 9:59 a.m., indicated, Resident D was being seen for an initial psychiatric consult. Resident D had increased anxiety and yelled out frequently, often for something he could reach, other times for assistance that he was unable to do alone. Resident D indicated he did not remember yelling out loudly. His medications were			

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	reviewed, and a new order was given to start Buspar (an anti-anxiety medication that can cause some people to become dizzy, lightheaded, drowsy, or less alert than they are normally). A nursing progress note, dated 12/23/22 at 3:37 p.m., indicated, Resident D was noted to have loud outbursts every 15-30 minutes and put his call light on. Staff would enter the room, and he would not remember putting the light on. He was checked for incontinence as he wore briefs. Resident D's therapy progress notes were reviewed and indicated the following: A Speech Therapy (ST) noted, dated 12/31/22 at 11:28 a.m., indicated, "Patient stated he had a fall reaching for his urinal earlier this morning and was requesting something for pain. Nursing was immediately notified and stated not being aware of his fall." A Physical Therapy (PT) note, dated 12/31/22 at 2:26 p.m., indicated, "transferred with maximum assistance from bed to wheelchair (wc) and wc to bed. Patient needed moderate assistance for supine to sit and moderate assistance for sit to supine getting lower extremities into bed as well. Patient needing visual cues for sequencing/safety and patient yelling out wincing due to pain throughout each transfer. Patient completed 15' (feet) on sci-fit (a specialized piece of therapy equipment similar to a seated bike and row machine) on level 2, with his left lower extremity and both upper extremities to improve strength, range of motion and endurance. Patient reported severe pain in right hip/thigh area due to fall. Per nursing nothing was reported. Patient was unable to extend right knee past 40 degrees today without pain increasing and patient resisting.			

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	Patient completed bilateral lower extremity exercises in sitting to improve strength and range of motion. Patient did what he could tolerate. Patient nurse notified of change in transfers and range of motion." A ST progress note, dated 1/2/23 at 1:54 p.m., indicated Resident D had increased confusion. A ST progress note, dated 1/3/23 at 4:03 p.m., indicated Resident D was seen in bed that day due to increased pain in his leg. During an interview on 1/27/23 at 12:21 p.m., PT 50 indicated she had worked with Resident D on 12/31/22 and put the above progress note in. She indicated, she saw him earlier in the day, before lunch time. She went down to get him that day and remembered his bed was at a normal height, not lowered, and not left very high. Ne needed maximum assistance to transfer into his wheelchair. He went to therapy and participated but with decreased ability, they only worked his left side since his right leg hurt. She took him back to the nurses' station and reported his pain, and the nurse was unaware of any new pain. A late entry nursing progress note was dated effective as of 12/31/22 at 2:50 p.m. but had been created 1/6/2023 at 3:03 p.m. The note indicated Resident D had no pain, even though ST and PT both reported pain in his right hip on 12/31/22 before lunch. A late entry nursing progress note was dated effective as of 12/31/22 at 3:03 p.m. but had been created 1/2/2023 at 10:46 a.m. The note indicated Resident D had no pain, even though ST and PT both reported pain in his right hip on 12/31/22 before lunch.			

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A late entry nursing progress note was dated effective as of 12/31/22 at 4:35 p.m. but had been created 1/1/2023 at 4:55 p.m. The note was a post fall evaluation which indicated the physician had been notified of the fall on 12/31/22 at 1:30 a.m., and Resident D complained of pain in his right hip.

A late entry nursing progress note was dated effective as of 12/31/22 at 8:32 p.m. but had been created 1/2/2023 at 9:00 a.m. The note indicated, "update to note: resident did fall. Upon further investigation, resident did admit to falling. Resident states he was in bed, reaching for his urinal and slid out of bed. When sliding out of bed resident states he hit his hip on the bed. Mild pain of 2, [as needed] given and effective. In house NP notified and ordered x-ray due to pain ...."

A late entry nursing progress note was dated effective as of 12/31/22 at 8:35 p.m. but had been created 1/4/2023 at 3:11 p.m., "family aware."

A late entry nursing progress note was dated effective as of 12/31/22 at 8:40 p.m. but had been created 1/3/2023 at 3:30 p.m.. the note indicated " ...spoke with NP and advised [a contracted mobile x-ray company] could not come out prior to 1/1/244 resident denies going to ER to be evaluated NP resident and family aware ...."

Resident D's completed and discontinued physician orders were reviewed. An order for Resident D's right hip/pelvis was not placed until 1/3/23 at 10:45 a.m. The x-ray was ordered due to fall, pain and decreased mobility.

He had an order for Acetaminophen (Tylenol) 325

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mg (milligrams) with instructions to give 2 tablets every 6 hours as needed for pain, which was only administered once in the month of December on the 31st at 7:34 p.m.

On 11/28/22, Resident D had a procedure to pace Vagal Nerve Stimulator, (VNS- an implanted medical device placed by a surgeon near the collarbone to help control seizure activity via electrical stimulation) and had been given a 6 tablet prescription for Oxycodone (a narcotic pain medication) 5 mg every 6 hours as needed for pain.

Although a pharmacy prescription summary was provided, no physician's ordered was placed in his record for the Oxycodone, therefore, no corresponding Medication Administration Record, (MAR) was available to verify the administration. The 6th and final tablet was signed out on 1/2/23 at 1:00 p.m., even though no pain was indicated on his MAR.

On 2/1/23 at 2:50 p.m., the Vice President of Compliance and Internal Operations for mobile x-ray company provided recorded phone messages and internal notes related to Resident D's x-ray orders.

A phone recording, timestamped 12/31/22 at 8:46 p.m., (approximately 9 hours after ST initially reported acute pain to nursing), Registered Nurse (RN) 50 called and ordered a regularly scheduled x-ray. At 8:52 p.m., six minutes later, she called back to verify the right hip had been requested.

A phone recording, timestamped 1/1/23 at 3:24 p.m., Licensed Practical Nurse (LPN) 52 called to inquire when they would be coming to complete Resident D's x-ray. His appointment was located

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	in the system as a routine x-ray scheduled for Tuesday 1/3/23, to which LPN 52 indicated, "oh no, no. He's complaining of pain, his family is here. We need that called in STAT, they are going to take him to the hospital, but he has dementia ...so he needs to be going to the hospital right now ...." Representative 53 checked to see if there was an x-ray technician in the area and re-ordered the x-ray from routine to STAT (immediately). LPN 52 asked for an estimated time of arrival and Representative 53 indicated, "the technologist is going to reach out to your facility to give you guys an ETA on when they are on the way to the facility, I can't guarantee a time frame they are going to be the ones to give the ETA, I do need to let you guys know there is only one tech and its extremely busy in the area so it could be a later than usual ETA." LPN 52 entered a late corresponding nursing progress note, dated effective 1/1/23 at 7:21 p.m., but created 1/3/23 at 4:08 p.m., which indicated, several attempts to call the mobile x-ray company were made and there were two patients before Resident D. A phone recording on 1/1/23 at 5:11 p.m., was the assigned x-ray technician, Tech 54 who called internally to see if Resident D's x-ray could be rescheduled due to care trouble. Representative 55 indicated she would tell the facility it would be tomorrow. Representative 55 called Evergreen on 1/1/23 at 5:16 p.m. but the call went unanswered. A mobile x-ray company GPS transmitter indicated X-Ray Tech 56 arrived to Evergreen on 1/2/23 at 5:47 p.m., and left at 6:17 p.m. The X-ray order was cancelled at that time due to no physician order for the exam was on the resident's file.			

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	A phone recording on 1/3/23 at 9:32 a.m., was Nurse Practitioner 56 who called to inquire about Resident D's x-ray. Representative 58 explained a technician had been out the day before but was unable to complete the x-ray because there was not a doctor's order so the exam was cancelled. NP 56 re-ordered the exam STAT and indicated, "can we please order that STAT because we are going to end up taking our patient to the ER." On 1/3/23 at 10:28 a.m., the x-ray was performed and the results were received at 10:41 a.m., which revealed, "an acute subcapital fracture proximal right femur with angulation and superior displacement of distal fragment." A nursing progress note, dated 1/2/23 at 8:49 a.m., indicated Resident D complained of mild pain, and his PRN medication was administered. However, there was no documentation on his Medication Administration Record (MAR) that the medication was administered. On 1/3/23 at 11:44 a.m., " ...patient alert and oriented has pain but continues to refuse any pain medication ..." New orders were given to send Resident D to the ER where he was admitted to the hospital for evaluation and treatment, approximately 72 hours after Resident D initially complained of pain. During an interview on 2/1/23 at 2:22 p.m., NP 57 indicated she had been notified of Resident D's complaints on pain on the evening of 12/31/22. By that time, he had self-reported a fall, so NP 57 ordered an x-ray. Initially he did not want to go to the hospital, and when she came in to see him on 1/3/23 a STAT x-ray was reordered because there was some mix up with the x-ray company, but throughout those day he never complained of			

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	pain. During an interview on 2/2/23 at 10:15 a.m., Certified Nursing Assistant (CNA) 14 indicated she worked with Resident D on New Year's Eve and her ADL charting activity was reviewed with her. She indicated Resident D called out for help a lot and often forgot that he had. He was used to using the urinal by himself. CNA 14 indicated she had finished working with another resident and was taking some trash out when she heard Resident D call out, "Help! Nurse nurse!" She indicated when she entered his room, she found him on the floor and asked, "oh my god, what happened?" and he only said, "I fell." She went to get help and it took three staff member to get him off the floor. During an interview on 2/2/23 at 10:39 a.m., Qualified Medication Aid, (QMA) 26 indicated she did not know Resident D had a fall until therapy reported it to her and she went to tell her nurse. QMA 26 indicated PT came down to get him and took him to therapy like usual, but when they returned the therapist indicated Resident D had complained of pain and could not continue. During a follow up interview on 2/2/23 at 2:23 p.m., CNA 14 indicated she may have remembered wrong and wanted to clarify that she did not find Resident D on the floor, but instead it appeared that he was slipping out of his chair and was almost on the ground, when she went in and was able to assist him back into his chair. On 2/2/23 at 2:33 p.m., the RN Divisional Risk Strategist provided a copy of the post fall investigation which included the following phone statements:			

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	a. RN 50 who indicated, "[Resident D] did not fall on my shift, he said he was in pain after therapy, I went to assess him, I called [NP 57] she ordered an x-ray, I asked him did he want to go to the hospital and he said no." [Refer above: ST progress note reported pain to nursing on 12/32/22 at 11:28 a.m., and RN 50 did not call mobile x-ray to place the x-ray request until 12/31/22 at 8:46 p.m.] b. QMA 26 who indicated, "He did not fall on my shift, I helped him in his chair, and he did complain of pain and we told the nurse." c. NP 57 who indicated, "A nurse called me and stated he was in pain, I don't remember what nurse, but I gave an order for an x-ray, I did not order STAT because his pain was mild, at that time they did not know he had called. They also called to tell me that the x-ray had not been done and I told them to send him to the ER they called and told me he refused. I came in and saw him and encouraged him to go to ER and he refused, I put in an order for a STAT x-ray." d. Electronic Health Record Coordinator, (EHR) 7 who indicated, "I came in Saturday 12/31/22 afternoon/evening. When I first came in, I did my rounds on the unit, I was not working the cart- I was helping on call person [nurse]. RN 50 stated patient was getting x-ray on patient due to pain states had fall. I asked her to come with me to patient's room, patient self-reported fall and instructed RN 50 to complete charting for fall-resident state he did not have pain at that time and refused to go to hospital." On 2/2/23 at 2:45 p.m., The RN Divisional Risk Strategist provided copies of an in-service sign in sheet, dated 11/28/22, and in-service material. At			

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	this time, she indicated, nursing staff had been in-serviced on the provided material upon Resident D's return from a procedure where he had a vagal nerve stimulator (VNS) placed for his epilepsy and seizure activity. She highlighted a portion of the training which stated, " ...all nursing staff must be aware that his seizures and VNS cause him to be at a higher risk for falls. Ensure that side effect monitor is in place, call light remains in reach, frequently used items (magnet, remote, cell phone, water, urinal wheelchair) are within reach, nonskid footwear as tolerated, environment clutter free, bed is locked, reminders to call for assistance as needed ...." On 1/31/23 at 2:00 p.m., the Administrator, (ADM) provided a copy of current facility policy titled, "Fall Prevention and Management," revised 6/1/22. The policy indicated, "Is it the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. Fall prevention and management is the process of identifying risk factors that can minimize the potential for falls and also a process to manage a resident's care if a call occurs ... If the resident is identified to be at risk for fall, a care plan should be initiated that includes a plan to potentially diminish the risk of falls. The care plan can include interventions that address environmental factors, ADL factors, risk factors that result from dementia and other mental diagnosis, medical diagnosis that put the resident at higher risk. Issues such as toileting, eating, transferring, and impulsiveness should be considered. The care plan can address furniture arrangements, footwear, medications that can cause dizziness, drowsiness and instability. The care plan should also address how the resident can be transferred in and out of bed as well as how the resident can ambulate and move			

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	around the facility. The care plan should be reviewed and updated as needed with each change of condition ...." On 1/31/23 at 2:00 p.m., the Administrator, (ADM) provided a copy of current, but undated facility policy titled, "Urinal: Placement of." The policy indicated, "If is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety is a primary concern for our residents, staff and visitors ... Self-Care: resident may be able to remove urinal himself and/or advise when he is finished, provide standby assist as needed, remain with resident if unable to advise when he is finished and provide privacy if you stay with resident, remove urinal ...." On 2/1/23 at 3:50 p.m., the RN Divisional Risk Strategist provided a copy of current facility policy titled, "Laboratory and Radiological Services and Results Reporting," revised 6/13/22. The policy indicated, " ...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents ... the facility will have an on-going written agreement with a qualified laboratory(ies) and radiology units to provide services to meet the needs of the resident population ... the facility will collaborate with the lab and/or radiology unit to provide reports to the facility in a timely manner...." On 2/1/23 at 3:50 p.m., the RN Divisional Risk Strategist provided a copy of the current Radiology Service Agreement, dated 2/25/21. The Agreement indicated, " ... all orders must include the exams to be performed, the number of views to be taken, the medical necessity of the exam, and if			

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	x-ray, why is was ordered to be done portably. As the legal custodian of the patient's medical records Facility will obtain and store within each patient's chart the signature of the practitioner who ordered that exam. Facility agrees to provide all required information and documentation for proper billing and/or related audits in a timely manner ...." This Federal tag related to Complaint IN00399180. 3.1-37(a) 3.1-37(b)			
F 0690 SS=D 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			

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	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 bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to ensure a Foley catheter bag and tubing was not on the floor and the tubing was not above the waist for 1 of 1 resident reviewed for correct Foley catheter and tubing care (Resident 290). Findings include: On 1/26/23 at 10:20 a.m., Resident 290 was observed in her wheelchair as staff pushed her in the hallway. Her catheter bag was observed on the back of her wheelchair at waist height and the Foley tubing was observed above her waist. On 1/26/23 at 4:06 p.m., Resident 290 was observed in her bed, the Foley catheter bag and tubing were not attached to the bed rail and were lying flat on the floor. The Foley bag was not in a dignity bag. On 1/30/23 at 2:58 p.m., Resident 290 was observed in her room, in her wheelchair, the catheter bag was in a non-disposable bag at the back of her wheelchair and the tubing was observed above her waist. On 1/31/23 at 2:05 p.m., Resident 290 was observed in her room, in her wheelchair, the	F 0690	***What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice*?** Resident 290 had their catheter placed into a dignity bag and had their tubing secured off of the floor during the survey process. Resident 290 catheter bag was changed and clips applied to tubing to keep it off of the floor. ***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 with a catheter have the potential to be affected by this alleged deficient practice. An audit will be completed to identify residents who have a catheter to ensure appropriate catheter supplies/drainage bags are in place and tubing is able to be kept off of the floor.	03/07/2023

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	catheter bag was under her wheelchair touching the floor. It was not in a dignity bag. On 1/26/23 at 4:19 p.m., Resident 290's record was reviewed. Her diagnoses included, but were not limited to, obstructive and reflux uropathy (discomfort or trouble voiding) and chronic kidney disease (long-term kidney dysfunction). Active physician catheter orders, dated 1/25/23, indicated: a. Suprapubic (inserted above the pubic bone) catheter 14 French (size)/10 mL balloon (anchoring device). Provide privacy bag. b. Measure and document the suprapubic catheter output every shift. c. Catheter care every shift and as needed to wash with soap and water. d. Suprapubic catheter changed monthly and as needed per physician's order. e. Clean and change T-sponge or gauze (dressing) to catheter site. Her care plan, dated 1/27/23, indicated she had a suprapubic catheter related to obstructive uropathy and she would remain free of catheter related trauma through review date. The intervention included enhanced barrier precautions when dressing, bathing, showering, transferring, personal hygiene, changes linens, toileting and peri-care, providing care to urinary catheter. Position catheter bag and tubing below the level of the bladder and provide privacy bag. During an interview, on 2/2/23 at 9:12 a.m., the Division Risk Strategist (DRS) indicated if a resident had a suprapubic catheter it was ok for the catheter tubing to be at the waist level during transfers and the catheter bag should not have been on the floor unless it was in a dignity bag.		***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** DON/designee to provide education on proper catheter care and maintenance; including the need to keep the catheter bag and tubing off of the floor. . ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** DON/designee to audit the residents with catheters daily to ensure proper care is in place. Any findings will be addressed. Auditing to occur: 2 residents with catheters daily x's 4 weeks, then 2 residents weekly x's 4 weeks, then 2 residents monthly x's 4 months for a total of 6 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist.	

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	During an interview, on 2/2/23 at 9:14 a.m., the Regional Director of Clinical Operations (RDCO) indicated during a transfer the staff might put the bag at the resident's waist level. The Foley bag was only allowed to be on the floor if there was a barrier of some kind like a dignity bag. A current policy, titled, "Catheter Care," dated 6/2/21, was provided by the RDCO, on 2/2/23 at 9:30 a.m. A review of the policy indicated, " ...Check that collection bag is not on the floor unless in dignity bag and or appropriate barrier and is draining properly and secure allowing for no reflux of urine back to the bladder ...." The CDC's (Center for Disease Control and Prevention) "Guideline for Prevention of Catheter-Associated Urinary Tract Infections," dated February 2017, was reviewed. It indicated, " ...Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor...." 3.1-41(a)(2)		The Administrator at Evergreen Crossing & The Lofts is responsible for ensuring compliance of this plan of correction.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on and record review and interview, the	F 0695	F695	03/07/2023

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	facility failed to ensure a resident with a tracheostomy (surgical opening in the neck to enable breathing) had clear respiratory orders and plans of care for 1 of 1 residents reviewed for tracheostomies (Resident F). Findings include: On 1/30/23 at 11:51 a.m., Resident F's medical record was reviewed. The resident was admitted to the facility on 10/4/22. The diagnoses included, but were not limited to end stage renal disease, hypertensive heart, chronic kidney disease with heart failure and stage 5 renal disease, diabetes, heart failure, and epilepsy. A care plan, dated 10/11/22, indicated, "(Name of Resident F) has Oxygen Therapy." The goal indicated, "Resident will have no s/sx [signs and symptoms] of poor oxygen absorption through the review date." The review date was listed as 2/5/23. The interventions were: "[left blank] L [liters] by [left blank] route for Hypoxia & [left blank] DX [diagnoses], Give medications as ordered by physician. Monitor/document side effects and effectiveness. Monitor for s/sx of respiratory distress and report to MD PRN: Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, Skin color. Resident non-compliant with O2 at times will continue praise when in compliance." A Nurse Practitioner (NP) note, dated 10/13/22, indicated, "Informed by nursing that resident was having difficulty breathing. Upon assessment, resident appeared to be in distress with labored breathing, having a difficult time to catch a breath,		Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident F has discharged from the facility. No residents were harmed by the alleged deficient practice. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents that require oxygen therapy via tracheostomy have the potential to be affected. No other resident residing in the facility has been identified as having the potential to be affected. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Education was provided to all licensed nurses utilizing the policy for Tracheostomy Care with emphasis on ensuring accurate orders are obtained and entered into medical chart and plan of care reflects oxygen therapy specific to flow rates, route of delivery. How the corrective measures will be monitored to ensure the alleged deficient practice does not reoccur: DON/Designee will conduct audits of orders for residents who require oxygen therapy via tracheostomy to ensure flow rate, route of delivery, and diagnosis are updated as needed for 3 residents per week for 4 weeks and then 1 resident per week for 8 weeks, then 1	

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	her O2 saturation was between 94-96% on oxygen NC [nasal cannula], oxygen mask was applied to help resident to catch a breath. Her blood sugar was 141, hypertensive B/P [blood pressure] 225/150, tachycardic HR [heart rate]125. Resident has a trach [tracheostomy], capped. She was able to shake her head for yes and no answers, alert. She admitted to facility on 10/4/22 after hospitalization in an LTACH facility. A Nurse Practitioner (NP) note, dated 10/21/22, indicated, "Follow-up visit for readmission Patient ...was sent out to the ED [emergency room] for SOB [shortness of breath]. Chest x-ray done in the hospital showed diminished lung volumes with patchy left lower lobe interstitial markings. Patient PMH [history] includes ESRD [end stage renal disease] on HD [dialysis], chronic combined systolic and diastolic heart failure, T2DM [diabetes] with CKD [chronic kidney disease], acute hypoxic respiratory failure with tracheostomy, HTN [high blood pressure], HLD [high cholesterol], anemia, status epilepticus, dementia, debility. Patient was diagnosed with hospital acquired pneumonia with concern for multi-drug resistant pathogens. She was treated with IV antibiotics and returned to facility once medical stable ...." A nurse's progress note, dated 10/25/22 at 1:53 p.m., indicated the resident complained of shortness of breath (SOB). The assessment indicated vitals oxygen saturation (SAT) 99%. Labored breathing and bilateral wheezing lung sounds. The resident denied pain, breathing treatment (tx) administered. Daughter present and phoned for ambulance. Patient transferred to local hospital. A physician consult progress note, dated 10/25/22		resident per month for 3 months. Any discrepancies will be immediately corrected and education will be provided as needed. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation	

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	at 9:54 p.m., indicated, diagnosis: acute respiratory failure, "...patient sent out to hospital 2 times already for respiratory distress - now visibly using accessory muscles and wheezing. Tachypneic, SP02 99% on 4L. Unclear etiology, needs further imaging and urgently. Send out to ED[emergency room] ...may go to alternative facility." A nurse progress note, dated 10/25/22 at 10:09 p.m., indicated, "Resident is gasping, SOB, few minutes after coming from the hospital. Resident is visibly using accessory muscles and wheezing. Resident been assessed via telehealth convergence system and order the patient to go to different hospital for treatment. Resident went back to [name of hospital] per daughter." On 10/25/22 a Hospital note indicated, "Patient presents via EMS [emergency medical service] secondary to respiratory distress reportedly DTs assisted ventilations and round with a GCS [glascow comma scale] of 3 recently discharged from this emergency department several hours ago. Physical exam acute distress awake responding to voice diminished breath sounds on the left but clear on the right neuro nonfocal patient was placed on 50% trach collar with a no assisted ventilations maintained her sat well. Will check labs CT scan head unclear etiology of respiratory difficulty question cardiac event versus seizure will admit to Medicine for further observation and evaluation." On 2/1/23 at 2:19 p.m., Qualified Medication Aid (QMA) 12 provided a copy of Resident F's hospital discharge papers, dated 10/25/22. Page 85 indicated, "...Assessment Plan: Agree with disposition to facility with RT VFs unable to fully abduct. Do not recommend capping trial or			

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	decannulation at this time as this may further respiratory distress given limited air movement due to abduction. Due to concern for pulmonary infection, would defer any intervention or capping trial in the acute setting Will schedule patient for outpatient follow-up with Otolaryngology-Head and Neck Surgery...." A nurse's progress note indicated, late entry, on 11/19/22 at 3:35 a.m. the QMA (Qualified Medication Aid) came and got the nurse to check on Resident F. Resident F was breathing but not responding to verbal. Vital signs were obtained, blood pressure 100/72 , pulse rate 60, respirations 14, oxygen saturation was "not able to get right away." Called Nurse on Lofts (upper floor of the facility) to come assist with resident, also . When nurse from upstairs came the resident's oxygen saturation was 60. Resident F then stopped breathing. A code blue was called and the nurse from upstairs started CPR. Resident F was a full code. The nurse did ambu bag, nurse from upstairs did compressions. 911 was called. EMT arrived and took over CPR. On 1/31/23 at 11:45 a.m., during an interview, the Infection Preventionist, Licensed Practical Nurse (LPN) 6, indicated she usually worked day shift, but she was at the facility when Resident F had coded, about 3:00 a.m., on 11/19/22. Resident F had been in her room, on the Health Hall, and LPN 6 was on another hall, in the bathroom. Certified Nurse Aid (CNA) 14 came knocking at the bathroom door. She indicated she went to answer Resident F's call light and she was acting "funny." LPN 6 asked her what that meant. CNA 14 indicated Resident F was awake, her eyes were open, but she was not talking. LPN 6 indicated she suctioned the resident's trach, checked her vital signs and got a blood sugar. Then her head			

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	went to the side, her eyes closed, and she stopped breathing. Qualified Medication Aid (QMA) 12 brought the code cart in and she opened the drawer and got the ambu bag, there may have been one already in the room, but she didn't look. Resident F normally wore a nasal cannula but did not like it and would take it off. She bagged her using room air and did not connect the bag to the oxygen. QMA 12 had called 911, they did maybe three cycles of CPR and the EMT's showed up and took over. She did not see what they did, she just moved out of the way. The EMT's were familiar with the resident because they have had to come before- when she gets obstructed. She got obstructed a lot A review of the most current physician's order set for the month of November included, but were not limited to, O2 (oxygen) via nasal cannula (delivered through a tube into nose) with humidifier, start at 2 liters to keep saturation above 90 % as needed for respiratory distress. Full code status. Additional trach care orders: pulse ox (oxygen saturation measurement) and O2 (oxygen) monitoring every shift and as needed (PRN), suction PRN, respiratory therapist to see to change inner cannula/trach, then schedule monthly, same size and one smaller/type trach, obturator (used to reinsert), lubrication kit, and large syringe for cuff inflation at bedside at all times, please obtain humidifier for trach, provide trach care every shift and as tolerated, provide manual inflation of the lungs prior to suctioning patient trach using ambu bag (deep bag inflation), change aerosol mask, O2/nebulizer tubing, humidification bottle, storage bag, and clean filter every week, change trach monthly (first change must be done by MD or EMT), change trach ties			

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	daily and prn, change inner cannula #6 portex every day and prn, inner cannula changed daily and prn, "trach q [every] shift and prn," Trach size 6 inner cannula size 6 Portex (name brand) uncuffed, trach: ambu bag, oxygen (e.g., E-Cylinder), suction canister and catheters in room at all times, trach care: change trach dressing, remove and inspect inner cannula-change or clean (if non-disposable) every shift and prn, lavage with normal saline for thick secretions, change trach ties if heavily soiled, suction trach prn. An order dated 10/7/22 indicated cool mist via airvo (machine to provide high flow warmed and humidified respiratory gases) or air compressor, bleed in the O2 as needed start at 2 liters, keep oxygen saturation above 90%. Wean prn if sat above 90%. Check sat prn and every shift. A second airvo order, dated 11/18/22, indicated airvo flow of 25 to keep oxygen sat above 90% at bedtime. This order was initialed as provided on the night of 11/18/22. On 2/2/23 at 10:08 a.m., the Administrator provided a respiratory ticket which indicated an airvo machine was delivered to the facility and set up by the Respiratory Consultant on 11/18/22. A respiratory therapist consult note, dated 11/18/22 at 1:30 p.m., indicated "set up airvo in room. Pt [patient] not available, flow was set at 25 and orders to read O2 to keep sat > 90%. Trach in-service was done with nursing service." On 1/31/23 at 1:57 p.m., during an interview, the Divisional Risk Strategist (DRS) indicated a resident with a tracheostomy should only have only had a nasal cannula if trach was capped.			

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	There was no order to cap the trach or documentation it was capped. The order to wean the oxygen didn't make sense. They couldn't wean O2 only a respiratory therapist could do that. If they wanted to decrease or increase the oxygen they would have had to call the doctor for an order each time. Their documentation of oxygen saturation did not show what amount of oxygen the resident was receiving at the time the saturation was obtained, just the method by which it was delivered, such as nasal cannula or trach collar (looked at documentation on record). The oxygen saturation documentation reviewed with the DRS, as documented on the resident's record from 10/4/22 to 11/19/22 varied from 94% to 100% with different modes of oxygenation varying from room air, trach, oxygen from nasal cannula, and oxygen from mask. The DRS indicated the documentation was inconsistent, staff had not documented the delivery system accurately. The resident had an order for nasal cannula because that was what she preferred, she did not have an order for a trach collar or mask. On 2/2/23 at 10:03 a.m., during a telephone interview, the Respiratory Consultant indicated she was familiar with Resident F. On November 18 she set up an airvo machine in the resident's room. There was no airvo in the room prior. No airvo had been delivered to the resident or the facility in October when the airvo PRN order had been written. She had delivered supplies to the resident weekly for her trach. Airvo tubing connects directly to the trach with secure tubing. Oxygen and humidity were provided by the machine. The trached resident had to have oxygen and humidity provided through the trach site. A nasal cannula (in the nose) could only be used to administer oxygen if the trach were capped off. Resident F did not have a capped trach, she needed to use a			

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trach collar (special fitting mask over her trach). She provided an education in-service, for the staff when she set up the machine. This was the only in-service she had been asked to provide in 2022.

On 2/2/23 at 10:50 a.m., during a telephone interview, the resident's daughter indicated, Resident F had come to the facility from an acute long term care hospital (LTAC Name). At the LTAC they sometimes would cap her trach so she could talk. When finished talking they removed the cap and administered oxygen, to her trach, so she could breath. She got short of breath when she tried to talk. Her trach was never capped at this facility. They had gotten use to how she talked and could understand her. Sometimes she had oxygen on, but they usually told her she didn't need oxygen. They had an oxygen collar, they could put over her trach, connected to the concentrator, sometimes they had oxygen tube for her nose. She was short of breath a lot. They would leave her light on all the time and not answer it. She would have to call family or the ambulance for herself when she got short of breath and needed help and needed help. She regrets not being able to move her elsewhere. She had contacted several places, but it was hard to find a place that would take a patient with a trach. If she had not been there she would still be alive.

On 2/3/23 at 10:09 a.m., during an interview with the NP, she indicated, Resident F was one of the few trachs they had had. Her trach was capped. When she was at the hospital, the goal was to remove the trach, but they couldn't because she couldn't breathe. She came in for rehab. She went to the emergency room multiple times while she was at the facility. She felt like she (the resident) may have had some anxiety. She had started her (the resident) on hydroxyzine. She had oxygen

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	orders and suctioning as needed. She was only at the facility for a month or so and was seen, by her, her several times. She went from an LTAC to there. When she complained of not being able to breath and staff would suction and get nothing back. Only used machine when her oxygen was low. Most of the times when her oxygen was low, she was sent to the hospital. Her lungs were diminished, and she was sent out for pneumonia. She was capped most the time. They would put the nasal cannula on during suctioning. She felt like a lot of the breathing was related to anxiety. Her vital signs were fine. They recommended sending resident to a facility where they have respiratory therapy. On 2/1/23 at 10:00 a.m., the Regional Director of Clinical Services provided a current, undated, policy, from the O2 Safe Solutions policy and procedure manual titled, "Tracheostomy Care," indicated, "...Objective: To keep the inner cannula of the tracheotomy tube clear of dried retained secretions and surrounding tissue clean and free from infections...." This Federal regulation relates to Complaint IN00400296. 3.1-47(a)(4) 3.1-47(a)(5) 3.1-47(a)(6)			
F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may			

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	permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			
	Based on interview and record review, the facility failed to ensure controlled narcotic was correctly documented upon administration to ensure proper reconciliation of the class two controlled substance for 4 of 5 residents reviewed for unnecessary medications, (Residents D, E, N, and L). Findings include: 1. On 1/27/23 at 8:30 a.m., Resident D's medical record was reviewed. Resident D had been	F 0755	F755- Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident D no longer resides at the facility. Resident E was not able to be identified due to being part of a complaint survey. Resident N no longer resides at the facility. Resident L was unable to be identified as due to being part of a complaint	03/07/2023

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	admitted to the facility on 10/28/22 after an acute hospital stay. A hospital discharge report, dated 10/28/22, indicated Resident D had been treated for breakthrough seizures which resulted in a fall with a hematoma (A pool of mostly clotted blood that forms in an organ, tissue, or body space) to his forehead. On 11/28/22, Resident D had a procedure to pace Vagal Nerve Stimulator (VNS- an implanted medical device placed by a surgeon near the collarbone to help control seizure activity via electrical stimulation). Resident D was prescribed 6 tablets of Oxycodone (a narcotic pain medication) 5 milligrams (mg) every 6 hours as needed for pain. Although a pharmacy prescription summary was provided, no physician's ordered was placed in his record, therefore there was no corresponding Medication Administration Record (MAR) to verify the administration. The controlled drug narcotic count sheet indicated his Oxycodone had been administered first on 11/3022 at 8:00 p.m., but was not administered again 12/9/22 at 1:00 a.m. On 12/11/22 two tablets were administered; one at 10 a.m., and a second at 3:00 p.m., which was only 5 hours, not 6 as ordered. The first tablet was signed out on 12/18/22 at 8:00 p.m., while the 6th and final tablet was signed out on 1/2/23 at 1:00 p.m., still with no MAR record for verification. 2. On 1/30/23 at 9:00 a.m., Resident E's medical		survey. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All resident who have orders to administer controlled substances have the potential to be affected. The facility has reviewed all residents whom receive narcotics from pharmacy to ensure there is an order in the medical record and a matching control inventory sheet Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Education was provided to all licensed nurses utilizing the Controlled Substance Policy with emphasis transcribing MD orders for narcotics, documenting narcotic administration on the EMAR as soon as it is administered and on control inventory sheet and completing disposition of controlled substances upon discharge. How the corrective measures will be monitored to ensure the alleged deficient does not reoccur: The DON/Designee will conduct audits of controlled substances to ensure all narcotic orders are transcribed to medical record, documentation of administration is completed on both EMAR and controlled inventory sheet at time of administration and disposition is	

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	record was reviewed. He was a long-term care resident with diagnoses, which included, but were not limited to, peripheral vascular disease and amputation of his right leg. He had physician's order for Oxycodone 10 mg as needed every 4 hours, which was discontinued on 1/20/23 when the order was changed from as needed to scheduled and was still active at the time of the review. A review and reconciliation of his controlled substance count sheet (Narc sheet) and MAR revealed multiple discrepancies of times when his narcotic was counted off on the Narc sheet, but not recorded as administered on his MAR, duplicated documentation and PRN administration without complaints of pain. Discrepancies included, but were not limited to the following examples: September 2022: (counted off the Narc sheet but not documented on the MAR) a. On the 1st, 1 tablet was counted off on the Narc sheet at 11:00 p.m., but there was no documentation it was administered on the MAR. b. On the 15th, 5 tablets were counted off on the Narc sheet at 3:00 a.m., 7:00 a.m., 11:30 a.m., 3:30 p.m., and 7:30 p.m., but there was no documentation the tablets were administered on the MAR. c. On the 23rd, 5 tablets were counted off on the Narc sheet at 5:00 a.m., 9:00 a.m., 2:00 p.m., 6:00 p.m., and 10:00 p.m., but there was no documentation it was administered on the MAR. October 2022: (duplicated documentation from different prescriptions) On October 3rd, 2022, two pills were signed out on		correctly completed upon discontinuation of medication or residents. The audit will be completed as follows 5 residents per week for 4 weeks, then 3 residents for 4 weeks, then 1 resident per week for 4 months. Any discrepancies will be immediately addressed and education provided to staff. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation	

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	the same time but from two separate prescriptions (RX) bingo cards: a. A count sheet for Oxycodone RX number ending in 327: one tablet was counted out at 8:00 a.m. b. A count sheet for Oxycodone RX number ending in 724: one tablet was counted out at 8:00 a.m. November 2022: (administered PRN without complaints of pain) a. On the 2nd, 6 tablets were counted off the Narc sheet at 1:30 a.m., 5:30 a.m., 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m., the record lacked documentation of complaints of pain, pain level, or reason for administration. 3. A comprehensive record review was completed for Resident N on 2/323 at 10:12 a.m. She had the following diagnoses but not limited to End Stage Renal Disease (ESRD, the final permanent stage of chronic kidney disease), Chronic Obstructive Pulmonary Disease (COPD, a chronic inflammatory lung disease that causes airflow blockage and breathing related problems), polyneuropathy (many nerves in different parts of the body are involved), Obstructive Sleep Apnea (OSA, a sleep-related disorder that involves a decrease or complete halt in airflow despite an ongoing effort to breathe), and hyperlipidemia (the blood has too many lipids in the blood). Resident N had an order for hydrocodone-acetaminophen oral tablet 10-325mg, give one tablet four times daily for pain. Resident N discharged from the facility on 1/26/23. A review of a "narcotic dispense" report provided by the pharmacy indicated on 1/25/23 hydrocodone-APAP 10-325mg tablets, amount 56 tablets was sent to the facility from the pharmacy.			

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On 2/3/23 at 2:35 p.m., the Divisional Risk Strategist provide a copy of Resident N's controlled drug administration tablet record. The record indicated in writing, "D/C (discontinue) home 1/26/23." Below the writing there was a signature that was illegible and a date of 1/26/23. The bottom of the record indicated to write in the date of discontinuance, amount remaining, disposition of the medication, date of disposition, and authorized signature. All areas were blank.

On 2/3/23 at 3:33 p.m., the Divisional Risk Strategist indicated the hydrocodone was sent with Resident N upon discharge from the facility.

On 2/4/23, at the survey exit, the Regional Risk Strategist was unable to provide a copy of Resident N's Medication Release Form.

A policy titled, "Discharge with Medications," was provided by the Administrator on 2/3/23 at 2:00 p.m. The policy indicated ... "the nurse documents the number of doses of each medication discharged to the patient or responsible party on the Medication Release Form ...."

A policy titled, "Controlled Substance Disposal," was provided by the Administrator on 2/2/23 at 2:00 p.m. The policy indicated ... "Medications classified as controlled substances by the Drug Enforcement Administration (DEA) are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal and state laws and regulations ...." 4. During a review of the narcotic medication binder on the Health Hall, on 1/30/23 at 10:27 a.m., Licensed Practical Nurse (LPN) 17 indicated it was not complete. She was observed to sign out two

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	narcotic medications without the observation of providing the narcotic medication to the resident. She indicated that morning, she provided 2 narcotics for Resident L and did not sign them out; Oxycodone 10 mg (Schedule II narcotic analgesic controlled substance: high potential of abuse) and Lyrica 75 mg (Schedule V controlled substance: low substance abuse medication). On 2/2/23 at 9:09 a.m., the Administrator provided the Medication Administration Record (MAR) for Resident L. It indicated to provide oxycodone 10 mg. Orders indicated to give 1 tablet by mouth three times a day for pain, and pregabalin (Lyrica) 75 mg: give 1 capsule by mouth every morning and at bedtime for pain/restless legs (syndrome). On 2/1/23 at 3:16 p.m., Resident L's record was reviewed. She was admitted on 12/21/22. Her diagnoses included, but were not limited to, cervical spinal fusion (the joining of 2 or more neck vertebra to prevent movement), cervical disc disorder with radiculopathy (pinched nerve in the neck), and chronic pain. On 1/31/23 at 2:33 p.m., the Division Risk Strategist (DRS) indicated as soon as the nurse removed a narcotic from the medication cart she should have signed it out immediately in the narcotic binder. A current policy, titled, "Medication Administration," with no date, was provided by the Division Risk Strategist (DRS), on 1/31/23 at 9:53 a.m. A review of the policy indicated, " ...Narcotics will be signed out when given ...Documentation of medications will follow accepted standards of nursing practice ...."			

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	A current policy, titled, "Medication Controlled Drugs and Security," dated 7/25/2018, was provided by the facility's executive staff. A review of the policy indicated, " ...Schedule Drugs of Controlled drugs: also known as "narcotics" - Drugs that have been classified by a Schedule of 1 -5 by the Drug Enforcement Administration (DEA) according to their potential for abuse, misuse, and ability to create dependence including physical and psychological dependence ...Safety is a primary concern for our residents, staff and visitors. Narcotics, schedule or controlled drugs are medication that pose a high risk for addiction when improperly taken, and are known to depress the respiratory system which, if taken inappropriately could lead to overdose up to and including death. For this reason, narcotics will be kept under double lock and will be counted by on-coming and off-going nurse at the end of each shift and before keys are passed to net shift. The purpose of this policy is to provide direction for the nurse regarding processes of operation for the administration and control of narcotics, depressants, and stimulant drugs and to provide maximum safety for resident and nursing personnel ...Narcotics will be counted at change of shift and upon being relieved from duty, the qualified staff shall transfer the key to the qualified staff accepting responsibility of the count ...Controlled drugs as well as the controlled drug count sheets and cards, are counted every shift change by the nurse reporting on duty with the nurse reporting off duty ...The inventory of the controlled drugs, count sheets and number of cards must be recorded on the narcotic records and signed for correctness of count ...." A current policy, titled, "Clinical Documentation Standards," with no date, was provided by the Administrator, on 1/31/23 at 3:31 p.m. A review of			

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	the policy indicated, " ...Nurses will follow the basic standard of practice for documentation including but not limited to providing a timely and accurate account of resident information in the medical record, documenting legibly in English using only acceptable medical abbreviations ...Each resident will have medical record maintained in accordance with state and federal guideline and will be kept secure, will be easily accessible and systematically organized per regulatory requirements ...Avoid overuse of Late Entries (LE) ...Late entries may be confusing contradictory and only used sparingly ...." A current policy, titled, "Controlled Substance Disposal," dated 8/2020, was provided by the Administrator, on 2/2/23 at 2:00 p.m. A review of the policy indicated, " ...Disposition is documented on the facility's Drug Destruction log or similar form ...The licensed nurse(s) and pharmacist witnessing the destruction ensure that a minimum, the following information is entered on the facility's Drug Destruction log or similar form ...date of destruction ...resident's name ...name and strength of medication ...prescription number ...amount of medication destroyed ...signature of witness ...Accountability records for controlled substances that are disposed of or destroyed are maintained with the unused supply until it is destroyed or disposed of and then stored for two years or per applicable law and regulation ...." This Federal regulation relates to Complaints IN00398951, IN00400347 and IN00400636. 3.1-25(o) 3.1-25(p) 3.1-25(q) 3.1-25(r) 3.1-25(s)(1)			

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	3.1-25(s)(2) 3.1-25(s)(3) 3.1-25(s)(4) 3.1-25(s)(5) 3.1-25(s)(6) 3.1-25(s)(7) 3.1-25(s)(8)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to discard expired milk from the Health Hall pantry refrigerator for 1 of 1 unit pantry refrigerator observed. This deficient practice had the potential to effect 18 of 18 residents who resided on the Health Hall.	F 0812	**F 812** **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:**	03/07/2023

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	Findings include: On 1/26/23 at 10:15 a.m., during a random observation of the Health Hall pantry refrigerator, the following individual milk cartons were noted to have expired or non-legible dates: a. 7 cartons of 2% milk expired on 1/23/23 b. 2 cartons of 2% milk had no legible expiration date c. 2 cartons of fat free milk expired on 1/21/23 d. 4 cartons of chocolate milk expired on 1/20/23 On 1/26/23 at 10:25 a.m., during an interview, Licensed Practical Nurse (LPN) 18 identified herself as the Wound Nurse. She indicated it was the kitchen's responsibility to check the pantry refrigerators for expired products. The kitchen staff monitored and maintained it. She was removed the expired items. On 2/1/23 at 9:51 a.m., the Administrator provided a current, undated, policy titled, "Storage of Resident Food." This policy indicated "...The dietary staff will monitor refrigerator contents for food safety and reserve the right to dispose of expired, unsafe foods...The dietary staff will monitor refrigerator storage areas for resident's food monitoring for outdated, unsafe or otherwise food unfit for consumption...." 3.1-21(i)(3)		·Residents did not experience a negative outcome from having expired milk in 1 refrigerator. Residents Were not served any of the expired milk in the 1 refrigerator. ·Expired milk was immediately discarded by unit manager **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** CDM completed an audit of all milk to validate there was no expired milk in the facility **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** ·CDM/designee to provide education to all dietary staff regarding auditing milk cartons and listing expired dates once delivered out of kitchen. Unit Managers/Designee will audit refrigerators daily and document expiration dates of milk on audit form. **How the corrective action will be monitored to ensure the deficient practice will not recur:** ·CDM and Unit manager will conduct routine audits of expiration dates coming out of kitchen and once In refrigerator on units. 4 refrigerators on units daily	

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			Mon-Fri x's 4 weeks, then 4 refrigerators on units weekly x's 4 weeks, then 4 refrigerators on units monthly x's 4 months for a total of 6 months of monitoring. Any findings of non-compliance will be addressed through associate re-education by the ED/designee, increased frequency and/or duration of auditing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist. The Facility Administrator at Evergreen Crossing & The Lofts is responsible for ensuring compliance with this plan of correction.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.			

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	The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or			

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	their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to ensure the glucometer (blood sugar measuring device) was cleaned according to manufacturer's instructions and facility policy for 2 of 2 residents reviewed for glucometer use (Resident 291 and 47). Findings include: 1. On 1/31/23 at 8:21 a.m., Qualified Medication Aide (QMA) 26 donned enhanced barrier protection to enter Resident 291's room to provide medication and get a glucometer reading. She laid the contaminated glucometer on top of the medication cart without barrier protection. She wiped the glucometer was a Sani-cloth bleach wipe for 30 seconds and placed it in the top right drawer of the medication cart. She did not wipe the top of the medication cart where the contaminated glucometer had been placed.	F 0880	Quality Improvement Initiative (Intervention and Improvement Plan) Tool QII ID: Directed Plan of Correction: Infection Prevention and Control Email non PHI information to: thostettler@qsource.org (Teresa Hostettler) nbridgewaters@qsource.org(Nedra Bridgewaters) Provider Contact: Teresa Hostettler/Nedra Bridgewaters Phone: 812-381-1581/317-678-9088	03/07/2023

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	On 2/1/23 at 3:13 p.m., Resident 291's record was reviewed. Her diagnoses included, but were not limited to, diabetes mellitus (blood sugar disorder), end stage renal disease (kidney disease), and morbid obesity due to excessive caloric intake. 2. On 1/31/23 at 9:15 a.m., QMA 26 indicated she needed to get a blood sugar for Resident 47. She donned a gown for enhanced barrier precautions. When she entered the resident's room she did not wear gloves. She laid the glucometer on the resident's over the bed table and put on gloves. After acquiring the blood for the glucometer, she placed the contaminated glucometer back on the over the bed table. She removed the contaminated gloves but with the contaminated gown still on and did not wash or gel her hands, she assisted Resident 56 out of their shared bathroom to her room. QMA 26 rolled up her gown and threw it in Resident 47's trash can. She picked up the contaminated glucometer with her bare hand, took it to the bathroom where she washed her hands after laying the glucometer on the bathroom countertop. She did not disinfect the over the bed table or the bathroom countertop where the contaminated glucometer was laid. She pulled a Sani-cloth bleach wipe out of the container and wiped the glucometer for 10 seconds before putting it back in the top right drawer of the medication cart. On 2/1/23 at 3:12 p.m., Resident 47's record was reviewed. Her diagnosis included, but was not limited to, diabetes mellitus (blood sugar disorder). Her physician's orders, dated 10/19/22, indicated to complete an accu-check (measuring blood		Title: Quality Improvement Advisor Email: thostettler@qsource.org Department: Qsource Fax: Quality Improvement Initiative II. Provider Name: Evergreen Crossing and the Lofts Provider #: 155826 III. Identify improvement team members: (include name and title) · Stacy Cromer -administrator · Tammy Milum IDON · Beth Davis IP Do you have a physician champion(s)? ¿ Yes ¿ No Name(s): Dr. Mustaklem Who is the lead team member? Stacy Cromer	

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	sugar with a glucometer) 4 times a day. On 1/31/23 at 9:27 a.m., the Sani-cloth bleach wipe container indicated to clean, disinfect and deodorize: treated surface must stay visibly wet for 4 minutes contact time. Use additional wipes as needed to assure a continuous 4 minute wet time. Let air dry. On 1/31/23 at 9:29 a.m., QMA 26 indicated she did not know she needed to keep the glucometer wet with the bleach wipe for four minutes, then let it air dry. On 1/31/23 at 9:30 a.m., Licensed Practical Nurse (LPN) 21 indicated to clean a glucometer, first lay down a clean paper towel on the medication cart to prevent contamination, then use a bleach wipe, and to keep the glucometer wet for 5 min, then let it air dry. Quickly wiping the glucometer with a bleach wipe and putting it away was a risk for infection. During an interview, on 1/31/23 at 2:23 p.m., the Division Risk Strategist (DRS) indicated the nurse used an incorrect technique to clean the glucometer and the contaminated glucometer should have had a clean barrier laid down and not set on the medication cart, the over the bed table or a resident's sink and should have been wet with bleach wipe moisture for 4 minutes. A current policy, titled, "Cleaning & Disinfection of Glucose Meter," dated 2/24/22, was provided by the Administrator, on 1/31/23 at 10:15 a.m. A review of the policy indicated, " ...a suggested method to obtain proper disinfection times for wet-contact is to wrap the machine in the wipe ensuring that all surfaced remain wet during the contact time period. Place the wrapped meter in a		- IV. Provide a description of the root cause of the concern(s) identified: Problem Statement: Facility failed to ensure the staff used proper sanitization techniques with glucometer cleaning after use -Nursing failed to ensure the glucometer was appropriately cleaned after use -Lack of adherence of the facilities policy and procedures related to cleaning and disinfection of glucose meters -need increased monitoring and education related to proper process/policy when use of glucometer Problem Statement: Facility failed to ensure that expired food products were discarded. -failed to check expiration dates of food items - Lack of adherence of the facilities policy and procedures related to checking food expiration dates - need for increased monitoring and education related to proper process/policy with food products and expiration dates	

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	clean cup on the med cart for the appropriate length of time. Allow meter to air dry prior to use ...Shared glucometers must undergo cleaning and disinfection after each resident use ...perform hand hygiene and done PPE's (personal protective equipment) when cleaning the machine to prevent microscopic contamination ...Follow the manufacturer's recommendation for cleaning and disinfecting the device use ...After cleaning, disinfect the machine/device after each use ...Place a clean barrier on resident bedside table, over bed table or other hard surface area when testing ...Return glucometer after use for disinfection process placing on a clean barrier until disinfection/cleaning is completed. Do not place a contaminate glucometer on top of the medication cart of other surface without a clean protective barrier. Disinfect the glucometer immediately before re-use with an EPA (environmental protection agency) approved wipe ...." A document titled, "Sani-Cloth Bleach Germicidal Disposable Wipe," dated 2019, was provided by Regional Director of Clinical Operations (RDCO), on 2/1/23 at 2:03 p.m. A review of the document indicated, " ...Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full four (4) minutes. Use additional wipes(s) if needed to assure continuous 4 minute wet contact time ...." 3.1-18(b)(1)		V. Describe in detail interventions you plan to implement to address the identified concern(s). You may attach any supporting documents, including revised procedures, monitoring process, approval process, evaluation process, etc. Based on a review of the ISDOH survey deficiencies and corrective action that were already implemented with the devised plan of correction the following interventions were identified as opportunities to ensure that all systems continue to remain in place and are being followed according to the facilities policies and procedures - - VI. Specify start date of interventions, projected date of completion and key interim implementation dates, if there are multiple steps to full implementation. Start Date-February 22 ,2023 End Date- August 22,2023 Project Plan: 1. Facility team to perform a root cause analysis and	

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			development needed solutions/systems change to address findings within the RCA February 23,2023 2. In-service's Policies and procedures related to glucometer cleaning. Policies and procedures of food services and maintenance of food products and expirations dates of All staff infection control in-service Orientation: In addition to the required infection control training will implement departmental specific infection control guidelines for each department of the facility Monitoring will be conducted for glucometer cleaning, proper techniques. Daily times x5daysper week x 6 weeks Weekly times 2 months Monthly times 2 months Audits will be reviewed by QAPI committee and the QIO/IP consultant to identify trending of missed opportunities and will adjust the DPOC as Warranted Facility	

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			will implement this monitoring on a routine and quarterly basis. Quarterly monitoring will be random and on all shifts. Skills competencies on glucometer cleaning will be conducted for all nursing immediately and then on an annual basis or as needed if deficiencies are present as a result of quarterly monitoring. 3. Food expiration dates All food within the facility expiration dates immediately audited for safe ranges by dietary manager or Designee Dietary to check expiration dates daily. All staff to check individual food items expiration dates before serving meals or snacks. All Staff infection control in-services Review of survey elements and infection control policies and procedures and review of facility self-assessments to ensure compliance in all areas -conducted by QIO/IP consultant at on site visit	

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			VII. List date(s) that improvement implementation will be evaluated. Midway check point -May 22,2023 Final check and wrap August 22,2023 VIII. Describe in detail how you will check progress: (include your plan for interim monitoring of cases) Touch base meetings. Virtual and or onsite Evaluation of process during midway checkpoint IX. If needed, indicate when alternative measures would be instituted: (trigger or projected timeline) Alternative measures will be instituted immediately if indicated by non-compliance. Need for alternative measures would be evaluated through completed audits monthly. X. Describe actions you will implement if original corrective measures are ineffective: Will meet with project team to discuss and preform an additional RCA.	