STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155270	A. BUILDING 00 B. WING	01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORE OF DALE	510 W MEDCALF ROAD DALE, IN 47523

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00398997, IN00399424, and IN00399570. Complaint IN00398997 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580, F656, F684, F727, F842. Complaint IN00399424 - Substantiated. Federal/State deficiencies related to the allegations are cited at F622. Complaint IN00399570 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: January 11, 12, 13, 17,18, 19, 2023 Facility number: 000170 Provider number: 155270 AIM number: 100287490 Census Bed Type: SNF/NF: 37 Total: 37 Census Payor Type: Medicaid: 36 Other: 1 Total: 37 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 27, 2023.	F 0000	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	
F 0580 SS=D	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lorri Maples	Administrator	02/12/2023

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

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Bldg. 00	§483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).			

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	§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to ensure significant changes in the resident's health condition were reported to the healthcare provider timely for 2 of 5 residents reviewed in total sample. Medical Doctor/Nurse Practitioner was not notified of a resident's abnormal lab results, change in neurological assessment, blood sugar levels greater then 401 mg/dL (milligrams per deciliter), behaviors and involuntary discharge from the facility. (Resident B, Resident D) Findings include: 1. On 1/11/23 at 10:00 A.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with mood disturbance, history of TBI (traumatic brain injury), hypothyroidism, and diabetes mellitus. The most recent annual MDS (Minimum Data Set) Assessment, dated 11/21/22, indicated the resident was moderately cognitively impaired and independent for bed mobility and transfers. Current physician's orders included, but were not limited to, resident being up in wheelchair ad lib (freely), dated 8/21/22	F 0580	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident # B did not return to the facility. Resident # D blood sugars are now being documented correctly per physician/NP orders and facility policy. The physician/NP are notified of any blood sugars not within range. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** An in-service education program was conducted by the Director of Nursing with all licensed nursing staff addressing circumstances that require notification of the resident's physician, resident's representative and how to notify them. Also, in-serviced staff on the use of TeleMedIQ applications. New I-Pads were placed at each	03/03/2023

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	Current care plans included, but were not limited to, the following: potential for injury-fall risk, dated 8/25/22 The medical record lacked a care plan for diabetes mellitus type II. On 12/13/22 at 5:10 A.M., lab work was drawn on Resident B that included, but was not limited to the following lab results: Glucose 309 mg/dL Reference range (74-106 mg/dL) Hemoglobin A1c 8.7% Reference range (4-6%) TSH (thyroid stimulating hormone) 0.419 uIU/ml (micro-international units per milliliter) Reference range (0.465--4.680 uIU/mL) The medical record lacked documentation of the healthcare provider being notified of the abnormal results until visit at the facility on 12/21/22. On 1/6/23 at 12:00 P.M., nursing notes indicated Resident B was coming out of the bathroom, slipped on loose stool on the floor, and fell. A slight bump was noted on the top, right side of his head. Neurological assessments from 1/6/23 at 12:00 P.M. until 1/7/23 at 6:45 A.M., were reviewed and 14 of 15 entries were unremarkable. On 1/7/23 at 6:45 A.M., documentation indicated sluggish pupil reaction, weakness of extremities, increased confusion, garbled speech, and restlessness. On 1/7/23 at 8:00 A.M., nursing notes indicate the resident was choking on medications. The ADON (Assistant Director of Nursing) was notified that the resident was not attempting to sit up to eat		nurse's station for use of the TeleMedIQ application, to notify the physician/NP of any changes in condition of residents, including blood sugar not within range, neurological status changes. Incidents/Accidents etcetera…. These notifications will then be printed with any orders given and placed on the charts. The facility is contracting with a new laboratory that works with our contracted medical providers, the physician/NP puts the order in the TeleMedIQ application, and the lab automatically receives the order, completes the draw, and all results will be provided to the physician/NP and the facility. The facility then has the capability to print out all orders and results for chart documentation. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing Services, or designee, will conduct an audit of 8 residents weekly for twelve (12) consecutive weeks, including any new admission who are diabetic, then 4 residents weekly for twelve (12) weeks, including any new admissions. These audits will ensure that the blood sugar monitoring is completed according to the orders and notification of the physician was completed if out of range. The Director of Nursing and/or	

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	which was unusual for him. The Nurse Practitioner was notified and order was received to send Resident B to the hospital for evaluation. During an interview on 1/12/23 at 12:05 P.M., the Nurse Practitioner indicated that Resident B was alert and oriented and he moved around with his wheelchair. She indicated she did not find out about the abnormal glucose, A1C (blood test that shows an average of blood sugars over the last 3 (three) months), or TSH (thyroid stimulating hormone) results until she came to the facility on 12/21/22. She further indicated that she would expect to be notified the same day the lab work results came back abnormal. She indicated that she received a call from staff on 1/7/23 at 8:04 A.M., notifying her that the resident had a decline in mental status, weakness in his extremities, and difficulty swallowing. When she questioned why she was not notified immediately, she indicated staff told her "they weren't sure". The Nurse Practitioner indicated that she would expect to be notified immediately of neurological status changes. 2. On 1/11/23 at 10:15 A.M., Resident D's clinical records were reviewed. Diagnosis included, but was not limited to diabetes mellitus, type 2. Resident D was admitted on 5/3/13. The most recent quarterly MDS Assessment, dated 11/28/22, indicated independence for bed mobility, transfer and toileting. Resident D was cognitively intact. Current physician's orders included, but were not limited to accucheck before meals and at bedtime with sliding scale Novolog insulin ordered on 2/22/16: 151-200=1 unit 201-250=2 units		designee will conduct an audit daily for 8 weeks, then 3 x week for 4 months of anyone who is put on neurological checks to ensure if there are any change of status, the physician/NP has been notified timely and any orders given were followed. Any noncompliance found during the audits will result in reeducation and counseling's of non-compliant staff, up to and including termination. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	

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	251-300=3 units 301-350=4 units 351-400=5 units >400=Call MD (medical doctor) A current care plan for Diabetes, dated 9/1/22, included, but was not limited to the following interventions: monitor for signs and symptoms of hypoglycemia and hyperglycemia and administer medications as ordered. Resident D's December 2022 and January 2023 Diabetic Flow Sheet and MAR (Medication Administration Record) indicated on the following dates the blood sugars were over 400 and the medical record lacked documentation that the Medical Doctor/Nurse Practitioner was notified and orders received for the amount of insulin given: 12/2/22 at 4:30 P.M. blood sugar 424 5 units of Novolog insulin documented as given 12/3/22 at 4:30 P.M. blood sugar 549 7 units of Novolog insulin documented as given; 10:00 P.M. blood sugar 596 3 units of Novolog documented as given 12/15/22 at 11:30 A.M. blood sugar 412 5 units of Novolog insulin documented as given 12/30/22 8:00 P.M. blood sugar 404 amount of insulin given was not documented During an interview on 1/12/23 at 3:00 P.M., RN 2 and LPN 9 indicated they should notify MD if blood sugars are less than 60 or greater than 400 for further orders. During an interview on 1/18/23 at 2:14 P.M., administrator indicated "the nurses use a (company name) app [method of communicating through technology with the nurse practitioner/medical doctor with staff concerning			

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	residents] to notify the physician." During an interview on 1/19/23 at 8:58 A.M., administrator indicated they were unable to find any documentation of notification in the (company name) app for Resident D for the last 6 months. A current non dated Provision of Physician Ordered Services policy provided by the Administrator on 1/13/23 at 11:35 A.M., indicated "Documentation of consultations, diagnostic tests, results, and date/time of Physician notification will be maintained in the resident's clinical record". A current non dated Blood Glucose Monitoring policy, provided by the Administrator on 1/13/23 at 11:35 A.M., indicated "Report critical test results to physician timely". A current non dated Notification of Changes policy, provided by the Administrator on 1/13/23 at 11:35 A.M., indicated "The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification". A current non dated Notification of Changes policy provided by the Administrator on 1/13/23 at 11:35 A.M., indicated "Circumstances requiring notification include: ... 2. Significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental, or psychosocial status ... 4. A transfer or discharge of the resident from the facility" This Federal tag relates to Complaint IN00398997.			

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	3.1-5(a)(2) 3.1-5(a)(3) 3.1-5(a)(4)			
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending,			

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	pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner			

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	responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.			
	Based on interview and record review, the facility failed to provide Notice of Discharge, failed to provide physician documentation of the need for the discharge, and failed to accept a resident back into the facility following hospitalization, for 1 of 4 residents reviewed for discharge. (Resident F) Findings include: On 1/17/23 at 2:18 P.M., Resident F's medical record was reviewed. The resident was admitted to the facility on 4/20/22. Diagnoses included, but were not limited to, paranoid schizophrenia, traumatic brain injury, and mild cognitive disorder. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 8/24/22, indicated Resident F required supervision only for bed mobility, transfer and eating and extensive assistance with toilet use. Cognitive status was not assessed. A physician's order, dated 12/20/22, indicated "D/c [discharge] resident from facility into County Police custody". Nurse's notes were reviewed and included, but	F 0622	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #F did not return to the facility. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents who have been transferred or discharged have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** An in-service education, using the ISDH guidelines, was conducted by the Director of Nursing, for nursing staff and social services, regarding required notices for residents upon transfer and/or discharge from the facility, including Involuntary discharge notices and documentation requirements by the nurse and attending physician. **4. How the corrective**	02/24/2023

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	were not limited to, the following: 12/20/22 at 1:00 A.M., "Resident became upset p [after] he received his Risperadol [Sic] Consta injection that was scheduled q 2 wks [every 2 weeks]. Stated to nursing staff it is poison; tried calming resident ... Resident continues to be angry, screaming & [and] hollering." 12/20/22 at 1:10 A.M., "Resident got up and came to nurse's station pushing w/c [wheelchair] screaming and yelling disturbing other residents ... Resident took his w/c and tried to run CNA [Certified Nursing Aide] over. CNA shut swinging doors by nurse's station on west. He then hollered I will kill you bitches." 12/20/22 at 1:15 A.M., "This nurse came up to area and explained in a calm voice that he gets this shot q 2 [every 2] weeks and that he would feel better. He immediately started swinging arms and going p [after] nurse. Nurse tried to get away. Resident kept following her trying to get away. Resident then had nurse cornered over by the west side door. Resident became belligerent hitting nurse on arm and head. Hollering I am gonna kill you. CNA intervened and resident started going p [after] her. She immediately ran to east nurse's desk and called police." 12/20/22 at 1:30 A.M., "Police here now resident in bed calm now. All information given to police. Resident to be transported to (hospital) for eval [evaluation]. ADON [Assistant Director of Nursing] aware ... Police stated that p [after] released from hospital they are to call the County Jail and transport him there and they will figure out what to do c [with] him." 12/20/22 at 1:40 A.M., "EMS [Emergency Medical Services] here. Resident cooperative; transferred onto gurney in sitting position & [and] will be transported to (hospital)." Documentation of a Notice of Transfer, Bed-Hold		**action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing and/or designee will audit all d/c and/or transfers to the hospitals, for 6 months, to ensure all required paperwork ie: Notice of Transfer, Bed Hold information and appeal information, has been completed and given to the resident and a copy in the chart. Any d/c requiring an Involuntary d/c will be audited to ensure the physician has provided a statement stating the facility is unable to care for the resident due to safety risk to staff and residents and the resident, Poa/Guardian and Ombudsman have been sent copies of the Involuntary d/c notice, & Bed hold policy and appeal information. Any noncompliance that is found during the audits, reeducation and counseling's will be given, up to and including termination. This plan of correction will be monitored at the monthly Quality Assurance meeting for 6 months or until such time consistent substantial compliance has been met. 2/24/23	

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	information, or appeal information was not found in the clinical record. Documentation of an Involuntary Discharge was not found in the clinical record. Documentation by the Physician regarding the facility being unable to care for the resident due to safety risk to staff and other residents was not found in the clinical record. During an interview on 1/17/23 at 12:20 P.M., the administrator indicated she didn't think Resident F's physician and facility's Medical Director, signed any statement saying he was a safety risk and could not come back to this facility. On 1/18/23 at 1:10 P.M., Notice of Discharge, and physician documentation of the need for the discharge was requested and not received. A current non dated Transfer and Discharge policy provided by the Administrator on 1/18/23 at 12:49 P.M., indicated " ... 4. The original copies of the transfer form and Advance Directive accompany the resident ... 12d. Copies are retained in the medical record ... 12g. Provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated ... 12l. The resident has the right to return to the facility pending an appeal of any facility-initiated discharge unless the return would endanger the health or safety of the resident or other individuals in the facility. The facility will document the danger that the failure to transfer or discharge would pose" This Federal tag relates Complaint IN00399424. 3.1-12(a)(4)(A)			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORE OF DALE	510 W MEDCALF ROAD DALE, IN 47523

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	3.1-12(a)(4)(C) 3.1-12(a)(5)(A)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document			

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	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 observation, interview and record review, the facility failed to develop and implement care plans for 3 of 5 residents reviewed for care plans. A resident's fall interventions were not observed in place. A resident's blood sugars were not documented as ordered. and A newly diagnosed diabetic resident with hypothyroidism did not have a care plan for hypothyroidism or diabetes. (Resident B, Resident D, Resident E) Findings include: 1. On 1/11/23 at 12:48 P.M., Resident E was observed lying in bed with the bed against the wall. No fall mat was observed on the floor. On 1/12/23 at 8:30 A.M., Resident E was observed lying in bed with eyes closed and the bed against the wall. The bed was observed to not be in the lowest position, and no fall mat was observed on the floor. On 1/12/23 at 9:15 A.M., CNA 14 observed Resident E's bed was not be in the lowest position and took bed remote and lowered it. On 1/12/23 at 10:00 A.M., Resident E's clinical	F 0656	1. Immediate action(s) taken for the resident(s) found to have been affected include: Care plan(s) of the resident identifier(s) RI#(s) D & E were reviewed and updated as indicated. Resident # B did not return to the facility. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** All interdisciplinary care plan team members responsible for writing care plans will be re-educated on the facility's policy and procedure for developing *Comprehensive Care Plans* and revising/updating as needed. **4. How the corrective action(s) will be monitored to**	03/03/2023

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	records were reviewed. Diagnoses included, but were not limited to insulin dependent, type 2 diabetes mellitus, schizoaffective disorder bipolar type, bilateral blindness, total retinal detachment, right below the knee amputation, left TMA (transmetatarsal amputation). The resident was admitted on 12/26/19. The most recent annual MDS (Minimum Data Set) Assessment, dated 10/11/22, indicated Resident E required extensive assistance with bed mobility, toileting and bathing. The MDS indicated transfer did not occur and resident was cognitively intact. Current physician orders included but were not limited to the following: Blood sugar 4 times a day and prn (as needed), dated 6/17/21 Bed to wall for safety, dated 11/6/22 Floor mat to open side of bed for safety, dated 11/6/22 A current Uncontrolled/Unstable Glucose Level Care Plan, initiated 12/11/20, included, but was not limited to, the following intervention: monitor lab values/finger stick blood glucose levels. A current Falls Care Plan, initiated on 12/14/20, included, but was not limited to, the following interventions: bed in low position, started on 12/14/20 mat to floor beside bed, started on 11/6/22 bed to wall, started on 11/6/22 Review of Resident E's December 2022 and January 2023 MARs (medication administration		**ensure the practice will not recur:** Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinator and IDT members. Care plans will be updated as indicated. The Director of Nursing, or designee, will complete 5 random weekly audits of care plans for 12 weeks then 3 random weekly audits for 12 weeks, to ensure that care plans are developed and implemented and/or updated/revised as needed and to ensure interventions are in place, and any new diagnoses are care planned, for current and new residents timely. Audit records will be reviewed by the Quality Assurance Committee, for 6 months, until such time consistent substantial compliance has been achieved as determined by the committee. 03/03/23	

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	record) and Diabetic Flow Sheets lacked documentation of an accucheck on the following dates: 12/12/22 at 6:00 A.M. and 11:00 A.M. 12/15/22 at 4:00 P.M. 12/16/22 at 8:00 P.M. 12/21/22 at 4:00 P.M. 1/4/23 at 11:00 A.M. and 4:00 P.M. During an interview on 1/12/23 at 9:25 A.M., LPN (Licensed Practical Nurse) 6 indicated the missing blood sugars could have been done and not recorded, and if it wasn't done, it should have been. During an interview on 1/12/23 at 9:47 A.M., LPN 6 indicated if an agency nurse was working, they may not have been aware the blood sugar needed to be recorded on the MAR and Diabetic Flow Sheet. During an interview on 1/12/23 at 1:51 P.M., LPN 6 indicated fall interventions for Resident E included keeping her bed in low position, checking on her frequently, neurological checks as needed and to have a mat on the floor which is not there. She further indicated she would have to check the order to see if the mat was discontinued. During an interview on 1/12/23 at 2:10 P.M., LPN 6 indicated Resident E's mat was taken out of the room to clean because it was dirty. They would get a mat to put on the floor. Other fall interventions included 1/2 rails for her bed, bed against the wall, call light within reach and toilet as needed. 2. On 1/11/23 at 10:15 A.M., Resident D's clinical records were reviewed. Diagnosis included, but			

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was not limited to diabetes mellitus, type II. Resident D was admitted on 5/3/13.

The most recent quarterly MDS Assessment, dated 11/28/22, indicated independence for bed mobility, transfer and toileting. Resident D was cognitively intact.

Current physician's orders included, but were not limited to accucheck before meals and at bedtime with sliding scale Novolog ordered on 2/22/16:
151-200=1 unit
201-250=2 units
251-300=3 units
301-350=4 units
351-400=5 units
>400=Call MD (medical doctor)

A current care plan for Diabetes, dated 9/1/22, included, but was not limited to the following intervention: monitor for signs and symptoms of hypoglycemia and hyperglycemia.

On 1/11/23 at 10:50 A.M., review of December 2022 MAR and the Diabetic Flow Sheet lacked documentation of an accucheck on 12/20/22.

During an interview on 1/12/23 at 8:35 A.M., RN (registered nurse) 2 indicated blood sugars were charted in two places, the diabetic sheet in the chart and the MAR. She further indicated she did not know why the blood sugars were not documented.

3. On 1/11/23 at 10:00 A.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with mood disturbance, history of TBI (Traumatic Brain Injury), hypothyroidism, and diabetes mellitus.

The most recent annual MDS Assessment, dated

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11/21/22, indicated the resident was moderately cognitively impaired and independent for bed mobility and transfers.

The medical record lacked documentation of care plans for diabetes and hypothyroidism.

During an interview on 1/11/23 at 12:05 P.M., the Nurse Practitioner indicated that Resident B was diagnosed with diabetes mellitus type II on 12/21/22 and has a history of hypothyroidism.

During an interview on 1/12/23 at 3:00 P.M., LPN 9 and RN 2 indicated that when the Nurse Practitioner gives an order, they are supposed to write it down on telephone order form, fax that to the pharmacy, notify family of changes, and document the order and actions taken in the nurse's notes of the medical record. Then they should place the order form in the basket at the nurse's station for the DON to review. The DON would update the current MAR/TAR, care plans, diagnoses if needed, have the Nurse Practitioner sign the order form and then it would get placed in the resident's medical record.

A current verbal orders policy, dated November 2017, provided by the Administrator on 1/17/23 at 2:04 P.M., indicated "3. Enter the order into the medical record manually ... 4. Write T.O. (telephone order) or V.O. (verbal order, including date, time, name of resident, the complete order; and sign the name of the physician or health care provider and nurse ... 5. The physician should sign the order on his/her next visit to the facility ... 6. Follow through with orders by making appropriate contact or notification ... "

A current non dated Comprehensive Care Plan policy provided by the Administrator on 1/13/23

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	at 11:35 A.M., indicated "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident ... " A current non dated Blood Glucose Monitoring policy provided by the Administrator on 1/13/23 at 11:35 A.M., indicated "The facility will perform blood glucose monitoring as per physician's orders" This Federal tag relates to Complaint IN00398997. 3.1-35(a) 3.1-35(b)(1)			
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 provide care to maintain the residents highest practicable well-being for 2 of 4 residents reviewed. The Nurse Practitioner was not notified of abnormal laboratory results, diabetic protocol was not implemented for a newly diagnosed diabetic resident, blood glucose levels were not checked and elevated blood glucose results were not reported to physician or nurse practitioner. This resulted in a hospitalization for a blood glucose level of 889 mg/dL (milligrams per	F 0684	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident # B is no longer at the facility. Resident # D blood sugars are now being documented correctly per physician/NP orders and facility policy. The physician/NP are notified of any blood sugars not within range. 2. Identification of other	03/03/2023

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	deciliter) and the incorrect dose of insulin being given. (Resident B and Resident D) Findings include: 1. On 1/11/23 at 10:00 A.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with/ mood disturbance, history of TBI (Traumatic Brain Injury), hypothyroidism, and diabetes mellitus. The most recent annual MDS (Minimum Data Set) Assessment, dated 11/21/22, indicated the resident was moderately cognitively impaired and independent for bed mobility and transfers. Resident B's clinical record lacked a care plan for diabetes care and hypothyroidism. On 12/13/22 at 5:10 A.M., lab work was drawn on Resident B that included, but was not limited to the following lab results: Glucose 309 mg/dL Reference range (74-106 mg/dL) Hemoglobin AC 8.7% Reference range (4-6%) TSH (thyroid stimulating hormone) 0.419 uIU/ml (micro-international units per milliliter) Reference range (0.465--4.680 uIU/mL) The clinical record lacked documentation that the ordering Medical Doctor (MD) or Nurse Practitioner (NP) was notified of abnormal results. Telephone orders, dated 10/26/22, included the following: D/C (discontinue) tramadol. Start Tylenol 500 mg 1 tablet by mouth four times daily.		residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** An in-service education program was conducted by the Director of Nursing with all licensed nursing staff addressing circumstances that require notification of the resident's physician, resident's representative and how to notify them. Also, in-serviced staff on the use of TeleMedIQ applications. New I-Pads were placed at each nurse's station for use of the TeleMedIQ application, to notify the physician/NP of any changes in condition of residents, including blood sugar not within range, neurological status changes. Incidents/Accidents etcetera…. These notifications will then be printed with any orders given and placed on the charts. The facility is contracting with a new laboratory that works with our contracted medical providers, and the physician/NP puts the order in the TeleMedIQ application, and the lab automatically receives the order, and completes the draw, then all results will be provided to the physician/NP and the facility.	

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	D/C atorvastatin. Start rosuvastatin 20 mg 1 tablet by mouth at bedtime. Telephone orders, dated 12/21/22, included the following: metformin 500 mg tablet 1 (one) tablet by mouth twice daily for diabetes mellitus type II. Decrease levothyroxine to 100 mcg daily for hypothyroidism. Repeat TSH in 2 weeks. Review of the December 2022 MAR indicated that levothyroxine 100 mcg by mouth daily at 8:00 A.M. and metformin 500 mg by mouth twice daily at 8:00 A.M. and 4:00 P.M., were administered starting on 12/23/22. Review of the December 2022 TAR (treatment administration record) indicated that a TSH level was to be drawn on 1/4/23. January 2023 physician's order rewrites included, but were not limited to, the following: levothyroxine 200 mcg (microgram) 1 (one) tablet by mouth daily for hypothyroidism, ordered on 4/11/14. January 2023 physician's order rewrites did not include metformin 500 mg (milligram) 1 (one) tablet by mouth twice daily for diabetes ordered on 12/21/22. Review of the January 2023 MAR indicated the order placed on 12/21/22 was not continued on the current MAR as the dose of levothyroxine was 200 mcg by mouth daily, and that the 8:00 A.M. dose of metformin 500 mg was not documented as given.		The facility then has the capability to print out all orders and results for chart documentation. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services, or designee, will conduct an audit of 8 residents weekly for twelve (12) consecutive weeks, including any new admission who are diabetic, then 4 residents weekly for twelve (12) weeks, including any new admissions. These audits will ensure that the blood sugar monitoring is completed according to the orders and notification of the physician was completed if out of range. The Director of Nursing and/or designee will conduct an audit daily for 8 weeks, then 3 x week for 4 months of anyone who is put on neurological checks to ensure if there are any change of status, the physician/NP has been notified timely and any orders given were followed. The Director of Nursing and designees will complete the monthly rewrites and follow up on new orders/progress notes matching the MAR/TAR. Any discrepancies will be clarified with the physician/NP.	

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	Review of the January 2023 TAR lacked an order for a TSH level to be drawn on 1/4/23. Lab results from 1/5/23 were reviewed and a repeat TSH level was not included with the other labs drawn. The progress note from the Nurse Practitioner, dated 12/21/22, was reviewed and included, but was not limited to, the following: "Patient did have low TSH as well as an elevated A1c. We will be decreasing his levothyroxine to 100 mcg and putting patient on metformin 500 mg b.i.d. [twice a day]. ... Spoke with staff about labs and medication changes. Spoke to staff about getting repeat labs ... " The progress note from the Nurse Practitioner, dated 12/21/22, included, but was not limited to the following medications: levothyroxine 100 mcg 1 capsule by mouth once a day atorvastatin 40 mg 1 tablet by mouth once a day Keppra 500 mg 1 tablet by mouth at bedtime acetaminophen 325 mg 2 capsules every four hours tramadol 50 mg 2 tablets twice a day metformin 500 mg 1 tablet twice a day The progress note from the Nurse Practitioner, dated 12/21/22, included, but was not limited to the following lab results, dated 12/13/22: A1c 8.70 TSH 0.419 Glucose 309 The progress note from the Nurse Practitioner, dated 12/21/22, included, but was not limited to the following assessments and plans: hypothyroidism: chronic-progressive; will continue to monitor levothyroxine will be decreasing to 100 mcg daily and will get repeat		Any noncompliance found during the audits will result in reeducation and counseling's of non-compliant staff, up to and including termination. Audit records will be reviewed by the Quality Assurance Committee **monthly for 6 months** until such time consistent substantial compliance has been achieved as determined by the committee.	

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	TSH in 3 weeks. diabetes mellitus type II: New diagnosis; will be starting patient on metformin 500 mg po BID and will get repeat labs in 3 months. Current MAR and order rewrites, signed by the nurse practitioner on 1/12/23, did not match the Nurse Practitioner's progress note, dated 12/21/22, list of medications and assessment and plan included the following: The Nurse Practitioner's note indicated resident was on levetiracetam (Keppra) 500 mg 1 tablet in the A.M. and Keppra 500 mg 1 tablet in the P.M. The current MAR/rewrite orders indicate Keppra 500 mg in the A.M. and Keppra 500 mg 2 tablets in the P.M. The Nurse Practitioner's note indicated resident was on levothyroxine 100 mcg daily. The current MAR and rewrite orders indicate levothyroxine 200 mcg daily. The Nurse Practitioner's note indicated acetaminophen 325 mg 2 capsules every 4 hours. The current MAR and rewrite orders indicate acetaminophen 500 mg 1 tablet four times a day. The Nurse Practitioner's note indicated atorvastatin 40 mg 1 tablet daily. The current MAR and rewrite orders indicated Rosuvastatin 20 mg at bedtime. The Nurse Practitioner's note indicated tramadol 50 mg 2 tablets twice a day. The current MAR and rewrite orders did not have tramadol listed. The Nurse Practitioner's note and the current MAR indicated metformin 500 mg twice daily but it was not included on the rewrite orders.			

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	The Nurse Practitioner's note indicated that the repeat TSH lab was due in 3 weeks. The Nursing notes dated 12/21/22 indicated the repeat TSH was due in 2 weeks. The current TAR and rewrite did not include orders to repeat TSH or repeat labs for diabetes in 3 months. Nursing Notes reviewed and included, but not limited to, the following: 12/21/22 1:53 P.M. Nurse practitioner here this day. Received new order to decrease levothyroxine to 100 mcg daily. Repeat TSH in 2 weeks (1/4/23). New order for Metformin 500 mg 1 (one) tablet by mouth twice daily. Resident aware. 1/5/23 10:30 A.M. Resident showing weakness and requiring assist to transfer. 1/5/23 1:45 P.M. Resident sitting in the lobby and started projectile vomiting. 1/6/23 12:00 P.M. Resident coming out of bathroom and had loose stool on the floor. Resident slipped and fell to the floor. Slight bump noted on top right side of head. 1/7/23 8:00 A.M. Resident choking on medications. Received order to send to hospital for evaluation. 1/7/23 EMS (emergency medical services) arrived. 1/10/23 9:30 A.M. Received a call from social worker at hospital. She indicated resident was on a ventilator and "not doing well". The Neurological assessment after the fall on 1/6/23 was reviewed and indicated documentation was completed from 1/6/23 at 12:00 P.M. to 1/7/23			

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	155270	A. BUILDING 00 B. WING	01/19/2023

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	at 6:45 A.M. Of those entries reviewed, 14 of 15 were normal until 6:45 A.M. Neurostatus Starting 12:00 P.M. cst (central stardard time) 1/6/23 14 of 15 neuro checks normal until 6:45 A.M. (cst) 1/7/23 recorded by LPN 12 (agency)-Nurse Practitioner was not notified until 8:04 A.M. of mental status and neuro changes Hospital records were reviewed and indicated the following: 1/7/23 "EMS dispatched at 8:25 [cst] en route at 8:27 [cst] arrived at 8:30 [cst] and w/pt at 8:35 [cst] pt [patient] and bed are saturated with urine to the point it is dripping through the mattress and onto the floor ...hematoma on right side of his head ... staff decided to call ambulance after him having trouble swallowing breakfast ... pupils are unequal and sluggish, left larger then right ...lungs clear ...staff indicated the last time anyone checked on him was probably when he fell yesterday ... staff initially stated that they wanted to clean him up now that we were here to help ... " "Resident arrived in ER [emergency room] and into room at 10:25 a.m est (eastern standard time used while at hospital), orders for labs placed by physician at 10:26 a.m, lab received order at 10:38 a.m, collected at 11:10 a.m ...physical exam ... pupils round, equal bilat ...tachycardic ...no respiratory distress, normal breath sounds., no stridor ...1/7/23 1115 (11:15 A.M.) point of care glucose monitor unable to register noting "high" ... 1158 (11:58 A.M.): ... given glucose of 889 ... 1241 (12:41 P.M.) clinical impression: hypernatremia, hyperglycemia, disorientation, fall from ground level ...chart review shows the patient had increasing serum levels approx. 3 wk ago with sodium at upper limit of normal ...believe hypernatremia is subacute ...patient admitted in			

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	stable condition to ICU ... On 1/7/23 at 12:07 A.M., "nurse called NH [nursing home] to request more info [information] from nurse in charge of pt [patient] per provider request ... nh [nursing home] nurse states he is not diabetic ... baseline is 'normally up going to the bathroom on his own and normally takes care of himself' nurse states the way pt [patient] was behaving before he left via ems was 'not his norm' ..." On 1/7/23 at 3:32 P.M., "Resident admitted to ICU ... positive for lethargy and altered mental status ... diminished breath sounds at bases bilat [bilaterally] ... " On 1/9/23 at 3:06 A.M., "Resident admitted to the hospital for hyperosmolar hyperglycemic state ... rapid intubation at bedside ... patient had become unresponsive" During an interview with the Nurse Practitioner on 1/12/23 at 12:05 P.M., they indicated that Resident B's baseline was alert and oriented and he used his wheelchair to get around. They would have expected a call the same day when that abnormal lab results from 12/13/22 came back with glucose of 309 and A1c of 8.7 but she was not notified until she was at the facility on 12/21/23. She did believe that was too long to not be notified of abnormal lab results. When they gave verbal order to the nurse, they were under the impression the facility had a diabetic protocol to initiate when a resident was newly diagnosed with diabetes mellitus. They would expect new medications to be ordered the same day from the pharmacy. The NP further indicated that she did not receive a call from staff about the resident's neurological and mental status change after his fall until 8:04 A.M.			

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	on 1/7/23. the NP indicated that she was told by staff at that time the resident had a decline in mental status, weakness in his extremities, and difficulty swallowing and that it started the night before. Staff told her they weren't sure why she wasn't notified at the time it was noticed The NP indicated she would have expected a call immediately. During an interview on 1/12/23 at 3:00 P.M., RN 2 and LPN 9 observed in current MAR that levothyroxine was listed as 200 mcg. They indicated that the dose should be 100 mcg. They observed that the levothyroxine package in the med cart was labeled 100 mcg daily with Resident B's name. They further indicated they were not sure why was it documented from 1/1/23 to 1/7/23 as giving 200 mcg when resident was actually getting 100 mcg. During an interview on 1/13/23 at 12:00 P.M., LPN 6 indicated she would need to follow an order for any medication given or treatment done for residents. She was unsure if the agency nurses knew Resident B should only get 100 mcg and not 200 mcg and why the dosage on the MAR was not clarified. She further indicated with using agency staff, she felt things may have gotten missed because they don't know the processes and procedures of how to do things, document things, what treatments need done, etc. She also indicated if they don't have agency come help, then it's short staffed and there's one nurse sometimes for the whole building and things get missed in documentation that way too. She indicated the previous DON (Director of Nursing) and ADON Assistant Director of Nursing) lived 2 hours away so if they needed them it usually took them approximately 3 hours to get to the facility.			

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	During an interview on 1/12/23 at 3:00 P.M., LPN 9 indicated she wasn't sure if she knew Resident B was a diabetic when he had called for assistance because of weakness and vomited on 1/5/23. An accu-check was not performed at that time. She is not sure why the nurse who noticed the decline after his fall did not call the provider sooner. During an interview on 1/12/23 at 3:00 P.M., LPN 9 and RN 2 indicated that if they received a lab back that was "that" abnormal, they would have called the provider to ask for new orders at that time. They were unaware of a newly diagnosed diabetic protocol. They indicated that when the Nurse Practitioner gives an order, the nurse should write it down on a telephone order form, fax that to the pharmacy, notify family of changes, and document the order and actions taken in the nurse's notes of the medical record. Then they should place the order form in the basket at the nurse's station for the DON to review. The DON would update the current MAR/TAR, care plans, diagnoses if needed, have the Nurse Practitioner sign the order form and then it would get placed in the resident's medical record. During an interview on 1/18/23 at 1:10 P.M., the Administrator indicated they use an app from (company name) to communicate to healthcare providers about the residents and the conversation is supposed to be documented in the nurse's notes as well. She indicated that (pharmacy name) is responsible for the monthly rewrites and that the DON was supposed to be reviewing the notes from the NP after visits with residents when they sent them because they went to the DON's email. She further indicated that the NP note, MAR, TAR, and order rewrites should have been verified that they all matched and clarified with the NP if needed. Those documents			

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	should have been updated along with any changes needed to be made in the chart. 2. On 1/11/23 at 10:15 A.M., Resident D's clinical records were reviewed. Diagnosis included, but was not limited to diabetes mellitus, type 2. Resident D was admitted on 5/3/13. The most recent quarterly MDS Assessment, dated 11/28/22, indicated independence for bed mobility, transfer and toileting. Resident D was cognitively intact. Current physician's orders included, but were not limited to accucheck before meals and at bedtime with sliding scale Novolog ordered on 2/22/16: 151-200=1 unit 201-250=2 units 251-300=3 units 301-350=4 units 351-400=5 units >400=Call MD (medical doctor) A current care plan for Diabetes, dated 9/1/22, included, but was not limited to the following interventions: monitor for signs and symptoms of hypoglycemia and hyperglycemia and administer medications as ordered. On 1/17/23 at 11:45 A.M., review of Resident D's December 2022 and January 2023 Diabetic Flow Sheet and MAR indicated on the following dates the blood sugars were over 400 and the medical record lacked documentation that the Medical Doctor/Nurse Practitioner was notified and orders received for the amount of insulin given : 12/2/22 at 4:30 P.M. blood sugar 424 Novolog 5 units documented as given 12/3/22 at 4:30 P.M. blood sugar 549 Novolog 7 units documented as given; 10:00 P.M. blood sugar 596 Novolog 3 units documented as given			

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	12/15/22 at 11:30 A.M. blood sugar 412 Novolog 5 units documented as given 12/30/22 8:00 P.M. blood sugar 404 amount of insulin given was not documented On 1/17/23 at 11:45 A.M., review of Resident D's December 2022 and January 2023 Diabetic Flow Sheet and MAR indicated on 12/14/22 at 4:30 P.M. blood sugar was 194 and 5 units of Novolog was given. December 2022 and January 2023 Diabetic Flow Sheet and MAR lacked documentation of the amount of insulin given on the following dates: 12/16/22 at 8:00 P.M. blood sugar 173 12/17/22 at 6:00 A.M. blood sugar 298 12/30/22 8:00 P.M. blood sugar 404 1/1/23 4:30 P.M. blood sugar 192 1/10/23 6:00 A.M. blood sugar 313; 11:30 A.M. 173 During an interview on 1/12/23 at 3:00 P.M., RN 2 and LPN 9 indicated they should notify MD if blood sugars are less than 60 or greater than 400 for further orders. During an interview on 1/18/23 at 1:14 P.M., the Administrator indicated "the nurses use (name of internet app) [method of communicating through technology with the nurse practitioner/medical doctor with staff concerning residents] to notify the physician." During an interview on 1/19/23 at 8:58 A.M., the Administrator indicated they were unable to find any documentation of notification in the (name of internet app) for Resident D for the last 6 months. A current Provision of Physician Ordered Services policy, dated October 2022, provided by the Administrator on 1/13/23 at 11:35 A.M., indicated "3. Qualified nursing personnel will receive and			

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	review the diagnostic test reports ... communicate the results to the ordering physician ....within 24 hours of receipt unless the reports fall outside of clinical reference ranges in accordance with facility policies ... ordering Provider will be notified of results upon receipt if deemed "critical" and/or require immediate attention ... 4. Documentation of consultations, diagnostic tests, the results, and date/time of Physician notification will be maintained in the resident's clinical record" A current non dated Notification of Changes policy provided by the Administrator on 1/13/23 at 11:35 A.M., indicated " the purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician ... when there is a change requiring notification ... Circumstances requiring notification include ... 2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status ... " A current Verbal Orders policy, dated November 2017, provided by the Administrator on 1/17/23 at 2:04 P.M., indicated "1. Repeat any prescribed orders back to the physician or healthcare provider. 2. Use clarification questions to avoid misunderstandings. 3. Enter the order into the medical record manually or electronically. 4. Write T.O. (telephone order) or V.O. (verbal order), including date, time, name of the resident, the complete order; and sign the name of the physician or healthcare provider and nurse ... " A current Medication Orders policy, dated November 2017, provided by the Administrator on 1/17/23 at 2:04 P.M., indicated "this facility shall use uniform guidelines for the ordering of medication ... the order should be recorded on the			

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	physician order sheet, and the MAR ... " A current non dated Blood Glucose Monitoring policy provided by the Administrator on 1/13/23 at 11:35 A.M., indicated "Report critical test results to physician timely". A current Comprehensive Care Plan policy, dated November 2017, provided by the Administrator on 1/13/23 at 11:35 A.M., indicated "it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident ... The comprehensive care plan will describe, at minimum, ... the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being" This Federal tag relates to Complaint IN00398997. 3.1-37(a)			
F 0727 SS=E Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.			

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	Based on interview and record review, the facility failed to provide an RN (registered nurse) for 8 consecutive hours, seven days a week, for 2 of 7 days reviewed. This had the potential of affecting the 37 residents living at the facility. Findings include: On 1/11/23 at 9:49 A.M., the Administrator provided the current census form identifying 37 residents were currently housed at the facility On 1/17/23 at 8:00 A.M., the review of nurse staffing from 1/4/23 through 1/11/23 indicated there was no RN coverage for 8 consecutive hours on 1/7/23 and 1/8/23. There was an RN working from 7:10 P.M. until 12:00 A.M. on 1/7/23 covering 4 hours and 50 minutes. On 1/8/23 there was an RN working from 12:00 A.M. through 6:00 A.M. covering 6 hours. During an interview on 1/17/23 at 10:30 A.M., the administrator indicated the facility's usual nursing staff protocol was to follow state guidelines for RN coverage. On 1/17/23 at 2:04 P.M., a current, undated Nursing Services and Sufficient Staff Policy indicated "Except when waived, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week". This Federal tag relates to Complaint IN00398997. 3.1-17(b)(3)	F 0727	1. Immediate action(s) taken for the resident(s) found to have been affected include: A new ad was placed online for hiring of RN staff members. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** Anyone involved in nurse scheduling, ie: DON, ADON, Scheduler etc., will be in-serviced by the Administrator regarding the facility policy to ensure there is RN coverage 8 hours a day, 7 days a week, scheduled. Should RN staff not be available, the facility will make every effort to schedule an RN through Agency Staffing. The Director of Nursing is RN coverage at least 5 days a week. An ad to hire has been running on INDEED for RN's with incentive bonus. A new ad was placed on Zip Recruiter for RN staff with incentive bonus. To date, no RN has applied to the job opening but will continue to seek RN staff through online ads and agency staff. **4. How the corrective**	03/03/2023

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			action(s) will be monitored to ensure the practice will not recur: The DON/Administrator will review the nursing schedule weekly to ensure an RN is scheduled 8 hrs.a day/7 days a week. Should an RN not be scheduled, every attempt will be made to ensure that an RN will be scheduled through Agency Staffing. Schedules will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	
F 0842 SS=E Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and			

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	(iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident;			

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	(ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on interview, observation and record review, the facility failed to ensure a medical record was complete, accurately documented, readily accessible and systematically organized for 4 of 5 residents reviewed. (Resident B, Resident D, Resident E, Resident F) Findings include: 1. On 1/11/23 at 10:15 A.M., Resident D's clinical records were reviewed. Diagnoses included, but was not limited to diabetes mellitus, type II. Resident D was admitted on 5/3/13. The most recent quarterly MDS Assessment, dated 11/28/22, indicated independence for bed mobility, transfer and toileting. Resident D was cognitively intact. Resident D's clinical record was observed to be thick, unorganized, difficult to turn the pages, with loose pages falling out. On 1/12/23 at 2:45 P.M., Resident D's clinical record was removed from the chart stand at the west nurse's station. After the record was reviewed, it was noticed that several pages from Resident D's chart were loose in the chart stand. The chart was so thick it was difficult to get the pages back into the chart. After working for 10	F 0842	1. Immediate action(s) taken for the resident(s) found to have been affected include: All current medical record charts have been thinned and organized to contain three (3) months of current documentation according to acceptable standards of practice and facility policy. Thinned records were filed in the secondary record also known as the overflow file for each resident in the medical records room. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** Nursing staff who assist with thinning of charts and monthly rewrites were in-serviced regarding the facility policy of ensuring charts are thinned and organized, contain 3 months of records and thinned records are filed in	03/03/2023

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CORE OF DALE	510 W MEDCALF ROAD DALE, IN 47523

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	minutes, the chart was put back together and put away in the chart stand. On 1/17/23 at 8:30 A.M., tried to remove Resident D's chart from the chart stand, pages started falling out of the chart, OT(Occupational Therapist) took the chart and indicated they would get someone to put the chart back together and bring it to me. On 1/17/23 at 8:41 A.M., when asked for the MDS for the last year on Resident D, administrator indicated "it might take a minute because we have to hunt and search for things". During an interview on 1/18/23 at 1:10 P.M., administrator indicated they use an (name of Internet app) app (method of communicating through technology with the nurse practitioner/medical doctor with staff concerning resident) to notify the physician. During an interview on 1/19/23 at 8:58 A.M., administrator indicated they were unable to find any documentation of notification in the (name of Internet app) for Resident D for the last 6 months. 2. On 1/12/23 at 10:00 A.M., Resident E's clinical records were reviewed. Diagnosis included, but were not limited to insulin dependent, type 2 diabetes mellitus, schizoaffective disorder bipolar type, bilateral blindness, total retinal detachment, right below the knee amputation, left TMA (transmetatarsal amputation). The resident was admitted on 12/26/19. The most recent annual MDS (minimal data set) Assessment, dated 10/11/22, indicated Resident E required extensive assistance with bed mobility, toileting and bathing. The MDS indicated transfer		resident overflow files in the medical records room. The Director of Nursing and/or designee(s) will thin charts monthly during the rewrite process for the next month, to ensure only 3 months of records are on the chart at a time, to eliminate older records falling out, or the chart becoming too bulky & hard to open. The Director of Nursing will work with the pharmacy monthly to ensure all orders are added accurately and timely according to physician/NP orders. The Director of Nursing and/or designee will follow up on new orders/progress notes, matching to the MAR/TAR. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing and/or designee will complete 5 random weekly resident chart audits for 6 months to ensure charts remain in an acceptable manner according to facility policy and standards of practice. Any records found not to be compliant with facility policy or standards of practice, will be pulled, thinned, and organized and thinned records will be filed in the overflow file in the medical records room. Audit records will be reviewed by	

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	did not occur and resident was cognitively intact. Resident E's clinical record was observed to be thick, difficult to turn pages, difficult to find the needed information, with loose pages falling out. During an interview on 1/12/23 at 9:25 A.M., LPN (Licensed Practical Nurse) 6 indicated the missing blood sugars could have been done and not recorded, and if it wasn't done, it should have been. During an interview on 1/12/23 at 9:47 A.M., LPN 6 indicated if an agency nurse was working, they may not have been aware the blood sugar needed to be recorded on the MAR(medication administration record) and Diabetic Flow Sheet. On 1/17/23 at 8:41 A.M., when asked for the MDS for the last year on Resident E, Administrator indicated "it might take a minute because we have to hunt and search for things". 3. On 1/17/23 at 2:18 P.M., Resident F's medical record was reviewed. The resident was admitted to the facility on 4/20/22. The diagnoses included, but were not limited to: paranoid schizophrenia, traumatic brain injury, and mild cognitive disorder. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 8/24/22, indicated Resident F required supervision only for bed mobility, transfer and eating and extensive assistance with toilet use. Cognitive status was not assessed. Resident F's chart was observed to be thick and difficult to find the needed information. On 1/18/23 at 1:07 P.M., Administrator was asked		the monthly Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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	for transport papers and involuntary discharge papers with physician's signature and statement for reason of discharge and papers could not be provided. During an interview on 1/18/23 at 1:10 P.M., the Administrator indicated that they have been through 2 Social Services Directors since this summer and the 3rd one just started. They knew one of the Social Service Directors was working on doing transfer at some point. The administration lacked any documentation regarding residents and/or staff that were fearful of Resident F. 4. On 1/11/23 at 10:00 A.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with/ mood disturbance, history of TBI (Traumatic Brain Injury), hypothyroidism, and diabetes mellitus. The most recent annual MDS Assessment, dated 11/21/22, indicated the resident was moderately cognitively impaired and independent for bed mobility and transfers. Current physician's order rewrites for January 2023 included, but were not limited to, the following: levothyroxine 200 mcg (microgram) 1 (one) tablet by mouth daily for hypothyroidism. Current rewrite orders for January 2023 did not include metformin 500 mg (milligram) 1 (one) tablet by mouth twice daily for diabetes. Telephone orders, dated 10/26/22, included the following: D/C (discontinue) tramadol. Start Tylenol 500 mg 1 tablet by mouth four times daily.			

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	D/C atorvastatin. Start rosuvastatin 20 mg 1 tablet by mouth at bedtime. Telephone orders, dated 12/21/22, included the following: metformin 500 mg tablet 1 (one) tablet by mouth twice daily for diabetes mellitus type II. Decrease levothyroxine to 100 mcg daily for hypothyroidism. Repeat TSH in 2 weeks. Resident B's clinical record lacked a care plan for diabetes care and hypothyroidism. The clinical record lacked documentation that the ordering healthcare provider was notified of abnormal results. Review of the December 2022 MAR indicated that levothyroxine 100 mcg by mouth daily at 8:00 A.M. and metformin 500 mg by mouth twice daily at 8:00 A.M. and 4:00 P.M., were administered starting on 12/23/22. Review of the December 2022 TAR (treatment administration record) indicated that a TSH level was to be drawn on 1/4/23. Review of the January 2023 MAR indicated the order placed on 12/21/22 was not continued on the current MAR as the dose of levothyroxine was 200 mcg by mouth daily, and that the 8:00 A.M. dose of metformin 500 mg was not documented as given. Review of the January 2023 TAR lacked an order for a TSH level to be drawn on 1/4/23. A progress note from the Nurse Practitioner (NP), dated 12/21/22, was reviewed and included, but			

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	was not limited to, the following: "Patient did have low TSH as well as an elevated A1c. We will be decreasing his levothyroxine to 100 mcg and putting patient on metformin 500 mg b.i.d. [twice a day]. ... Spoke with staff about labs and medication changes. Spoke to staff about getting repeat labs ... " The medications listed on the Nurse Practitioner's progress note dated 12/21/22 included, but were not limited to the following: levothyroxine 100 mcg 1 capsule by mouth once a day atorvastatin 40 mg 1 tablet by mouth once a day Keppra 500 mg 1 tablet by mouth at bedtime acetaminophen 325 mg 2 capsules every four hours tramadol 50 mg 2 tablets twice a day metformin 500 mg 1 tablet twice a day Current MAR and order rewrites, signed by the nurse practitioner on 1/12/23, did not match the Nurse Practitioner's progress note, dated 12/21/22, list of medications and assessment and plan: The Nurse Practitioner's note indicated resident was on levetiracetam (Keppra) 500 mg 1 tablet in the A.M. and Keppra 500 mg 1 tablet in the P.M. The current MAR/rewrite orders indicate Keppra 500 mg in the A.M. and Keppra 500 mg 2 tablets in the P.M. The Nurse Practitioner's note indicated resident was on levothyroxine 100 mcg daily. The current MAR and rewrite orders indicate levothyroxine 200 mcg daily. The Nurse Practitioner's note indicated acetaminophen 325 mg 2 capsules every 4 hours. The current MAR and rewrite orders indicate acetaminophen 500 mg 1 tablet four times a day.			

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The Nurse Practitioner's note indicated atorvastatin 40 mg 1 tablet daily. The current MAR and rewrite orders indicated Rosuvastatin 20 mg at bedtime.

The Nurse Practitioner's note indicated tramadol 50 mg 2 tablets twice a day. The current MAR and rewrite orders did not have tramadol listed.

The Nurse Practitioner's note and the current MAR indicated metformin 500 mg twice daily but it was not included on the rewrite orders.

The Nurse Practitioner's note indicated that the repeat TSH lab was due in 3 weeks. The Nursing notes dated 12/21/22 indicated the repeat TSH was due in 2 weeks. The current TAR and rewrite did not include orders to repeat TSH or repeat labs for diabetes in 3 months.

Nursing Notes reviewed and included, but not limited to, the following:
12/21/22 1:53 P.M. Nurse practitioner here this day. Received new order to decrease levothyroxine to 100 mcg daily. Repeat TSH in 2 weeks (1/4/23). New order for Metformin 500 mg 1 (one) tablet by mouth twice daily. Resident aware.

Resident B's clinical record was observed to be thick, unorganized, difficult to turn the pages, with loose pages falling out.

On 1/17/23 at 9:00 A.M., another resident's order rewrites were found in Resident B's clinical record. When given to staff, they indicated "we were looking for those, he just returned from the hospital".

During an interview on 1/12/23 at 3:00 P.M., RN 2

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	and LPN 9 observed in current MAR that levothyroxine was listed as 200 mcg. They indicated that the dose should be 100 mcg. They observed that the levothyroxine package in the med cart was labeled 100 mcg daily with Resident B's name. They further indicated they were not sure why was it documented from 1/1/23 to 1/1/7/23 as giving 200 mcg when resident was actually getting 100 mcg. During an interview on 1/13/23 at 12:00 P.M., LPN 6 indicated she would need to follow an order for any medication given or treatment done for residents. She was unsure if the agency nurses knew Resident B should only get 100 mcg and not 200 mcg and why the dosage on the MAR was not clarified. She further indicated with using agency staff, she felt things may have gotten missed because they don't know the processes and procedures of how to do things, document things, what treatments need done, etc. She also indicated if they don't have agency come help, then it's short staffed and there's one nurse sometimes for the whole building and things get missed in documentation that way too. During an interview on 1/18/23 at 1:10 P.M., the Administrator indicated they use an app from (company name) to communicate to healthcare providers about the residents and the conversation is supposed to be documented in the nurse's notes as well. She indicated that (pharmacy name) is responsible for the monthly rewrites and that the DON was supposed to be reviewing the notes from the NP after visits with residents when they sent them because they went to the DON's email. She further indicated that the NP note, MAR, TAR, and order rewrites should have been verified that they all matched and clarified with the NP if needed. Those documents			

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	should have been updated along with any changes needed to be made in the chart. During an interview with the Nurse Practitioner on 1/12/23 at 12:05 P.M., she indicated it was hard to find information needed in the medical records of the residents. She indicated she relied heavily on the nurses to get information. During an interview on 1/19/23 at 9:00 A.M., the Administrator indicated the (company name) app was supposed to be used to communicate between staff and the healthcare provider but that it should also be documented in the nurse's notes. On 1/17/23 at 1:04 P.M., a current Maintenance of Clinical Records policy, date October 2022, indicated the facility must maintain medical records on each resident that are complete, accurately documented, readily accessible, systematically organized, and maintained in folders or chart holders sufficient in size for the volume of the record. This Federal tag relates to Complaint IN00398997. 3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(a)(3) 3.1-50(a)(4)			