DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING 00 B. WING	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARBOR HEALTH & REHAB	5025 MCCOOK AVE EAST CHICAGO, IN 46312

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00400563, IN00401921, and IN00401979. Complaint IN00400563 - Substantiated. Federal/state deficiencies related to the allegations are cited at F686 and F921. Complaint IN00401921 - Substantiated. Federal/state deficiencies related to the allegations are cited at F580, F655, F684, and F697. Complaint IN00401979 - Substantiated. No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey date: February 28, 2023 Facility number: 000108 Provider number: 155653 AIM number: 100267410 Census Bed Type: SNF/NF: 76 Total: 76 Census Payor Type: Medicare: 12 Medicaid: 63 Other: 1 Total: 76 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 3/2/23.	F 0000	Please reference the enclosed 2567 as "plan of correction" for Complaint survey that was conducted at Harbor Health & Rehab I will submit signature sheets of the in-servicing, content of in-service and audit tools. Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and / or executed solely because it is required by the provision of the Federal State Laws. This facility appreciates the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better our Elders in our community. The Plan of Correction submitted on 3/23/23 serves as our allegation of compliance. The provider respectfully request a desk review on or after 3/28/2023. Should you have any questions or concerns regarding our	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
sherri shelby	NHA	03/23/2023

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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			Plan of Correction , please don't hesitate to Contact me. Sherri Shelby RN, HFA **Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.**	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified			

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	in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on record review and interview, the facility failed to promptly notify the resident's family after a fall for 1 of 3 residents reviewed for falls. (Resident C) Finding includes: The closed record for Resident C was reviewed on 2/28/23 at 1:50 p.m. The resident was admitted on 1/16/23 and discharged to hospital on 1/20/23. Diagnoses included but were not limited to, stroke, high blood pressure, non traumatic subdural hemorrhage, craniectomy, and osteoarthritis.	F 0580	**F580 Notify of Changes** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of*	03/28/2023

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	The 5 Day Minimum Data Set (MDS) assessment, dated 1/20/23, indicated the resident was cognitively intact and was an extensive assist for all of Activities of Daily Living (ADLs). Nurses' Notes, dated 1/19/23 at 11:20 p.m., indicated the writer was informed by the nurse the resident had slipped to the floor on the 3-11 shift. The resident was observed sleeping at an angle in the bed with both legs towards the edge of the bed. Floor mats were placed on both sides of the resident's bed and wedges were placed on the sides of the resident for safety. There was no documentation the resident's family was notified the resident had fallen out of bed. Nurses' Notes, dated 1/20/23 at 2:37 a.m., indicated the resident's daughter had called the facility and was asking about her well being. The daughter was informed of the resident's slip to the floor on the previous shift and floor mats were placed on both sides of resident's bed for safety and wedges were used. The resident's daughter was concerned for her mother and requested for the Director of Nursing (DON) to call her father in the morning. A Risk Management Assessment, dated 1/19/23, indicated the actual time of fall was at 9:00 p.m. The CNA notified the writer the resident was in a side lying position on the floor. The bed was in a low position and the pillow had fallen out of bed with the patient. It looked as though she had slid out of the bed from leaning on her side. The resident indicated she did not know what happened. Vital signs at the time of fall were blood pressure 121/64, heart rate was 80, oxygen saturation was 96%, and respirations were 17. A full head to toe assessment was completed and		*deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Immediate action taken for those residents identified?** Resident C no longer resides in the facility. **How the facility identified other residents?** All residents who reside in the facility have the potential to be affected by this deficient practice. **Measures put into place/System changes?** Licensed Staff have been educated on the importance of notifying family for change of conditions. **How will the corrected actions be monitored?** Director of Nursing or Designee will audit falls 5 days a week then 3x's a week then weekly thereafter to ensure that family members have been notified of falls. The Director of Nursing is responsible for compliance of this deficiency. **The results of these audits will be reviewed in Quality**	

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	active range of motion times 4 was noted. The resident had no complaints of pain. The resident was assisted back to bed using hoyer mechanical lift. Interview with the DON on 2/28/21 at 3:30 p.m. indicated the resident's family was not notified of the fall until the daughter had called in, however, she had called the resident's spouse in the morning. The current and updated 11/13/18, "Physician-Family Notification-Change in Condition" policy, provided by the DON on 2/28/23 at 4:27 p.m., indicated the facility will notify the resident's legal representative or an interested family member where there has been a significant change in the resident's physical, mental or psychosocial status. This Federal Tag relates to Complaint IN00401921. 3.1-5(a)(2)		**Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **Date of Completion: 03/28/2023**	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a			

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	resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.			
	Based on record review and interview, the facility failed to ensure a baseline Care Plan was completed within 48 hours off admission for 1 of 8 residents whose Care Plans were reviewed. (Resident C) Finding includes: The closed record for Resident C was reviewed on	F 0655	**F655 Baseline Care Plans** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.*	03/28/2023

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	2/28/23 at 1:50 p.m. The resident was admitted on 1/16/23 and discharged to hospital on 1/20/23. Diagnoses included but were not limited to, stroke, high blood pressure, non traumatic subdural hemorrhage, craniectomy, and osteoarthritis. The 5 Day Minimum Data Set (MDS) assessment, dated 1/20/23, indicated the resident was cognitively intact and was an extensive assist for all of Activities of Daily Living (ADLs). A Resident/Family Notification, dated 1/16/23, indicated the resident was high risk for falls with a score of 18. The Baseline Care Plan, dated 1/16/23, was incomplete and there was no Care Plan for falls. Nurses' Notes, dated 1/19/23 at 11:20 p.m., indicated the writer was informed by the nurse the resident had slipped to the floor on the 3-11 shift. The resident was observed sleeping at an angle in the bed with both legs towards the edge of the bed. Floor mats were placed on both sides of resident's bed and wedges were placed on the sides of the resident for safety. A Care Plan for falls was put into place on 1/19/23. Interview with the Director of Nursing (DON) on 2/28/21 at 3:30 p.m. indicated the baseline Care Plan for fall risk was not completed within 48 hours of admission. This Federal tag relates to Complaint IN00401921. 3.1-35(a)		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident C no longer resides in the facility. **2) How the facility identified other residents:** All residents who admit to the facility have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** Licensed staff will be reeducated on the importance of completing Baseline care plans within 48 hours of admission. **4) How the corrective actions will be monitored:** Director of Nursing or designee will complete admission audits 5 days a week to ensure that baseline care plans have been initiated	

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			within 48 hours of admission. The Director of Nursing is responsible for compliance of this deficiency. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 03/28/2023**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to ensure fall follow up with vital signs, and an assessment of the resident was completed for 72 hours post fall for 2 of 3 residents reviewed for falls. (Residents C and E) Findings include:	F 0684	**F684 Quality of Care** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.*	03/28/2023

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	1. The closed record for Resident C was reviewed on 2/28/23 at 1:50 p.m. The resident was admitted on 1/16/23 and discharged to hospital on 1/20/23. Diagnoses included, but were not limited to, stroke, high blood pressure, non traumatic subdural hemorrhage, craniectomy, and osteoarthritis. The 5 Day Minimum Data Set (MDS) assessment, dated 1/20/23, indicated the resident was cognitively intact and was an extensive assist for all of Activities of Daily Living (ADLs). A Resident/Family Notification, dated 1/16/23, indicated the resident was high risk for falls with a score of 18. The Baseline Care Plan, dated 1/16/23, was incomplete and there was no Care Plan for falls within 48 hours of admission. A Care Plan, dated 1/19/23, indicated the resident was at risk for falls secondary to impaired mobility. Nurses' Notes, dated 1/16/23 at 7:46 p.m., indicated the resident was admitted to the facility. The resident was alert and oriented times 3 with the admitting diagnoses of stroke, right craniectomy with evacuation of hematoma, and right occipital hemorrhage and subdural hematoma. Nurses' Notes, dated 1/18/23 at 8:08 a.m., indicated the resident was alert and oriented times 2. The resident was observed thrashing around in the bed and disrobing, this continued for 6 minutes. A helmet was on at this time for protection. Nurses' Notes, dated 1/19/23 at 11:20 p.m.,		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** 1. Resident C no longer resides in the facility. 2. Resident E no negative outcome noted for inaccurate fall follow up. **2) How the facility identified other residents:** All residents who reside in the facility have the potential to be affected by this deficient practice **3) Measures put into place/ System changes:** Staff will be re-educated on assessing and completing post-fall follow up assessments accurately to reflect a current set of vitals. **4) How the corrective actions**	

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	indicated the writer was informed by the nurse the resident had slipped to the floor on the 3-11 shift. The resident was observed sleeping at an angle in the bed with both legs towards the edge of the bed. Floor mats were placed on both sides of resident's bed and wedges were placed on the sides of the resident for safety. Nurses' Notes, dated 1/20/23 at 2:37 a.m., indicated the resident's daughter had called the facility and was asking about her well being. The daughter was informed of the resident's slip to the floor on the previous shift and floor mats were placed on both sides of resident's bed for safety and wedges were used. The resident's daughter was concerned for her mother and requested for the Director of Nursing (DON) to call her father in the morning. A Risk Management Assessment, dated 1/19/23, indicated the actual time of the fall was at 9:00 p.m. The CNA notified the writer the resident was in a side lying position on the floor. The bed was in a low position and the pillow had fallen out of bed with the patient. It looked as though she had slid out of the bed from leaning on her side. The resident indicated she did not know what happened. Vital signs at the time of fall were blood pressure 121/64, heart rate was 80, oxygen saturation was 96%, and respirations were 17. A full head to toe assessment was completed and active range of motion times 4. The resident had no complaints of pain. The resident was assisted back to bed using hoyer mechanical lift. A Nurses' Note, dated 1/20/23 at 3:13 a.m., indicated the resident was observed in bed with her legs off the side of the mattress. The blanket, sheet, and pillow were on the floor. The resident was again angled to the side of the bed pulling at		**will be monitored:** Director of Nursing or designee will review fall follow up documentation 5 days a week for 4 weeks then 3x's a week for 4 weeks then weekly thereafter to ensure that the follow up fall assessments are accurate and have current vitals . The Director of nursing is responsible for the oversight of this deficiency. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 03/27/2023**	

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the disposable brief. The resident was repositioned in bed.

A Follow Up Fall Note: dated 1/20/23 at 4:42 a.m., indicated the most recent pulse was checked on 1/18/23 at 3:15 p.m., the most recent blood pressure was checked on 1/18/23 at 3:15 p.m., and the resident had no pain.

There was no assessment of the resident's helmet if it was on at the time of the fall or thereafter.

There were no Physician's Orders for the resident to wear a helmet. The only mention/assessment of the helmet was on 1/18/23 in the Nursing Progress Notes.

A Fall IDT Progress Note, dated 1/20/23 at 9:50 a.m., indicated the resident had a recent fall without injury due to sliding out of the air loss mattress. Bolsters will be ordered and placed on the bed, and a floor mat will be placed on the open side of the bed.

A Nurses' Note, dated 1/20/23 at 10:59 a.m., indicated the resident was transported to the hospital for an evaluation.

Interview with the Director of Nursing (DON) on 2/28/21 at 3:30 p.m. indicated the resident was admitted wearing the helmet as it was there after the craniectomy. There was no assessment of the helmet in any of the documentation and she would have expected her staff to have assessed the helmet at the time of admission. The vital signs checked after the fall for the fall follow up were not current and fall assessments were to be done every shift for 72 hours. The resident had been observed leaning to the affected side due to the stroke and the air loss mattress was slippery

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	so floor mats and wedges were immediately put in place. 2. Resident E's record was reviewed on 2/28/23 at 10:38 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and history of stroke. The Quarterly Minimum Data Set (MDS) assessment, dated 12/29/22, indicated the resident was cognitively intact for daily decision making. He required supervision for activities of daily living including bed mobility, transfers, dressing, and toilet use. A Nurses' Note, dated 12/14/22 at 9:49 a.m., indicated the resident reported he had a fall as he became weak while transferring and his legs gave out. The Interdisciplinary Team met and discussed the resident's fall. The physician gave new orders for the resident to receive physical therapy to increase strength. A Fall Follow-up Assessment, dated 12/15/22 at 2:02 a.m., had vital signs which included pulse (84 beats per minute), respirations (24 breaths per minute), and blood pressure (117/72) assessed from 12/12/22 at 5:14 a.m. The same set of vital signs from 12/12/22 at 5:14 a.m. were used for the Fall Follow-up Assessment on 12/15/22 at 10:02 a.m., 12/15/22 at 6:02 p.m., 12/16/22 at 2:02 a.m., and 12/16/22 at 9:18 a.m. Interview with the Director of Nursing on 2/28/23 at 3:58 p.m., indicated the vital signs were being copied and pasted within the documentation system so it was not prompting the nurse to complete a new set of vital signs. A policy titled "Fall Reduction Program," received from the Director of Nursing on 2/28/23 at 4:27			

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	155653	A. BUILDING 00 B. WING	02/28/2023

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	p.m., indicated ...Program Steps: Investigative Guidelines... O. Each nurse, each shift will observe resident and document for 72 hours in the resident's medical record. i. Vital signs ii. Neuro-checks (for unwitnessed falls) iii. Behavior changes iv. Physical changes v. Neurological changes... This Federal tag relates to Complaint IN00401921. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			
	Based on record review and interview, the facility failed to ensure a resident with pressure ulcers received the necessary treatment and services to promote healing, related to treatments not completed as ordered for 1 of 3 residents reviewed for pressure ulcers. (Resident J)	F 0686	**F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer** The facility requests paper compliance for this citation. *This Plan of Correction is the*	03/28/2023

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	Finding includes: Resident J's record was reviewed on 2/28/23 at 2:54 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, diabetes mellitus, heart failure, and peripheral vascular disease. The Quarterly Minimum Data Set (MDS) assessment, dated 12/15/22, indicated the resident was severely cognitively impaired. She required extensive assistance with one person physical assist for bed mobility, dressing, toilet use, and personal hygiene. The resident had 1 unstageable deep tissue injury. A Physician's Order, dated 12/15/22, indicated to cleanse the right heel with normal saline or wound cleanser, pat dry, and apply betadine every day shift. The January 2023 Treatment Administration Record (TAR), indicated the treatment was not completed as ordered on 1/1/23, 1/5/23, 1/6/23, 1/8/23, 1/13/23, 1/19/23, and 1/27/23. A Physician's Order, dated 2/14/23, indicated to cleanse the right heel with normal saline or wound cleanser, pat dry, and apply skin prep every day shift. The February 2023 TAR, indicated the treatment was not completed as ordered on 2/16/23, 2/17/23, and 2/21/23. Interview with the Wound Nurse on 2/28/23 at 4:05 p.m., indicated she completed the treatments however she must not have signed them out on the TAR.		*center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Treatment to resident's D's right heel was completed. **2) How the facility identified other residents:** All residents who have pressure areas have the potential to be affected by this deficient practice. **3) Measures put into place/ System changes:** Licensed Staff will be re-educated on the importance of ensuring that residents have dressings in place to pressure ulcers and treatments are completed per physicians' orders. **4) How the corrective actions**	

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	This Federal tag relates to Complaint IN00400563. 3.1-40(a)(2)		**will be monitored:** Director of Nursing or designee will complete 5 observations a week then 3 observations a week until substantial compliance is met on residents with pressure ulcers to ensure that the dressing is clean, dry and intact. Also audit the TAR to ensure that the treatment order has been signed out. The Director of Nursing is responsible for compliance. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 03/28/2023**	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure a resident's pain was effectively managed related to a scheduled pain medication	F 0697	**F697 Pain Management** The facility requests paper	03/28/2023

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	not administered as ordered for 1 of 3 residents reviewed for pain. (Resident J) Finding includes: Resident J's record was reviewed on 2/28/23 at 2:54 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, diabetes mellitus, heart failure, and peripheral vascular disease. The Quarterly Minimum Data Set (MDS) assessment, dated 12/15/22, indicated the resident was severely cognitively impaired. She required extensive assistance with one person physical assist for bed mobility, dressing, toilet use, and personal hygiene. A Physician's Order, dated 2/21/23, indicated hydrocodone-acetaminophen (a pain medication) 5-325 milligrams (mg), 1 tablet by mouth two times a day for pain. The February 2023 Medication Administration Record (MAR), indicated the hydrocodone-acetaminophen pain medication was not signed out as administered on the following dates and times: - 2/21/23 at 8:00 p.m. - 2/22/23 at 8:00 a.m. - 2/22/23 at 8:00 p.m. - 2/23/23 at 8:00 a.m. - 2/23/23 at 8:00 p.m. - 2/24/23 at 8:00 a.m. - 2/26/23 at 8:00 a.m. - 2/27/23 at 8:00 p.m. Interview with the Director of Nursing on 2/28/23		compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident J received pain medication as ordered. **2) How the facility identified other residents:** All residents receiving pain medications have the potential to be affected by this alleged deficient practice. An audit was completed on all residents with pain medication to ensure that medications were available. **3) Measures put into place/ System changes:** Licensed Staff was educated on the importance of monitoring,	

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	at 4:07 p.m., indicated she had no further information to provide regarding the pain medication. This Federal tag relates to Complaint IN00401921. 3.1-37(a)		assessing, documenting, and providing pain medication according to physician's order and resident plan of care. **4) How the corrective actions will be monitored:** Director of Nursing or designee will review documentation 5 days a week to ensure that pain medications were given and available. The Director of Nursing is responsible for compliance. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 03/28/23**	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or			

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	§483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.			
	Based on record review and interview, the facility failed to manage medications appropriately related to ensuring medications were administered as ordered for 1 of 3 residents reviewed for a change in condition. (Resident C) Finding includes: The closed record for Resident C was reviewed on 2/28/23 at 1:50 p.m. The resident was admitted on 1/16/23 and discharged to hospital on 1/20/23. Diagnoses included but were not limited to, stroke, high blood pressure, non traumatic subdural hemorrhage, craniectomy, and osteoarthritis. The 5 Day Minimum Data Set (MDS) assessment, dated 1/20/23, indicated the resident was cognitively intact and was an extensive assist for all of Activities of Daily Living (ADLs). Physician's Orders, dated 1/16/23 at 9:26 p.m., indicated the following medications: - Amlodipine Besylate Tablet (a medication used	F 0757	**F757 Drug Regimen is free from unnecessary Drugs** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:**	03/28/2023

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	to lower the blood pressure) 2.5 milligrams (mg). Give 2.5 mg one time a day. - Atorvastatin Calcium (a medication used to lower cholesterol) Tablet 20 mg. Give 20 mg one time a day. - Vitamin D3 Tablet 25 micrograms (mcg). Give 50 mcg one time a day. - Glycolax Powder give 17 grams one time a day. - Hydrochlorothiazide (a medication used to lower blood pressure) Tablet 12.5 mg. Give 12.5 mg every morning and at bedtime. - Doxycycline Hyclate (an antibiotic medication) Tablet 100 mg. Give 100 mg every 12 hours for 5 days. - Docusate Sodium Tablet 100 mg. Give 1 capsule one time a day. The 1/2023 Medication Administration Record (MAR), indicated the above medications were not signed out as being administered on 1/16 and 1/17/23 at 8:00 a.m. Interview with the Director of Nursing on 2/28/21 at 3:30 p.m. indicated the medications were not signed out as being administered as ordered by the Physician. 3.1-48(a)		Resident C no longer resides in the facility. **2) How the facility identified other residents:** All residents who receive medications have the potential to be affected by this deficient practice. **3) Measures put into place/ System changes:** Licensed nurses will be educated on the importance of following up with the physicians and pharmacy when medications are not available for resident to receive. **4) How the corrective actions will be monitored:** The Director of Nursing or designee will complete a medication review audit 5 days a week to ensure that residents have received medications per physician's order. The Director of Nursing is responsible for compliance. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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			5) Date of compliance: 03/28/2023	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to marred walls, doors, and door frames, and discolored caulking for 2 of 2 floors. (The First and Second Floors) Findings include: During random observations on the First and Second Floors on 2/28/23 at 3:00 p.m. the following was observed: a. Room 102 - The room and bathroom doors were marred with black scuff marks. The wall behind the room door was marred and the closet door had a crack in it. There was 1 resident residing in the room and 3 residents who shared the bathroom. b. Room 204 - The walls, room door and bathroom door were marred. The door stopper was coming out of the wall. The baseboard was peeling away from the wall. The caulking around the toilet was yellow. There was 1 resident residing in the room and 2 residents who shared the bathroom. c. Room 223 - The bathroom door was marred and gouged. The bathroom walls were marred as well as the door frame. There were 2 residents who	F 0921	**F 921** **The facility request paper compliance for this citation** PLAN OF CORRECTION **Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** 1. **The corrective action taken for the resident found to have been affected by the deficient practice:** room 102, 204, 223, 227 were corrected. **2. How facility identified other residents to be at risk**	03/28/2023

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	shared the bathroom. d. Room 227 - The wall behind the bed was white and patched and in need of painting. There was 1 resident residing in the room . Interview with the Administrator on 2/28/23 at 3:00 p.m., indicated all of the above was in need of cleaning and/or repair. This Federal tag relates to Complaint IN00400563. 3.1-19(f)		Audit was completed by admin of all rooms requiring touch ups. List is being addressed. **3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:** daily guardian angel rounds & preventative maintenance program **4. To ensure the deficient practice does not reoccur, the monitoring system established is to:** **Administrator / Designee** will monitor 3 rooms weekly for 4 weeks. Then 2 rooms weekly for 4 weeks **Any issues will be addressed immediately.** **The audits will be discussed during our monthly QA meeting.** **QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated**. **5. Completion date systemic changes will be completed:** 3/28/23 Update	

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