STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(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 Investigation of Complaint IN00373497, IN00373322, IN00373790, IN00374098, IN00373886, IN00374619 and IN00374610. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00373497 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00373322 - Substantiated. Federal/State deficiencies related to the allegations are cited at F686, F689, F732, F759 and F842. Complaint IN00373790 - Substantiated. Federal/State deficiencies related to the allegations are cited at F921. Complaint IN00374098 - Substantiated. Federal/State deficiencies related to the allegations are cited at F755 and F842. Complaint IN00373886 - Unsubstantiated due to lack of evidence. Complaint IN00374619 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689 and F842. Complaint IN00374610 - Substantiated. Federal/State deficiencies related to the allegations are cited at F686, F755, F759 and F842. Survey dates: March 7, 8, 9 and 10, 2022 Facility number: 012548 Provider number: 155790	F 0000	A credible POC requesting desk review.	

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

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

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	AIM number: 201023760 Census Bed Type: SNF/NF: 75 Total: 75 Census Payor Type: Medicare: 14 Medicaid: 38 Other: 23 Total: 75 These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed March 18, 2022.			
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 interview and record review, the facility failed to provide dressing changes for a pressure wound as ordered by the physician for 1 of 3 residents reviewed for pressure wounds. (Resident L)	F 0686	F686-Treatment/Services to Prevent/Heal Pressure Ulcer 1. Resident L could not be identified for confidentiality. 2. All residents receiving	04/12/2022

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	Finding includes: The record for Resident L was reviewed on 03/10/22 at 10:15 a.m. Diagnoses included, but were not limited to, osteomyelitis (an infection in the bone), pressure ulcer of left buttock and neuropathy (a nerve problem which caused numbness, pain and tingling in different parts of the body). A physician's order, dated 02/24/22, indicated to cleanse the resident's left buttock wound with normal saline (salt water) or wound cleanser and pack the wound with 1/4 Dakins solution (an antiseptic solution used to treat wounds) moistened gauze and cover with a dry dressing one time a day for wound care. A MAR (Medication Administration Record), for 03/22, indicated the resident did not receive wound dressing changes on 3/2/22, 3/4/22 and 3/6/22 as indicated by the lack of nursing documentation on those days. During an interview, on 03/10/22 at 12:52 p.m., the Director of Nursing indicated if a physician's order was not documented with the nurses initials in the resident's MAR then it was not completed. The Director of Nursing could not produce a specific policy for following physician's orders but it was an expectation for nursing to do so. This Federal tag relates to Complaint IN00374610 and IN00373322. 3.1-40(a)(2)		wound treatments have the potential to be affected by the alleged deficient practice. The DON or designee will complete an audit of the treatment orders and dressings for validation of accuracy and completion. Any findings not consistent with completion, physician notified of findings. 3. The DON or designee will educate the licensed nurses on the facility policy for Skin Care and Wound Management Overview, to include ensuring that treatments are completed as ordered as well as documented appropriately in EMR. 4. The following audits will be conducted by the Director of Nursing or designee to ensure compliance with completion of dressing changes as order by the MD: audit treatment orders as well as dressing changes of 5 residents 5 X'S a week for 4 weeks, 5 residents 3 X's a week for 2 months, and 5 residents once a week for 3 months. 5. The DON/Designee will bring the results of the audits to the monthly QAPI meeting. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months, Then randomly thereafter for further recommendations.	

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to complete an admission fall risk assessment, document a root cause analysis, complete a post fall assessment and implement a new intervention for an unwitnessed fall for 3 of 3 residents reviewed for falls. (Resident E, F and K) Findings include: 1. The record for Resident E was reviewed on 03/07/22 at 3:53 p.m. Diagnoses included, but were not limited to, dementia, unsteadiness on feet and history of falling. An incident note, dated 2/18/22 at 7:30 a.m., indicated the resident had an unwitnessed fall on 02/18/22. The time was not documented. He rolled out of bed and was found wrapped up in his sheets. A care plan, dated 02/19/22, indicated the resident was at risk for falls. There was no new intervention implemented after the fall on 2/18/22. 2. On 03/07/22 at 11:15 a.m., Resident F was sitting up in her bed. Her wheelchair was near the bottom of her bed.	F 0689	F689-Free of Accident Hazards/Supervision/Devices 1. Residents E, F, and K are confidential as part of the compliant survey. All residents have the potential to be affected by the alleged deficient practice. 2. The DON or designee will complete an audit on all falls in the last 14 days to ensure the following are in place post fall: a fall risk assessment, root cause analysis, post fall assessment, implementation of a new intervention and care plan update of new intervention. If any discrepancies are found, the medical record will be updated and the MD will be notified. 3. The DON or designee will educate the licensed nurses on the facility policy for Fall Prevention Management, to include completion of fall risk assessment, root cause analysis, post fall assessment, implementation of new intervention and care plan update of new	04/12/2022

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	The record for Resident F was reviewed on 03/07/22 at 9:53 a.m. Diagnoses included, but were not limited to, dementia, behavioral disturbances and history of falling. A progress note, dated 02/25/22 at 3:19 p.m., indicated the resident had a fall on 02/25/22 at 3:19 p.m. She was found sitting on the floor near the side of the bed. A progress note, dated 02/28/22 at 12:01 a.m., indicated the resident had an unwitnessed fall on 02/27/22 at 11:30 p.m., she was found sitting next to her bed. She tried to get up to find a family member and slid off the bed. She had done this several times this week and might benefit from a perimeter mattress. A care plan, initiated on 12/30/21 and revised on 01/18/22, indicated the resident was at risk for falls. There were not any new interventions implemented after the falls. 3. On 03/08/22 at 4:39 p.m., Resident K was observed in bed with her head elevated. She had a scoop mattress on her bed and her bed was in the lowest position with her call light within reach. The record for Resident K was reviewed on 03/08/22 at 11:24 p.m. Diagnoses included, but were not limited to, mild cognitive impairment, weakness and history of falls. A progress note, dated 02/27/22 at 6:10 a.m., indicated the resident yelled out for help around 2:00 a.m. She was found by the nurse, on the floor alongside her bed, laying on her back and the fall protocol would be completed.		intervention after each fall. 4. The following audits will be conducted by the Director of Nursing or designee to ensure compliance with completion of fall risk assessment, root cause analysis, post fall assessment, implementation of new intervention and care plan update of new intervention after each fall: audit resident falls in daily clinical meeting Monday-Friday to ensure documentation of post fall is complete. This process is ongoing. 5. The DON/Designee will bring the results of the audits to the monthly QAPI meeting. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months, Then randomly thereafter for further recommendations. Date of Compliance 4-12-2022	

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	A care plan, dated 02/23/22, indicated the resident was at risk for falls related to unsteady balance, impaired cognition and history of falls. Interventions included, but were not limited to, assess risk for falls on admission and initiate neurological checks if the fall was unwitnessed. There were no other new or updated interventions put into place after her fall on 02/27/22. During an interview, on 3/9/22 at 2:38 p.m., the Director of Nursing indicated she could not provide a completed fall risk assessment, a root cause analysis or any fall follow-up documentation for Resident K's fall. They should have been completed and documented in her medical record. During an interview, on 3/9/22 at 3:53 p.m., the Director of Nursing indicated interventions were supposed to be tailored to each resident and their care plans should be updated with new interventions after a fall. A current facility policy, titled "Fall Prevention and Management," dated 5/26/21 and provided by the Director of Nursing on 03/09/22 at 12:57 p.m., indicated "...Fall prevention and management is the process of identifying risk factors that can minimize the potential for falls...A Fall Risk Assessment should be completed upon admission...A report should be initiated in Risk Watch. Update the care plan with the new intervention...Interdisciplinary Team Review...The team should discuss the fall, potential causes of the fall, interventions put into place...A deep root cause investigation should be discussed...." This Federal Tag relates to Complaints IN00374619 and IN00373322.			

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	3.1-45(a)(2)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the			

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	posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, record review and interview, the facility failed to ensure posted staffing information was accurate and current for 1 of 1 random observation during the facility initial tour. Finding includes: During an initial tour of the facility, on 03/07/22 at 6:41 a.m., the daily staff posting indicated staffing information for 02/27/22, 02/28/22 and 03/01/22. During an interview, at that time, the Director of Nursing indicated staff posting information should be accurate and reflect the current date. A current facility policy, titled "Nursing Staffing Information," dated 06/09/2017 and provided by the Director of Nursing on 03/09/22 at 12:31 p.m., indicated "...The facility will post the nurse staffing data daily at the beginning of each shift...." This Federal Tag relates to Complaint IN00373322. 3.1-17(b)	F 0732	F732-Posted Nurse Staffing Information 1. The current nurse staffing information is posted. 2. The current nurse staffing information is posted. 3. The ED or designee will educate the Scheduler and nursing management team on the facility policy Nurse Staffing Information, to include ensuring staffing posting is updated daily to reflect staffing levels. 4. The following audits will be conducted by the Director of Nursing or designee to ensure compliance with the posting of accurate and current staffing information daily: audit staff postings 5 X'S a week for 4 weeks, then 3 X's a week for 2 months, and once a week for 3 months. 5. The DON/Designee will bring the results of the audits to the monthly QAPI meeting. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months, Then randomly thereafter for further recommendations. Date of Compliance 4-12-2022	04/12/2022
F 0755 SS=D	483.45(a)(b)(1)-(3) Pharmacy			

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Bldg. 00	Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview and record review, the facility failed to ensure nurses verified the controlled substance (narcotics) counts and acknowledged the accuracy with signatures from the nurse coming on and the nurse going off duty for 3 of 3 Shift Change Controlled Substance	F 0755	F755-Pharmacy Services/Procedures/Pharmacist/ Records 1. No residents were affected by this alleged deficient practice. 2. All residents have the	04/12/2022

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	Inventory Tracker documentation's reviewed. (Medication Carts 1, 2 and 3) Findings include: 1. During a count of the narcotics, in the medication cart 1 on the 5000 hall, with LPN 3 on 03/07/22 at 5:38 a.m., the "Shift Change II Controlled Substance Inventory Tracker" indicated from 02/19/22 through 03/07/22 the count sheets were incomplete 24 out of 46 possible times. 2. During a count of the narcotics, in the medication cart 2 on the 5000 hall, with LPN 3 on 03/07/22 at 5:38 a.m., the "Shift Change II Controlled Substance Inventory Tracker" indicated from 02/19/22 through 03/07/22 the count sheets were incomplete 18 out of 46 possible times. 3. During an observation of the narcotics count, between LPN 4 and QMA (Qualified Medication Assistant) 5 on 03/07/22 at 6:00 a.m., "Shift Change II Controlled Substance Inventory Tracker" indicated from 02/20/22 through 03/07/22 the count sheets were incomplete 13 out of 45 possible times. During an interview, on 03/08/22 at 9:30 a.m., the Director of Nursing indicated nursing should have counted the narcotics every shift verifying the count was accurate. A current facility policy, titled "Medication Controlled Drugs and Security," dated 01/13/22 and provided by the Director of Nursing on 03/08/22 at 8:45 a.m., indicated "...a. Controlled drugs...are counted every shift change by the nurse reporting on duty with the nurse reporting		potential to be affected. The DON/Designee will complete an audit of all medication carts to validate the accuracy of the controlled substance (narcotics) count sheets, narcotic cards, and inventory tracker sheets to ensure signatures from the nurse coming on and nurse going off duty are in place for each shift change. The DON or designee will educate the licensed nurses and qualified medication aides on the facility policy Medication Controlled Drugs and Security, to include the process of verifying the controlled substance (narcotics) counts and acknowledged the accuracy with signatures from the nurse/QMA coming on and the nurse/QMA going off of duty each shift. 3. The following audits will be conducted by the Director of Nursing or designee to ensure compliance with completion of the shift change controlled substance inventory tracker sheets for signatures: audit 5 days per week X's 1 month, then 3 days per week for 2 months, and once a week for 3 months. 4. The DON/Designee will bring the results of the audits to the monthly QAPI meeting. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months, Then randomly thereafter for further recommendations. Date of Compliance: 4-12-2022	

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	off duty...c. The controlled drugs...must be recorded on the narcotic records and signed for correctness of count...d. The controlled drug record must be signed by the nurse coming on duty and going off duty to verify that the count of all controlled drugs is correct after the count has been completed...." This Federal Tag relates to Complaint IN00374098 and IN00374610. 3.1-25(e)(3)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review and interview, the facility failed to ensure a medication error rate of less than 5 percent based on medication errors observed during 2 of 25 opportunities for errors during random medication administration observations, resulting in a medication error rate of 8 percent (Residents G and P). Findings include: 1. During a random medication administration observation, on 03/07/22 at 7:30 a.m., LPN 1 administered one potassium chloride (a supplement used to treat a low blood potassium level) 20 mEq ER (milliequivalent extended release) tablet to Resident G. LPN 1 was observed to crush the medication and mix with applesauce. The pharmacy directions on the medication indicated do not crush. During an interview, at that time,	F 0759	F759-Free of Medication Error Rates 5 percent or more 1. Residents G and P could not be identified due to confidentiality. 2. All residents that receive medications that must be crushed have the potential to be affected by this alleged deficient practice. The DON or designee will complete an audit of residents receiving crushed medications. Any medication that cannot be crushed, the MD will be notified and a request made to change so medication can be administered appropriately. 3. The DON or designee will educate the licensed nurses and qualified medication aides on the	04/12/2022

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	LPN 1 indicated according to the directions she should not have crushed the medication. Resident G's record was reviewed on 03/07/22 at 11:00 a.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing), chronic kidney disease and hypertension. A current physician's order indicated the resident was to receive potassium chloride extended release tablet in the morning for a supplement. A current physician's orders indicated may crush medications unless contraindicated per pharmacy protocol. A current care plan indicated the resident was at risk for nutritional decline. Interventions included, but were not limited to, administer supplemental potassium per physician order. 2. During a random medication administration observation, on 03/10/22 at 8:37 a.m., LPN 2 administered one potassium chloride (a supplement used to treat a low blood potassium level) 20 mEq ER (milliequivalent extended release) tablet to Resident P. LPN 2 was observed to crush the medication and mix with applesauce. The pharmacy directions on the medication indicated do not crush. During an interview, at that time, LPN 2 indicated she missed the pharmacy directions and should not have crushed the medication. Resident P's record was reviewed on 03/10/22 at 10:00 a.m. Diagnoses included, but were not limited to, stroke, hypertension and anemia. A current physician's order indicated the resident was to receive potassium chloride 20 mEq ER daily		facility policy Medication Administration, to include following the manufacturer's recommendations for medications that noted do not crush. 4. The following audits will be conducted by the Director of Nursing or designee to ensure compliance with following manufacture recommendations for medications noted do not crush: audit new medication orders in clinical meeting 5 X'S a week for 4 weeks, 5 residents 3 X's a week for 2 months, and once a week for 3 months. The following observations will be conducted by the Director of Nursing or designee to ensure compliance with following manufacture recommendations for medications noted do not crush: observe 3 Nurses or QMAs during medication administration 5 X'S a week for 4 weeks, 5 residents 3 X's a week for 2 months, and once a week for 3 months. 5. The DON/Designee will bring the results of the audits to the monthly QAPI meeting. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months, Then randomly thereafter for further recommendations. Date of Compliance 4-12-2022	

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	155790	A. BUILDING 00 B. WING	03/10/2022

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	on Monday, Thursday and Saturday for a supplement. A current physician's orders indicated may crush medications unless contraindicated per pharmacy protocol. A current care plan indicated the resident has increased health risks. Interventions included, but were not limited to, provide supplements per physician orders. During an interview, on 03/09/22 at 4:19 p.m., the Director of Nursing indicated the nurse should have followed the special instructions on the medication card from the pharmacy, if it indicated "do not crush" she should not have crushed the medication. A current facility policy, titled "Medication Administration," dated 01/05/22 and provided by the Director of Nursing on 03/08/22 at 8:45 a.m., indicated "...Follow manufacturer's recommendations for medications that note [do not crush]...." This Federal Tag relates to Complaint IN00374610 and IN00373322. 3.1-48(c)(1)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the			

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	information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, 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			

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	retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and 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 and record review, the facility failed to maintain medical records which were complete and accurate as indicated by missing documentation of medications for multiple days for 2 of 13 residents reviewed for medication administration. (Residents B and J) Findings include: 1. The record for Resident B was reviewed on 03/07/22 at 7:25 a.m. Diagnoses included, but were not limited to, diverticulitis (a condition were pouches in the small bowel become inflamed or infected) with perforation and abscess, hernia (a protrusion of intestine or other tissue through a weakness or gap in the abdominal wall) and lower abdominal pain. A physician's order, dated 01/21/22, indicated the	F 0842	F842-Resident Records-Identifiable Information 1. Resident B and Resident J could not be identified for confidentiality. 2. All residents receiving medications have the potential to be affected by this alleged deficient practice. The DON/designee will complete an audit of the last 7 days has been completed of the MAR's and TAR 's . Any discrepancies will be reported to the physician. 3. The DON or designee will educate the licensed nurses and qualified medication aides on the facility policy for Medication Administration, to include	04/12/2022

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	resident was to receive two Hydrocodone-Acetaminophen (Norco) 5-325 mg (milligrams) four times a day for pain for two weeks, discontinued 02/04/22. A MAR (Medication Administration Record), for 01/22, indicated the resident did not receive this pain medication on 01/24 at 5 p.m., and 01/27 at 1:00 p.m. A physician's order, dated 02/06/22, indicated the resident was to receive two Norco 5-325 mg three times a day, discontinued 02/07/22. A MAR (Medication Administration Record), for 02/22, indicated the resident did not receive this pain medication on 02/07 at 12 p.m. A physician's order, dated 02/07/22, indicated the resident was to receive one Norco 5-325 mg every 6 hours for pain, discontinued 02/16/22. A MAR (Medication Administration Record), for 02/22, indicated the resident did not receive this pain medication on 02/15 at 6 a.m. A care plan, dated 01/19/22, indicated the resident had complaints of acute and chronic pain related to his disease process and medical procedure. Interventions included, but were not limited to, provide medications per orders. 2. The record for Resident J was reviewed on 03/07/22 at 10:24 a.m. Diagnoses included, but were not limited to, subdural abscess (a pocket of pus which develops between the skull and the top layer tissues covering the brain) and pneumonia. A physician's order, dated 02/16/22, indicated the resident was to receive Cefazolin (an antibiotic) 2		medications and treatments to be charted when administered. 4. The following audits will be conducted the Director of Nursing or designee to ensure compliance with compliance with completion medication administration documentation: audit of 5 residents per day/ 5 days a week for 1 month, 5 residents 3 days a week for 2 months, and 5 residents once a week for 3 months thereafter. 5. The DON/Designee will bring the results of the audits to the monthly QAPI meeting. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months, Then randomly thereafter for further recommendations. Date of Compliance: 4-12-2022	

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	grams intravenously every eight hours for bacteremia (an infection in the blood stream). A physician's order, dated 02/16/22, indicated the resident was to receive one Norco 5-325 mg six times a day. A MAR (Medication Administration Record), for 02/22 and 03/22, indicated the resident did not receive his antibiotic 7 doses out of 60 total doses and 17 doses of pain medication out of 75 total doses. A care plan, dated 02/09/22, indicated the resident had complaints of acute and chronic pain related to his disease process and medical procedure. Interventions included, but were not limited to, provide medications per orders. During an interview, on 03/20/22 at 12:42 p.m., the Director of Nursing indicated she could not provide any further documentation the resident's received any of the missing medications and she indicated if the MAR was not documented with nursing initials then the medication was not given. A current facility policy, titled "Medication Administration," dated 01/05/22 and provided by the Director of Nursing on 03/08/22 at 8:45 a.m., indicated "...Administer medication...as prescribed by the provider...Medications will be charted when given...Documentation will follow accepted standards of nursing practice...." This Federal tag relates to Complaints IN00373322, IN00374610, IN00374098 and IN00374619. 3.1-50(a)(1) 3.1-50(a)(2)			

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F 0921 SS=F 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 resident common areas, halls and floors were clean as well as 2 of 11 resident rooms observed for cleanliness. (5000 unit, 3000 unit 2000 unit, Room 3002 and 3006) Findings include: 1. During an initial tour of the facility, on 03/07/22 at 5:20 a.m., the following were observed: a. The 5000 unit common area was noted to have dirty Styrofoam cups and food crumbs on the table tops. The tops were sticky with rings from dirty cups left on them and scattered food crumbs and trash. b. The 3000 unit floors were noted to have dried sticky stains throughout, paper trash on the hall floor and in the dining area. 2. During a tour of the facility, on 03/07/22 at 10:54 a.m., the following were observed: a. The 5000 hall dining counter top area had a used plastic sleeve protector and was noted to have dirty cups in the sink. The dining area had food and trash on the floor b. Room 3006 was noted to have trash and old food on the floor. The bathroom trash can was over flowing with paper towels and toilet paper. There was a brief on top of the toilet paper dispenser and the toilet bowl was dirty.	F 0921	F921-Safe/Functional/Sanitary/Comfortable Environ 1. The common areas on 2000, 3000 and 5000 were cleaned, the resident room trash cans were emptied and resident room floors were cleaned. 2. All residents have the potential to be affected by this alleged deficient practice. All areas have been cleaned and addressed immediately. 3. The Environmental Service Director or designee will in-service the Environment Staff on the implementation of the updated daily cleaning schedules. 4. The following audits will be conducted by the Environmental Service Director or designee to ensure compliance with cleanliness of the common areas and resident rooms: audit the daily cleaning check offs and 5 rooms on each hallway 5 days a week for 4 weeks, 3 days a week for 2 months, and 1 time a week for 3 months. 5. The Housekeeping Supervisor/Designee will bring the results of the audits to the monthly QAPI meeting. The results of the audit will be reported, reviewed, and trended for	04/12/2022

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	3. During a tour of the facility, on 03/07/22 at 12:11 p.m., the following were observed: a. The 2000, 3000, and 5000 halls were noted to have dried spills of fluid with footprints and wheel prints from carts on the floor and heavy dust accumulation of the floor next to the cove base. b. Room 3002 was noted to have wrappers and other debris on the floor. The floor was heavy with dust accumulation making it slick when walked on. During an interview, on 03/09/22 at 3:16 p.m., the Housekeeping Supervisor indicated resident's rooms and halls were to be cleaned every day and the facility was "short" and had only 1 housekeeper at this time. No policy was provided. This Federal tag relates to Complaint IN00373790. 3.1-19(f)(5)		a minimum of 6 months, Then randomly thereafter for further recommendations. Date of Compliance 4-12-2022	