STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigations of Complaints IN00411686 and IN00412761. Complaint IN00411686 - No deficiencies related to the allegations are cited. Complaint IN00412761 - No deficiencies related to the allegations are cited. Survey dates: August 23, 24, 25, 26, 28, 29, 30 and 31, 2023 Facility number: 012534 Provider number: 155792 AIM number: 201028420 Census Bed Type: SNF: 8 SNF/NF: 128 Total: 136 Census Payor Type: Medicare: 5 Medicaid: 97 Other: 34 Total: 136 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on September 8, 2023.	F 0000	Countryside Meadows respectfully requests a desk review in lieu of a post survey review on or after September 23, 2023. Please feel free to contact Tara McGlothlin if you need any additional information to support the desk review at 765-730-9322. Thank you for your consideration.	
F 0558 SS=E	483.10(e)(3) Reasonable Accommodations			

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

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Bldg. 00	Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation and interview, the facility failed to ensure resident's call lights were in reach for 5 of 24 residents reviewed for call lights. (Resident 9, 74, 31, 17, and 54) Findings include: 1. On 8/23/23 at 10:42 a.m., Resident 9 was in bed, her call light was observed on the floor, at the end of the bed. On 8/24/23 at 9:35 a.m., Resident 9 was in her bed, her call light was observed on the floor, at the end of the bed. On 8/28/23 at 12:30 p.m., Resident 9 was in her recliner. Her call light was behind her bed. 2. On 8/23/23 at 10:55 a.m., Resident 74 was in her bed, her call light was clipped on the top, posterior corner of her bed. She was unable to see or reach it. 3. On 8/23/23 at 11:17 a.m., Resident 31 was in her wheelchair. Her call light was on the floor behind her. She indicated she could not reach it. 4. On 8/23/23 at 11:42 a.m., Resident 17's call light was on the floor out of her reach. 5. On 8/23/23 at 11:56 a.m., Resident 54's call light was clipped on the top, posterior corner of her bed. The resident could not see or reach it.	F 0558	F558 Reasonable Accommodations Needs/Preferences What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Call lights are within reach for Residents 9, 74, 31, 17, and 54. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Observational rounds were completed by Care Companions daily to ensure that call lights are in reach for all residents. All staff will be in-serviced on call lights in reach for residents by ED/designee on or before 9/21/23 for all staff to include ensuring call lights are in reach for residents. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	09/23/2023

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	On 8/24/23/23 at 10:20 a.m., Resident 54's call light was clipped on the top, posterior corner of her bed. The resident could not see or reach it. On 8/28/23 at 11:56 a.m., Resident 54's call light was out of reach, hanging off over her bedside table. On 8/28/23 at 2:49 p.m., the Executive Director (ED) indicated the facility did not have a call light policy but call lights should have been in reach for the residents. 3.1-3(v)(1)		All staff will be in-serviced on call lights in reach for residents by ED/designee on or before 9/21/23 for all staff to include ensuring call lights are in reach for residents. Observational rounds will be completed by Care Companions daily to ensure that call lights are in reach for all residents. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete a Call Light CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The Call Light CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	
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			

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	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). §483.10(g)(15) Admission to a composite distinct part. A			

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	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 ensure a resident, (Resident 138) had the right for his physician to be notified of an alteration of his medication administration, when a blood pressure medication was withheld due to parameters that were not ordered for his medication, and the facility failed to ensure a resident, (Resident 115) had the right for his physician to be notified of elevated blood sugar levels, as ordered, for 2 of 3 residents reviewed for change of condition. Findings include: 1. On 8/28/23 at 3:27 p.m., Resident 138's medical record was reviewed. Resident 138 admitted to the facility on 5/19/23 after an acute hospital visit, due to an increase of severe orthostatic hypotension episodes. (OH), (a sudden drop in blood pressure which occurs when a person stands up which can cause lightheadedness, dizziness or even cause a person to faint). Upon his admission, he had diagnoses which included, but were not limited to, OH, syncope and collapse (the medical term for "fainting" or "passing out"), and end stage renal (kidney) disease. Due to his advanced kidney disease, he required a	F 0580	**F 580 Notify of Changes** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident 138 no longer resides in the facility. ·Physician was notified of Resident 115 elevated blood sugar level **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. A 1x audit will be completed to ensure applicable blood pressure medications have hold orders and blood sugars outside of call parameters have physician notification. ·An in-service will be completed by DNS/designee on or before 9/21/23 for nursing staff to include physician is notified of pertinent	09/23/2023

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	life-sustaining process of peritoneal dialysis, (PD) a type of treatment for kidney failure which uses the lining of the abdomen, to filter blood inside the body by using the peritoneum in a person's abdomen as the membrane through which fluid and dissolved substances are exchanged with the blood. This process removes excess fluid, corrects electrolyte problems, and removes toxins from the body. Resident 138 had a physician's order for peritoneal dialysis with 2 yellow bags (2.5%) 1 green bag (1.5%), for a total of 3 bags = 18,000 ml (milliliters) which should run over a period of 10 hours. PD solutions are often color-coded based on the dextrose (sugar) concentration. Dextrose is used as the osmotically active agent. An osmotic agent increases the oncotic pressure of the blood; this pulls water from tissues and increases the volume of the blood acutely. The increased blood volume will inhibit renin release, thus increasing renal blood flow. Resident 138's physician order and instructions for PD did not include any parameters or limitations based on blood pressure. Upon his admission on 5/19/23, Resident 138 had a physician's order for midodrine 2.5 mg (milligrams). Midodrine is a medication used to treat low blood pressure, (hypotension) which works by stimulating nerve endings in blood vessels, causing the blood vessels to tighten, as a result, blood pressure is increased. His initial order for midodrine, did not include any parameters or limitations based on blood pressure. A nursing progress note, dated 5/25/23 at 3:46 p.m., indicated during a hospital follow-up		order or status change **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·An in-service will be completed by DNS/designee on or before 9/21/23 for nursing staff to include physician is notified of pertinent order or status change ·DNS/Designee will review resident administration record daily to ensure blood sugar call parameters are being followed and any applicable blood pressure medications have hold orders in place per MD order. Any changes or concerns meeting the specified requirements will be made to physician and documented by the DNS/Designee. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·To ensure compliance the DNS/Designee will complete an Annual Survey Plan of Correction audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The audit tool will be reviewed monthly by	

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	appointment, he had to be admitted due to a very low blood pressure (BP). Upon his return to the facility, on 5/30/23, his order for midodrine had been increased from 2.5 mg every 8 hours to 5 mg 4 times a day without any parameters or limitations based on BP. Resident 138's record lacked documentation for any routine BP monitoring, parameters and or limitation based on BP. Resident 138's Medication Administration Record (MAR) was reviewed and revealed: On 6/1/23, his scheduled dose for 6:00 a.m., was held by Registered Nurse (RN) 40. The MAR comment indicated "Not Administered: Other. BP: 127/77. I did not give [resident] his 15 mg midodrine." The record lacked documentation of physician notification for clarification to give the midodrine or not due to BP, and lacked notification the physician was notified the medication was withheld. On 6/2/23, his scheduled dose for 6:00 p.m., was held by RN 41. The MAR comment indicated "Not Administered: Due to Condition. Comment: BP 142/72." The record lacked documentation of physician notification for clarification to give the midodrine or not due to BP, and lacked notification the physician was notified the medication was withheld. On 6/3/23, his scheduled dose for 12:00 a.m., was held by RN 42. The MAR comment indicated "Not Administered: Due to Condition. Comment: [resident] BP 127/68." The record lacked documentation of physician notification for clarification to give the midodrine or not due to		the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	BP, and lacked notification the physician was notified the medication was withheld. On 6/4/23, his scheduled dose for 12:00 a.m., was held by RN 42. The MAR comment indicated "Not Administered: Other. Per [resident] his max should be 45 mg per day opt not to take at this time." The record lacked documentation of physician notification for clarification to give the midodrine or not due to BP, and lacked notification the physician was notified the medication was withheld. A nursing progress note, dated 6/5/233 at 6:21 a.m., indicated Resident 138 experienced a change of condition when his BP and oxygen (02) saturation dropped. His 02 was 85% and his BP was 88/56. 911 was called and although his 02 increased to 90% he stopped breathing and the emergency medical technician (EMT) pronounced his death shortly after arrival. During an interview, on 8/30/23 at 8:52 a.m., the Administrator (ADM) and Director of Nursing (DON) indicated after review of Resident 138's midodrine medication/doses, it appeared staff had pulled his increased 5 mg dose from another resident who had discharged. During an interview, on 8/30/23 at 3:47 p.m., Licensed Practical Nurse (LPN) 43 indicated there had been another resident (Resident 250) who had since discharged but had also used midodrine. She had been very particular, even "aggressive" with staff about when to give her the medicine or not and this made staff uneasy. It appeared, when staff pulled the midodrine from Resident 250 to supplement Resident 138's order, the nurses held the medication for his blood pressures readings even though there were no parameters for him.			

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	LPN 43 indicated they should not have held the medicine without notifying the physician. On 8/31/23 at 8:30 a.m., the ADM provided a copy of a Charge Nurse Position Description which was dated 11/2014. The Position Description outlined the roles and responsibilities of the Nurse, which included, but was not limited to, "...ensures compliance on unit with residents rights...administered medications and specialized treatments and diet as prescribed...promptly consults with their Nursing Supervisor/Unit Manager/ADNS and/or Social Worker if unsure of proper course of action that respects resident's rights...uses good judgement to prepare, administer and immediately document medications and treatments as ordered by physicians...." On 8/31/23 at 8:30 a.m., the ADM provided a copy of current facility policy, titled "General Dose Preparation and Medication Administration," revised 1/1/22. The policy indicated "...facility staff should comply with Facility policy, applicable law and the State Operations Manual when administering medications...facility staff should verify that the medication name and dose are correct when compared to the medication order on the medication administration record...facility staff should: verify each time a medication is administered that it is the correct medication, at the correct dose, a the correct route, at the correct rate, at the correct time for the correct residents, as set forth in facility's medication administration schedule...Confirm that the MAR reflects the most recent medication order...."2. On 8/30/23 at 2:31 p.m., Resident 115's medical record was reviewed. Resident 115 was admitted, on 6/14/23, and had diagnoses which included, but were not limited to,			

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	schizoaffective disorder (a mental health condition with a combination of symptoms which may include delusions, hallucinations, depressed episodes, and manic periods of high energy), type 2 diabetes mellitus (a disease which causes dysregulation and disruption of the body's ability to process blood sugar, [BS]), chronic obstructive pulmonary disease ([COPD] a group of diseases which cause airflow blockage and breathing-related problems), paroxysmal atrial fibrillation (a rapid, erratic heart rate), and epilepsy (a seizure disorder). He had current Physician's orders, which included, but were not limited to the following: a. insulin glargine- insulin pen; 100 unit/mL (3 mL); amount: 10 units; subcutaneous (a long-acting insulin medication). b. instructions to notify the Medical Doctor (MD) for blood sugar (BS) less than 70 and greater than 350. c. insulin lispro insulin pen; 100 unit/mL; amount: 5 units; subcutaneous, which included instructions to notify MD for BS less than 70 and greater than 350. Resident 115's Medication Administration Record (MAR) was reviewed and revealed, 9 separate occasions between the dates of 6/14/23-8/31/23, when his BS was recorded to exceed 350. The record lacked documentation the physician had been notified of the elevated BS levels. On 8/30/23 at 3:19 p.m., the Director of Nursing (DON) provided a document, which indicated, a record of blood glucose readings from 8/1/23 to 8/30/23. The record indicated Resident 115's blood glucose readings were documented to be above 350 on 9 separate occasions.			

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	During an interview, on 8/30/23 at 3:19 p.m., the DON indicated the Nurse Practitioner (NP) was scheduled to be at the facility on Mondays, Tuesdays, Thursdays, and Fridays from 9:00 a.m., to 4:00-5:00 p.m. During her visits, she would look at the communication board to identify which residents needed to be seen or which residents needed medical review. At this time, the DON provided a copy of the Communication Board record which indicated the following BS documentation for Resident 115. a. 8/19/23 at 5:13 a.m., BS= 389. The record lacked documentation of physician notification. b. 8/19/23 at 5:54 a.m., BS= 389. The record lacked documentation of physician notification. An NP progress note, dated 8/21/23 at 2:04 p.m., indicated the NP had reviewed Resident 115's blood glucose. The note indicated "...blood sugars reviewed and addressed blood sugars are running mostly 200-300s with sugar of 500 today. He is on glargine 5 units q hs with no other antihyperglycemic medications. Vital signs reviewed and stable. Face to face assessment warranted to assess for resolution of rash and direct proper medical care ...." The Communication Board BS record for Resident 115 indicated, on 8/21/23 at 8:10 p.m., his BS was 359. Although the record indicated the NP was notified, the record lacked documentation of the date, time, or method the NP was notified or the date and time the information was reviewed by the NP, and the medical record lacked documentation of notification to the physician of blood glucose reading above 350, as ordered. The Communication Board BS record for Resident 115 indicated, on 8/22/23 at 7:35 a.m., his BS was			

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	346. Although the NP was notified of elevated blood sugar reading, the record lacked documentation of the date, time, or method the NP was notified, and the record lacked documentation of notification to the physician of blood glucose above 350, as ordered. The Communication Board BS record for Resident 115 indicated, on 8/22/23 at 5:03 p.m., his BS was 362. The record lacked documentation of notification to the physician of blood glucose above 350, as ordered. The Communication Board BS record for Resident 115 indicated, on 8/22/23 at 6:49 p.m., his BS was 374. The record lacked documentation of notification to the physician of blood glucose above 350, as ordered. The Communication Board BS record for Resident 115 indicated, on 8/25/23 at 5:16 p.m., his BS was 362. A request was entered on the communication board for the NP to see Resident 115, however the record lacked documentation of the date, time, or method the NP was notified. The record lacked documentation of notification to the physician of blood glucose above 350, as ordered. On 8/31/23 at 8:30 a.m., the Administrator (ADM) provided a copy of a current facility policy, titled "Resident Change of Condition Policy," dated 11/2018. The policy indicated "...It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely and effective intervention takes place...Procedure...2. Acute Medical Change a. Any sudden or serious change in the resident's condition manifested by a marked change in physical or mental behavior will be communicated			

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	to the physician...Non-Urgent Medical Change...a. All symptoms and unusual signs will be documented in the medical record and communicated to the attending physician promptly...b. The nurse in charge is responsible for notification of physician and family/responsible party prior to end of assigned shift when significant change in the resident's condition is noted...f. Document resident change of condition and response in the medical record. Documentation will include time and family/physician response...." 3.1-5(a)(3)			
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).			

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	(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 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 ensure a person-centered comprehensive care plan was initiated and implemented to prevent the worsening of contractures for 1 of 2 residents reviewed for mobility/range of motion/positioning (Resident 42). Findings include: On 8/29/23 at 11:28 a.m., Resident 42 was observed, lying in bed with a cover over her. Her arms and hands were outside of the cover. Her nails on both hands were long and thickened with brown debris under the nails. The nails were	F 0656	**F 656 Develop/Implement Comprehensive Care Plan** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Care plan was initiated for resident number 42 regarding contracture to right hand. **How will you identify other residents having the potential to be affected by the same**	09/23/2023

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	pressed into the residents contracted left hand. A rolled-up wash cloth was in the palm of the residents contracted right hand. On 8/29/23 at 11:28 a.m., Resident 42 was observed. She laid in bed with her eyes closed and her arms at her sides. Her left hand was observed to be contracted (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints). The nails of her left had begun to press into the palm of her hand. A rolled-up wash cloth was observed in the palm of her right hand, which was also observed to be contracted. During an interview, on 8/29/23 at 11:45 a.m., Registered Nurse (RN) 18 indicated Resident 42 should have an anti-contracture device in each hand. During an interview, on 8/29/23 at 11:50 a.m., Unit Manager (UM) 3 indicated he did not know if the Resident 42 had an order for an anti-contracture device. Resident 42 should have anti-contracture devices in both hands to prevent the worsening of her contracture and to help prevent her nails from pressing further into her palms. During an interview, on 8/29/23 at 12:00 p.m., the Director of Nursing (DON) indicated Resident 42 refused to allow staff to clean or trim her nails. She was not aware if the resident had anti-contracture devices in her hands. On 8/30/23 at 11:24 a.m., Resident 42's medical record was reviewed. She had diagnoses which include, but were not limited to, hemiplegia (a loss of strength in the arm, leg, and sometimes face on one side of the		**deficient practice and what corrective action will be taken?** All residents are at risk of being affected by the alleged deficient practice. DNS or designee will evaluate all current residents to evaluate for contracture by 9/21/23. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Observational rounds will be completed monthly by clinical team and will observe Residents for contractures. MDS coordinator or designee will initiate care plans for any residents found with contracture. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete an Annual Survey Plan of Correction audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for	

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	body), hemiparesis (a relatively mild loss of strength) following cerebral infarction (the medical term for a stroke, which occurs when blood flow to a part of the brain is stopped either by a blockage or the rupture of a blood vessel), affecting right dominant side, chronic obstructive pulmonary disease, (a unspecified group of diseases which cause airflow blockage and breathing-related problems), moderate protein-calorie malnutrition, type 2 diabetes mellitus with other specified complication (a disease which occurs when your blood glucose, also called blood sugar, [BS] is too high), dysphagia (difficulty swallowing) following cerebral infarction, chronic diastolic (congestive) heart failure (a condition in which your heart's main pumping chamber (left ventricle) becomes stiff and unable to fill properly). On 8/29/23 at 1:29 p.m., the Administrator (ADM) provided a copy of an Occupational Therapy (OT) discharge Summary, dated 7/19/23. The document indicated instructions for the trial use of a palm protector for Resident 42's left hand put in place to reduce the risk of her contracture worsening and to help maintain joint integrity. Skilled service interventions included, but were not limited to, passive stretch range of motion (ROM), manual treatment pain management techniques, hygiene of elbow joint and trialing an elbow splint. The record lacked documentation of a physician's order for an anticontracture device as recommended by therapy. A quarterly minimum data set (MDS) assessment, dated 3/9/23, indicated splints or braces were not being used at the time of the assessment. A care plan, dated 4/27/2023, indicated the		the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	resident required a brace program and active range of motion due to a contracture of her right elbow. "Resident is cooperative with care. Resident follows directions." The goal indicated "Resident can turn head side to side. Resident can make a fist with left/right hand. Resident can bend right/left leg at the knee. Resident can flex and extend toes on right/left. Resident has activity intolerance: shortness of breath, tires easily, weakness, pain-right elbow. Needs cues/ reminders/task segmentation. Interventions included, but were not limited to, active range of motion to: Bilateral upper/lower extremities, 2 sets of 10, 6 days/week on day shift. Evaluation notes, dated 7/24/23, indicated the resident needed to continue the restorative program to maintain current strength and joint mobility. Continue current goals. Continue current interventions. Goals/interventions will not be revised at this time. The care plan lacked documentation of the implementation of a plan of care to address the contractures of her right and left hand. Her care plan for range of motion lacked revision to include individualized, person-centered interventions to prevent the worsening of her contractures of the right and left hand. The care plan lacked revision or documentation of an intervention to prevent the nails from pressing into the palms of the residents' hands and lacked documentation of revision or interventions for resident refusal to allow nail care. On 8/29/23 at 1:29 p.m., the ADM provided a copy of a document, titled "Restorative Nursing Program," dated 11/2018. The ADM indicated the Restorative Nursing Program was the current facility policy. The program indicated			

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	"...Process...Program documentation...A resident centered Care Plan will be developed by the nurse and include measurable objectives, specific interventions to maintain or improve function, or to prevent, to the extent possible, further declines in resident function...." On 8/31/23 at 8:30 a.m., the ADM provided a copy of a current facility policy, titled "IDT comprehensive Care Plan Policy," dated 10/2019. The policy indicated "...It is the policy of this facility that each resident will have a comprehensive person-centered care plan developed based on comprehensive assessment. The care plan will include measurable goals and resident specific interventions based on resident needs and preference to promote the residents highest level of functioning including medical, nursing, mental, and psychosocial needs...Procedure: Care plan review will be interdisciplinary and should include, to the extent possible, nursing, social services, activities, dietary, therapy, pharmacy, physician, direct care staff, and hospice personnel (if indicated) ...Care plan problems, goals, and interventions will be updated based on changes in resident assessment/condition, resident preferences or family input...." 3.1-35(a)			
F 0690 SS=E Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.			

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	§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview and record review, the facility failed to ensure physician's orders for a Foley catheter (a flexible tube inserted through the urethra and into the bladder to drain urine) securement device was in place for a resident (Resident 126), failed to honor resident preferences to have a leg bag in place for two residents (Resident 126 and 21), and failed to ensure residents catheter tubing and drainage bags were positioned correctly for 5 residents (Residents 126, 21, 76, 41 and 94) for 5 of 7 residents reviewed for bowel & bladder.	F 0690	**F690 Bowel/Bladder, Incontinence, Catheter, UTI** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 126 has foley catheter securement device in place Resident 126 and 21 have a leg bag offered to them per	09/23/2023

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	Findings include: 1. On 8/28/23 at 9:07 a.m., Resident 126 was observed in the Secured Memory Care (MC) dining room. He was seated in his wheelchair (WC) with a Foley catheter hung beneath the chair. His catheter tubing was observed with cloudy urine in the tube, and the tube was touching the floor. On 8/29/23 at 9:41 a.m., Resident 126 was observed in the MC dining room. He was wearing shorts, so his catheter tubing was visible. The tubing was pulled back against the edge of his WC seat, so the urine drainage port appeared to be pinched off. At that time, Licensed Practical Nurse (LPN) 7 was asked about the positioning of his catheter tube. She observed the tube and indicated it was pulled to tight and caused the tube to be closed off. She indicated this could be a problem and could cause a blockage and/or urine to backflow back into the bladder and increase the risk for infection. On 8/30/23 at 9:45 a.m., Resident 126 was observed as he received incontinent care. Certified Nursing Aid (CNA) 45 and CNA 46 entered his room and gently positioned him for peri-care as he had an incontinent bowel movement. When the aids removed his pants, his Foley catheter tube was observed, lose, and unsecured. When Resident 126 was positioned onto his side, the aids did not move his catheter tube to the front of his thigh, but allowed it to remain between his closed legs, pressed against the bottom of his scrotum. As CNA 46 wiped, the motion tugged against the tubing, and Resident 126 flinched and yelled out, it hurt.		preference Resident 126, 21, 76, 41, and 94 catheter tubing and drainage bags are positioned correctly **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents with a foley catheter have the potential to be affected by the alleged deficient practice. A 1x audit/questionnaire completed to ensure residents with a foley catheter have securement device in place, drainage bag per preference, and tubing / drainage bags are positioned correctly Licensed nursing personnel will be in-serviced on or before 9/21/23 by the DNS/designee to review Foley Catheters including securement devices in place per order, drainage bag preference, and positioning of catheter tubing / drainage bag. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Licensed nursing personnel will be in-serviced on or before 9/21/23 by the DNS/designee to review Foley Catheters including	

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	On 8/30/23 at 11:22 a.m., Resident 126 was observed in his room. He was seated upright in his WC with his eyes closed. His Foley catheter drainage bag was detached from under the chair and rested flat on the floor. The tubing was observed looped and rested on the floor. On 8/30/23 at 11:25 a.m., Resident 126 was observed with Registered Nurse (RN) 47. She indicated his drainage bag should be hooked on the bottom of the chair and both the bag and tubing should be off the floor. At that time, she indicated he was not wearing a securement device at that time, and she had not seen one on him all week. RN 47 indicated Resident 126 tolerated the use of a leg bag better than the larger hanging drainage bag and the securement device helped keep the tubing secure and decrease his risk for tugging or pulling on his tube which would cause irritation. On 8/30/23 at 10:15 a.m., Resident 126's medical record was reviewed. He admitted to the facility, on 6/5/23, with diagnoses which included, but were not limited to, vascular dementia (a degenerative brain disease which affects reasoning, planning, judgment, memory and other thought processes caused from impaired blood flow to the brain), benign prostatic hyperplasia (BPH, a condition in men where the prostate gland is enlarged and not cancerous) with lower urinary tract symptoms, retention of urine, and gross hematuria (visible blood in the urine). He had physician's orders for the use of a urinary catheter which included, but were not limited to the following: a. Foley catheter, size 16 Fr. (French, the unit of		securement devices in place per order, drainage bag preference, and positioning of catheter tubing / drainage bag. CNAs will be inserviced on catheter care on or before 9/21/23. DNS or designee will round daily to ensure securement devices are in place per order, drainage bag preference is being provided, and catheter tubing and drainage bags are positioned correctly **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete a Catheter CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The Catheter CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	measurement for how catheters are sized). b. Change Foley catheter and urinary drainage bag as needed for dislodgement, leakage, or occlusion. c. Foley catheter care, securement device in place. d. Must have a Statlock for his Foley. (Statlock is a stabilization device which locks the Foley catheter in place, stabilizes the catheter and reduced the change of a sudden pull and discomfort from tugging). Resident 126 had a comprehensive care plan initiated 6/6/23 and revised on 8/4/23. The care plan indicated he required the use of an indwelling catheter related to his diagnosis of obstructive uropathy. The care plan goal indicated Resident 126 used a suprapubic catheter, (a different type of catheter which is inserted through a small incision of the abdomen) which would be managed appropriately. The care plan had not been revised to reflect the correct Foley catheter equipment. Interventions for this care plan included, but were not limited to, Statlock to foley, avoid obstructions in the drainage, do not allow tubing or any part of the drainage system to touch the floor and manipulate tubing as little as possible during care. Resident 126 had a comprehensive care plan initiated 6/25/23 and revised 8/4/23. The care plan indicated he sometimes pulled out his catheter. Interventions for the care plan included, but were not limited to, staff to assist with leg bag placement. A nursing progress note, dated 6/24/23 at 2:15 a.m., indicated Resident 126 had somehow tangled his urinary bag on his WC and was pulling on his foley catheter. He indicated, "it's going to cut my prostate." Bright red bleeding was noted after			

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urinary bag was untangled.

A nursing progress note, dated 6/25/23 at 11:28 a.m., indicated Resident 126 continued to pull on his catheter saying he needed to urinate.

A nursing progress note, dated 6/25/23 at 8:34 p.m., indicated Resident 126's family member said he would likely stop pulling his catheter if he used a leg bag. He used the leg bag at prior facility and it was what worked the best. A leg bag was placed with no issues.

2. On 8/23/23 at 10:20 a.m., Resident 21 was observed. She was reclined in her bed with her eyes closed. A Foley catheter tube and drainage bag were observed at that time. Because her bed was in the lowest position, her drainage bag had been placed in a plastic bin to keep it off the floor. However, the inside of the bin was observed to have some debris and what appeared to be dried droplets/splashes of urine.

On 8/23/23 at 11:35 a.m., Resident 21 was observed as she was assisted out of her room to go into the MC dining room. Her Foley catheter drainage bag was observed to be hooked to the bottom of her rollator walker, and the tubing was looped under the walker and dragged on the floor.

On 8/23/23 at 11:40 a.m., Resident 21 was seated at a table in the MC dining room. When asked how she felt, she curled her lips and shrugged her shoulders. She indicated towards the catheter tubing and indicated she, "did not like that thing," and it was always in the way.

On 8/28/23 at 9:14 a.m., Resident 21 was observed. She sat in a chair in the MC hallway across from the nurses' desk. Her catheter tubing was

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	observed as it ran out from the bottom of her pants, and touched the floor. During an interview, on 8/28/23 at 11:57 a.m., CNA 48 indicated there had been an attempt to discontinue Resident 21's catheter because she did not like it, but her bladder would just "fall asleep" so the catheter was replaced. CNA 48 indicated she still hated the catheter, but tolerated a leg bag better so she could walk with her walker more freely. On 8/28/23 at 2:59 p.m., Resident 21 was observed in the MC dining room. When asked about her catheter, she smiled and indicated it had been changed to a leg bag which she thought was much better and did not get in the way of her walker. On 8/29/23 at 3:12 p.m., Resident 21's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, unspecified dementia and neuromuscular dysfunction of the bladder (a disfunction in the nerves and muscles of the bladder which may result in the bladders inability to fill or empty correctly). Although she had a current physician's order for a 16 Fr. Foley catheter with instructions to change as needed for dislodgement, leakage or occlusion, the orders lacked revision for regularly schedule maintenance. Resident 21's Medication/Treatment Administration Record was reviewed and lacked documentation her catheter had been changed on 8/28/23 as observed above.			

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She had a comprehensive care plan initiated 3/23/23 which was revised 6/29/23. The care plan indicated Resident 21 required the use of an indwelling urinary catheter related to her diagnosis of neurogenic bladder. Interventions for this plan of care included, but were not limited to, do not allow tubing or any part of the drainage system to touch the floor. The care plan lacked revision to include Resident 21's preference for the use of a leg bag.3. On 8/25/23 at 10:50 a.m., Resident 76's diagnoses included, but were not limited to dementia (progressive deterioration of the brain), bipolar disease (illness with maniac and depressive events) and obstructive uropathy (blockage of urine flow).

Resident 76's care plans indicated her catheter care would be managed appropriately and she had a history of recurrent urinary tract infections (UTI).

On 8/28/23 at 11:55 a.m., Resident 76 was observed in her bed watching TV, her catheter bag was lying flat on the floor.

4. On 8/29/23 at 9:28 a.m., Resident 41's diagnoses included, but were not limited to, schizophrenia (mental disorder of thought, emotion, and behavior), obstructive uropathy (blocked urine flow), overactive bladder (frequent and sudden urges to urinate), and a personal history of urinary tract infections.

Resident 41's care plan indicated he required a suprapubic catheter. An intervention indicated to position the bag below the level of the bladder and do not allow the tubing or any part of the drainage system to touch the floor.

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	155792	A. BUILDING 00 B. WING	08/31/2023

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	On 8/28/23 at 4:25 p.m., Resident 41 was observed tightly grasping the Foley bag at his waist level. He was being pushed in his wheelchair from the shower to his room by Certified Nursing Aide (CNA) 30. On 8/28/23 at 4:27 p.m., Registered Nurse Unit Manager (RN UM) 30 indicated the Foley bag should have been below Resident 41's bladder. 5. On 8/30/23 at 10:00 a.m., Resident 94's diagnoses included, but were not limited to, dementia, chronic kidney disease (decreased kidney ability to filter the blood), neuromuscular dysfunction of the bladder (lack of bladder control), and a personal history of urinary tract infections (UTI). Resident 94's care plan indicated he required a suprapubic catheter. An intervention indicated to not allow tubing or any part of the drainage system to touch the floor. On 8/29/23 at 4:09 p.m., Resident 94 was in his wheelchair near the main nurse's station. He Foley tubing was dragging the floor as he moved forward. A current policy, titled "Indwelling Urinary Catheters-Suprapubic or Urethral," with no date, was provided by the Director of Nursing (DON), on 8/29/23 at 3:30 p.m. A review of the policy indicated "...It is recommended that catheter care be performed every shift or as indicated per physician orders...." The policy did not indicate any appropriate infection control measures regarding the urinary catheter bag or tubing touching the floor. 3.1-41(a)(2)			

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review, the facility failed to ensure a nebulizer mask was covered and nasal cannula (NC) tubing was observed disconnected from the oxygen concentrator for 2 for 8 residents observed. (Resident 29 and 69) Findings include: 1. On 8/29/23 at 3:54 p.m., Resident 29's diagnoses included, but were not limited to, dementia and chronic obstructive pulmonary disease (constriction of the airway causing difficulty breathing). Resident 29's care plan indicated she would have adequate respiratory functions. Her physician's order, dated 6/12/23, indicated ipratropium-albuterol solution (dilates airways) was used for nebulizer treatments, three times a day. Another physician order, dated 5/1/23, indicated albuterol sulfate (dilates airways) solution was used for nebulizer treatments as needed.	F 0695	**F 695 Respiratory/ Tracheostomy Care and Suctioning** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #29's nebulizer mask was replaced. Resident #69 nasal cannula equipment was replaced **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents with respiratory care orders are at risk from alleged deficient practice. DNS or designee audited all nebulizer masks and NC tubing to ensure proper storage and connection in place for oxygen tubing.	09/23/2023

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	On 8/24/23 at 10:07 a.m., her nebulizer mask was observed uncovered and unbagged. On 8/26/23 at 4:22 p.m., her nebulizer mask was observed uncovered and unbagged. 2. On 8/30/23 at 9:33 a.m., Resident 69's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and acute (sudden) and chronic (long-term) respiratory failure with hypoxia (lack of oxygen). Resident 69's care plan, dated 8/28/23, indicated she was at risk for impaired gas exchange related to complaints of shortness of breath, related to her diagnosis of COPD, heart failure, cardiomegaly (enlarged heart), respiratory failure, pleural effusion (excess fluid between layers of the chest wall and lung), history of pneumonia and atelectasis (partial collapsed lung), and history of Covid-19. Interventions included to administer oxygen as ordered. Her current physician's order, dated 10/25/19, indicated oxygen at 3 liter per minute (LPM) every shift. On 8/23/23 at 10:35 a.m., Resident 69 was in bed with her eyes closed. She was wearing her nasal cannula (NC) (tubing to deliver oxygen), the other end of the NC was observed to not be attached to the oxygen concentrator, as it was laying on the floor near her bed. On 8/23/23 at 10:41 a.m., Licensed Practical Nurse (LPN) 14 indicated her NC should have been attached to the oxygen concentrator. To get to it, she had to move her rollator, then her wheelchair. The oxygen concentrator was under the wheelchair seat against the wall. She indicated the		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Care Companions or Manager on Duty will complete daily observational rounds to assure nebulizer masks are in bags and nasal cannula tubing is attached to oxygen concentrator. Nursing will be inserviced on respiratory equipment by 9/21/23. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete an Annual Survey Plan of Correction audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	oxygen concentrator should not be enclosed like that since the machine felt warm. She indicated her oxygen was set at 3.5 LPM. Her physician's order, dated 10/25/19, indicated to provide oxygen at 3 LPM on every shift. On 8/24/23 at 3:10 p.m., a policy was requested for oxygen and nebulizer storage, cleaning, and supplies. On 8/28/23 at 8:30 a.m., the Executive Director (ED) indicated the facility did not have policies regarding respiratory services because they were contracted out. 3.1-47(a)(6)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may 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-			

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	§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 record review and interview, the facility failed to follow up with the pharmacy to ensure a resident (Resident 138) received medications as ordered by his physician for 1 of 6 residents reviewed for unnecessary medications. Findings include: On 8/28/23 at 3:27 p.m., Resident 138's medical record was reviewed. Resident 138 admitted to the facility, on 5/19/23, after an acute hospital visit, due to an increase of severe orthostatic hypotension episodes (OH), a sudden drop in blood pressure that occurs when a person stands up which can cause lightheadedness, dizziness or even cause a person to faint. Upon his admission, he had diagnoses which included, but were not limited to, OH, syncope and collapse (the medical term for "fainting" or "passing out"), and end stage renal (kidney) disease. He had a physician's order for midodrine 2.5 mg	F 0755	**F755 Pharmacy Services/Procedures/Pharmacist/Records** **What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** Resident 138 no longer resides in the facility **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents that are administered medications have the potential to be affected by the alleged deficient practice. An in-service will be completed by DNS/designee with all nursing staff on or before 9/21/23 regarding procedure for unavailable medications and reviewing/responding to applicable	09/23/2023

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	(milligrams) to be given every 8 hours. (Midodrine is a medication used to treat low blood pressure, [hypotension] which works by stimulating nerve endings in blood vessels, causing the blood vessels to tighten, as a result, blood pressure is increased.) On 5/25/23, his physician's order for midodrine was revised to change the language from "2.5 mg every 8 hours," to "three times a day." A nursing progress note, dated 5/25/23 at 3:46 p.m., indicated during a hospital follow-up appointment, he had to be admitted due to very low blood pressure (BP). Upon his return to the facility, on 5/30/23, his order for midodrine had been increased from 2.5 mg to 5 mg to be given four times a day. On 8/29/23 at 3:38 p.m., the Pharmacist in Charge for the contract pharmacy used by the facility, provided a written statement which indicated "The resident was admitted on 5/19/23 and at 3:19 p.m. on that date we received an electronic order for Midodrine 2.5 mg orally every 8 hours. This order was processed per normal procedures and a quantity of 45 tablets were dispensed on the next regular delivery which arrived at the facility at 3:07 a.m. on 5/20/23. On 5/25/23 at 7:26 a.m. the order was updated from 2.5 mg orally every 8 hours to 2.5 mg orally three times daily. As it was too soon to process an additional fill, no additional quantity was sent. On 5/30/23 at 4:51 p.m. a new order was received for Midodrine 5 mg tablets with the directions of 15 mg orally every 6 hours. The pharmacist reviewing the order felt that this dose needed clarification, so no additional quantity was dispensed. Clarification was requested via fax."		pharmacy communication Observational rounds were completed by the DNS/designee to ensure medications are being administered per facility policy and pharmacy communication is being reviewed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Observational rounds will be completed by the DNS/designee to ensure medications are being administered per facility policy and pharmacy communication is being reviewed. Pharmacy communication will be reviewed by DNS/designee daily to ensure it is responded to in a timely manner. DNS/designee will review all new/re - admissions at time of admission to ensure that proper procedure is followed for obtaining medications and pharmacy communication has been addressed. An in-service will be completed by DNS/designee with all nursing staff on or before 9/21/23 regarding procedure for unavailable medications and reviewing/responding to applicable pharmacy communication in a timely manner **How the corrective action will be monitored to ensure the**	

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	Resident 138's record lacked documentation the facility followed up with the pharmacist's request for clarification. During an interview, on 8/30/23 at 3:47 p.m., Licensed Practical Nurse (LPN) 43 indicated she did not know why Resident 138's order clarification was not followed up with. To ensure Resident 138 received the appropriate dose of medication, the facility pulled the same medication from another resident who had since discharged from the facility. On 8/29/23 at 3:30 p.m., the DON provided a copy of current facility policy titled, "Physician/Prescriber Authorization and Communication of Orders to Pharmacy," revised 1/1/22. The policy indicated "...once admission orders are verified, staff should promptly transmit medication orders to the pharmacy. A delay in transmission of new orders to the pharmacy may impact the time of delivery and resident access to medically necessary medications... pharmacy may contact facility via fax, telephone, or e-mail before dispensing a medication when the pharmacist believes that there is a need to clarify the medication order because the order is unclear, incomplete or vague, contraindicated, or has a severe drug interaction, is duplicate therapy, the resident has an allergy to it, or is written for an inappropriate dose or frequency...facility staff should regularly check the fax machines for any pharmacy communication, pharmacy will hold medication orders until physician/prescriber is able to clarify the order, facility should contact physician/prescriber when staff is notified by pharmacy of an order requiring clarification...." 3.1-25(a)		**deficient practice will not recur i.e. what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete a Pharmacy Services and Recommendations audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The Pharmacy Services CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure insulin labels were consistent with the physician's orders (Residents 82 and 241) and to ensure an insulin opened date was legible (Resident 53) for 3 of 3 residents reviewed for insulin storage. Findings include: 1a. On 8/29/23 at 12:04 p.m., Resident 82's order for insulin was reviewed with Registered Nurse (RN)	F 0761	F 761 Label/Store Drugs and Biologicals **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Skills validation will be completed for RN 32 by 9/22/23. Resident 82 is receiving insulin per	09/23/2023

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	32. RN 32 indicated her Medication Administration Record (MAR) indicated she had a standing order for 6 units of Lispro insulin per insulin pen. With her current blood sugar, she would receive a total of 10 units per sliding scale. RN 32 indicated she would give one additional unit for every 50 points over the blood sugar of 150. RN 32 removed an insulin vial from the medication cart. The physician's instructions on the pharmacy bottle indicated to give 4 units of insulin scheduled. On 8/20/23 at 12:12 p.m., RN 32 indicated see knew the label on the insulin prescription bottle was different than the instructions on the MAR. She indicated Resident 82's MAR order required her to give 4 units scheduled. She indicated Resident 82 used to have 4 units scheduled, but the order had changed to 6 units scheduled and she would follow the MAR. She indicated pharmacy would not send a new label. On 8/29/23 at 12:36 p.m., RN 32 indicated she should have waited 3-5 seconds before removing needle from Resident 82's upper arm. On 8/29/23 at 1:47 p.m., Resident 82's record was reviewed. Her diagnoses included, but were not limited to, diabetes mellitus (DM) (blood sugar disorder) with diabetic neuropathy and diabetic cataract. Resident 82's physician's order for insulin, dated 8/24/23 for 12:00 p.m., was for a Lispro insulin pen, 100 units/mL. Give 6 units, plus sliding scale (SS), subcutaneously (SQ) (under the skin), once daily. Special Instructions: If BS (blood sugar) is less than 70 or greater than 350 notify the physician.		MD order. Candy will be labeled with resident name. All medications with blurred dates were disposed of and replaced. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by alleged deficient practice. DNS or designee will audit med carts and review insulin vials vs pens per MD order. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All nurses and QMAs will be in-serviced on insulin administration, items allowed in med cart and reviewing physician orders by 9/22/23. Skills validation will be completed for insulin administration for all licensed nurses by 9/22/23. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance the	

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	Resident 82's physician's order for SS insulin, dated 8/18/23 for 12:00 p.m., was Lispro insulin pen, 100 units/mL. Give SQ. If Blood Sugar was less than 70, call MD. If Blood Sugar was 150 to 200, give 1 Units. If Blood Sugar was 201 to 250, give 2 Units. If Blood Sugar was 251 to 300, give 3 Units. If Blood Sugar was 301 to 350, give 4 Units. If Blood Sugar was greater than 350, call MD (physician). Resident 82's diabetic care plan, dated 7/31/23, indicated to give medications as ordered. 1b. On 8/29/23 at 12:26 p.m., Resident 241's order for insulin was reviewed with RN 32. RN 32 indicated her MAR had a standing order of 4 units of Humalog Kwik Pen insulin. She indicated the pharmacy had not been sending the Humalog Kwik Pens, but the vials instead. So, they used the vials. She knew the order indicated to use the Humalog Kwik Pen. On 8/29/23 at 2:14 p.m., Resident 241's record was reviewed. Her diagnoses included, but were not limited to, diabetes mellitus with ketoacidosis (blood sugar disorder with excessively low insulin level), diabetic retinopathy (loss of vision), diabetic nephropathy (deterioration of kidney function), and chronic (long-term) kidney disease. A diabetic care plan, dated 8/15/23, indicated Resident 241 was at risk for adverse effects of hyperglycemia or hypoglycemia. An intervention indicated to provided medications as ordered. A physician's order indicated to give Humalog Kwik Pen per SS.		DNS/Designee will complete an Annual Survey Plan of Correction audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	If Blood Sugar was less than 70, call MD. If Blood Sugar was 150 to 200, give 1 Units. If Blood Sugar was 201 to 250, give 2 Units. If Blood Sugar was 251 to 300, give 3 Units. If Blood Sugar was 301 to 350, give 4 Units. If Blood Sugar was greater than 350, call MD. On 8/29/23 at 1:52 p.m., one of the facility's Registered Pharmacist (RPh) 33 indicated she could not print a new label if the physician's orders had changed. She indicated the company which owned this facility wanted vials of insulin instead of insulin pens because they were cheaper. When the pharmacy sent the vials of insulin, someone at the facility should have changed the order for the resident to receive the insulin from a vial, instead of an insulin pen. 2. On 8/30/23 at 3:55 p.m., the 200 Hall Odds Medication Cart with observed with the Assistance Director of Nursing (ADON). Memory Care (MC) Resident 53's Humalog Kwik Pen's open date was smeared illegibly. RN 47 indicated her Humalog Kwik Pen was opened 8/9/23. Then, she indicated the pharmacy label indicated the insulin arrived from the pharmacy on 8/16/23. There was a insulin pen cap in the pharmacy Ziploc bag that indicated the medication was opened on 7/29/23. She indicated the insulin pen cap must have been switched. On 8/30/23 at 4:00 p.m., the ADON indicated Resident 53's Humalog Kwik Pen would be disposed of because the open date was unsure. On 8/30/23 at 5:00 p.m., Resident 53's record was reviewed. Her diagnoses indicated she had paranoid schizophrenia (delusion and hallucination that			

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	persecute or threaten), Alzheimer's disease (progress brain degeneration), and diabetes mellitus. Her diabetes care plan indicated she would not experience symptoms of hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar). A current policy, titled "Physician/Prescriber Authorization and Communication of Orders to Pharmacy," was provided by the Director of Nursing (DON), on 8/29/23 at 3:30 p.m. A review of the policy indicated "...The physician/prescriber must also provide identical or verbal chart orders to facility staff...Facility staff should immediately record the new orders in the resident's medical record and medication administration record...Upon receipt of medications from the pharmacy that have been electronically prescribed, facility staff should reconcile the medications received to the orders entered in the resident's medical record...Facility staff should notify the physician/prescriber of any identified discrepancies in electronically prescribed orders entered from the pharmacy and orders entered into the resident's medical record for resolution...Facility should ensure that food is not to be stored in the refrigerator, freezer, or general storage areas where medications and biologicals are stored...." A current policy, titled "General Dose Preparation and Medication Administration," was provided by the DON, on 8/29/23 at 3:30 p.m. A review of the policy indicated "...Facility staff should not administer a medication if the medication or prescription label is missing or illegible...Facility staff should verify that the medication name and dose are correct when compared to the medication order on the medication administration			

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	record...Facility staff should enter the date opened on the label of medication with shortened expiration dated (e.g., insulins, irrigation solutions, etc.)...." 4.1-25(j)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure the three-compartment sink had sufficient chemicals to disinfection items washed, chef assistant (CA) had his moustache covered, and did not touch his eyeglasses while serving resident lunches and washed his hands correctly before returning to serve on the lunch line again. The facility failed to	F 0812	**F 812 Food Procurement, Store/Prepare/Serve Sanitary** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	09/23/2023

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	ensure a Certified Nursing Aide (CNA) while assisting a resident with did not contaminate her hands for 1 of 2 observed. (Resident 15) Findings include: 1a. During the first kitchen tour, on 8/23/23 at 9:55 a.m., the Certified Dietary Manager (CDM) indicated the facility did not have internal thermometers in their 2 milk coolers. On 8/23/23 at 11:05 a.m., Head Chef 24 checked the chemicals in the three-compartment sink. He indicated the chemicals were so low the litmus strip did not read any chemicals. They had been using the three-compartment sink for cleaning stainless steel pans. He indicated the reason the sink had no chemicals was because the dietary aides continued to add water until the chemicals were diluted to the point of not being readable on the litmus strip. 1b. On 8/28/23 at 12:03 p.m., Chef Aide (CA) 25 was observed placing food on lunch trays for residents waiting in the dining room. He was wearing a beard guard, but his moustache was still out. Twenty-five residents were observed in the dining room. On 8/28/23 at 12:18 p.m., the Infection Preventionist (IP) indicated CA 25 should have had his moustache inside the beard restrain, especially while serving resident trays. 1c. On 8/28/23 at 12:19 p.m., CA 25 was observed to touch his face with his bare hands to move the beard guard over his moustache. Then, he was observed to touch his eyeglasses frame to adjust them on his face. He did not hand wash after touching his face. He continued to serve 7		Sink was drained and refilled with correct water and chemical ratio. Chef Aid was educated on beard net and handwashing. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents are at risk from alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All Culinary staff will be educated on sufficient chemicals for 3 compartment sink, beard nets and hand washing requirements and techniques. CNAs inserviced on hand washing, assisting residents, not standing while assisting with resident intake and to not talk to other staff while assisting the residents. Will post a reminder to front line near the serving line for beard net use and handwashing requirements or techniques. Culinary Services manager or designee will review chemicals in sink daily to ensure proper levels. Culinary Services manager or designee will observe a meal service daily to ensure proper use	

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	additional resident lunch trays. On 8/28/23 at 12:21 p.m., the IP indicated CA 25 should have washed his hands before serving more resident food. She asked him to wash his hands. On 8/28/23 at 12:23 p.m., CA 25 was observed washing his hands. He turned the faucet off with his bare hand, then dried them on paper towels. He returned to the serving line and prepared 2 more resident lunches. On 8/28/23 at 12:24 p.m., the IP indicated he should have turned the faucet off with the paper towel after drying his hands. A current policy, titled "Culinary Personal Hygiene," dated 5/23, was provided by the Director of Nursing (DON), on 8/28/23 at 3:21 p.m. A review of the policy indicated "...Proper handwashing is the most critical aspect of personal hygiene. Culinary employees must wash their hands...after the following tasks...Touching the hair, face, or body...All employees working in the culinary department must wear a clean hair restraint which effectively covers all hair...Culinary employees with facial hair must also wear a beard restraint...." 2. On 8/23/23 at 12:40 p.m., Certified Nursing Aide (CNA) 20 provided Resident 15 his lunch. She picked up his orange drink with her fingers around the rim. She pulled up a chair with her left hand to sit down to assist him with eating. She was observed resting her left forearm on his wheelchair arm rest. Then, she used both hands with his eating utensils to cut up his grill cheese sandwich.		of beard nets and handwashing. DNS or designee will round during meals to ensure proper handwashing and assistance with residents during meal. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance the Culinary Services manager or designee will complete an Annual Survey CULINARY Plan of Correction audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	On 8/23/23 at 12:46 p.m., CNA 20 was observed to stand up while assisting Resident 15 with eating. She briefly talked with CNA 21. When she sat down, she used both hands to adjust her chair. She cut up more of Resident 15's food without washing her hands. On 8/23/23 at 12:49 p.m., CNA 21 talked with CNA 20 while she was still assisting Resident 15 with eating. Unit Manager 3 and Registered Nurse (RN) 18 were in the dining room, they were not assisting residents with eating. On 8/23/23 at 12:50 p.m., CNA 26 slightly leaned over Resident 15 to talk with CNA 20. On 8/23/23 at 12:55 p.m., RN 18 indicated the staff should not be talking with another staff member while they are assisting a resident with eating. A current policy, titled "Culinary Personal Hygiene," dated 5/23, was provided by the DON, on 8/28/23 at 3:21 p.m. A review of the policy indicated "...Employees will maintain good personal hygiene to prevent food contamination...." 3.1-21(i)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control			

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

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	lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview and record review, the facility failed to ensure glucometers (device for measuring blood sugar) were cleaned according to the package instructions on the disinfecting wipe for 2 of 2 residents observed for glucometer cleaning. (Resident 82 and 241) Findings include: On 8/29/23 at 11:56 a.m., Registered Nurse (RN) 32 indicated each medication cart had its own glucometer. She used a bleach germicidal wipe to clean the glucometer in preparation to check Resident 82's blood sugar (BS). She indicated the glucometer should be wiped for 1 minute and let sit for 3 minutes to dry. On 8/29/23 at 11:57 a.m., RN 32 indicate the whole glucometer was not wet. She was just waiting 3	F 0880	**F880: Infection Control** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** RN 32 was immediately educated on glucometer cleaning in regards to proper infection control practices **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents using a glucometer have the potential to be affected by the deficient practice.	09/23/2023

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	minutes for the other tiny, bubbled areas to dry. On 8/29/23 at 1:45 p.m., the packaging was reviewed for the Clorox Healthcare Bleach Germicidal Wipes: Instructions. It indicated to wipe the surface to be disinfected. Use enough wipes for the treated surface to remain visibly wet for 3 minutes, then let it air dry. On 8/29/23 at 11:59 a.m., RN 32 dropped the glucometer on the floor in Resident 82's room. On 8/29/23 at 12:01 p.m., RN 32 wiped the glucometer again. She wiped less than one minute, and was finished on 8/29/23 at 12:01 p.m. She indicated she needed to wait the 3 minutes for it to dry. 2. On 8/29/23 at 12:08 p.m., RN 32 was observed wiping the glucometer for about a minute before laying it on a paper towel on the medication cart. She let it dry. On 8/29/23 at 12:19 p.m., RN 32 picked up the glucometer and laid it in the contaminated bin on a clean paper towel. On 8/29/23 at 12:24 p.m., after taking Resident 241's BS, she cleaned the glucometer again, wiping with a bleach wipe for about one minute and let it dry. During an interview, on 8/29/23 at 2:20 p.m., the Director of Nursing (DON) indicated she trained everybody to wipe it down, then let it dry for 3 minutes. She indicated she would revisit the training and provide further information. No further information was provided. A current policy, titled "Blood Glucose Meter		All nurses will be educated by the DNS/Designee on Infection Control procedures including cleaning of glucometers properly on or before 9/21/23 1x observation round to be completed by DNS/designee to ensure glucometers are being cleaned per facility policy **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All nurses will be educated by the DNS/Designee on Infection Control procedures including cleaning of glucometers properly on or before 9/21/23 Observational rounds will be completed daily by DNS/designee to ensure that staff are cleaning glucometers per facility policy **How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete a Blood Glucose Meter Cleaning Skills Validation for nurses weekly x4 then monthly thereafter. The Skills Validation will be reviewed monthly by the CQI Committee for six months after	

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	Cleaning/Disinfecting and Testing," dated 6/2023, was provided by the DON, on 8/29/23 at 3:30 p.m. A review of the policy indicated "...Wipe entire external surface of the blood glucose meter with wipe and allow the surface of the meter to remain wet for 3 minutes...allow the meter to completely dry..." 3.1-18(b)		which the CQI team will re-evaluate the continued need for the audit. If not satisfactory an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee. To ensure compliance the DNS/Designee will complete an Annual Survey Plan of Correction audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee.	