STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155682	A. BUILDING 00 B. WING	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODMONT HEALTH CAMPUS	1325 ROCKPORT RD BOONVILLE, IN 47601

(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 a Recertification and State Licensure Survey and Investigation of Complaint IN00404924. This visit included a State Residential Licensure Survey. Complaint IN00404924 - Federal/State deficiency related to the allegations is cited at F740. Survey dates: June 4, 5, 6, 7, 8, 9, 2023 Facility number: 002724 Provider number: 155682 AIM number: 200309330 Census Bed Type: SNF/NF: 43 SNF: 6 Residential: 27 Total: 76 Census Payor Type: Medicare: 8 Medicaid: 37 Other: 4 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 20, 2023.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and			

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

Jessica West | Executive Director | 06/30/2023

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

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	communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record	F 0550	1. Resident #199 was immediately assessed with no findings and	07/12/2023

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	review, the facility failed to ensure a resident experienced a dignified existence for 1 of 3 residents reviewed for respect and dignity. (Resident 199) Findings include: On 6/4/23 at 8:45 A.M., Resident 199 was observed asleep in bed, uncovered, wearing only a brief, with the door to the room wide open. There were no staff in the room. Several staff were in the hallway outside the resident's room across from his door and no one closed his door or covered him. The resident was in a private room. On 6/5/23 at 7:00 A.M. Resident 199 was observed asleep in bed, uncovered, wearing only a brief, with the door to the room wide open. There were no staff in room. Several staff were passing by the room in the hallway and no one closed his door or covered him. During an interview on 6/5/23 at 8:39 AM with LPN 25, she indicated resident was going home on Tuesday with Specialty Home Health. On 6/5/23 at 12:17 P.M. the resident's clinical records were reviewed. The Admission Minimum Data Set (MD'S) Assessment, dated 3/16/23, indicated the resident had severe cognitive impairment and required extensive assistance of 2 or more for bed mobility and transfers, setup and assistance of 1 for eating, and physical assistance with part of bathing. Diagnoses included, but were not limited to, traumatic subdural hemorrhage with loss of consciousness, multiple fractures of ribs, right side, orthostatic hypotension.		suffered no ill physical or psychosocial effects. Resident clothed at time of assessment; staff present educated on appropriate clothes/covering resident and closing door/pulling curtains for resident respect and dignity. Social Services updated and monitored psychosocial wellbeing. 2. All residents have the potential to be affected. Director of Health Services completed Health Care Center audit to ensure all residents had appropriate clothing/were covered and doors shut/curtains pulled for privacy. Inservice completed with staff regarding appropriate clothing/covering residents and closing doors/pulling curtains for privacy. ED/nursing leaders monitor daily during rounding. 3. As a measure of quality assurance, The Director of Health Services and/or Designee will complete an audit to ensure residents are properly clothed/covered and doors are shut/curtains are pulled for privacy when indicated. The audit will include three residents 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks then weekly for 4 weeks then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any	

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	Current physician orders included, but were not limited to, therapy evaluation and treatment by physical therapy (PT); occupational therapy (OT), and speech therapy (ST); Activity - sit to stand lift; Sera-Stedy with 2 assist for all transfers. Care plan dated 4/14/23 indicated the resident likes to sleep late and resident's preferences would be honored. The facility resident rights policy, revised on 12/31/22, and received from the administrator on 6/9/23 at 11:00 A.M., indicated that residents have a right to be treated with dignity and respect. 3.1-3(a)		findings and corrective action at least quarterly and ongoing in the campus Quality Assurance Performance Improvement meetings until 100% compliance achieved. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if needed, until 100% compliance met.	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance			

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	directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on interview and record review, the facility failed to ensure compliance with the requirements for advance directives. An advanced directive order and DNR (Do Not Resuscitate) form was not signed by the physician for 1 of 2 reviewed for advanced directives. (Resident 24) Finding includes: On 6/5/23 at 1:59 P.M., Resident 24's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II and non-pressure chronic ulcer of other part of left foot.	F 0578	1. Resident #24 was assessed with no findings and suffered no ill effects from the alleged deficient practice. Social Service Designee reviewed residents advanced directive with resident and confirmed stated desire for Do Not Resuscitate (DNR) status. Out of Hospital DNR form sent to physician via fax to be signed and was returned to the campus with physicians' signature in place then scanned into the medical record. Physicians' order confirmed in medical record and staff notified of resident's code status. 2. All residents have the potential	07/12/2023

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	The most recent quarterly MDS (Minimum Data Set) Assessment, dated 4/12/23, indicated Resident 24 was an extensive assist of 2 staff for transferring and supervision of 2 staff for bed mobility and toileting. The resident was cognitively intact. Current physician's orders included, but were not limited to, the following: Code Status: DNR, dated 4/11/23 The DNR order lacked a physician or nurse practitioner's signature. A "State of Indiana Out of Hospital Do Not Resuscitate Declaration and Order" form, dated 4/7/23, lacked a physician or nurse practitioner's signature. Interview on 6/07/23 at 9:45 A.M., LPN (Licensed Practical Nurse) 23 indicated they would look in (name of electronic health record) for code status, but administration keeps a paper copy of advanced directives up front. At that time they indicated if the order was not signed in (name of electronic health record) then they would go to administration to get the paper copy of the DNR. They further indicated if the resident did not have an advanced directive, the facility protocol was full code (if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures would be provided to keep them alive) status. Interview on 6/7/23 at 9:56 A.M., the Administrator indicated upon admission, the admitting nurse would verbally ask if the resident had an advanced directive. If it was a DNR, she would choose that and a "DNR" indicator would appear in the top left corner of the resident's		to be affected. Audit completed of all residents Advanced Directives. Physicians' signatures present on documents as appropriate with no additional findings and all resident advanced directives correlate with physician orders in medical record. Staff educated on Advance Directive policy and process. The interdisciplinary team will monitor new admissions in CCM daily for advance directive/physician order accuracy. 3. As a measure of quality assurance, The SSD and/or Designee will complete an audit to ensure to ensure Advanced Directives are in place and signed in the medical record during Admission Resident First meetings 3 x weekly for 4 weeks, twice weekly for 4 weeks, weekly for 4 weeks then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing in the campus Quality Assurance Performance Improvement meeting until 100% compliance achieved. The plan will be reviewed and updated as warranted.	

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	clinical record as a reference for the staff to look at. They did not keep paper copies of the signed advanced directives. Once signed, they were scanned into (name of electronic health record). At that time, the Administrator was not sure if an order and/or DNR form that was not signed by the physician or nurse practitioner would be valid to use as a code status or if the resident would default to the facility protocol of full code status. Interview on 6/7/23 at 10:04 A.M., the Regional Consultant indicated the physician would indicate DNR status, an order would be put into (name of electronic health record), and the DNR form would be signed by the resident and witnesses. At that time, it would be scanned into the chart. The paper copy of the signed DNR would be given or sent to the physician to sign. Once signed, it would be scanned into (name of electronic health record) again. The order would be put into (name of electronic health record) and should go into an electronic list of orders to be signed by the physician. Until the DNR form was signed by the resident, the facility protocol was full code status. At that time, the Regional Consultant and Administrator observed the unsigned DNR order and DNR form in (name of electronic health record). Both indicated that the physician should sign orders/DNR form within 30 days or sooner. Interview on 6/8/23 at 3:05 P.M., QMA (Qualified Medication Aide) 15 indicated if there was a DNR order that was not signed by the physician, they would use the protocol and treat the resident as a full code status. At that time, LPN 23 indicated if the DNR order was not signed by the physician then the order was not valid and they would be treated as a full code status. A current Guidelines for Orders policy, dated May			

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	2016, was provided by the Administrator on 6/8/23 at 11:12 A.M., and indicated " ... physician orders/progress notes must be signed and dated in accordance with state regulations ... Telephone or verbal orders shall be countersigned by the physician as designated by state regulation ... " A current Guidelines for Advanced Directives policy, dated 11/28/16, was provided by the Administrator on 6/7/23 at 12:00 P.M., and indicated " ... The 'DNR' form will be completed documenting these desires and scanned into the medical record ... " 3.1-4(f)(7)			
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)			

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	(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document 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 an intervention was implemented for 1 of 5 residents reviewed for accidents. Resident's bathroom did not have non skid strips placed in front of the toilet. (Resident 24) Finding includes: During an interview on 6/4/23 at 9:28 A.M., Resident 24 indicated she was able to transfer herself without help of staff.	F 0656	1. Resident #24 comprehensive care plan reviewed and fall intervention put in place according to the care plan. Resident #24 suffered no ill effects from the alleged deficient practice. Staff educated on fall intervention per plan of care. 2. All residents have the potential to be affected by the alleged deficient practice. An audit has been completed to ensure all fall interventions are in place	07/12/2023

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	On 6/5/23 at 1:59 P.M., Resident 24's clinical record was reviewed. Diagnoses included, but were not limited to, history of falls, unsteadiness on feet, abnormalities of gait and mobility, and non-pressure chronic ulcer of other part of left foot. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 4/12/23, indicated Resident 24 was an extensive assist of 2 staff for transferring and supervision of 2 staff for bed mobility and toileting. The resident was cognitively intact. Current physician's orders included, but were not limited to, the following: Non skid strips in front of toilet, dated 5/25/23 A current falls care plan, dated 2/21/22, included but was not limited to, the following interventions: Educated resident to call for assistance and grip strips placed in from (sic) of toilet, dated 5/25/23 The TAR (Treatment Administration Record) for 5/25/23-5/31/23 was reviewed and indicated non skid strips were observed in front of the toilet twice daily from 6:00 A.M.-6:00 P.M. and 6:00 P.M. -6:00 A.M. The TAR (Treatment Administration Record) for 6/1/23-6/7/23 was reviewed and indicated non skid strips were observed in front of the toilet twice daily from 6:00 A.M.-6:00 P.M. and 6:00 P.M.-6:00 A.M. Interview on 6/8/23 at 3:05 A.M., QMA (Qualified Medication Aide) 15 observed non skid strips were not placed on the floor in front of the toilet. At that time, they indicated if there is an order for		according to each residents comprehensive plan. Staff has been inserviced regarding following careplanned fall interventions. 3. As a measure of ongoing compliance, the interdisciplinary team will monitor new fall interventions and comprehensive care plan updates daily in Clinical Care Meeting. The Director of Health Services and/or designee will audit 3 residents comprehensive care plans and safety interventions three times per week for 30 days, then twice weekly for 30 days, then weekly for 1 month, then ongoing as needed. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing in the campus Quality Assurance Performance Improvement meetings until 100% compliance achieved. The plan will be reviewed and updated as warranted.	

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	them, they should be placed. Interview on 6/9/23 10:10 A.M., the Administrator indicated the facility used an electronic system for maintenance work orders and everyone had access to put in things that needed to be done. When a nurse puts an order into the resident's chart, they should have also put it into the maintenance system so he was aware it needed to be done. He should prioritize those tasks but she would expect it to be done in a timely manner. Interview on 6/9/23 at 2:09 P.M., the Administrator indicated the maintenance man was not aware non skid strips needed to be placed in Resident 24's bathroom. At that time, she also indicated there was not a policy on following orders, but it would be the facility policy to carry out any orders given. 3.1-35(a) 3.1-35(d)(2)(B)			
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 that a resident who needs respiratory care is provided care according to the physician orders and	F 0695	1. Resident #8 suffered no ill effects from the alleged deficient practice. Resident assessed and monitored for adverse effects with	07/12/2023

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	maintenance of the respiratory equipment for 1 of 1 residents reviewed for respiratory care. (Resident 8) Findings included: On 6/5/23 at 10:34 A.M., Resident 8 was observed out of bed, dressed, and sitting in wheelchair. A Continuous Positive Air Pressure (CPAP) machine was on her night stand. During an interview, the resident indicated she only uses CPAP when sleeping. Upon inspection, the gross particle filter on the CPAP machine was observed to be covered with white lint-like substance. There was no oxygen concentrator in the room and the resident indicated she was not using oxygen at that time. On 6/6/23 at 11:47 AM the resident's clinical records were reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus with unspecified complications, obstructive sleep apnea (adult), shortness of breath, and acute respiratory failure. The annual Minimum Data Set (MDS) Assessment, dated 2/15/23, indicated the resident was cognitively intact, and required extensive assistance of 1 for bed mobility, transfers, and toileting, setup and supervision for eating, and physical help with part of bathing. Physician orders included, but were not limited to: Oxygen 1 to 4 liters per minute (LPM) as needed to keep oxygen saturation levels above 90% (dated 9/21/22); place CPAP on at bedtime, remove upon rising. This order must be followed and checked on during bed checks (dated 11/19/22). Care Plan: Resident has potential for		no findings. All tubing replaced, physician orders verified, and external filters cleaned immediately. Nursing department staff were immediately educated on respiratory equipment monitoring, dating/care of tubing and cleaning of filters. Respiratory equipment provider contacted and monthly service of resident bipap machine verified. 2. All residents with respiratory equipment have the potential to be affected. Nursing staff educated by the infection preventionist on the respiratory care/oxygen use policy. IP nurse will complete visual observation during daily rounds to ensure that respiratory equipment is free of dust, tubing is dated/ stored appropriately when not in use. Respiratory therapist will communicate with DHS/designee monthly to notify of dates of service for cpap/bipap machines in campus. 3. As a measure of ongoing compliance, the DHS, IP, or designee, will complete audits of 3 residents to ensure that oxygen equipment is free from dust, oxygen tubing is dated, and tubing is stored appropriately when not in use daily for 4 weeks, then 3x weekly for 4 weeks, then weekly for 4 weeks, then monthly for 3 months.	

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	155682	A. BUILDING 00 B. WING	06/09/2023

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	complications, functional and cognitive status decline related to respiratory disease R/T: COPD, and OSA (start date 3/3/22). Interventions included: 1. Respiratory therapy per orders. 2. Monitor oxygen saturation via pulse oximetry as ordered. 3. Administer oxygen per orders. (3/3/22) 4. Resident requires elevation of head of bed due to shortness of breath while lying flat as needed. 5. Monitor lung sounds per orders or as needed. 6. Observe and report signs of respiratory distress (restlessness, wheezing, dyspnea, difficulty with expectoration, diaphoresis, crackles, bubbling, tachycardia, cyanosis, decreased breath sounds). 7. Assess for change in level of consciousness, coherency. Report changes. The care plan lacked an intervention for the CPAP machine. On 6/7/23 at 10:27 A.M. the resident's clinical records were reviewed and indicated oxygen saturations from 5/7/23 to 6/7/23 ranged from 93% to 100% on room air. On 6/6/23 at 1:30 PM the tubing on resident's CPAP machine was observed. There was no date or time noted on tubing or machine. During an interview on 6/6/23 at 9:16 A.M. with the resident, she indicated she did not sleep well last night because her CPAP machine was beeping. The large particle filter was observed to still be covered with white lint-like substance. During an interview on 6/6/23 at 11:34 A.M. with representative of respiratory care company, the representative indicated he did not know if the CPAP machine had any filters. When asked to check, he saw the gross particle filter. He removed		4. As a quality measure, the DHS or designee will review any findings and required corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	it and showed the clean side. When asked to show the other side, he turned it over and saw it was dirty. He then washed it out. The representative said he does not usually do that. He indicated he did not know if the CPAP had a fine particle filter. He indicated the respiratory therapists (RT's) are the only ones who can do anything with the machines. When asked how often the RT's make rounds to the facilities, he indicated he did not know. The reason for his visit was to put new tubing on resident's CPAP machine, he indicated it was on the truck and he was going to go get it and replace the tubing. Interview with the Administrator on 6/6/23 at 11:41 A.M., a copy of the agreement with respiratory care company was requested and not received. Interview with the Administrator on 6/6/23 at 11:57 A.M., the administrator provided a copy of the bill from respiratory company, which indicated the respiratory therapist had visited the facility on 3/20/23. She indicated they have oxygen concentrators on site if they are needed. Interview with the administrator on 6/9/23 at 2:00 P.M., the administrator indicated the RT's had been to the facility in April and May to service machines. The facility's policy on respiratory care was requested but not received. 3.1-47(a)(6)			
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			

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	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 posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation, interview, and record review, the facility failed to ensure posted nurse staffing records contained the correct information daily for 1 of 6 days during the survey.	F 0732	1. No residents were affected by the deficient practice. Updated daily staffing sheet with counts was immediately posted. 2. No residents have the	07/12/2023

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	Findings include: On 6/4/23 at 9:15 A.M., a staffing record was observed posted on the wall next to the nursing station located in the common area dated 6/2/23. During an interview on 6/8/23 at 8:55 A.M., the Administrator indicated she was not sure who was responsible for changing the posted nurse staffing on the weekend. During an interview on 6/8/23 at 9:21 A.M., the Administrator indicated she found out the nurse on night shift changed the posted nurse staffing for the weekend. On 6/8/23 at 11:12 A.M., a policy on Guidelines for Staff Posting, revised 5/11/16, provided by the Administrator, indicated "At the beginning of the day the number and amount of hours of licensed nurses (RN and LPN) and the number and hours of unlicensed nursing personnel, per shift, who provide direct care to residents will be posted."		potential to be affected by the alleged deficient practice. Education was provided to the interdisciplinary team on the requirements and process of posting the daily staffing sheet with counts. 3. As a measure of ongoing compliance, the ED or designee will audit daily staffing sheet with counts for accuracy 5x/weekly for 4 weeks, 3 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and required corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.			

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	Based on observation, interview, and record review, the facility failed to ensure behavioral health services were provided to maintain resident's highest practicable well-being. A Resident that required behavioral health monitoring was not evaluated for these services and not monitored for behaviors for 1 of 3 residents reviewed for dignity. (Resident G) Findings include: During an observation on 6/4/23 at 12:42 P.M., Resident G indicated that she needed to use the restroom. At that time, CNA (certified nurse aide) 3 was passing drinks to other residents as Resident G continued to say she needed to go to the restroom. CNA 3 indicated in a harsh tone "you can't go right now, you can only go pee every 2 hours." On 6/6/23 at 9:34 P.M., Resident G's clinical record was reviewed. Diagnosis included, but were not limited to, heart failure, hypertension, and overactive bladder. The most recent annual MDS (minimum data set) Assessment, dated 5/12/23, indicated Resident G's cognitive status was severely impaired, and Resident G was occasionally incontinent. During an observation on 6/07/23 at 10:09 A.M., a white dry erase board was observed sitting in Resident G's room that indicated " bathroom again at 12:30 am." Resident G's clinical record lacked any orders related to her repeated requests to go to the bathroom. Documentation related to behavior monitoring was requested and not received. Resident G's clinical record lacked any care plans	F 0740	1. Resident G was assessed with no findings and suffered no ill effects from the deficient practice. MD updated with order received for Deer Oaks Behavioral Health consult and targeted behavior monitoring added to plan of care with care plan updated. 2. All like residents have the potential to be affected. An audit was completed for residents with behavioral health needs to ensure behavioral health management and monitoring in place. Education provided to nursing staff related to the Mental Health Wellness program and behavioral health monitoring. The interdisciplinary team will monitor clinical documentation in CCM daily to identify any residents requiring additional services and/or monitoring. 3. SSD or designee will audit documentation of 5 residents to ensure behavior management and monitoring is in place as appropriate 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks then weekly for 4 weeks then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing in the campus Quality Assurance Performance Improvement	07/12/2023

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	related to her repeated requests. During an interview on 6/9/23 at 8:35 A.M., the DON (director of nursing) indicated that Resident G had a behavior of repeatedly asking to use the restroom, and it should be monitored and care planned. A dry erase board was in her room and indicated when the resident was able to use the restroom. It was used as a reminder when Resident G asked 5 minutes after going to the restroom. On 6/9/23 at 9:17 A.M., the administrator provided a Guideline for Mental Health Wellness Program policy, dated 12/31/22. The policy indicated "...3. If behavior concerns are identified a baseline Behavior Plan of Care shall be developed and initiated. a. The plan of care shall address the identified root cause of the behaviors. 4. Behavior interventions shall be communicated to the interdisciplinary team for implementation...10. The Mental Health Wellness/ Behavior Management Program shall consist of: a. A care plan initiated or updated with realistic, effective interventions which complements the resident's cognitive status, and incorporates their total care. b. Communication to Social Service Director and Physician alerting them to new, exacerbated behaviors, current status, intervention of effectiveness...11. Interdisciplinary team findings shall be contained in the clinical record..." This Federal tag relates to Complaint IN00404924. 3.1-37(a) 3.1-43(a)(1)		meetings until 100% compliance achieved. The plan will be reviewed and updated as warranted.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use			

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	§483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for			

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	the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, interview, and record review, the facility failed to ensure residents were free from unnecessary medications for 1 of 5 residents reviewed for unnecessary medications and 1 of 1 residents reviewed for antibiotic use. A resident received 9 doses of an antibiotic that were double the ordered dose and a resident's as needed anti-anxiety medication was ordered for greater than 14 days. (Resident 9, Resident 13) Findings include: 1. On 6/8/23 at 9:54 A.M., Resident 9's clinical record was reviewed. Diagnoses included, but were not limited to, non-Hodgkin lymphoma, hypo-osmolality, and hyponatremia. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 3/14/23, indicated that the resident was moderately cognitively impaired and an extensive assist of 2 staff for bed mobility and toileting. The current physician's orders included, but was not limited to, the following: Bactrim 400-80 mg (milligram) tablet orally once a day on Tuesday, Thursday, and Saturday for UTI (urinary tract infection) prevention A current ADL (Activities of Daily Living) care	F 0758	F758A 1. Resident #13 assessed/monitored with no findings and suffered no ill physical or psychosocial effects. Medication orders reviewed with MD with no changes indicated as prn Ativan was previously discontinued on 6/6/23. 2. All residents have the potential to be affected. An audit was completed of all psychoactive medication orders to ensure any prn orders are limited to 14 days then reviewed. Physicians notified and orders updated if indicated. Education completed with licensed nursing staff on Psychotropic Medication Usage and Gradual Dose Reduction policy and procedure. The interdisciplinary team monitors daily in Clinical Care Meeting for any new prn psychotropic medications and to ensure orders are limited to 14 days then reviewed for further orders. 3. DHS/designee will audit to ensure any prn psychotropic orders are for 14 days then reviewed for 3 residents weekly x	07/12/2023

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	plan, dated 3/21/23, included, but was not limited to the following intervention: Medications per MD (Medical Doctor) order, dated 3/21/23 Progress notes included, but were not limited to, the following: 4/14/23 12:51 P.M. QMA noted wrong dose of Bactrim 4/13/2023 was given double strength (sic) on Tuesday, Thursday, and Saturday. Nine pills were punched out. Daughter and nurse practitioner were notified. No ill effects from double strength. Pharmacy was called and informed wrong dose was sent to our building. The March 2023 MAR (Medication Administer Record) was reviewed from 3/16/23-3/31/23 and indicated 1 dose of Bactrim 400-80 mg was given on the following dates: 3/16/23 3/18/23 3/21/23 3/23/23 3/25/23 3/28/23 3/30/23 The April 2023 MAR was reviewed from 4/1/23-4/13/23 and indicated 1 dose of Bactrim 400-80 mg was given on the following dates: 4/1/23 4/4/23 4/6/23 4/8/23 4/11/23 4/13/23 During an interview on 6/8/23 at 1:40 P.M., LPN (Licensed Practical Nurse) 23 indicated when a medication was delivered from the pharmacy, staff		4 weeks, 3 residents biweekly x 8 weeks then 3 residents monthly x 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing in the campus Quality Assurance Performance Improvement meetings until 100% compliance achieved. The plan will be reviewed and updated as warranted. F758B 1. Resident #9 assessed/monitored with no findings and suffered no ill physical or psychosocial effects. Medication orders reviewed with MD with no changes indicated. 2. All residents have the potential to be affected. An audit was completed of all medication orders to ensure dose matches current physician orders; no findings. Education completed with licensed nursing staff regarding medication administration and unnecessary medications. Random observations completed by nursing leaders during rounding to ensure medication administration compliance. 3. DHS/designee will audit medication carts for accuracy of 5	

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	should check the order and check the card to make sure they match before putting it into the cart. At that time, they indicated while the medication was administered, one should check the order in the electronic record and make sure it matched the label on the medication card from the cart three times before the patient received the medication. During an interview on 6/8/23 at 2:45 P.M., (pharmacy name)'s Executive Director/pharmacist indicated they received an order for single dose Bactrim 400-80 mg from the facility; however, when it was dispensed on 3/14/23, it was mistakenly dispensed as Bactrim 800-160 mg. He indicated there were 9 doses given until the error was discovered on 4/14/23 by facility. correct dose was dispensed on 4/14/23 so the facility should have received it 4/15/23. During an interview on 6/8/23 at 4:09 P.M., the Regional Consultant indicated Resident 9 received 9 incorrect doses of Bactrim. 2. On 6/8/23 at 8:03 A.M., Resident 13's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and anxiety disorder. The most recent quarterly MDS Assessment, dated 5/19/23, indicated that the resident was cognitively intact and needed an extensive assist of 2 staff for bed mobility and transfers. Current physician's orders included, but were not limited to, the following: lorazepam 0.5 mg administer 0.25 mg orally once daily PRN for anxiety, dated 4/18/23-6/6/23 Resident 13's clinical record lacked documentation that a physician or nurse practitioner reviewed the		medication cards compared to physician orders 5 weekly x 4 weeks, 3 x weekly x 4 weeks, twice weekly x 4 weeks then twice monthly x 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing in the campus Quality Assurance Performance Improvement meetings until 100% compliance achieved. The plan will be reviewed and updated as warranted.	

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	PRN lorazepam order every 14 days. During an interview on 6/8/23 at 10:40 A.M., the Administrator indicated there was no documentation of the PRN lorazepam being reviewed every 14 days. During an interview on 6/8/23 at 10:46 A.M., the Regional Consultant indicated a review should have been done by the physician or nurse practitioner for the PRN lorazepam order to continue. During an interview on 6/8/23 at 4:09 P.M., the Regional Consultant indicated there was not a policy for staff to follow to put medication cards delivered from the pharmacy into the medication cart, but she would expect staff to match the manifest (delivery list) to the cards delivered and the staff that administered the medication would verify dosage before administering to residents. She indicated there was no policy for following doctor orders, but it was standard nursing practice to follow physician's orders. A current medication administration policy, dated November 2018, was provided by Regional Staff and indicated " ... 4. Five Rights--Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away ... a. Check #1: Select the Medication--label, container and contents are checked for integrity, and compared against the medication administration record (MAR) by reviewing the 5			

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	Rights. b. Check #2: Prepare the dose-- the dose is removed from the container and verified against the label and the MAR by reviewing the 5 Rights. c. Check #3: Complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 Rights when putting the medication away ... " A current psychotropic medication policy, dated October 2017, was provided by the Administrator on 6/8/23 at 11:12 A.M., and indicated " ... PRN orders for psychotropic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication " 3.1-48(a)(6)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. 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,			

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

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	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 infection control practices were followed for 2 of 4 observations of resident care. Handwashing was not completed between dirty to clean tasks. Gloves were not changed between dirty and clean tasks. (Resident G, Resident 15) Findings include: 1. During an observation on 6/8/23 at 8:23 A.M., CNA (certified nurse aide) 6 toileted Resident G in the restroom. CNA 6 donned gloves, used the remote to raise the recliner, opened the door, removed gloves, donned a new pair of gloves and wiped the resident after she used the restroom. CNA 6 failed to sanitize or wash hands between changing gloves. During an interview on 6/9/23 at 8:37 A.M., the IP (infection preventionist) indicated between dirty to clean tasks that hands should be washed for 20 seconds or hand sanitizer should be used. 2. On 6/9/23 at 8:45 A.M., Resident 15's clinical record was reviewed. Diagnoses included, but were not limited to, Osteoarthritis, urinary incontinence, and pain. The most recent MDS Assessment, dated 5/19/23,	F 0880	1. Residents G and #15 were assessed with no findings and suffered no ill physical or psychosocial effects from the deficient practice. 2. All residents have the potential to be affected. Education provided to nursing staff related to hand hygiene policy including hand hygiene/ glove changing between dirty and clean tasks. Random observations completed and ongoing education provided as indicated by nursing leaders during daily rounding. 3. As a measure of ongoing compliance, the DHS or designee, will audit staff infection control practices to ensure hand hygiene and glove changing is completed between dirty and clean tasks. Audits of hand hygiene and glove changing will be completed with 5 staff members weekly x4 weeks, then 3 staff members weekly x 2 months, then 5 staff monthly for 3 months.	07/12/2023

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	indicated Resident 15 was cognitively intact and an extensive assist of 2 staff for bed mobility and toileting and totally dependent on 2 staff for transfers. On 6/8/23 at 1:44 P.M., Resident 15 was observed for incontinence care. CNA (Certified Nurse Aide) 3 and CNA 6 put on gloves upon entering the room. CNA 3 browsed the resident's closet touching the clothes. Wearing the same gloves, CNA 6 left the room to get the sit to stand lift and brought it back into the room, moved the resident's bedside table, pulled the privacy curtain, went back out of room to get the resident's wheelchair, moved the sit to stand lift, pulled privacy curtain, moved the wheelchair, grabbed clothes from CNA 3, moved bedside table that was blocking Resident 15's roommate's walker that she needed to use to go to the restroom, moved the roommate's walker to her, opened and closed the restroom door. Then CNA 3 and CNA 6 pulled Resident 15's blankets down, grabbed the bed pad and lifted it to move the resident up in bed. CNA 6 lowered the bed, put on Resident 15's pants, put shoes on and touched shoe bottoms, grabbed sit to stand lift, put lift pad on Resident 15, adjusted the lift, pulled on privacy curtain, went back into the restroom to get wipes while CNA 3 held the resident up in a sitting position from the back. CNA 6 lifted the resident to the standing position with the lift while she held wipes in her left hand, undid the incontinence brief, preformed incontinence care in the front then in back, removed soiled brief and held brief in left hand while snapping the new incontinence brief on and pulling up pants with right hand. CNA 6 went to the restroom to dispose of soiled brief, changed gloves without sanitizing or washing hands, lowered resident into wheelchair, unhooked straps of lift pad, removed pad from		4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing in the campus Quality Assurance Performance Improvement meetings until 100% compliance achieved. The plan will be reviewed and updated as warranted.	

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	behind resident, took off the resident's shirt, put on new shirt, removed gloves, and washed her hands. CNA 3 removed gloves and washed her hands. On 6/9/23 at 8:45 A.M., the administrator provided a current Guideline for Handwashing/ Hand Hygiene policy, revised 2/9/17. The policy indicated "...3. Health Care Workers (HCW) shall use hand hygiene at times such as:...d. After removing gloves..." During an interview on 6/9/23 at 10:40 A.M., the DON (Director of Nursing) indicated hand hygiene should be done before and after going into and out of room. She indicated if staff went out of room with gloves on, and come back into the room to do incontinence care, she would expect staff to take off those gloves, sanitize hands, and put on new gloves. At this time, the Regional Consultant indicated there was not a policy to specifically change gloves after touching multiple surfaces before doing incontinence care on a resident. 3.1-18(l) 3.1-18(b)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaint IN00404924. Survey dates: June 4, 5, 6, 7, 8, 9, 2023 Facility number: 002724	R 0000		

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	Residential Census: 27 This State Residential Finding is cited in accordance with 410 IAC 16.2-5.			
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on observation, interview, and record review, the facility failed to ensure the QMAs (Qualified Medication Aides) obtained authorization by a licensed nurse for the administration of a PRN (as needed) medication for 1 of 7 resident records reviewed. (Resident 8) Finding includes: On 6/9/23 at 10:23 A.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, fracture of left wrist, pain, and COPD (chronic obstructive pulmonary disease). Current physician's orders included, but were not limited to, the following: benzonatate 100 mg (milligram) capsule orally three times a day PRN for cough, dated 4/7/23 hydrocodone-acetaminophen 5-325 mg tablet orally every 6 hours PRN for moderate pain, dated 4/7/23	R 0246	1. Resident #8 assessed/monitored with no findings and suffered no ill physical or psychosocial effects. Medication orders reviewed with MD with no changes indicated. Staff immediately educated related QMA administration of prn medications. 2. All residents have the potential to be affected. Education completed with licensed nursing staff regarding QMA administration of prn medications. Random observations completed by nursing leaders during rounding to ensure prn medication administration compliance. 3. DAL/designee will audit prn medication administration by QMA's via controlled substance	07/12/2023

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	Resident 8's May 2023 MAR (Medication Administration Record) was reviewed for PRN benzonatate administration and indicated the following doses were administered by a QMA: 5/3/23 9:44 P.M. 5/7/23 1:04 A.M. 5/19/23 4:24 A.M. 5/19/23 4:42 P.M. 5/23/23 10:45 P.M. Resident 8's May 2023 MAR was reviewed for follow up of PRN benzonatate efficacy and indicated the following were assessed by a QMA: For 5/3/23 PRN dose 1 5/4/23 6:24 A.M. Follow-up: effective For 5/19/23 PRN dose 1 5/19/23 3:18 P.M. Follow-up: effective For 5/23/23 PRN dose 1 5/24/23 3:20 A.M. Follow-up: effective Resident 8's May 2023 MAR was reviewed for PRN hydrocodone-acetaminophen administration and indicated the following doses were administered by a QMA: 5/1/23 10:57 P.M. 5/2/23 9:31 P.M. 5/3/23 9:44 P.M. 5/4/23 11:03 P.M. 5/5/23 9:19 P.M. 5/8/23 11:27 P.M. 5/9/23 9:58 P.M. 5/10/23 9:59 P.M. 5/11/23 11:24 P.M. 5/13/23 9:47 P.M. 5/14/23 9:33 P.M. 5/18/23 9:31 P.M. 5/20/23 9:31 P.M. 5/21/23 8:52 P.M. 5/23/23 10:45 P.M. 5/27/23 9:51 P.M.		log and medication administration observation 5 weekly x 4 weeks, 3 x weekly x 4 weeks, twice weekly x 4 weeks then twice monthly x 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing in the campus Quality Assurance Performance Improvement meetings until 100% compliance achieved. The plan will be reviewed and updated as warranted.	

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	5/30/23 9:35 P.M. Resident 8's May 2023 MAR was reviewed for follow up of PRN hydrocodone-acetaminophen effectiveness and indicated the following were assessed by a QMA: For 5/2/23 PRN dose 1 5/3/23 12:30 A.M. Follow-up: effective For 5/3/23 PRN dose 1 5/4/23 6:24 A.M. Follow-up: effective For 5/5/23 PRN dose 1 5/5/23 10:56 P.M. Follow-up: effective For 5/6/23 PRN dose 1 5/7/23 1:04 A.M. Follow-up: effective For 5/7/23 PRN dose 1 5/7/23 11:10 P.M. Follow-up: effective For 5/10/23 PRN dose 1 5/11/23 3:17 A.M. Follow-up: effective For 5/11/23 PRN dose 1 5/12/23 3:11 A.M. Follow-up: effective For 5/14/23 PRN dose 1 5/15/23 3:16 A.M. Follow-up: effective For 5/22/23 PRN dose 1 5/23/23 3:11 A.M. Follow-up: effective For 5/23/23 PRN dose 1 5/24/23 3:20 A.M. Follow-up: effective For 5/24/23 PRN dose 1 5/2523 5:14 A.M. Follow-up: effective For 5/25/23 PRN dose 1 5/26/23 4:09 A.M. Follow-up: effective For 5/27/23 PRN dose 1 5/27/23 2:41 A.M. Follow-up: effective For 5/28/23 PRN dose 1 5/30/23 12:42 A.M. Follow-up: effective Resident 8's June 2023 MAR was reviewed for follow up of PRN benzonatate effectiveness and indicated the following were assessed by a QMA: For 6/1/23 PRN dose 1 6/2/23 1:25 A.M. Follow-up: effective			

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	For 6/5/23 PRN dose 1 6/5/23 6:49 P.M. Follow-up: effective Resident 8's June 2023 MAR was reviewed for PRN hydrocodone-acetaminophen administration and indicated the following doses were administered by a QMA: 6/5/23 7:30 P.M. 6/7/23 928 P.M. 6/8/23 7:20 P.M. Resident 8's June 2023 MAR was reviewed for follow up of PRN hydrocodone-acetaminophen effectiveness and indicated the following were assessed by a QMA: For 6/1/23 PRN dose 1 6/2/23 1:25 A.M. Follow-up: effective For 6/3/23 PRN dose 6/4/23 6:55 A.M. Follow-up: effective May and June 2023 Controlled Drug Use Forms for hydrocodone-acetaminophen administered to Resident 8 by QMAs were reviewed and lacked cosigning/authorization from a nurse. Progress notes for May and June of 2023 were reviewed and lacked documentation of a nurse authorizing QMAs to give PRN benzonatate and hydrocodone-acetaminophen and assessments of the effectiveness of the drugs given. During an interview on 6/9/23 at 11:01 A.M., RN (Registered Nurse) 21 indicated QMAs should get authorization from a nurse before giving a PRN medication. The nurse would need to assess the resident before and after the medication was given. The QMA would sign the MAR, the nurse would open an observation in the electronic clinical record and co-sign authorization of giving the medication and then the nurse or QMA would			

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	follow up for the effectiveness of the medication. If the QMA would document effectiveness in the MAR, then the nurse should document assessment in the progress notes. During an interview on 6/9/23 11:05 A.M., LPN (Licensed Practical Nurse) 10 indicated QMA should ask the nurse to authorize giving the PRN medication. The nurse should open an observation in (name of electronic health record)and should assess if the medication was effective or ask the QMA if it was. The effectiveness of the medication was documented in the MAR by whoever assessed the resident. During an interview on 6/9/23 at 11:15 A.M., the Administrator indicated the nurse could sign the narcotic sheet, make a progress note, or open an observation to record authorization of giving medication. During an interview on 6/9/23 at 11:44 A.M., QMA 15 indicated that the first thing they should do before administering a PRN medication was have a nurse come over and assess and determine whether the resident needs it. During an interview on 6/9/23 at 12:10 P.M., the Administrator indicated that there was no other documentation of nurses giving authorization to QMAs before administering PRN medications or assessing the resident before or after the medication was given. At that time, she indicated there was not a policy on documentation of the authorization from a nurse or assessments being done by a nurse for PRN medications. "Qualified Medication Aide Scope of Practice" was retrieved on 6/9/23 from the Indiana Government website. The Scope of Practice			

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	included, but was not limited to the following: "Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the need for the medication and time the symptoms occurred. (B) Document in the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact. (C) Obtain permission to administer the medication each time the symptoms occur in the resident. (D) Ensure that the resident 's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift, or if the nurse was on call, by the end of the nurse's next tour of duty"			