| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155370 | A. BUILDING 00<br>B. WING | 02/24/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PREMIER HEALTHCARE OF NEW HARMONY | 251 HIGHWAY 66<br>NEW HARMONY, IN 47631 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00372378 and IN00372320. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy.<br><br>Complaint IN00372378- Substantiated. Federal/State deficiencies related to the allegations are cited at F689, F744, and F759.<br><br>Complaint IN00372320 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689 and F744.<br><br>Unrelated deficiency cited at F888.<br><br>Survey dates:<br>February 16, 21, 22, 23, and 24, 2022<br><br>Facility number: 000555<br>Provider number: 155370<br>AIM number: 100267530<br><br>Census Bed Type:<br>SNF/NF: 41<br>Total: 41<br><br>Census Payor Type:<br>Medicare: 8<br>Medicaid: 29<br>Other: 4<br>Total: 41<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. | F 0000 | Submission of this Plan of Correction by the facility is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited. In addition, preparation and submission of this POC does not constitute an admission or agreement of any kind by the facility of the truth of any facts set forth in this allegation by the survey agency. Please accept the following as the facility's credible allegation of compliance. | |

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

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| F 0689<br>SS=J<br>Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>Based on observation, interview, and record review, the facility failed to ensure a cognitively impaired resident, who had exhibited exit seeking behavior, did not elope from the facility, placing the resident at risk for severe adverse outcome, for 1 of 3 residents reviewed for elopement risk. (Resident B)<br><br>The immediate jeopardy began on 1/31/22 when Resident B eloped from the facility by climbing out of a window, and drove a car unaccompanied into a nearby town. The Administrator was notified of the immediate jeopardy at 12:15 P.M. on 2/23/22. The immediate jeopardy was removed on 2/24/22, but noncompliance remained at the lower scope and severity level of isolated of no actual harm with potential for more than minimal harm that is not immediate jeopardy.<br>.<br>Findings include:<br><br>On 2/16/22 at 11:20 A.M., the clinical record of Resident B was reviewed. Diagnoses included, but were not limited to, dementia with behavioral disturbance. | F 0689 | 1. The facility has taken the following corrective action(s) to address those residents and areas specifically identified as affected:<br><br>A. Maintenance has inspected all windows to ensure that they were restricted from opening more than 6 inches;<br>B. Resident B has been assessed for any injury or negative outcome. None were noted;<br>C. Resident B continues to be closely monitored and supervised by staff; and<br>D. Resident B has been re-assessed for elopement risk and his plan of care was updated.<br><br>2. The facility has identified that residents identified as at risk for elopement have the potential to be affected by this alleged deficient practice. All residents in the facility have been re-assessed for elopement risk and their plans | 02/26/2022 |

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| | The resident was admitted to the facility on 11/11/21.<br><br>Nurses notes included the following notations:<br><br>11/11/21 at 9:57 P.M.: "Admitted to facility today, to dementia secured unit...Alert to self, unaware of surroundings...Ambulates without difficulties...continues to pace hallway of secured unit, to continue to monitor."<br><br>11/15/21 at 11:31 P.M.: "Res [resident] continues to wander throughout the secured unit with confusion...Res approaches nrsg [nursing] with repetitive verbalizations with exit seeking behaviors as evidenced by attempting to exit and follow staff out of doors...."<br><br>11/18/21 at 12:56 A.M.: "Res continues to approach staff frequently when awake with exit seeking verbalizations and behaviors as witnessed by staff observing res requesting staff and others to phone his family to pick him up . Res will approach exit doors and attempt to push locked secured doors. Res is gently guided with 1:1 and re-assurance offering res activities-food-fluids. Res is receptive to meds-snacks and fluids at this time. Res continues with repetitive actions throughout the evening, res resting at this time."<br><br>An admission Minimum Data Set (MDS) assessment, dated 11/18/21, indicated Resident B had a severely impaired cognition, had behaviors of rejecting care and wandering 1-3 days, and required supervision of set up help to walk in room and hall.<br><br>Nurses notes continued:<br><br>11/19/2021 at 9:08 P.M.: "Res requires repeated | | of care have been updated as warranted.<br><br>3. Measures and systematic changes the facility has taken to correct this alleged deficient practice and ensure it does not recur include:<br><br>A. The facility immediately inspected ALL facility windows to ensure that they were secured and could not be opened more than six (6) inches.<br>B. The facility immediately began re-assessed all residents for elopement risk/potential and updated their plans of care as warranted.<br>C. The facility's maintenance procedure regarding inspection of window restriction mechanisms was changed to being done weekly.<br>D. In servicing was provided to facility staff by Administrator regarding the importance of monitoring the physical environment and residents during the course of their duties. This training included, but was not limited to, the following:<br><br>· Identifying unsafe conditions in the resident room and/or resident areas. Specific discussion was given to missing window stops,<br>· Identifying when a resident is acting out of the ordinary, | |

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| | re-approaches to successfully manage res to accept meds to control current health needs. Res is witnessed frequently with hurried gait wandering without purpose with at times verbalizing exit seeking behaviors with attempts to follow others out and approaching staff to let him leave Now. Res is easily distracted with poor retention....."<br><br>11/29/21 at 11:39 A.M.: "Resident has increased agitation today. Resident moving objects that do not belong to him into his room. When explaining to resident that these are his items and he can not move them due to it being unsafe, resident becomes very agitated and aggressive with staff and other residents. Resident also refusing shower and getting aggressive with staff when trying to attempt, re approaching is unsuccessful."<br><br>12/2/21 at 2:21 A.M.: "Res up fully dressed will not allow staff to assist with changing clothing, res observed pacing back and forth unaware of his surroundings as he wanders without purpose, mood is rude towards staff with attempts to provide reminders and assist with care-res frequently rejects food when up wandering throughout the night res is offered alternate activities and exhibits poor retention and exits away. Res denies pain yells at staff when attempting assessments."<br><br>12/11/21 at 10:57 P.M.: "Res wandering throughout the unit without purpose rejecting food and fluids. Res is alert to self and unaware of his surroundings, res frequently exits away from staff with staff attempting to assist. Res becomes easily annoyed and verbally agitated with staff with attempts to assist." | | behaving in an unusual manner, showing interest in how alarms and/or window restriction devices operate, work, or can be bypassed,<br>· Monitoring residents for any change of emotional, mental, or behavioral conditions. Specific areas regarding elopement, agitated behaviors, and wandering were targeted. Specific discussion was presented that included a review of possible circumstances that might trigger resident behaviors including, but not limited to, room changes, presence of National Guard personnel, or other activities that are outside the normal day-to-day operations of the facility.<br>· Staff were instructed to report any concerns, suspicious behaviors, unusual circumstances and/or environmental safety risks immediately to the Administrator and/or DON. Staff were also instructed to stay in the affected area with residents if the situation appears to pose significant immediate risk and to have another staff member immediately report the situation. Staff were instructed to ensure they are not creating unsafe conditions such as leaving their car keys accessible to residents and other like circumstances.<br><br>E. Began elopement drills were completed on all shifts and will be | |

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| | 12/21/21 at 11:39 A.M.: "...Up ad lib pacing the hallways w/o [without[ purpose...."<br><br>1/12/22 at 3:38 P.M.: "Social Services...IDT [interdisciplinary team] behavior review. [Resident B] has been noted to have several behaviors. Accusing of others, threatening others, rummaging, exit seeking, hoarding, refusing care. Redirection and 1:1 did not change behavior...Meds are to be reviewed. Sees [psychology service] for psych services. Will continue to monitor."<br><br>A Psychology note, dated 1/13/22, indicated, "Staff report resident has behaviors of aggression, cursing and threatening others...Resident is positive for dementia related behaviors such as confusion, wandering...."<br><br>A care plan regarding wandering behaviors or exit seeking was not observed in the clinical record.<br><br>An elopement assessment, dated 1/31/22, indicated the resident had a history of or an attempted elopement while at home, had a history of or attempted leaving the facility without informing staff, verbally expressed the desire to go home, wandered aimlessly, and was at risk for elopement. Clinical Suggestions included: "Monitor location frequently. Utilize exit alarm(s). Encourage participation in recreational activities, and Notify staff of wandering risk."<br><br>An elopement assessment prior to 1/31/22 was not observed in the clinical record.<br><br>An Indiana State Department of Health incident indicated, "Incident Date: 01/31/2022. Incident Time: 11:30 AM...[Resident B] was noted to be | | performed a minimum of quarterly thereafter moving forward for all shifts<br><br>4. The Administrator, DON, Maintenance Supervisor and/or their appointed designee(s) will monitor that actions taken are effective and ongoing via:<br><br>A. Monitoring of the weekly window restrictive device inspections logs to ensure that all devices are in place and there is no evidence of tampering or failure;<br>B. Resident clinical records shall also be monitored via the 24-hour reports to identify, emotional status, wandering or elopement behaviors, or other changes in residents' behavior so that timely and effective interventions and approaches can be implemented as warranted;<br>C. Elopement drills for each shift shall be performed and an evaluation of staff response shall be performed. Corrective and/or improvement actions shall be implemented as needed.<br><br>Noted problems shall be addressed immediately and identified patterns/trends of non-compliance shall be reported to the Quality Assurance Committee for further action(s) as necessary. | |

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| | missing during regular rounding by staff. An immediate search of the facility and grounds did not locate him...Resident was subsequently located at a private home and returned to the facility...Investigation:...Police findings confirmed that this resident was located at at community private home and he had driven a car to this home by himself...Resident continued to exit-seek after he returned to the facility. He kept attempting to climb out facility windows...In addition, during an inspection of the facility grounds, a window screen was noted to be removed from the window and lying on the ground outside. Due to these observations, the facility believes it is likely that the resident climbed that [sic] window...."<br><br>On 2/16/22 at 12:15 P.M., Resident B was observed in his room on the Memory Care unit, pacing. He stated, "Are you going to get me out of here now?" Resident B had an irritated look on his face.<br><br>CNA 1 indicated at that time that she was not working when Resident B climbed out of the window. She indicated she heard he pushed out the screen of a fellow Resident's room window, climbed out, and then took a car. CNA 1 indicated Resident B "was pretty sharp."<br><br>CNA 2 indicated at that time that she was not working when Resident B climbed out of the window. She indicated that she heard the incident occurred when staff were busy setting up the "COVID unit." Since that incident, a screw had been placed in all of the windows, so that windows could only be opened approximately 6 inches.<br><br>On 2/16/22 at 2:40 P.M., the Administrator was | | | |

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| | interviewed. She indicated a staff member informed her they couldn't find Resident B. Staff searched for the resident on and off the grounds. The police were called. The resident had "popped" out a window screen, and climbed out of the window. He found a staff member's car which still had the keys in the ignition, and took the car to a nearby residence. The police found the resident, and returned him to the facility. The resident was out of the facility for approximately 1 1/2 hours. During their investigation, it was discovered that the Maintenance Supervisor had removed screws in the windows, which would have prevented the windows from opening fully. The Maintenance Supervisor thought the screws were a fire safely hazard.<br><br>At that time, the Administrator indicated there had not been a care plan regarding the resident's behaviors until the first day of the survey, 2/16/22. The corporate nurse had created a care plan regarding the resident's behaviors on 2/16/22.<br><br>On 2/23/22 at 11:30 A.M., the Administrator indicated she was unsure when the screws had been removed, but it would have been sometime prior to November 2021.<br><br>On 2/21/22 at 1:45 P.M., the Social Services Director (SSD) was interviewed. She indicated she created the behavior plans on the memory care unit. The facility started having monthly behavior meetings in January. CNAs can fill out a behavior sheet, and nurses can document a behavior note. She will run a report at the end of the month. If there are behaviors, the staff can discuss interventions and the physician can make medication recommendations. | | | |

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| | On 2/24/22 at 9:10 A.M., the Administrator provided the current "Guide to Elopement Risk Assessment," dated 2/23/22. The policy included: "1. Upon admission, a resident's potential for elopement will be determined by risk factors which may include, but not limited to: History of wandering/elopement, New Admission with adjustment difficulties or desire to return home, Dementia...Restlessness, irritability, Acute or chronic confusion/disorientation, Anxiety. 2. Risk factors will be identified and documented in the appropriate assessments. 3. Interventions will be developed and entered on the interim plan of care for all residents identified as being an elopement risk. 4. Communication of residents' risk and interventions will be completed daily....Inservice education and elopement drills will be conducted quarterly on different shifts to strive to assure that all staff is aware of what steps to take to prevent or interrupt elopement attempts."<br><br>The Administrator indicated at that time that there had not been an elopement risk policy prior to that date.<br><br>The immediate jeopardy that began on 1/31/22 was removed on 2/24/22 when the facility ensured that the screws were in place in all of the windows, elopement assessments were completed and care plans initiated, staff were inserviced on elopement drills, but the noncompliance remained at the lower scope and severity level of isolated of no actual harm with potential for more than minimal harm that is not immediate jeopardy because the facility will continue to monitor residents for any change in emotional, mental, or behavioral conditions and environmental safety risks. Elopement drills continue on all shifts. | | | |

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| | This Federal tag relates to Complaints IN00372378 and IN00372320.<br><br>3.1-45(a)(2) | | | |
| F 0744<br>SS=D<br>Bldg. 00 | 483.40(b)(3)<br>Treatment/Service for Dementia<br>§483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.<br>Based on observation, interview, and record review, the facility failed to ensure a behavior plan was created and implemented for a resident with dementia exhibiting aggressive behaviors, for 1 of 3 residents with dementia reviewed for behaviors (Resident J).<br><br>Findings include:<br><br>On 2/16/22 at 9:20 A.M., during the initial tour of the locked Memory Care unit, the Director of Nursing (DON) indicated Resident P had exhibited behaviors. Resident P required one on one staff monitoring. Resident P was observed sitting in her room at that time. A staff member was sitting by her.<br><br>The clinical record of Resident P was reviewed on 2/21/22 at 12:05 P.M. Diagnoses included, but were not limited to, dementia with behavioral disturbance.<br><br>Nurses notes included the following notations:<br><br>12/28/21 at 10:20 P.M.: "Resident urinated on her roommate's bed. Bed linens changed. | F 0744 | 1. The facility has taken the following corrective action(s) to address Resident P :<br><br>A. Resident P has been re-assessed for behaviors and a behavior plan was created and implemented to address Resident P's dementia with episodes of aggressive behaviors.<br><br>2. The facility has identified residents diagnosed with dementia with episodes of behaviors as having the potential to be at risk for this alleged deficient practice.<br><br>3. Measures and systematic changes the facility has taken to correct this alleged deficient practice and ensure it does not recur include:<br><br>A. The facility has audited the plans of care of all residents diagnosed with dementia to | 02/26/2022 |

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| | Resident has urinated and defecated on her room mate's bed in the past. Will monitor and inform dayshift."<br><br>1/7/22 at 2:13 P.M.: "Res [resident] during care became aggressive towards staff striking staff with forearms-hands and spitting at them mood was not easily altered. Res was soiled of both bowel and bladder. Res scheduled for med changes with noted titration to begin with new meds added. Res now ambulating at this time."<br><br>1/12/22 at 3:32 P.M.: "Social Services... IDT [interdisciplinary team] behavior review. [Resident J] has had many noted behaviors. Physically aggressive towards staff, anxious, restless, refusing care, sad/tearful, wandering. Redirection, 1:1, food/fluids did not change behaviors often. Meds to be reviewed...Will monitor behaviors and update."<br><br>1/13/22 at 6:54 P.M.: "...res continues to pace the hallway swatting at other res and staff. Staff continues to redirect res. Res is very agitated."<br><br>1/16/22 at 2:26 P.M.: "CNA's [sic] on unit with QMA reported res mood is worsening as evidenced by hitting staff during care and kicking them. Res was soiled of urine after defecating in unit hallway. Will continue to re-approach and re-direct."<br><br>2/6/22 at 3:54 P.M.: "Res became physically agitated towards staff punching staff when changing soiled brief, res was incontinent of both bowel and bladder. Res was in hallway on secured unit ambulating with visible incontinence requiring staff to immediately assist with care. Res mood is altered with agitation with current medications in place and currently receiving | | ensure that appropriate plans are in place for those who exhibit aggressive or otherwise negative behaviors.<br>B. The Interdisciplinary Team (IDT) has been in-serviced by Administrator regarding policies and procedures for assessing resident behaviors; developing needed plans of care for behaviors; monitoring effectiveness of the plan of care; and making revisions/updates as warranted. Specific discussion was given to creating a plan that will ensure that residents who displays or are diagnosed with dementia, receive the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.<br><br>4. The facility has implemented the following Quality Assurance Plan to monitor on-going facility performance and compliance with this requirement:<br><br>A. The DON, Social Worker, Administrator and/or their appointed designee(s) shall review behavior tracking documentation on-going to ensure that appropriate plans of care are in place to address the needs of residents who display or are diagnosed with dementia are receiving the appropriate treatment and services to attain or | |

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| | facility psych services."<br><br>2/6/2022 at 7:00 P.M.: "Resident ambulating in hallway. Very combative to staff and peers. Resistive to care from staff. Attempting to hit staff and peers. Unable to redirect. [Name of physician] paged. New order received: Send to [hospital] ER for evaluation...."<br><br>The resident returned to the facility on 2/8/22 at 7:30 P.M. Nurses notes continued:<br><br>2/10/22 at 11:35 A.M.: "Res remained in bed until after breakfast this am...Up ad lib. Ambulates hallways freely. Staff continues to redirect res when agitated. Res often swats at other residents in the hallway or tv lounge. During ADL [activities of daily living] care res was combative with staff. Res insisted to be nude in the hallway. X3 assist res is now dressed after multiple attempts. Pleasant Mood Currently. Will continue to monitor."<br><br>2/10/22 at 4:38 P.M.: "Res was in hallway swatting at other res. Staff went to intervene when res then proceeded to push a res down. Staff separated the residents... new order to send out to [hospital] for eval [evaluation] due to continuous behaviors towards staff and other residents...."<br><br>The resident returned to the facility after being diagnosed with a urinary tract infection. (Date and time of return to facility was missing from the record.)<br><br>Nurse's notes continued:<br><br>2/12/22 at 7:42 A.M.: "Res continues with 1:1 supervision due to worsening behaviors...." | | maintain his or her highest practicable physical, mental, and psychosocial well-being. Noted problems shall be addressed immediately and identified patterns/trends of non-compliance shall be reported to the Quality Assurance Committee for further action(s) as necessary. | |

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| | 2/13/22 at 3:00 A.M.: "Resident became combative with staff while going to bed. Resident was redirected and slept."<br><br>2/14/22 at 12:11 P.M.: "Resident was swinging a towel at another resident. No contact was made with towel. Staff intervined [sic] and asked resident to walk down the hall with her. Resident went without any issues."<br><br>A care plan regarding the resident's behaviors was not found in the clinical record prior to 2/18/22.<br><br>The care plan and interventions, dated 2/18/22, indicated: "[Resident J] has been physically expressive aeb [as evidenced by]: pushing in the past d/t [due to] dx [diagnosis] of dementia and poor impulse control." Interventions included: "Administer medications as ordered. Monitor/document for side effects and effectiveness. Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. Assess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc. provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated. When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later."<br><br>On 2/21/22 at 1:45 P.M., the Social Services Director (SSD) was interviewed. She indicated | | | |

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| | she created the behavior plans on the memory care unit. The facility started having monthly behavior meetings in January. CNAs can fill out a behavior sheet, and nurses can document a behavior note. She will run a report at the end of the month. If there are behaviors, the staff can discuss interventions and the physician can make medication recommendations.<br><br>On 2/21/22 at 1:55 P.M., the Assistant Director of Nursing provided the current facility policy, "Dementia - Clinical Protocol," dated February 2022. The policy included: "The staff and physician will review the current physical, functional, and psychosocial status of each individual with dementia to formulate an accurate overall picture of the individual's condition, related complications, and functional impairments...For the individual with confirmed dementia, the staff and physician will identify a plan to maximize remaining function and quality of life...The physician will order appropriate medications and other interventions to manage behavioral and psychiatric symptoms related to dementia...The physician will help staff adjust interventions and the overall plan depending on the individual's responses to those interventions...."<br><br>This Federal tag relates to Complaints IN00372378 and IN00372320.<br><br>3.1-43(a)(1) | | | |
| F 0759<br>SS=D<br>Bldg. 00 | 483.45(f)(1)<br>Free of Medication Error Rts 5 Prcnt or More<br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not | | | |

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| | 5 percent or greater;<br><br>Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5%, for 2 of 25 opportunities resulting in an error rate of 8%. (Residents K and L)<br><br>Findings include:<br><br>1. On 2/16/22 at 9:45 A.M., during observation of a medication pass, QMA 1 was observed to administer medications to Resident K. One of the medications was Reguloid .4 grams (a bulk laxative). The prescription label indicated that the medication should be given 2 hours before or after other medications. QMA 1 administered the medication with 6 other medications.<br><br>On 2/16/22 at 11:40 A.M., the clinical record of Resident K was reviewed.<br><br>A Physician's order, dated 10/31/21 and on the current February 2022 orders, indicated, "Metamucil Capsule [Reguloid] Give 1 capsule by mouth in the morning related to diverticulosis of large intestine...."<br><br>On 2/16/22 at 12:00 P.M., QMA 1 was interviewed. QMA 1 indicated she had only recently started at the facility. She did not see the warning on the prescription card to administer the Reguloid 2 hours before or after other medications.<br><br>On 2/21/22 at 10:55 A.M., the Assistant Director of Nursing (ADON) indicated she was unaware the Reguloid would have to be administered 2 hours before or after other medications. She had called the pharmacy | F 0759 | 1.The facility has taken the following corrective action(s) to address those residents and staff specifically identified as affected:<br><br>A. QMA 1 has been provided 1:1 in-service education regarding the policies and procedures for medication pass. Specific discussion was given to identifying medication instructions prior to administration (e.g., Giving medications 2 hours before or after other medications & administering the correct dosage of medications as ordered by the physician);<br>B. Resident K's medication administration time for Reguloid was changed to 10:00 a.m. to ensure it is not given within two hours of other medications;<br>C. Resident L's physician was notified of this medication error and the correct dose was administered. Staff continue to provide Resident L medications as ordered by their physicians.<br><br>1.The facility has identified all residents as having the potential to be at risk for this alleged deficient practice.<br><br>1.Measures and systematic changes the facility has taken to correct this alleged deficient practice and ensure it does not recur include: | 02/26/2022 |

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| | regarding the Reguloid, and the pharmacist informed her that the medication could interfere with other medications. The ADON indicated she would get the administration time changed to 10:00 A.M., since Resident K received her other medications at 8:00 A.M.<br><br>2. On 2/16/22 at 10:00 A.M., during an observation of a medication pass, QMA 1 was observed administering medications to Resident L, including Topiramate 100 mg (an anti-convulsant). The prescription card indicated the resident was to receive Topiramate 100 mg give 150 mg.<br><br>The clinical record of Resident L was reviewed on 2/16/22 at 11:45 A.M.<br><br>A Physician's order, dated 7/3/21 and on the February 2022 orders, indicated, "Topiramate 100 mg Give 1.5 tablet by mouth two times a day."<br><br>On 2/16/22 at 12:00 P.M., QMA 1 was interviewed regarding the Topiramate. She indicated she gave 1 tablet instead of 1 and 1/2 tablets.<br><br>On 2/21/22 at 1:30 P.M., the ADON provided the current facility policy, "Administering Medications," undated. The policy included, "Medications shall be administered in a safe and timely manner, and as prescribed...The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication..." The ADON indicated at that time that Resident L should have received 1 1/2 tablets of the Topiramate. | | A. Licensed nursing staff have been educated and trained regarding the facility's Medication Administration policies and procedures. Specific discussion was given to the importance of following physician orders and pharmacy recommendations.<br><br>1.The facility has implemented the following Quality Assurance Plan to monitor on-going facility performance and compliance with this requirement:<br><br>A. The DON, ADON, and/or their appointed designee(s) shall observe medication administration to a minimum of three residents weekly for a minimum of 90 days (this may continue longer based upon monitoring findings). Noted medication errors shall be addressed immediately and identified patterns/trends of non-compliance shall be reported to the Quality Assurance Committee for further action(s) as necessary. | |

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| | This Federal tag relates to Complaint IN00372378.<br><br>3.1-48(c)(1) | | | |
| F 0888<br>SS=K<br>Bldg. 00 | 483.80(i)(1)-(3)(i)-(x)<br>COVID-19 Vaccination of Facility Staff<br>§483.80(i)<br>COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.<br><br>§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:<br>(i) Facility employees;<br>(ii) Licensed practitioners;<br>(iii) Students, trainees, and volunteers; and<br>(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.<br><br>§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: | | | |

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| | (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and<br>(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.<br><br>§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:<br>(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;<br>(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;<br>(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; | | | |

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| | (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;<br>(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;<br>(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;<br>(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:<br>(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and<br>(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;<br>(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 | | | |

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| | vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and<br>(x) Contingency plans for staff who are not fully vaccinated for COVID-19.<br><br>Effective 60 Days After Publication:<br>§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;<br>A. Based on observations, interviews and record reviews, the facility failed to properly prevent and/or contain COVID-19 by failing to ensure 100% of the 49 staff were vaccinated and had 11 residents who were COVID-19 positive in the past 4 week, one of which expired at the hospital with a diagnosis of sepsis due to COVID-19 pneumonia. (Residents M, N, P, R, S, T, V, W, X, Y, BB)<br><br>B. Based on interview and record review, the facility failed to follow CDC/CMS guidelines for medical exemptions for 3 of 3 staff, and failed to track Covid -19 vaccination status for staff which included booster vaccinations. (Staff 1, Staff 2, Staff 3)<br><br>The immediate jeopardy began on 2/14/22 when the facility failed to ensure that 100% of the | F 0888 | 1. The facility has taken the following corrective action(s) to address those residents and staff specifically identified as affected:<br><br>A. All residents noted with COVID, and who are still in the facility, are receiving care and services in accordance with their physician orders and CMS/CDC guidelines. Staff continue to monitor these residents for further negative outcomes. None have been noted at this time.<br>B. All staff identified as not in compliance with CMS/CDC vaccination guidance were immediately placed on leave until achieving compliance with | 02/26/2022 |

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| | staff were vaccinated. The Assistant Director of Nursing [ADON] and RN 1 were notified of the immediate jeopardy at 2:10 P.M. on 2/22/22. The immediate jeopardy was removed on 2/24/22 but the noncompliance remained at the lower scope and severity level of pattern of no actual harm with potential for more than minimal harm that is not immediate jeopardy.<br><br>Findings include:<br><br>A1. On 2/16/22 at 1:15 P.M., the Administrator provided a spreadsheet of current employees. The spreadsheet indicated the following: 49 staff members. 7 were partially vaccinated. 24 were completely vaccinated, and 8 had exemptions. 3 of those were medical exemptions (Staff 1, Staff 2, and Staff 3).<br>3 employees were not vaccinated, and had no exemptions (Staff 4, Staff 5, and Staff 6). 73.4% staff were vaccinated, partially vaccinated and had approved exemptions.<br><br>On 2/21/22 at 1:45 P.M., Staff 4 was interviewed. Staff 4 indicated she was unvaccinated, and did not have an exemption.<br><br>On 2/21/22 at 2:00 P.M., Staff 5 was interviewed. Staff 5 indicated she was unvaccinated, and didn't plan on getting vaccinated, and did not have an exemption.<br><br>On 2/23/22 at 9:50 A.M., the Administrator provided the timesheets for Staff 4, Staff 6 and Staff 5. Staff 4 worked 7 days from 2/14/22-2/22/22. The Administrator indicated Staff 4 normally worked 5 days a week. Staff 6 worked 1 day between 2/14/22-2/22/22 and Staff 5 worked 6 days between 2/14/22-2/22/22. | | CMS/CDC guidance.<br><br>2. The facility recognizes that all residents have the potential to be at risk for this identified non-compliance and has taken the actions identified in #3 below.<br><br>3. Measures and systematic changes the facility has taken to correct this alleged deficient practice and ensure it does not recur include:<br><br>A. A full and comprehensive audit of the vaccination status all facility employees; licensed practitioners; students, trainees, and volunteers; and (iv) individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement was completed. Those noted as not in compliance with CMS/CDC vaccination guidance were placed on leave until achieving compliance with CMS/CDC guidance.<br>B. Please note that the facility has, and will continue, to COVID test individuals who provide care, treatment, or other services for the facility and/or its residents bi-weekly.<br>C. The Administrator, DON, and HR personnel have been inserviced regarding the CMS/CDC guidance, with emphasis given to all information | |

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| | On 2/21/22 at 11:20 A.M., during an interview with the HR [Human Resources] director, she indicated she looked at the employee files, and verified that Staff 4, Staff 5 and Staff 6 were unvaccinated and without exemptions.<br><br>A2. On 2/22/22 at 9:15 A.M., the ADON provided a list of residents who had been diagnosed with COVID-19 in the facility in the previous 4 weeks. The list included Residents M, N, P, R, S, T, V, W, X, Y, and BB. The dates of diagnosis ranged from 1/30/22 to 2/18/22. One resident, Resident P, had passed away in the hospital from COVID. The ADON indicated there were 7 residents currently (2/22/22) in the facility "Red Zone," who were COVID positive. Three of those residents had been admitted from the hospital with COVID.<br><br>The clinical record of Resident P was reviewed on 2/22/22 at 9:35 A.M. Diagnoses included, but were not limited to, dementia and chronic obstructive pulmonary disease.<br><br>Nurses notes did not indicate when the resident was diagnosed with COVID+.<br><br>The first documentation in the clinical record that mentioned Resident P and COVID, dated 2/8/22 at 10:00 P.M., included, "Resident is alert with intermittent confusion. [Vital signs within normal limits]. Denies c/o [complaints of] body aches...Takes fluids well. Pleasant mood with staff. Remains on Covid precautions."<br><br>Nurses notes included the additional notations:<br><br>2/10/22 at 10:01 A.M.: "Res [resident] remains on Covid precautions. Pleasant mood this am. Res continues to improve... VS [vital signs] | | in Attachment A of the CMS QSO letter 22-09-ALL. Specific discussion was also provided regarding the topic of exemptions and the importance of following all policies and procedures for vaccination exemptions.<br>D. The facility's Medical Accommodation Policy has been revised to include specific reference to the CDC's approved reasons for vaccine contraindications.<br>E. The facility's Medical Accommodation Request form has been revised to include direction/explanation to the physician as to approved CDC vaccination contraindications and to specifically identify which vaccination is contraindicated.<br><br>4. The Administrator, DON, HR Personnel and/or their appointed designee(s) will monitor that actions taken are effective and ongoing via:<br><br>A. Maintaining a log of all individuals providing care (as identified in the CMS/CDC guidance: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement). This log shall be | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
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| | remain stable... Poor appetite this am... Will continue to monitor."<br><br>2/13/22 at 7:07 A.M.: "Res continues with good oral acceptance...remains on precautions due to previous positive results with Covid."<br><br>2/14/22 at 10:40 A.M.: "Resident coughing up brown fluid from lungs... labored breathing. Resident also has small amount of blood coming from ureta [sic] at this time. This nurse asked resident if was feeling ok. Resident stated that he did not feel well and hurt all over. Notified MD at this time. received order to send resident to [name of hospital] for evaluation."<br><br>The resident was transferred to the hospital on 2/14/22 at 11:21 A.M.<br><br>A hospital Emergency Room record, dated 2/14/22, included: "Chief Complaint: Patient presents with<br>COVID +, Hemoptysis [coughing up blood]...Patient presents via [ambulance service] from nursing home for evaluation of weakness and cough and not eating or drinking well. Patient tested positive for COVID-19 one week ago. Timing of onset was gradual. Severity is rated as severe. Quality is described as weakness and cough. Symptoms have been worsening...Assessment: 1. Acute sepsis<br>2. Pneumonia due to COVID-19 virus...."<br><br>A hospital discharge summary, dated 2/16/22, indicated the resident had expired on 2/16/22. The summary included: "Discharge Diagnoses: Septic shock from COVID-19 pneumonia and UTI...COVID-19 pneumonia."<br><br>On 2/2/22 at 11:30 A.M., the Assistant Director | | updated daily for any changes. Individuals who are not in compliance with CMS/CDC requirements shall not be allowed to work until meeting all requirements. Specific and close monitoring will also be given to newly hired personnel or contracted staff. This shall be ongoing.<br><br>Noted problems shall be addressed immediately and identified patterns/trends of non-compliance shall be reported to the Quality Assurance Committee for further action(s) as necessary. | |

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| | 155370 | A. BUILDING 00<br>B. WING | 02/24/2022 |

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| | of Nursing provided "SARS COVID-19 Testing Documentation" for Resident P. The documentation indicated Resident P had a routine COVID test on 2/7/22 at 1:00 P.M., which was positive.<br><br>B1. On 2/21/22 at 10:25 A.M., the ADON provided the Medical Exemption form for Staff 3. The form, dated 11/29/21, indicated, "Requested accommodation: COVID 19 vaccine exemption...I have already been exposed to COVID 19 and never tested positive." The form did not specify the type of vaccine or a valid clinical reason for the exemption.<br><br>On 2/23/22 at 9:50 A.M., the Administrator provided the working schedule for Staff 3. Staff 3 worked 7 days from 2/14/22-2/22/22. The schedule indicated Staff 3 normally worked 5 days a week.<br><br>On 2/21/22 at 10:25 A.M., the ADON provided the Medical Exemption form for the Staff 1. The form, dated 11/29/21, indicated, "Requested accommodation: COVID 19 vaccine exemption...Tested on 10/5/21 for COVID 19 Antibodies positive. Already had COVID 9/2020." The form did not specify the type of vaccine or a valid clinical reason for the exemption.<br><br>On 2/23/22 at 9:50 A.M., the Administrator provided the timesheet for Staff 1. Staff 1 worked 6 days in nursing from 2/14/22-2/22/22. The Administrator indicated Staff 1 normally worked 5 days a week.<br><br>On 2/22/22 at 9:30 A.M., the Human Resources (HR) Director provided the Medical Exemption form for Staff 2, dated 1/4/21. The form | | | |

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| | indicated, "Patient has medical reasons not to obtain the COVID vaccine...Risk of miscarriage." The form did not specify which COVID vaccine the staff member could not take.<br><br>On 2/23/22 at 9:50 A.M., the Administrator provided the working schedule for Staff 2. Staff 2 worked 2 days from 2/14/22-2/22/22. The schedule indicated Staff 2 normally worked 2-3 days a week.<br><br>On 2/21/22 at 10:20 A.M., during an interview with the HR director, she indicated that the spreadsheet does not include booster vaccination information. Staff are supposed to inform her when they get a booster, and then a copy is made of their card and put in their employee files. That would be the only way the facility would know of booster information.<br><br>On 2/21/22 at 2:20 P.M., the HR director provided the current facility policy, "Vaccination of Facility Staff," dated December 2021. The policy included: "All staff shall be fully vaccinated for COVID-19 except where exemption or temporary exemption from this requirement has been approved...Employees without approved exemptions shall provide they have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series...prior to providing any care, treatment, or other services for the facility and/or its residents...Requests for medical exemption are to be submitted to the Administrator and/or Human Resource department and shall be approved for recognized clinical contraindications to COVID-19 vaccines if supporting documentation...contains information specifying which of the authorized COVID-19 vaccines are clinically | | | |

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| | contraindicated...based on the recognized clinical contraindications...."<br><br>The immediate jeopardy that began on 2/14/22 was removed on 2/24/22 when the facility started an audit of the vaccination status of all employees; placed staff on leave who were not in compliance with CMS/CDC guidelines; revised the facility's medical exemption form; and began a new system to track staff vaccinations, including boosters, but the noncompliance remained at the lower scope and severity level of pattern of no actual harm with potential for more than minimal harm that is not immediate jeopardy because the facility was continuing their monitoring, tracking, and implementation for new employees.<br><br>3.1-18(a) | | | |