| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155334 | A. BUILDING 00<br>B. WING | 10/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| WILDWOOD HEALTHCARE CENTER | 7301 E 16TH ST<br>INDIANAPOLIS, IN 46219 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00444624 and IN00444022.<br><br>Complaint IN00444624 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00444022 - No deficiencies related to the allegations are cited.<br><br>Survey dates: October 23, 24, 25, 28, 29, and 30, 2024.<br><br>Facility number: 000227<br>Provider number: 155334<br>AIM number: 100267520<br><br>Census bed type:<br>SNF/NF: 137<br>Total: 137<br><br>Census payor type:<br>Medicare: 5<br>Medicaid: 115<br>Other: 17<br>Total: 137<br><br>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on November 6, 2024. | F 0000 | On October 30, 2024 an annual recertification survey from ISDH was completed at Wildwood Healthcare. Enclosed please find the stated list of the deficiency with the facility's plan of correction for this alleged deficiency. Please consider this letter and plan of correction to be the facility's credible allegation of compliance. This letter is our request for a desk review/ paper compliance to verify the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the plan of correction as November 28 2024.<br><br>Respectfully<br>Ethan Peak, Executive Director | |
| F 0559<br>SS=D<br>Bldg. 00 | 483.10(e)(4)-(6)<br>Choose/Be Notified of Room/Roommate Change | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Ethan Peak | Executive Director | 11/18/2024 |

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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| | Based on interview and record review, the facility failed to ensure notification and documentation was provided to Resident 23 regarding a room change for 1 of 1 resident reviewed for room change.<br><br>Findings include:<br><br>The clinical record for Resident 23 was reviewed on 10/29/2024 at 1:20 p.m. The medical diagnoses included chronic obstructive pulmonary disease.<br><br>A Significant Change Minimum Data Set Assessment, dated 8/27/2024, indicated Resident 23 was cognitively intact.<br><br>A census report provided by the Director of Nursing, on 10/30/2024 at 9:45 a.m., indicated Resident 23 moved rooms on 7/1/2024.<br><br>During an interview and observation on 10/23/2024 at 12:36 p.m., Resident 23 indicated a couple months ago, they were coming back from lunch and their items had been moved from their room to a room across the hall. When they asked the Certified Nurse Aide (CNA), unable to recall CNA name, they were told they were moved across the hall for a "little bit" so their room could be renovated. Resident 23 stated, "I was never told about coming over here [to the new room] before it happened" and they wished to go back to their old room but, the facility "already moved other people in". Resident 23's previous room was noted to have two other residents residing there.<br><br>During an interview and observation on 10/29/2024 at 1:52 p.m., Social Services Director (SSD) 3 indicated she did not notify Resident 23 of the room move, but she believed the Unit | F 0559 | A Resident 23 was not harmed by the deficient practice. Resident 23 was offered a room move to available empty rooms and declined.<br>B All residents who have been moved rooms have the potential to be affected. An audit was conducted of room moves in the last 30 days to ensure adequate notification was given and documented. For deficiencies noted residents were provided psychosocial support and offered a room move if able and appropriate.<br>C IDT team was educated on “Resident Room Change Policy” with an emphasis on ensuring adequate notification is given and documented.<br>D All potential room moves will be discussed in morning clinical meeting and residents will be provided adequate notification. This will be an ongoing facility practice. Results of the audit will be brought to QAPI for 6 months or until 100% compliance has been achieved. | 11/28/2024 |

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| | Manager did. She did not complete the Room Change Notification, because the move was supposed to be temporary, and she was not sure why Resident 23 was not moved back to their pervious room after renovations were completed.<br><br>A policy entitled "Resident Room Change Policy" was provided by the Director of Nursing on 10/30/2024 at 9:45 a.m. The policy indicated, "...Social Services will discuss room change options with resident ..." and "...Social Services will complete Notification of Room Change...in the EMR [electronic medical record] ..."<br><br>3.1-3(v)(2) | | | |
| F 0641 SS=A Bldg. 00 | 483.20(g)<br>Accuracy of Assessments<br><br>Based on interview and record review, the facility failed to ensure accuracy of Minimum Data Set (MDS) assessments regarding Preadmission Screening Resident Review (PASRR) Level II for 2 of 3 residents reviewed for PASRR and 1 of 1 resident reviewed for resident assessment. (Residents 18, 36, and 63)<br><br>Findings include:<br><br>1. The clinical record for Resident 18 was reviewed on 10/25/24 at 10:59 a.m. Her diagnoses included, but were not limited to, major depression and anxiety.<br><br>The 6/12/22 Notice of PASRR Level II Outcome was provided by the Director of Nursing (DON) on 10/28/24 at 10:27 a.m. It indicated she had a serious mental illness and had long term approval without specialized services. | F 0641 | Due to being an A level citation, no written plan is needed. | 11/28/2024 |

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| | The 9/28/24 Annual MDS assessment indicated Resident 18 was not considered by the state PASRR Level II to have a serious mental illness.<br><br>An interview was conducted with the Minimum Data Set Coordinator (MDSC) on 10/29/24 at 11:40 a.m. She indicated the social services department completed the Level II portion of MDS assessments and Resident 18's, 9/28/24, Annual MDS assessment was not accurate.<br><br>2. The clinical record for Resident 36 was reviewed on 10/29/24 at 11:47 a.m. Her diagnoses included, but were not limited to, schizoaffective disorder.<br><br>The 3/17/22 Notice of PASRR Level II Outcome indicated she had a serious mental illness and had long term approval without specialized services.<br><br>The 5/15/24 Annual MDS assessment indicated Resident 36 was not considered by the state PASRR Level II to have a serious mental illness.<br><br>An interview was conducted with the MDSC on 10/29/24 at 11:40 a.m. She indicated the social services department completed the Level II portion of MDS assessments and Resident 36's, 5/15/24, Annual MDS assessment was not accurate.<br><br>3. The clinical record for Resident 63 was reviewed on 10/24/24 at 11:55 a.m. His diagnoses included, but were not limited to, schizophrenia.<br><br>The 11/7/18 PASRR Level I indicated to refer for Level II onsite due to suspected or confirmed mental health disability. | | | |

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| | There was no PASRR Level II in Resident 63's clinical record, but there was a PASRR Level II care plan, dated 11/12/18, indicating he had a PASRR Level II completed.<br><br>An interview was conducted with Social Services Director (SSD) 2 on 10/29/24 at 12:47 p.m. She indicated she contacted the company responsible for Level II completion, and they confirmed a Level II was completed, on 11/18/18, but a third company conducted it, so they did not have access to the report. | | | |
| F 0677 SS=D Bldg. 00 | 483.24(a)(2)<br>ADL Care Provided for Dependent Residents<br><br>Based on observation, interview, and record review, the facility failed to ensure accurate care planning of Resident 56's bathing preferences, failed to assist a resident with shaving (Resident 120), and failed to provide nail care (Resident 39) for 3 of 5 residents reviewed for activities of daily living (ADLs).<br><br>Findings include:<br><br>1.) The clinical record for Resident 56 was reviewed on 10/28/2024 at 1:20 p.m. The medical diagnoses included multiple sclerosis.<br><br>A Quarterly Minimum Data Set (MDS) assessment, dated 8/21/2024, indicated Resident 56 was cognitively intact.<br><br>A care plan, last revised on 2/5/2024, indicated Resident 56 was dependent on helper for bathing tasks and wished to have showers on Friday mornings. | F 0677 | A Residents 39, 56, and 120 were not harmed by the deficient practice. Resident 56 was interviewed by unit manager and shower preferences and care plan were updated according to resident's new preferences. Resident 39 had fingernails trimmed and cleaned on 10/29/24. Resident 120 had facial hair shaved on 10/29/24.<br>B All residents have the potential to be affected by the deficient practices. An audit was completed on all residents to ensure shower preferences were current and care plans updated, fingernails were cleaned and trimmed per resident preferences, and facial hair was trimmed/shaved per resident preferences.<br>C Nurses and CNA's were educated on "Routine Resident | 11/28/2024 |

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| | A care plan, last revised on 2/5/2024, indicated Resident 56 was dependent on helper for bathing tasks and wished to have showers on Wednesday and Saturdays.<br><br>Review of the care tasks, last updated 9/13/2024, indicated Resident 56 was to receive showers on Fridays.<br>During an interview and observation, on 10/24/2024 at 12:45 p.m., Resident 56 indicated they would like to have a bed bath daily and shower on Fridays.<br><br>During an interview with the Director of Nursing (DON) on 10/29/2024 at 11:45 a.m., she indicated she goes to each resident to routinely assess their bathing preferences, updated their care plan, tasks, and Certified Nurse Aide (CNA) shower assignment sheets. She indicated Resident 56 should have only one shower preference care plan, the second was likely not updated during the last assessment, and she would go reassess Resident 56's preferences.<br>2.) During an observation and interview with Resident 39 on 10/23/24 at 12:45 p.m., the resident's fingernails were long with a dark substance underneath them. Resident 39 indicated he had not refused to have his fingernails trimmed and cleaned. The resident indicated he would like to have them trimmed and cleaned.<br><br>During an observation on 10/24/24 at 11:43 a.m., Resident 39's fingernails were long with a dark substance underneath them.<br><br>During an observation on 10/25/24 at 1:02 p.m., Resident 39's fingernails were long with a dark substance underneath them.<br><br>During an observation on 10/28/24 at 12:42 p.m., | | Care Policy" with an emphasis on fingernail care, shaving/trimming facial hair, and showers/bathing given per resident preferences.<br>D Director of nursing or designee will perform 10 resident observations weekly x 4 weeks to ensure residents nails cleaned/trimmed per resident preference and facial hair trimmed/shaved per resident preference, then 5 observations weekly x 8 weeks, then 3 observations weekly x 12 weeks.<br>Director of nursing or designee will interview 10 residents weekly x 4 weeks to validate current shower preferences, then 5 interviews weekly x 8 weeks, then 3 interviews weekly x 12 weeks.<br>Results of the audit will be brought to QAPI for 6 months or until 100% compliance has been achieved. | |

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| | Resident 39's fingernails were long with a dark substance underneath them.<br><br>During an observation and interview on 10/29/24 at 11:53 a.m., Resident 39's fingernails were long with a dark substance underneath them. Resident 39 indicated the staff had not offered to trim and clean his fingernails and he would like to have them cleaned and trimmed.<br><br>During an interview with the DON on 10/29/24 at 11:55 a.m., she indicated it was the responsibility of the nurse to trim Resident 39's fingernails because he was diabetic. The DON offered to trim and clean Resident 39's fingernails at that time and the resident agreed.<br><br>Review of the record of Resident 39, on 10/28/24 at 1:20 p.m., indicated the diagnoses included, but were not limited to, diabetes, acute respiratory failure, psychoactive substance abuse, hypertension, and acquired absence for right and left leg below the knee.<br><br>The activities of daily living (ADLs) plan of care for Resident 39, dated 9/13/24, indicated ADL self-care performance related to encephalopathy, diabetes, and respiratory failure with hypoxia. The interventions included, but were not limited to, shower and bathing the resident was substantial/maximal assistance. The helper did more than half the effort.<br><br>3.) During an observation on 10/24/24 at 11:40 a.m., Resident 120 had a moderate amount of facial hair<br><br>During an observation on 10/25/24 at 1:01 p.m., Resident 120 had a moderate amount of facial hair. | | | |

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| | During an observation on 10/28/24 at 12:41 p.m., Resident 120 had a moderate amount of facial hair.<br><br>During an observation on 10/29/24 at 11:52 a.m., Resident 120 had a moderate amount of facial hair.<br><br>During an interview with the DON on 10/29/24 at 11:56 a.m., she indicated CNAs were responsible to provide Resident 120 with shaving during their bath.<br><br>Review of the record of Resident 120, on 10/29/24 at 12:37 p.m., indicated the diagnoses included, but were not limited to, major depressive disorder, hypertension, hemiplegia and hemiparesis following cerebral infarction (stroke) affecting the right dominant side, dysphagia, and gastrostomy (feeding tube) status.<br><br>The plan of care for Resident 120, dated 10/7/24, indicated the resident had Activities of Daily Living (ADL) self-care performance deficit. The interventions included, but were not limited to, the resident was totally dependent of one person for personal hygiene. The helper did all the effort, and the resident did none of effort.<br><br>The Admission MDS for Resident 120, dated 10/10/24, indicated the resident was severely cognitively impaired for daily decision making. The resident did not speak. The resident was totally dependent for personal hygiene, including shaving.<br><br>The routine resident care policy provided by the DON, on 10/29/24 at 12:15 p.m., indicated the routine resident care that was not necessarily medically or clinically based but necessary for quality of life to promote dignity and independence. The licensed staff would provide | | | |

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| | the following services based on their scope of practice, but not limited to, provide a nursing assessment, nursing diagnosis, care planning, implementation and evaluation.<br><br>3.1-38(a)(3)(D)<br>3.1-38(a)(3)(E) | | | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br><br>Based on interview and record review, the facility failed to hold a resident's insulin, as ordered, and ensure a resident had an off-loading cushion in her wheelchair, as care planned, for 1 of 1 resident reviewed for insulin and 1 of 1 resident reviewed for skin integrity. (Residents 11 and 14)<br><br>Findings include:<br><br>1. The clinical record for Resident 11 was reviewed on 10/25/24 at 11:41 a.m. His diagnoses included, but were not limited to, diabetes mellitus.<br><br>The diabetes care plan for Resident 11, revised 8/18/23, indicated to administer insulin injections per physician orders.<br><br>The active physician's orders indicated to inject seven units of Humalog (fast acting insulin) solution subcutaneously in the morning with breakfast, in the afternoon with lunch, and in the evening with dinner. The orders indicated to "Hold for results less than 100."<br><br>The October 2024 medication administration record (MAR) indicated his blood sugar was 72 on 10/6/24 at dinner, 87 on 10/7/24 at breakfast, 70 | F 0684 | A Residents 11 and 14 were not harmed by the deficient practices. Resident 11 physician orders and medication administration record were reviewed with the physician and new orders were received. Resident 14 was provided with an off-loading cushion for her wheelchair.<br>B All residents have the potential to be affected by the deficient practices. All residents receiving insulin had the MAR reviewed for the last 2 weeks to ensure if hold orders were in place that they were being followed and orders were reviewed to see if hold orders were ordered. All residents in wheelchairs were audited to ensure that off-loading cushions were in place.<br>C Nurses were educated on “Medication Administration Policy” with an emphasis on ensuring medications are held per resident physician orders. Nurses and CNA’s were educated on “Use of Supportive Surfaces” with an | 11/28/2024 |

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| | on 10/8/24 at breakfast, 78 on 10/12/24 at breakfast, 96 on 10/16/24 at dinner, 91 on 10/21/24 at breakfast, 80 on 10/22/24 at breakfast, 76 on 10/23/24 at breakfast, and 76 on 10/24/24 at dinner, but the seven units of Humalog was still administered with meals for all of these blood sugar readings.<br><br>An interview was conducted with the Director of Nursing (DON) on 10/28/24 at 10:27 a.m. She indicated Resident 11 was the only resident in the facility with an insulin hold order, as all other residents had call orders instead.<br><br>The Medication Administration policy was provided by the DON on 10/28/24 at 10:27 a.m. It read, "Administer medication only as prescribed by the provider."<br><br>2. The clinical record for Resident 14 was reviewed on 10/29/2024 at 11:40 a.m. The medical diagnoses included cerebral palsy.<br><br>A Quarterly Minimum Data Set assessment, dated 8/10/2024, indicated Resident 14 was cognitively intact, was at risk for developing skin alternations, but did not currently have skin alternations.<br><br>A skin alternation care plan, last revised on 5/10/2024, indicated Resident 14 was at risk for skin alternations with an intervention of utilizing on off-loading cushion.<br><br>During an interview and observation on 10/24/2024 at 12:36 p.m., Resident 14 was sitting in their wheelchair with a folded white linen under them. Resident 14 stated, "The girl took my cushion out to wash last night and it is out there [the hallway] somewhere." | | emphasis on ensuring off-loading cushions are in place for all residents in wheelchairs.<br>D Director of nursing or designee will review 5 residents MAR weekly x 4 weeks to ensure hold orders are being followed, then 3 residents weekly x 8 weeks, then 1 resident weekly x 12 weeks. Director of nursing or designee will perform 10 resident observations weekly x 4 weeks to ensure off-loading cushions are in place for residents in wheelchairs, then 5 resident observations weekly x 8 weeks, then 3 resident observations weekly x 12 weeks. Results of the audit will be brought to QAPI for 6 months or until 100% compliance has been achieved. | |

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| | During an interview and observation on 10/30/2024 at 12:48 p.m., Resident 14 was observed sitting in their wheelchair without a cushion in place. Resident 14 indicated it was still missing after the staff person cleaned it.<br><br>During an interview with Certified Nurse Aide (CNA) 4, on 10/30/2024 at 12:49 p.m., they indicated Resident 14's cushion was wet, but they would place a cushion under Resident 14 next time Resident 14 utilized the toilet.<br><br>A policy entitled, "Use of Supportive Surfaces", was provided by the Director of Nursing on 10/29/2024 at 10:20 a.m. The policy indicated, " ...The standard seat cushion for wheelchairs are pressure redistribution seat cushions ..."<br><br>3.1-37(a) | | | |
| F 0688 SS=D Bldg. 00 | 483.25(c)(1)-(3)<br>Increase/Prevent Decrease in ROM/Mobility<br><br>Based on observation, interview, and record review, the facility failed to ensure a resident's palm guard was applied, as ordered, and initiate a range of motion (ROM) program for 1 of 3 residents reviewed for positioning and mobility and 1 of 1 resident reviewed for rehabilitation and restorative services. (Residents 99 and 109)<br><br>Findings include:<br><br>1. The clinical record for Resident 109 was reviewed on 10/23/24 at 12:30 p.m. Her diagnoses included, but were not limited to, right side hemiparesis.<br><br>The activities of daily living (ADLs) care plan, | F 0688 | A Residents 99 and 109 were not harmed by the deficient practice. Resident 109 had palm guard applied at time deficiency was noted and continues her restorative program as ordered. Resident 99 was initiated on a restorative program.<br>B All residents requiring splints and/or restorative programs have the potential to be affected by the deficient practice. All residents' physician orders were audited for orders for splints/palm guards and/or orders for referral to restorative nursing programs. Residents with orders were | 11/28/2024 |

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| | revised 8/19/24, indicated Resident 109 had a self-care performance deficit related to cerebral vascular accident, right side hemiparesis, depression, insomnia, substance abuse, and hypertension. The goal was for her to maintain her current level of function. An intervention was provision of substantial/maximal assistance with upper body dressing.<br><br>The undated Therapy Referral Restorative nursing form indicated Resident 109 was to participate in the Range of Motion and Splint/Brace Care program to prevent further contracture and maintain functional status. Her splint was to be on for four hours a day and wear a palm guard when the splint was off.<br><br>The 10/11/24 physician's order indicated, "Pt [Patient] to wear slim grip hand splint on R [right] hand 4 hours on, 4 hours off as pt tolerates. Pt should wear palm guard when splint is off. Check for redness/irritation when donning/doffing and inform charge nurse if any issues are noted."<br><br>An observation of Resident 109 was made on 10/23/24 at 12:43 p.m. She was sitting in her wheelchair in her room. Her right hand was flaccid, resting in her lap. She was not wearing her right-hand splint or palm guard at that time. The palm guard was observed in a bin on the nightstand next to her bed.<br><br>An observation of Resident 109 was made on 10/29/24 at 12:09 p.m. She was sitting in her wheelchair in her room. Her right hand was flaccid, resting in her lap. She was not wearing her right-hand splint or palm guard at that time. The palm guard was observed in a bin on the nightstand next to her bed. | | audited to ensure splints/palm guards were in place and orders with referrals to restorative nursing programs were initiated on restorative nursing programs.<br>C IDT team, nurses, and restorative aides were educated on “Restorative Program Policy” with an emphasis on ensuring ordered splints/palm guards are in place as ordered and that residents who are referred to restorative nursing programs are initiated on them in a timely manner.<br>D Director of nursing or designee will perform 10 resident observations weekly x 4 weeks to ensure physician ordered splints/palm guards are in place per order, then 5 resident observations weekly x 8 weeks, then 3 resident observations weekly x 12 weeks. MDS coordinator and therapy manager or designees will review 5 residents weekly x 4 weeks, then 3 residents weekly x 8 weeks, then 1 resident weekly x 12 weeks to ensure any residents discharging therapy with recommendations to restorative nursing programs are initiated in a timely manner. Results of the audit will be brought to QAPI for 6 months or until 100% compliance has been achieved. | |

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| | An observation and interview were conducted with Licensed Practical Nurse (LPN) 7 on 10/29/24 at 12:13 p.m. Resident 109 was still sitting in her wheelchair in her room, not wearing her splint or palm guard. Resident 109 kept pointing to her right hand. After inquiry with LPN 7 regarding Resident 109's palm guard, LPN 7 retrieved Resident 109's palm guard from the bin on her nightstand and applied it to Resident 109's right hand. Resident 109 smiled and gave the thumbs up with her left hand and thanked LPN 7 for applying her palm guard. LPN 7 indicated restorative nursing usually applied splints and palm guards, "but they're not here today."<br><br>2. The clinical record for Resident 99 was reviewed on 10/25/24 at 12:45 p.m. The medical diagnoses included, but were not limited to, quadriplegia, acute infarction of the spinal cord, neuralgia (nerve pain) and neuritis (inflamed nerves), and anxiety disorder.<br><br>During an interview with Resident 99 on 10/24/24 at 1:10 p.m., the resident indicated they would like to receive restorative therapy and was not receiving any.<br><br>A Quarterly Minimum Data Set (MDS) assessment, dated 9/9/24, indicated Resident 99 was cognitively intact, had limited range of motion to both upper and lower extremities, and used a wheelchair.<br><br>An Activities of Daily Living (ADL) care plan, dated 12/14/23, indicated Resident 99 was totally dependent of two or more helpers for toileting, rolling left to right, sit to lying position, lying to sitting on the side of the bed, chair to bed and bed to chair, and all hygiene activities were total assistance of one person. | | | |

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| | An occupational discharge summary note, dated 9/25/24, indicated Resident 99 was referred for Restorative Nursing Therapy (RNP) for Range of Motion (ROM) and brace management.<br><br>During an interview with the Physical Therapy Director on 10/29/24 at 10:45 a.m., they indicated if a resident was to be set up with restorative services after they were discharged from physical or occupational therapy, the MDS nurse receives a list of the case load and was responsible for the restorative program.<br><br>During an interview with the MDS Coordinator on 10/29/24 at 11:44 a.m., they indicated Resident 99 had been given the order for splints and the MDS Coordinator should have received a Therapy Referral to Restorative document with type of program ordered, goals, times, amount of assistance required, and special instructions. The MDS Coordinator indicated she did not receive this form from the Physical Therapy Director.<br><br>A Restorative Program Policy provided by the Director of Nursing (DON), on 10/29/24 at 12:15 p.m., indicated the following, "...The purpose of this policy is to provide direction and guidance to the clinical team to assess and implement a plan of action for resident-specific care to maintain or improve mobility with the maximum practicable independence ..."<br><br>3.1-42(a)(2) | | | |
| F 0740<br>SS=D<br>Bldg. 00 | 483.40<br>Behavioral Health Services<br><br>Based on interview and record review, the facility | F 0740 | A Resident 93 was not harmed by the deficient practice. | 11/28/2024 |

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| | failed to ensure a resident had a care plan to address her individualized needs related to substance use disorder for 1 of 2 residents reviewed for hospitalization. (Resident 93)<br><br>Findings include:<br><br>The clinical record for Resident 93 was reviewed on 10/24/24 at 10:30 a.m. Her diagnoses included, but were not limited to, depression and substance use disorder (SUD).<br><br>The 9/25/24 Quarterly Minimum Data Set (MDS) assessment indicated she was cognitively intact.<br><br>An interview was conducted with Resident 93 on 10/24/24 at 10:46 a.m. She indicated she smoked "weed" in the facility in the "back area." In December 2023, she smoked a joint outside in the smoking area and then sat in the gazebo. It was her own weed that she smoked, but she and a couple other residents usually put weed together to smoke, so she couldn't say for sure where the weed in the joint she smoked that day came from. Staff kept coming outside but left her in the gazebo throughout the night. Eventually they brought her inside with her rollator walker. Nursing took her blood pressure a couple of times, and it was low, so they called an ambulance, and she went to the emergency room of a nearby hospital. She was given Narcan (medication used to treat narcotic overdose in an emergency situation) twice, and Suboxone (medication used to treat narcotic dependence) was found in her system. She stated, "I don't do drugs." When she woke up at the hospital, there was blood everywhere, and she couldn't remember anything that happened, and couldn't remember where she lived. She was giving hospital staff "a hard time, kept asking where I was and why I'm | | Resident 93 care plan was updated to reflect history of substance use disorder.<br>B All residents with history of substance use disorders have the potential to be affected. An audit was completed to ensure that residents with diagnosis of substance use disorders had care plans and interventions in place.<br>C Nurse management, MDS and Social Services were educated on “Resident Substance abuse in facility policy” with an emphasis on ensuring all residents with history of or new substance abuse have care plans and interventions updated accordingly.<br>D Social Services director or designee will review 5 residents with substance abuse history weekly x 4 weeks, then 3 residents weekly x 8 weeks, then 1 resident weekly x 12 weeks to ensure residents have care plans in place with interventions. Any new substance abuse that is notated will be reviewed in morning clinical meeting and care plans will be updated accordingly. This is an ongoing facility practice. Results of the audit will be brought to QAPI for 6 months or until 100% compliance has been achieved. | |

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| | here." One of the hospital staff let her out the back door and told her to go towards the direction of a nearby bus stop. She was walking around for two days afterwards. She remembered she had a friend who lived on the other side of town, so a lady she ran into took her to the bus stop to go to her friend's house. Once she got to the other side of town, it was dark, and she didn't know where she was, and ended up finding a church. She knocked on the door of the church and was let inside, where they called the police. The police came and took her to a different hospital. The psychiatrist at that hospital took her off her medications and eventually she came back to the facility. There was no place else for her to go. The facility told residents to sign out and smoke weed off the property, but staff knew they were doing it on the property.<br><br>The 12/2/23 Change of Condition progress note read, "Altered mental status Tired, Weak, Confused, or Drowsy...Mental Status Evaluation: Unresponsiveness Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse) Increased confusion (e.g. disorientation) - Functional Status Evaluation: General weakness...Respiratory Status Evaluation: Other respiratory changes. Cardiovascular Status Evaluation: Resting pulse greater than 100 or less than 50...Neurological Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse) Nursing observations, evaluation, and recommendations are: Resident was reported to have stayed out all night at thee [sic] Gazebo and was extremely tired and sleepy when she was back in the building. Nursing report given was that resident has been resting mostly in bed all day, but responsive and verbal when awake. Primary Care Provider Feedback: Primary Care Provider responded with | | | |

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| | the following feedback: A. Recommendations: Gave order for resident to be sent out to [name of hospital] for Evaluation & TX [treatment] of change in LOC [level of consciousness,] & [and] rapid increase in Hyper-Glycemia. Was also informed that while waiting for return response from MD felt that resident's condition began to decline so rapidly a decision was made in the best interest of the resident was to send resident to [name of hospital] ER [emergency room] for TX [treatment] & evaluation. Nurse practitioner stated that she agreed."<br><br>The 12/3/23 1:58 a.m. nurses' note read, "Resident was sent to [name of hospital] for TX & evaluation R/T [related to] change in LOC. Exited Building per two EMT [emergency medical technicians] & ambulance. per MD orders. 6:30PM vital signs-BP [blood pressure] 102/68, P. [pulse] 78, 02 [oxygen saturation] 92%, R. [respirations] 18, T. [Temperature] 97.5. Resident was groggy & sleepy around 6:30 p.m., this writer checked on resident and took vital signs since it was given in report that resident had stayed outside on the Gazebo all night & was exhausted. but responded to touch and refused her meal saying she wasn't hungry, this nurse tried to encourage resident to take few bites. BS [blood sugar] 257 was given scheduled insulin with her consent. Resident declined and told this writer to let her sleep. At approx. [approximately] 21:00hr [9:00 p.m.] -Resident BS [blood sugar] had increased to 357, BP 85/67, P.109, 02 90% R/A, R.14, T.97.3. Still in the ER being evaluated at this time."<br><br>The 12/2/23 11:15 p.m. Drug Screen results from the hospital indicated she was positive for Cannabinoids and Buprenorphine [opioid medication used to treat pain and opioid addiction.] | | | |

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| | The 12/3/23 11:00 p.m. hospital emergency department physician note read, "Brought in by EMS from [name of facility] for altered mental status first reported tonight. Not [sic] be hypoxic 50% on room air. Suspect this is due to some type of ingestion. Initially patient was quite somnolent and nearly unresponsive. Did receive Narcan prior to arrival and in the hospital with some improvement. Patient admits to taking half of Suboxone tonight not prescribed to her but denies additional ingestions including alcohol although she was found surrounded by alcohol bottles. Initial presentation quite consistent with narcotic overdose..."<br><br>The 12/4/23, 8:47 a.m. nurse's note read, "Writer called [name of hospital] to get update on this resident, [name of hospital] staff stated resident left hospital AMA [against medical advice]."<br><br>The 12/8/23 hospital discharge summary, from the second hospital to which Resident 93 went, indicated she presented to the emergency room with altered mental status on 12/5/23. The History of Present Illness section indicated she was reportedly picked up by emergency medical services in a church parking lot. She was just admitted to another hospital, on 12/2/23, with encephalopathy and concern for opioid overdose. A urine drug screen was notably positive for Cannabinoids and Buprenorphine. She apparently left AMA as she wanted to smoke a cigarette. The hospital course section indicated she had a repeat urine drug screen and was positive for Buprenorphine and Cannabinoids. Her encephalopathy resolved and believed that this was caused by drug intoxication. The Barriers to Care section referenced substance use disorder. | | | |

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| | There was an Illegal Drug in Facility policy scanned into Resident 93's clinical record and signed by Resident 93, on 12/8/23, via fax from the hospital.<br><br>Resident 93's physician's orders did not include an order for Narcan in an emergency situation and Resident 93 had no substance use disorder care plan at the facility that referenced encouraging her to participate with SUD programming; encouraging her to explore and identify triggers and feelings regarding addiction; what her specific triggers were; educating her on following her prescribed treatment regimen and the leave of absence policy; providing her with structured activities and diversional tasks; or encouraging a support system of family and friends.<br><br>An interview was conducted with Social Services Director (SSD) 2 and SSD 3 on 10/28/24 at 1:25 p.m. SSD 3 indicated she was "pretty sure" Resident 93 had a history of SUD and signed a consent that she would not use drugs and alcohol in the facility. Resident 93 also saw their psyche nurse practitioner. SSD 3 reviewed Resident 93's clinical record and indicated she did not see where she signed a consent to receive or refuse drug and alcohol treatment, nor did she see an order for Narcan in an emergency situation. SSD 2 indicated when they knew a resident had SUD, they offered video meetings or in person meetings via an outside provider for drug and alcohol counseling. Typically, they have the resident sign a consent form to either receive or decline SUD services. SSD 2 reviewed Resident 93's clinical record and indicated she did not see a care plan regarding her substance use disorder, but she should have one. SSD 2 also did not see they had Resident 93 sign a consent to receive or refuse drug and alcohol treatment while in the facility, but she should have | | | |

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| | one. SSD 2 was unsure whether Resident 93 having an order for Narcan was discussed.<br><br>An interview was conducted with the Director of Nursing (DON) on 10/28/24 at 2:00 p.m. She indicated Resident 93 did not have an order for Narcan, and the facility was not currently providing AA (Alcoholics Anonymous) or NA (Narcotics Anonymous) in the facility, because none of the residents wanted to participate at that time.<br><br>On 10/29/24 at 10:17 a.m., the DON provided a Drug and Alcohol Assistance form signed by Resident 93 and, dated 12/8/23, that indicated she declined AA or NA provided in the facilities activities room.<br><br>The Resident Substance abuse in facility policy was provided by SSD 3 on 10/28/24 at 1:45 p.m. It read, "It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety is a primary concern for our residents, staff and visitors. The purpose of this policy is to provide guidance to the staff when substance abuse is confirmed or suspected in a resident and not intended by be a step-by-step procedure. Each resident will be provided care based on their individual medical and emotional needs and on their physical ability to self-perform or have assistance to perform the operation...Procedure: I. Information...b. For suspected or known substance abusers consider obtaining a physician order to provide naloxone (brand name Narcan) in the event of an emergency, if required...IV. Follow up care for a resident abusing substances...b. Care plan and education i. Provide options for treatment available to resident/representative including but | | | |

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| | not limited to: 1. Psychological evaluation and/or counseling 2. Medical evaluation and/or counseling ii. Care plan resident specific triggers for abusing drugs, if known."<br><br>3.1-37(a) | | | |
| F 0761 SS=D Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br><br>Based on observation, interview, and record review, the facility failed to ensure 1 of 2 medical storage rooms were free of expired supplies.<br><br>Findings include:<br><br>During an observation of the storage room on the 700 hall on 10/25/24 at 11:50 a.m., with Licensed Practical Nurse (LPN) 5, there were multiple expired items. Items included the following: three packages of twenty-two gauge by one inch BD Insyte Autoguard IV catheter- expired 11/30/23, five packages of BD Vacutainer push button blood collection set twenty-one gauge by three fourths inch by twelve inch- expired 9/30/20, nine packages of BD Vacutainer safety-lok blood collection set, twenty-three gauge by three fourths inch by one inch (six expired 9/30/24 and three expired 1/31/23), two packages of Progressive Medical Administration set with flow controller- expired 1/5/23, and one package of disposable inner cannula for use with tracheotomy tube - expired 8/1/23.<br><br>During an interview with Registered Nurse (RN) 6 on 10/25/24 at 12:00 p.m., they indicated the pharmacy sends a pharmacy consultant to the facility quarterly to check for expired tubing, syringes, and other miscellaneous items. RN 6 did | F 0761 | A No residents were harmed by the deficient practice.<br>B All residents have the potential to be harmed by the deficient practice. An audit was performed on all medication storage rooms to ensure they were free of expired supplies.<br>C Nurses were educated on “Storage of Medications Policy” with an emphasis on ensuring expired supplies are discarded properly.<br>D Director of nursing or designee will audit medication storage rooms 3 days weekly x 4 weeks, then 2 days weekly x 8 weeks, then weekly x 12 weeks to ensure expired medications have been discarded properly. Results of the audit will be brought to QAPI for 6 months or until 100% compliance has been achieved. | 11/28/2024 |

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| | not know why the expired items were not removed.<br><br>A Storage of Medications Policy provided by the Director of Nursing (DON), on 10/25/24 at 1:01 p.m., indicated the following, "...10. Medication storage conditions are monitored on a regular basis by the consultant pharmacist and corrective action is taken if problems are identified..."<br><br>3.1-25(j) | | | |