STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWALK VILLAGE	1302 N LESLEY AVE INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00370919, IN00373295, IN00373757, IN00379977, IN00387240, and IN00387465. Complaint IN00370919- Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00373295 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00373757 - Substantiated. No deficiencies cited. Complaint IN00379977 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00387240 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684 . Complaint IN00387465- Substantiated. Federal/State deficiencies related to the allegations are cited at F921. Survey dates: October 19, 20,21, 24, 25. 26, and 27, 2022 Facility number: 000222 Provider number: 155329 AIM number: 100274950 Census Bed Type: SNF/NF: 91 SNF: 9 Total: 100 Census Payor Type:	F 0000	Rosewalk Village of Indianapolis respectfully requests desk review in lieu of a post survey review on or after November 23, 2022. Please feel free to contact Omar Johnson, ED, if you need any additional information to support the desk review at 317-353-8061. Thank you for your consideration.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Omar Johnson	Executive Director	11/18/2022

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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	Medicare: 9 Medicaid: 78 Other: 13 Total: 100 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 2, 2022			
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do			

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	not interfere with the rights of other residents in the facility. Based on interview and record review, the facility failed to honor a resident's choice about using an outside laboratory for blood work for 1 of 2 residents reviewed for choices (Resident 60). Findings include: The clinical record for Resident 60 was reviewed on 10/20/22 at 2:23 p.m. The Resident's diagnosis included, but were not limited to, atrial fibrillation and congestive heart failure. A Quarterly MDS (Minimum Data Set) Assessment, completed 9/21/22, indicated he was cognitively intact. A progress note, dated 5/18/2022 at 1:17 p.m., indicated Resident 60 had refused labs. Education was provided and he indicated he would allow to have labs drawn. The physician had been made aware. A progress note, dated 8/11/22 at 10:10 a.m., indicated that the physician had been notified of Resident 60 refusing to have his blood drawn. During an interview on 10/20/22 at 2:23 p.m., Resident 60 indicated that he did want his blood drawn by the lab employee who routinely came to the facility because she had to stick him multiple times to get a sample and she used "a harpoon" to stick him. She would not use a "butterfly" needle to draw his blood. He wanted to have his blood drawn at a local hospital. He had asked the staff about getting his blood drawn at the local hospital and been told that is not the way it was done.	F 0561	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident 60 has been given the opportunity to choose where he wants his ordered labs to be drawn. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by the alleged deficient practice. · 1x resident interviews will be completed by Customer Care Representatives by 11/22/22 to ensure resident choices are being met. · An in-service will be completed by 11/22/22 by the DNS/designee for all staff to include ensuring knowledge of resident's right to choose. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · An in-service will be completed by 11/22/22 by the DNS/designee for all staff to include ensuring knowledge of resident's right to choose.	11/22/2022

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	During an interview on 10/24/22 at 1:42 p.m., Unit Manager 2 indicated she had spoken with Resident 60 about his refusal of blood draws. He had expressed that he wanted to go to an outside emergency room to have his blood drawn due to not liking the way the phlebotomist from the contracted lab drew his blood. She had educated him that she could not send him the emergency room to have his blood drawn, but he could have it drawn at the outpatient lab at the hospital. He had refused the offer of the outpatient lab. During an interview on 10/26/22 at 10:44 a.m., Resident 60 indicated he did not want to go to the emergency room to have his blood drawn, he wanted to go to the outpatient lab. When he lived in the community that is where he went for blood draws and that one of the staff there was very good at drawing his blood. During an interview on 10/26/22 at 3:40 p.m., the Director of Nursing indicated there was no documentation or care plan that addressed offering a choice of lab providers in Resident 60's clinical record. The phlebotomist who came to the facility did not use "butterfly" needles to draw blood when she had witnessed it being drawn. Resident 60 could be offered means to have his blood drawn obtained. On 10/27/22 at 9:55 a.m., the Director of Nursing provided the Resident Bill of Rights Policy, last revised 12/2017, which read "...(j)...2. Choose the attending physician and other providers of services, including arranging for onsite health care services unless contrary to Community policy. Any limitations on the resident's right to choose attending physician and/ or service provider shall be clearly stated in the admission		· The DNS/designee will be responsible for monitoring or auditing the completion of resident or POA's re-education of resident's rights and right to choose. With all new admissions, residents and families will be given a copy of resident's rights including the right to choose outside entities for services. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · To ensure compliance the SS/Designee will complete a Resident Rights CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The Resident Rights CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee. By What date will the systematic changes be completed · Compliance date 11/23/22	

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	agreement...." 3.1-3(u)(3)			
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to provide bathing twice weekly and offer hair shampooing during complete bed baths, provide incontinent care as care planned, and to apply lotion to legs and feet as ordered by the physician, and to ensure the removal of hospital bands for 5 of 7 residents reviewed for ADL(activities of daily living) (Resident B, G, 4, 9, and 28), 1 of 2 residents reviewed for dignity. (Resident E). Findings include: 1. The clinical record for Resident G was reviewed on 10/24/22 at 11:51 a.m. The diagnoses included, but were not limited to: left side hemiparesis, anemia, asthma, osteoarthritis, diabetes with neuropathy, morbid obesity, chronic pain, hypertension, and intervertebral disc displacement. He was admitted to the facility on 12/16/21 and discharged on 3/24/22. The 12/22/21 Admission MDS (Minimum Data Set) assessment indicated he required total dependence of 2 persons for bathing in the 7 day look back period. The ADL care plan indicated he needed	F 0677	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident G is being provided showers according to his shower schedule and ADL care per care plan/preferences · Resident 9 is being provided dressing and hygiene per schedule and ADL care per care plan/preferences · Resident 28 is being provided complete bed baths and hair washed each time per schedule and ADL care per care plan/preferences · Resident B has been provided incontinent and ADL care per care plan/preferences. Resident refusals for showers will be documented. · Resident 4 is being provided lotion to legs and feet per MD orders.	11/22/2022

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	assistance of one person with bathing/grooming. The 12/21/21 and 3/8/22 Preferences for Customary Routine and Activities assessments indicated it was very important to Resident G to choose between a tub bath, shower, or bed bath/sponge bath. He preferred showers and to be bathed twice per week in the morning. On 10/25/22 at 9:50 a.m., an interview was conducted with the DON who provided one shower sheet for Resident G. The shower sheet was dated 12/20/21 and indicated a shower was given; lotion was applied; oral care was provided; he was shampooed and shaved; and his bed linens were changed. The DON indicated they kept shower sheets for a year, and she was only able to locate this one for him. The ADL category report for bathing was provided by the DON (Director of Nursing) on 10/25/22 at 4:01 p.m. It indicated he received the following types of bathing on the following days between 12/16/22 and 3/9/22: 12/21/21-bed bath 12/22/21-shower 12/28/21-bed bath 1/2/22-bed bath 1/5/22-bed bath 1/9/22-shower 1/12/22-bed bath 1/29/22-shower 2/5/22-bed bath 2/12/22-shower 2/17/22-shower 2/26/22-shower 3/9/22-shower 2. The clinical record for Resident 9 was reviewed on 10/20/22 at 11:01 a.m. The Resident's diagnosis		· Resident E hospital bands have been removed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by the alleged deficient practice. · An audit will be completed by DNS/designee by 11/22/2022 of all residents to determine ADL preferences, ensure hospital bands are removed, and treatment orders being followed per MD orders. · An in-service will be completed by DNS/designee with all staff by 11/22/2022 on following ADL preferences per place on care, removal of hospital bands, and following MD orders. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · An in-service will be completed by DNS/designee with all staff by 11/22/2022 on following ADL preferences per place on care, removal of hospital bands, and following MD orders. · Observational rounds will be completed daily by Customer Care Representatives to ensure appropriate provision of ADL care.	

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	included, but were not limited to, cerebral infarct (stroke) and aphasia. A care plan, initiated 7/7/22, indicated she had a self care deficit and needed assist with ADL (Activities of Daily Living) such as bathing, and personal hygiene. The goal was for her to have basic needs met by staff daily as evidenced by her being neat, clean, and well groomed. The interventions included, but were not limited to, assist with dressing and hygiene as needed, initiated 7/7/22, and offer showers two times per week, partial baths in between, initiated 7/7/22. An Admission MDS (Minimum Data Set) Assessment, completed 7/14/22, indicated she had a short- and long-term memory deficit and was able to recall staff names and faces and the location of her room. She needed extensive assist of 1 staff member for personal hygiene and total assist of 1 staff member for bathing. On 10/20/22 at 11:01 a.m., Resident 9 was observed laying in her bed. Her hair was in braids and appeared matted and unkept. On 10/21/22 at 11:51 a.m., She was observed laying in bed with her eyes closed. Her hair continued to be in braids with an unkept appearance. During an interview on 10/24/22, CNA (Certified Nursing Assistant) 9 indicated she had just gotten Resident 9 dressed and ready for the day. On 10/24/22 at 11:34 a.m., Resident 9 was observed dressed in a yellow shirt and print pants. She was sitting on the side of her bed. Her hair continued to be in unkept braids. She indicated that she liked to be dressed and that		· Audit of shower and treatment records to be completed by DNS/designee daily to ensure all residents are receiving showers per preference and MD orders being followed. During GEMBA, DNS/designee will ensure new/re-admissions have hospital bands removed. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · To ensure compliance the SS/Designee will complete the Accommodation of Needs CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The Accommodation of Needs CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee. By What date will the systematic changes be completed	

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	staff had not washed or done her hair. During an interview on 10/24/22 at 1:54 p.m., Unit Manager 2 and LPN (Licensed Practical Nurse) 4 indicated Resident 9 was able to answer yes and no questions with accuracy. On 10/25/22 at 11:32 a.m., Resident 9 was observed in laying in bed with her eyes closes. Her hair continued to be in braid and look unkept. On 10/25/22 at 4:27 p.m., the Director of Nursing provided Resident 9's bathing documentation and Shower Reports for October 2022 which indicated she had received a complete bed bath on 10/3 and 10/14. On 10/18 she had received a shower and her hair was shampooed, and on 10/24 she had received a complete bed bath. 3. The clinical record for Resident 28 was reviewed on 10/20/22 at 2:19 p.m. The Resident's diagnosis included, but were not limited to, chronic hypertensive kidney disease and atrial fibrillation. A care plan, initiated 3/30/22, indicated he had a self care deficit and needed assistance with bathing and personal hygiene. He preferred to stay in bed at times. The goal was for him to have his basic needs met daily with staff assistance as evidenced by being neat, clean, and well groomed. The interventions included, but was not limited to, offer showers two times per week and partial baths in between, initiated 3/30/22. A Significant Change of Status MDS (Minimum Data Set) Assessment, completed 8/23/22, indicated he was cognitively intact. He required extensive assist of 1 staff member for personal hygiene and total assist of 2 staff members for		· Compliance date 11/23/22	

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	bathing. During an interview on 10/20/22 at 2:10 p.m., Resident 28 indicated he received a bed bath about once a week. He had his hair washed about a week ago. It was the first time it had been washed since he came to the facility. He would like to have more complete bed baths and his hair washed each time. On 10/26/22 at 10:11 a.m., the Director of Nursing provided Resident 9's Shower Reports for September and October 2022, which indicated he had refused a complete bed bath on 9/5/22. He had received a complete bed bath 9/12, 9/15, 9/26, and 10/3/22. On 10/13/22 he had received a complete bed bath and a shampoo. During an interview on 10/26/22 at 3:23 p.m., CNA 10 and CNA 11 indicated they did not offer to shampoo residents' hair when they gave a complete bed baths. They would wash the resident's hair during a complete bed bath if the resident requested it. During an interview on 10/26/22 at 3:30 p.m., the Director of Nursing indicated that she would expect the CNAs to ask about hair washing. If the resident could not make their needs know, she would expect them to wash their hair during a complete bed bath. On 10/26/22 at 3:31 p.m., the Director of Nursing provided the Skills Validation for Shampoo, last reviewed April 2012, which read "...Bed Shampoo...7. Pour water carefully over resident's hair. 8. Lather hair with shampoo using fingertips. Rinse thoroughly. 9. use conditioner if requested and rinse..."4 a. The clinical record for Resident B was reviewed on 10/24/22 at 3:19 p.m. Resident			

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	B's diagnoses included, but not limited to, hemiplegia, vascular dementia, diabetes type II, and congestive heart failure. Resident B's care plan dated 10/20/14 indicated, she has a self care deficit and needs assistance with ADLs including, but not limited to, personal hygiene. Interventions included, but not limited to, check every two hours and change as needed ,dated 4/13/2022, and provide shower two times per week, partial bath in between ,dated 4/14/2015. Resident B's care plan dated 3/29/22 indicated, she had impaired mobility related to right hemiparesis. Interventions included, but not limited to, assist with incontinent care as needed, turn and repositioning every two hours and as needed. Resident B's quarterly MDS (minimum data set) dated 8/23/22 indicated, Resident B was cognitively intact and required extensive assistance of one person for bed mobility and personal hygiene; extensive assistance of two persons for transfers and toileting; and was totally dependent on assistance of one person for bathing. An interview was conducted with Resident B on 10/20/22 at 2:20 p.m. Resident B indicated, she wasn't provided incontinent care often enough. A continuous observation period for Residents B was started on 10/25/22 at 10:02 a.m. The continuous observation period ended at 12:10 p.m. During the continuous observation, Residents B was not provided incontinent care nor checked in the 2 hour period and was in the same position for over 2 hours. An interview with Resident B's family member was			

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	conducted on 10/26/22 at 3:55 p.m. Resident B's family member indicated, the staff at the facility did not provide incontinent care often enough and that Resident B was often left in soiled clothing. 4 b. A review of Resident B's point of care (POC) for bathing was conducted on 10/24/22 at 3:19 p.m. It indicated, for the month of October 2022, Resident B received a complete bed bath/shower on the following dates: 10/5, and 10/23. The POC further indicated, she had not refused a complete bed bath/shower during October 2022. Resident B's shower sheets were provided by DON (Director of Nursing) on 10/25/22 at 8:38 a.m. The only shower sheet provided for October 2022 indicated a bed bath was provided on 10/12. No further shower sheets indicated Resident B had refused a complete bed bath/shower during October 2022. 5. The clinical record for Resident 4 was reviewed on 10/24/22 at 11:07 a.m. Resident 4's diagnoses included, but not limited to, venous insufficiency, malignant melanoma(cancer) of right leg, and neuropathy. A physician's order dated, 6/11/202 indicated to, apply Eucerin Intensive Repair cream to feet and legs twice a day 7 a.m.-12 p.m. and 5 p.m. 10 p.m. Resident 4's Quarterly MDS Assessment, dated 10/5/22, indicated, she required extensive assistance of 2 persons for bed mobility; was totally dependent on the assistance of two persons for transfers; extensive assistance of one person for personal hygiene; and totally dependent on one person for bathing.			

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	An observation was made on 10/19/22 at 2:13 p.m. of Resident 4's legs and feet. Her legs are feet appeared dry and flaky. Her legs had yellow patches of skin and her feet appeared almost white in color related to the dryness of the skin. An interview with Resident 4 conducted at the same time as the observation indicated, the facility had not applied lotion to her legs or feet. An observation of Resident 4 occurred on 10/24/22 at 2:38 p.m. Her legs and feet again appeared dry and flaky. The MAR (medication administration report) for Eucerin was reviewed on 10/24/22 at 2:38 p.m. It indicated, the lotion had been applied for the morning dose. An interview with Resident 4 conducted on 10/24/22 at 2:38 p.m. indicated, no one had put any lotion on her legs or feet yet that day. An interview with UM(unit manager) 2 was conducted on 10/24/22 at 2:54 p.m. at Resident 4's bedside. UM 2 indicated, Resident 4's legs and feet "could use" some lotion. Resident 4 restated that lotion had not been applied to her feet and legs as of yet that day. The facility was unable to provide an ADL policy. 6. The clinical record for Resident E was reviewed on 10/25/22 at 9:30 a.m. The diagnosis for Resident E included, but was not limited to, heart failure. The resident was admitted to the facility on 10/18/22. An observation was made of Resident E on 10/19/22 at 3:00 p.m. The resident's left arm was observed with 3 hospital bands.			

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	155329	A. BUILDING 00 B. WING	10/27/2022

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	An observation was made of Resident E on 10/25/22 at 8:30 a.m. The resident's left arm was observed with 1 fall risk yellow hospital band. An observation was made of Resident E on 10/26/22 at 10:50 a.m. The resident's left arm was observed with a fall risk yellow hospital band. The resident indicated at that time, he had been trying to remove his hospital bands. He was able to get some off, but was having trouble getting the yellow one off. An observation was made of Resident E with the Director of Nursing (DON) on 10/26/22 at 11:00 a.m. Resident E was observed with a yellow fall risk hospital band on his left arm. She indicated she was unaware the resident wanted his hospital bands removed. At that time, the DON using scissors removed the hospital band. This Federal Tag relates to complaint IN00370919 , IN00373295 and complaint IN00379977 . 3.1-38(a)(2)(A) 3.1-38(a)(3) 3.1-38(b)(6)			
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 0684	What corrective action(s) will be	11/22/2022

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	Based on observation, interview and record review, the facility failed to inform the physician prior to holding a blood pressure medications, failed to monitor and address an unhealed gastrostomy tube (G-tube) site, failed to obtain weights as ordered by the physician, and failed to administer a resident's medication timely for 4 of 5 residents reviewed for unnecessary medications (Resident 28, 9, 33, E, and Resident 200) 1of 4 residents reviewed for skin conditions (Resident 79) and 1 of 1 resident reviewed for change of condition. (Resident F). Findings include: 1. The clinical record for Resident 28 was reviewed on 10/20/22 at 2:19 p.m. The Resident's diagnosis included, but were not limited to, chronic hypertensive kidney disease and atrial fibrillation. A physician's order, dated 4/27/22, indicated he was to received metoprolol succinate (beta blocker to treat high blood pressure) extended-release tablet 100 mg (milligram) daily. A physician's order, dated 5/16/22, indicated he was to receive hydralazine (vasodilator to treat high blood pressure) 10 mg twice daily. A Significant Change of Status MDS (Minimum Data Set) Assessment, completed 8/23/22, indicated he was cognitively intact. On 10/26/22 at 10:11 a.m., the DON provided Resident 28's MAR (Medication Administration Records) for October 1 through October 25, 2022. The October MAR indicated that his hydralazine had been held on the following days and times:		accomplished for those residents found to have been affected by the deficient practice? · Resident 28 MARs reviewed, and MD notified of resident's medications being held and is currently receiving their medication as ordered · Resident 79 G-tube site was assessed, and treatment order obtained, monitored weekly as applicable · Resident 200, 33, and E weights were obtained, and MD notified. Weights continue to be obtained daily. · Resident F no longer resides in the facility How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents that receive blood pressure medications, have open areas, and daily weights have the potential to be affected by the alleged deficient practice. · 1x audit of the physician medication report to see what residents' medications have been on hold or missed have MD notification. · 1x full house skin sweep will be completed, and all skin impairments have treatments as applicable and monitored per policy · All resident with daily	

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	10/9/22 evening dose held due to blood pressure of 114/51, 10/18/22 morning dose held due to heart rate of 47, 10/19/22 morning dose held due to blood pressure of 105/59, 10/23/22 morning dose held due to blood pressure of 110/59, and 10/24/22 morning dose held due to low heart rate of 52. His metoprolol succinate had been held on the following days: 10/2/22 due to being unavailable, 10/18/22 due to heart rate of 47, 10/19/22 due to heart rate of 55, 10/23/22 due to heart rate of 59, and 10/24/22 due to heart rate of 52. The clinical record did not contain information that the physician had been notified of the medications being held. During an interview on 10/27/22 at 10:45 a.m., the Physician indicated that she would have liked to have been informed of his low pulse rate and low blood pressures when the metoprolol and the hydralazine had been held. She did not recall being informed that the medications were being held. 2. The clinical record for Resident 200 was reviewed on 10/26/22 at 10:14 a.m. The Resident's diagnosis included, but were not limited to, hypertensive heart disease with heart failure and anxiety. She was admitted to the facility on 10/10/22 for short-term rehabilitation following an accident. A physician's order, dated 10/7/22, indicated she		weights will be reviewed x1 and ensure they have been obtained · All nurses will be in-serviced by 11/22/2022 that a medication must be given per MD order, if a medication is held without hold orders MD will be notified. · All nurses will be in-serviced by 11/22/2022 to have a new skin event for any new open areas not present upon admission, ensure treatment orders are in place, accurate weekly assessments to include all open areas per policy · All nurses will be in-serviced by 11/22/2022 ensuring daily weights are obtained per order What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · All nurses will be in-serviced by 11/22/2022 that a medication must be given per MD order, if a medication is held without hold orders MD will be notified. · All nurses will be in-serviced by 11/22/2022 to have a new skin event for any new open areas do not present upon admission, ensure treatment orders are in place, accurate weekly assessments to include all open areas per policy · All nurses will be	

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	was to received daily weights for heart failure. On 10/26/22 at 10:11 a.m., the DON provided the October 2022 MAR for Resident 200. It indicated that she had not been weighed on the following days: 10/15/22 weight had been on hold, 10/16/22 weight had been on hold, 10/22/22 weight had been on hold, and 10/23/22 no reason indicated. During an interview on 10/26/22 at 2:56 p.m., Resident 200 indicated staff did not weigh her on the weekends. 3. The clinical record for Resident 33 was reviewed on 10/25/22 at 2:30 p.m. The diagnosis for Resident 33 included, but was not limited to, heart failure. A physician order dated 2/23/22 indicated staff was to obtain Resident 33's weight daily. The medical provider would need to be notified if resident had 2 pound weight gain in a day or 5 pounds in a week. The October 2022 Medication/Treatment Administration Record (MAR/TAR) indicated the following days Resident 33's weights were not obtained: 10/1/22, 10/2/22, 10/8/22, 10/9/22, 10/22/22, and 10/23/22 An interview was conducted with the Director of Nursing on 10/26/22 at 12:14 p.m. She indicated she was unsure why the weights were not obtained as ordered for Resident 33 and 200. 4. The clinical record for Resident E was reviewed on 10/25/22 at 9:30 a.m. The diagnosis for Resident E included, but was not limited to, heart		in-serviced by 11/22/2022 ensuring daily weights are obtained per order · A nurse will pass all medications as ordered by the MD, if he/she makes a decision to hold a medication without hold parameter orders, the nurse will notify the MD. · DNS/designee will run daily medication report for “on hold” medications, missed administrations to ensure compliance, and daily weights obtained per MD order with MD notification as applicable. · When a nurse finds a new skin area, he/she will open a new skin event and complete the documentation and ensure a treatment is in place. The next business day the IDT team will review new skin events and follow up and initiate wound management tracking as applicable. Floor nurses will monitor the skin weekly with weekly skin assessments. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · To ensure compliance the DNS/Designee will complete the Physician Order and Skin Injury CQI audit tool for six months with audits being completed once	

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	failure. The resident was admitted to the facility on 10/18/22. A physician order dated 10/19/22 indicated the staff was to obtain Resident E's weight daily. The medical provider was to be notified if the resident had a weight gain of 2 pounds in a day or 5 pounds in a week. The October 2022 Medication and Treatment (MAR/TAR) Administration Record indicated the resident's weight had not been obtained daily as ordered. The vitals task indicated the resident had been weighed on 10/25/22. An interview was conducted with the Nurse Consultant on 10/27/22 at 2:07 p.m. She indicated Resident E had an admission weight, but she was unable to locate any additional daily weights that had been obtained for the resident. 5. The clinical record for Resident 79 was reviewed on 10/19/22 at 11:30 a.m. The diagnosis for Resident 79 included, but was not limited to, gastrostomy. The 9/28/22 Quarterly Minimum Data Set (MDS) assessment indicated Resident 79 was cognitively intact. A progress note dated 9/27/22 indicated "Resident [79] sitting in w/c [wheelchair] when his g-tube fell out per resident report. No trauma to site noted. No drainage or foul odor noted. No pain or discomfort noted..." A weekly skin assessment dated 9/30/22 indicated the resident had an open area that was a g-tube		weekly for one month, and then monthly for 5 months by a nurse manager or designee. The Physician Order and Skin Injury CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee. By What date will the systematic changes be completed · Compliance date 11/23/22	

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	site. A weekly skin assessment dated 10/5/22 indicated the resident had an open area that was a g-tube site. A weekly skin assessment dated 10/12/22 indicated Resident 79 did not have any open areas. A weekly skin assessment dated 10/19/22 indicated Resident 79 did not have any open areas. A physician order dated 6/9/22 indicated "Cleanse g-tube site with normal saline and pat dry. Apply clean split gauge to g-tube site. Change daily and PRN [as needed] for soilage." The order was discontinued on 10/4/22. Resident 79's clinical record did not include treatment orders or assessments of the resident's unhealed g-tube site. An observation was made of Resident 79 in his room on 10/19/22 at 2:05 p.m. The resident was observed with a towel over his stomach. Underneath the towel, the resident's abdomen was exposed with a dressing and a piece of tape. The dressing appeared to be brown and dingy. Resident 79 indicated he did have a g-tube, but it had come out. He changed the dressings himself, because the site had not healed yet. An observation was made of Resident 79 on 10/25/22 at 9:40 a.m. The resident's abdomen had a bandage with white tape on it dated, 10/24/22. The dressing and tape had specks of brown flakes on it. The resident indicated he was getting a shower that day, so the dressing would be changed. The			

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	g-tube has been out for about a month. He currently eats by mouth. The area was not painful, but itchy due to all the drainage that comes from it. At times, the drainage makes his shirt wet. An observation was made of the dressing change to Resident's abdomen with the Director of Nursing (DON) and the Wound Nurse on 10/25/22 at 10:10 a.m. The DON removed the dressing and tape dated, 10/24/22. The dressing against the skin was observed saturated with brown drainage. The unhealed site was a round area the size of a quarter. Inside the round area the skin was pink-red color. The outer surrounding skin below the open area was red in color. The Wound Nurse indicated at that time, the outer portion of his skin was always red. The resident's site did have gastric drainage which made the outer skin red. The resident's g-tube had come out about a month ago, and it was not being monitored or assessed by the wound team. Nursing was monitoring. During the treatment, the DON was observed cleansing the site with normal saline, placing an abdominal pad over the site and taped the pad to secure. An interview was conducted with the DON on 10/25/22 at 10:22 a.m. She indicated it had been recognized that day the unhealed g-tube site did not have current physician orders to treat the site. The physician orders had been discontinued on 10/4/22 by error. The staff had not documented treatments had been conducted after 10/4/22. The dressing had been changed the day prior due to the written date of 10/24/22 on the dressing. She was unable to provide documentation the site had been assessed and daily dressing changes had been provided prior to 10/24/22. The redden area of the surrounding skin was concerning. She did not feel it was gastric drainage, because odor was			

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	not present. A wound assessment dated 10/25/22 conducted by the Wound Nurse indicated the unhealed g-tube site was currently measuring 0.3 centimeters in length x 0.6 centimeters in width and 0.2 centimeters in depth. It had moderate drainage of serosanguineous (pale red to pink, thin and watery) drainage with no odor present. The surrounding skin was red. A skin management policy was provided by the DON on 10/25/22 at 10:58 a.m. It indicated "...Policy: It is the policy of American Senior Communities to ensure that each resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Purpose: To promote the prevention of pressure ulcers/injury development; promote the healing of existing pressure ulcers/injuries and prevent development of additional pressure ulcer/injury...6. Any skin alterations noted by the direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment, to include but not limited to bruises, open areas, redness, skin tears, blisters, and rashes. The license nurse is responsible for assessing all skin alterations by the direct caregivers on the shift reported...2. Treatment order will be obtained from MD [medical provider]/NP [nurse practitioner]...4. All newly identified areas after admission will be documented on the new skin event...6. A plan of care will be initiated to include resident specific			

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	risk factors and contributing factors with appropriate interventions implemented..." 6. The clinical record for Resident F was reviewed on 10/24/22 at 10:14 a.m. The diagnoses included, but were not limited to, hypertension and anemia. She was admitted to the facility on 7/29/22. The 8/2/22 care plan indicated she was at risk for ineffective tissue perfusion related to anemia and hypertension. The goal was for her to maintain adequate tissue perfusion as evidenced by her blood pressure within normal limits. An approach was to administer her medications as ordered. The 7/29/22 physician note indicated to administer one 25 mg tablet of carvedilol (medication to treat high blood pressure and heart failure) with breakfast and with evening meal. The Meal Service Times were provided by the ED on 10/24/22 at 11:30 a.m. It indicated breakfast was served at the facility between 7:00 a.m. and 7:45 a.m. The physician's orders indicated to administer one 25 mg tablet of carvedilol twice a day, starting 7/29/22. The August, 2021 MAR (medication administration record) was blank for the 8/1/22 morning administration of carvedilol. The 8/1/22 ED (emergency department) note from a local hospital indicated the first provider contact with Resident F in the emergency department was on 8/1/22 at 12:17 p.m. The note read, "[Name, age, and gender of Resident F] with a PMHx [past medical history] of HTN [hypertension] who states that she is staying at [name of facility] due to broken right femur. She states that they have			

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	not been giving her HTN medications and gives it to her 'when they feel like it.' She is concerned about her blood pressure. Pt [Patient] denies any symptoms at this time...Medications carvedilol (Coreg) tablet 25 mg oral given 8/1/22 12:56)...Upon arrival pt was hypertensive, initial blood pressure was 209/105. Gave pt her daily 25 mg carvedilol and blood pressure improved to 157/74 here in the ED....Clinical Impression: 1. Uncontrolled hypertension." The 8/2/22, 7:41 p.m. physician note read, "Pt readmitted back to ECF [extended care facility] after ER [emergency room] evaluation and treat for uncontrolled blood pressure. Pt medicated with dose Coreg. Pt returned back to ECF for continued care and treatments." An interview was conducted with the DON (Director of Nursing) on 10/25/22 at 10:59 a.m. She indicated Resident F should have received her 8/1/22 morning dose of carvedilol at the facility. The General Dose Preparation and Medication Administration policy was provided by the DON (Director of Nursing) on 10/25/22 at 10:59 a.m. It read, "Facility staff should: Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident..." This Federal tag relates to complaint IN00387240. 3.1-37(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a			

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	resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.			
	Based on interview and record review, the facility failed to provide appropriate services and assistance to maintain or improve mobility by not ensuring transfer restorative services were provided as necessary for 1 of 1 residents reviewed for restorative services. (Resident 17) Findings include: The clinical record for Resident 17 was reviewed on 10/26/22 at 11:47 a.m. Resident 17's diagnoses included, but not limited to, aftercare following joint replacement surgery, abnormalities in gait and mobility, and right artificial knee. Resident 17's quarterly MDS (minimum data set) dated 5/15/22 indicated, Resident 17 was cognitively intact and required extensive assistance of two persons for bed mobility, transfers, and toileting; limited assistance of one person for personal hygiene; and was totally dependent on the assistance of two persons for	F 0688	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident 17 is receiving restorative programing as indicated in MD order and Care plan. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents receiving restorative programming have the potential to be affected by the alleged deficient practice. · In-service to be completed by therapy director/designee on the restorative program	11/22/2022

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	bathing. An interview with Resident 17 was conducted on 10/21/22 at 10:37 a.m. Resident 17 indicated, she was on the wellness program with restorative services but had not been up to do the needed transferring exercises because the staff members who assist her with it had been busy working the floor instead. A copy of the Restorative Wellness program flowsheets for Resident 17 were received on 10/26/22 at 10:47 a.m. from MDSA (minimum data set assistant) 5 for the month of October 2022. The flowsheets indicated the following under the section of Transfer Program- Resident will sit to stand transfer in parallel bars with assistance of one person; encourage resident to stand 2 to 3 minutes with each repetition; 2 to 3 repetitions: - On 10/1, 10/2, 10/3 10/7, 10/8, 10/9, 10/11, 10/12, 10/14, 10/15, 10/20, 10/21, 10/24 under minutes spent doing the activity were "/" marks. - On 10/10, 10/16, and 10/18 under minutes spent on transfer activity were blank spaces. An interview with MDSA(minimum data set Assistant) 5, who also oversees the Restorative Wellness program, was conducted on 10/26/22 at 11:04 a.m. She indicated, on the Restorative Wellness program flowsheets a "/" indicated the therapy/activity had not been offered that day. She also indicated, she had just learned that morning, Resident 17 had not been offered the transfer program activity for all the days indicated on the flowsheet with an "/". She stated, although the order stated for the transfer program activity to occur once a day, it was not really supposed to be done daily but rather an ideal goal for Resident 17 would be to perform the transfer program/activity 3 times per week, but should be		11/22/2022 · 1x audit of residents on restorative programming to ensure receiving services to be completed by therapy director/designee. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Therapy Director / designee will monitor Restorative logs daily to ensure completion of restorative program · In-service to be completed by therapy director/designee on the restorative program 11/22/2022 · Restorative aides will notify therapy director/designee if resident refuses to participate in their personalized program. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · To ensure compliance the Therapy Director/Designee will complete the Restorative Nursing CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. Restorative Nursing CQI audit tool will be reviewed monthly by the CQI Committee for six months after	

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	offered at least 1-2 times weekly. An interview with RNA (Restorative nursing assistant 7 was conducted on 10/26/22 at 11:29 a.m. She indicated, the reason Resident 17 did not receive therapy on the days she had worked was because Resident 17 needed the assistance of two persons in order to conduct the transfer program of sit to stand at the parallel bars and stand for 2-3 minutes and many times there wasn't enough staff to enlist the assistance of another person or she was assigned to work the floor as a CNA (certified nursing assistant) and could not do both duties to completion An interview with RNA 6 was conducted on 10/26/22 at 11:33 a.m. She indicated, on the days she worked with Resident 17, she was unable to complete the transfer program part of the restorative care related to either requiring another persons assistance or because she had been assigned to work the floor as a CNA. Resident 17's care plan dated 8/31/22 indicated, resident had transfer program to maintain current level of function and transfer ability. Interventions included, but not limited to, resident will sit to stand in parallel bars with assistance of one person, encourage resident to stand 2-3 minutes with each repetition, and complete 2-3 repetitions. A Restorative Nursing Program policy was received from MDSC (minimum data set coordinator) on 10/26/22 at 11:42 a.m. The policy indicated, "...This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning" For the restorative nursing program to be effective and successful, the support of every member of the		which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee. . By What date will the systematic changes be completed · Compliance date 11/23/22	

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	staff is essential...MDS coordinator, MDS Assistant or designated Licensed Nurse: monitors the restorative nursing programs...Wellness Assistants carry out assigned restorative nursing programs under the direction of the designated licensed nurse... Restorative meeting:...when: weekly...what: review current Restorative Nursing Programs...Identify any changes in functional status..." 3.1-42(a)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to timely address a resident's pain for 1 of 1 residents during an observation. (Resident B) Findings included: The clinical record for Resident B was reviewed on 10/24/22 at 3:19 p.m. Resident B's diagnoses included, but not limited to, hemiplegia, vascular dementia, diabetes type II, and congestive heart failure. Resident B's quarterly MDS (minimum data set) dated 8/23/22 indicated, Resident B was cognitively intact and required extensive assistance of one person for bed mobility and personal hygiene; extensive assistance of two persons for transfers and toileting; and was	F 0697	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident B pain has been addressed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by the alleged deficient practice. · A 1x audit to include interview residents to assess for pain. Any residents with pain will be addressed immediately. · An in-service will be	11/22/2022

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	totally dependent on assistance of one person for bathing. An interview and observation was conducted on 10/25/22 at 10:02 a.m. of Resident B. Resident B was lying on her right side in her bed and was whimpering. She indicated, she was in pain and stated that her bottom was hurting. QMA(Qualified Medication Assistant) 3 was informed of Resident B's pain on 10/25/22 at 10:13 a.m. QMA 3 indicated, she though Resident B had a treatment on order for what was causing her pain and then indicated, the wound nurse does the treatments. A continuous observation period for Residents B was started on 10/25/22 at 10:02 a.m. The continuous observation period ended at 12:10 p.m. when another resident on the 100 hallway had an emergent situation arise. During the continuous observation, Residents B's pain had not been addressed within the 2 hours of observation. An interview with QMA 3 was conducted on 10/25/22 at 2:05 p.m. QMA 3 indicated, after being informed of Resident B's pan she looked up to see if she had any treatments because according to her, she had already administered Tylenol to the resident. She indicated, she told UM (unit manager) 2 about Resident B's pain and stated, Resident B required something stronger for her pain because she had already given Resident B a Tylenol previously and it was not "holding her". QMA 3 could not remember the exact time when she had informed UM 3 of Resident B's pain but that it was before lunch time. A review of Resident B's MAR (medication		completed by DNS/designee on 11/22/2022 for all staff to include addressing resident's complaints of pain are addressed timely. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · An in-service will be completed by DNS/designee on 11/22/2022 for all staff to include addressing resident's complaints of pain are addressed timely. · DNS/ADNS or designee will review daily progress notes and pain events to ensure all pain issues have been addressed timely and MD notified. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? To ensure compliance the DNS/Designee will complete a pain management CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The pain management CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in	

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	administration record) was conducted on 10/25/22 at 2:14 p.m. while conducting the interview with QMA 3. When asked about the missing documentation for the Tylenol, QMA 3 indicated, "I don't know what happened to it". An interview with UM 2 was conducted on 10/25/22 at 2:21 p.m. UM 2 indicated, she had been informed of Resident B's pain around the same time the emergent situation on the 100 hallway was was occurring. UM 2 indicated, QMA 3 told her Resident B was "having discomfort". UM 2 indicated, she went to talk with Resident B and Resident B indicated her pain was related to constipation and rated her pain as a 7 out of 10. Resident B's pain was reported at 10:13 a.m. and was not addressed until around 12:10 p.m. A Pain Management policy was received on 10/25/22 at 1:52 p.m. The policy indicated, "Residents are assessed for pain upon admission, weekly and during medication administration as outlined below. 2. The following will be used when assessing pain. Nursing Admission Observation Weekly Summary IDT[sic, interdisciplinary team] Pain Interview... Ongoing nursing assessment can also be documented in matrix progress notes or matrix vitals... 5. The physician will be notified unrelieved or worsening pain... 8. Documentation of administration of ordered PRN [sic, as needed] pain medication will be initialed on the Medication Administration Record (MAR)... Note-QMA's administering pain medications will inform the charge nurse of the need to give PRN medication for approval."		disciplinary action up to and or including termination of the responsible employee By What date will the systematic changes be completed · Compliance date 11/23/22	

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	3.1-37(a)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to clarify a resident's medication and provide a substantial snack while at dialysis for 1 of 1 resident reviewed for dialysis. (Resident 80) Findings include: The clinical record for Resident 80 was reviewed on 10/24/22 at 10:31 a.m. The diagnoses included, but were not limited to, ESRD (end stage renal disease.) An interview was conducted with Resident 80 on 10/20/22 at 10:18 a.m. She indicated the facility used to provide her with snacks to take with her to dialysis, but no longer provided them. The physician's orders indicated her dialysis times were at a certified dialysis facility at 9:55 a.m. on Mondays, Wednesdays, and Fridays, effective 8/23/21. She was to receive a Rena-Vite tablet once a day at 5:00 a.m. on her dialysis days, effective 5/23/22, due to ESRD, and a Nephro-Vite tablet daily at 5:00 a.m., effective 10/29/21, due to ESRD. The October, 2021 MAR (Medication Administration Record) indicated the Nephro-Vite	F 0698	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident 80 is provided a meal/snack when leaving facility for dialysis and any medication changes during therapeutic exchange have been clarified. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents on dialysis have the potential to be affected by the alleged deficient practice. · DNS/designee will review daily orders during clinical meeting to verify and ensure all therapeutic exchanges are accurate in dose, day, and time. · RD/designee will ensure all dialysis residents have a meal/snack packed and delivered to the resident prior to going to dialysis	11/22/2022

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	was on hold on the following days: 10/2/22, 10/13/22, 10/14/22, and 10/18/22 through 10/27/22. An interview was conducted with Resident 80 on 10/26/22 at 3:00 p.m. She indicated she just returned from dialysis and was not provided with a snack to take with her. The facility did not routinely send her to dialysis with a snack or lunch and she got hungry while there. She would sometimes buy a bag of chips out of the vending machine at the facility to take with her. She would like for the facility to provide her with a bag of chips and cookies to take with her. She did not get the Nephro-Vite daily, hadn't for months, and did not know why. An interview was conducted with the RD (Registered Dietician) on 10/26/22 at 3:24 p.m. She indicated all residents who received dialysis were to be sent with a sack lunch that included a sandwich, chips, crackers, piece of fruit, and dessert. The staff member who assisted the resident out of the facility into their transportation was supposed to stop by the kitchen to retrieve the sack lunch. She was unsure why Resident 80 was not provided with a sack lunch. An interview was conducted with the DON on 10/27/22 at 9:54 a.m. She indicated she looked into Resident 80's Rena-Vite and Nepho-Vite orders with the dialysis center. They went ahead and discontinued the Nephro-Vite and changed the Rena-Vite to daily. No one realized the 2 medications were the same, and it should have been clarified sooner. The Dialysis Care policy was provided by the ED (Executive Director) on 10/24/22 at 11:30 a.m. It read, "The facility will assure that each resident receives care and services for the provision of		· An in-service will be completed by DNS/designee on 11/22/2022 for all staff to include ensuring dialysis residents are provided a meal/snack when leaving for dialysis and all medications are clarified · 1x audit of all residents on dialysis to ensure no duplicate medication orders are present. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · An in-service will be completed by DNS/designee on 11/22/2022 for all staff to include ensuring dialysis residents are provided a meal/snack when leaving for dialysis and medications are clarified · DNS/designee will review daily orders during clinical meeting to verify and ensure all therapeutic exchanges are accurate in dose, day, and time. · RD/designee will ensure all dialysis residents have a meal/snack packed and delivered to the resident prior to going to dialysis · How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · To ensure compliance the DNS/Designee will complete a Dialysis CQI audit tool for six	

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	hemodialysis and/or peritoneal dialysis consistent with professional standards of practice including: ...Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services....For those residents receiving dialysis at a certified dialysis facility: ...Provide assistance and safe transportation to and from dialysis center." 3.1-37(a)		months with audits being completed once weekly for one month, then monthly for 5 months by a nurse manager/designee. The Dialysis CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee By What date will the systematic changes be completed · Compliance date 11/23/22	
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.			

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	(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on interview and record review, the facility failed to timely address a resident's pharmacy recommendation for 1 of 6 residents reviewed for unnecessary medications. (Resident 64) Findings include: The clinical record for Resident 64 was reviewed on 10/25/22 at 2:49 p.m. The diagnoses included, but were not limited to, polyneuropathy, anxiety, and anorexia. The at risk for falls care plan indicated she was at increased risk for falls related to receiving fall risk medications.	F 0756	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident 64 Pharmacy recommendations have been addressed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by the alleged deficient practice.	11/22/2022

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	The 8/14/22 fall event indicated she had an unwitnessed fall in her room. She was found sitting on her bottom with her back against her bed. The 8/16/22 fall event indicated she had an unwitnessed fall in her room. She was found sitting on her buttocks in the doorway in between the bedroom and bathroom. The 8/16/22, 8:44 a.m. nurse's note read, "Resident found sitting on floor in doorway of bedroom and bathroom. Resident stated she was going to the bathroom, and then ended up on the floor, unaware of how she got there. Resident had no apparent injuries. ROM [Range of motion] and neuro [neurological] checks WNL [within normal limits.] Resident assisted to wheelchair by staff. VS [Vital signs] WNL. Skin intact. Resident stated her "R [right] wrist is sprained" from her previous fall, resident also noted using same wrist without pain or complications. Resident has more confusion than normal, noted by staff. New neuro checks started. VM [Voicemail] left for family regarding fall. MD [Medical Doctor] and DNS [Director of Nursing Services] aware. Requesting resident have UA [urinalysis] C&S [culture and sensitivity] completed and evaluated by PT [physical therapy.] The 9/5/22 fall event indicated she had an unwitnessed fall in her room. Resident 64 indicated she was transferring herself from her wheel chair to bed. She complained of pain to her right hand and right upper extremity. The 9/5/22, 10:00 a.m. nurse's note read, "QMA [Qualified Medication Aide] informed Writer resident had a fall in her room attempting to		· A 1x audit of all current pharmacy recommendations and those residents that need immediate attention will be addressed · An in-service conducted by DNS/designee will be conducted on 11/22/2022 for pharmacy recommendations What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Order/Vital reviews will be completed daily by DNS/Designee and addressed. Any identified change of condition, the DNS/Designee will notify the physician the POA/family and document the notification. DNS/ADNS or Designee will review pharmacy recommendations when received and forward to MD. · An in-service conducted by DNS/designee will be conducted on 11/22/2022 for pharmacy recommendations How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · To ensure compliance the DNS/Designee will complete a Unnecessary Medication CQI audit tool for six months with audits being completed once	

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	transfer from her wheelchair to her bed. Resident was noted sitting in her wheelchair in dining area by this Writer. Writer took resident to her room to assess her. Resident c/o [complained of] pain right right hand and RUE [right upper extremity.] Resident informed writer that she does have pain to right hand at times. NP [Nurse Practitioner] made aware of fall, order for x-ray obtained for right hand and RUE. Resident's Brother made aware of fall by this writer. The 9/6/22, 2:19 p.m. nurse's note read, "Resident had a fall and X-ray show (sic) fractures noted and called the family and the brother is aware and the referral to ortho for f/u [follow up] d/t [due to] the fracture." The physician's orders indicated she was to receive 600 mg of Gabapentin 3 times daily from 11/29/22 through 8/11/22 and 300 mg of Gabapentin 4 times daily, starting 8/11/22; 25 mg of Sertraline once daily, starting 3/3/22; and 7.5 mg of Mirtazapine (Remeron) at bedtime, starting 5/16/22. The 7/14/22 psychiatry note, written by NP 10, indicated, "Patient is doing well overall except that she has been having trouble sleeping lately. She has PRN [as needed] melatonin, however, I am going to schedule it and see if this helps....Diagnoses & Problems...Generlized anxiety disorder...Major depressive disorder...Follow-up Plan: Will round on Pt's [Patient's] unit again next month. Will see Pt for follow-up at that time if medically necessary....Please consult this provider prior to making adjustments to any of the prescribed psych meds....Medication Orders Continue: REMERON 7.5mg PO [by mouth] QHS [every evening] SERTRALINE HCL 25mg PO daily. Begin:		weekly for one month, and then monthly for 5 months by a nurse manager or designee. The Unnecessary Medication CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee. By What date will the systematic changes be completed · Compliance date 11/23/22	

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	155329	A. BUILDING 00 B. WING	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWALK VILLAGE	1302 N LESLEY AVE INDIANAPOLIS, IN 46219

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	MELATONIN 5mg PO QHS." The 10/4/22 pharmacy consultation report read, "[Name of Resident 64] receives three or more CNS [central nervous system] active medications which can cause an increase risk for falls and fractures: Sertraline 25 mg daily, Remeron 7.5 mg qhs, and Gabapentin 300 mg qid [4 x daily.] Per CMS [Centers for Medicare and Medicaid Services] reg's [regulations] she is due for a dose reduction evaluation for Sertraline. Recommendation: Please reevaluate this combination and consider a trial off Sertraline, if appropriate at this time." The physician's respone section of the report was blank. An interview was conducted with the NC (Nurse Consultant) on 10/25/22 at 3:10 p.m. She indicated they were waiting to address the recommendation with NP 10 at their monthly behavior meeting on 10/27/22. An interview was conducted with the NC on 10/26/22 at 12:05 p.m. She indicated the pharmacy recommendations were emailed to the DON (Director of Nursing,) then disbursed appropriately. The DON hadn't worked at the facility for very long, so she didn't think Resident 64's history of falls and fracture would have triggered the DON to act on the recommendation sooner. An interview was conducted with NP 10 on 10/27/22 at 10:30 a.m. She reviewed the 10/4/22 pharmacy recommendation and indicated she was unsure why it wouldn't have been reviewed sooner. She was present at the facility on 10/12/22, could have reviewed it then, and would have preferred to do so on 10/12/22. They would "probably" be lowering the Sertraline today and			

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	considered this medication review as clinically significant since she fell and broke her wrist. She indicated communication was key and stated, "At the end of the day, we could have reviewed this on the 12th when I was here." The Medication Regimen Reviews and Pharmacy Recommendations policy was provided by the NC on 10/26/22 at 1:25 p.m. It read, "The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The drug regimen review must include a review of the resident's medical chart....Pharmacy recommendations should be reviewed with follow up by the physician within 30 days of the facility receiving....Clinically Significant means a potential or actual issue that warrants physician communication and completion of physician's prescribed/recommended actions by midnight of the next calendar day....Clinically significant medication issues must have Physician follow up by midnight of the next calendar day." 3.1-25(i)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure the kitchen flooring was clean and free of food wrappers, food debris and dirt. This had a potential to affect 99 of 99 residents that eat food prepared in the kitchen. Findings include:	F 0921	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Kitchen floors are cleaned daily per policy How will you identify other residents having the potential to be affected by the same deficient	11/22/2022

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	An observation was made of the kitchen with the Registered Dietician (RD) on 10/19/22 at 11:22 a.m. During the tour, the kitchen flooring of the dry storage area was observed with food particles and food wrappers/containers along the back wall behind the storage racks. The walk-in refrigerator and freezer flooring had food wrappers and dirt under the storage shelfing. The flooring under the 3 compartment sink and dishwasher area were observed to have food debree and dirt substance that was black and yellow in color along the back wall flooring. At that time, the RD indicated the kitchen had not had a dietary manager for awhile. During a kitchen tour with the RD on 10/21/22 at 11:36 a.m., the kitchen flooring was observed. The dry storage flooring had food debris and food wrappers/containers along the back walls under the shelving. The walk-in refrigerator and freezer had food and dirt debris under the storage racks. An observation was made of the 3 compartment sink area and dishwasher area. The flooring under the units had food debris and a dirt substance. An interview was conducted with the RD on 10/21/22 at 11:44 a.m. She indicated the flooring under the storage racks and units should be swept. She would provide the cleaning schedule, and the dietary staff cleaning logs for completion of the cleaning tasks. An interview was conducted with the Administrator on 10/21/22 at 2:29 p.m. He indicated the RD was unable to locate cleaning schedule logs for the cleaning tasks of the kitchen. A "Sanitiation of Kitchen" policy was provided by the Administrator on 10/24/22 at 11:58 a.m. It indicated "...Policy. The dietary staff will maintain		practice and what corrective action will be taken? · All residents have the potential to be affected by the alleged deficient practice. · An in-service will be completed by RD/CM for the kitchen staff regarding the policy and standards for sanitation on or before 11/23/2022 by RD/designee · A 1x audit of cleaning schedule will be conducted by RD/desingee What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · An in-service will be completed by RD/CM for the kitchen staff regarding the policy and standards for sanitation on or before 11/23/2022 by RD/designee · RD/CM or designee to audit the daily cleaning schedule and observe for floor cleanliness How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · To ensure compliance the DNS/Designee will complete a Cleaning Schedule CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or	

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	the sanitiation of the dietary department through compliance with a written, comprehensive cleaning schedule. Procedure. 1. The Dietary Services Manager will record all cleaning and sanitation tasks for the department. 2. A cleaning schedule will be posted for all cleaning tasks, and employees will inital tasks as completed. 3. This Federal Tag relates to complaint IN00387465. 3.1-19(f)(5)		designee. The Cleaning Schedule CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee. By What date the systematic changes be completed · Compliance date 11/23/22	