| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155628 | A. BUILDING 00<br>B. WING | 12/05/2023 |

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| CREEKSIDE HEALTH AND REHABILITATION CENTER | 3114 EAST 46TH STREET<br>INDIANAPOLIS, IN 46205 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigations of Complaints IN00421422 and IN00411851. This visit was in conjunction with the Investigation of Complaint IN00423107.<br><br>Complaint IN00421422 - Federal/State deficiencies related to the allegations are cited at F565.<br><br>Complaint IN00411851 - Federal/State deficiencies related to the allegations are cited at F550 and F684.<br><br>Complaint IN00423107 - No deficiencies related to the allegations are cited.<br><br>Survey dates: November 28, 29, 30, December 1, 4, and 5, 2023<br><br>Facility number: 009569<br>Provider number: 155628<br>AIM number: 200139920<br><br>Census Bed Type:<br>SNF/NF: 104<br>Total: 104<br><br>Census Payor Type:<br>Medicare: 1<br>Medicaid: 88<br>Other:15<br>Total: 104<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on December 12, 2023 | F 0000 | **The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.** | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Stacia Dawson | ED | 12/22/2023 |

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| F 0550 SS=E Bldg. 00 | 483.10(a)(1)(2)(b)(1)(2)<br>Resident Rights/Exercise of Rights<br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his | | | |

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| | or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>Based on interview and record review, the facility failed to ensure residents' respect and dignity was maintained by staff not being respectful and ensuring a resident was able to exercise her right to vote for 1 of 23 residents reviewed for activities and 26 of 104 residents reviewed for dignity. (Residents' B, C, D, E, F, G, H, J, K, L, M, N, P, Q, R, S, T, V, W, X, Y, Z, BB, CC, DD, EE, and FF)<br><br>Findings include:<br><br>1a. A resident council meeting was conducted on 11/28/23 at 2:30 p.m. The residents that attended the meeting was the following: B, C, D, E, F, G, J, K, L, M, N, P, Q, R, S, T, V, W, X, Y, Z, BB, and CC. During the meeting, the council indicated they do not feel the staff are respectful. Some staff use foul language and are on their personal cell phones during care. They do not respond to the call lights timely. The staff will come into the residents' rooms turn off their call lights and then immediately leave the room without providing the service that was needed.<br><br>1b. A Quarterly Minimum Data Set (MDS) assessment, dated 10/2/23, indicated Resident FF was cognitively intact.<br><br>An interview was conducted with Resident FF on 11/29/23 at 11:20 a.m. She indicated the Certified Nursing Assistants (CNA)s staff are rude and disrespectful. They will be in the room providing care and always on their cell phones. "They are very inconsiderate." The CNAS will come into the room turn off the call light, and leave the room without provided the assistance needed. | F 0550 | The facility will ensure this requirement is met through the following corrective measures:<br>1. No residents were harmed. See below for corrective measures.<br>2. All residents have the potential to be affected. See below for corrective measures.<br>3. The Voting and Absentee Ballot Policy was reviewed and revised to include that a staff member will be assigned should the pollster come to the facility to round with them and ensure all residents wishing to vote are visited. Activity staff will be educated on this policy. Facility staff will be reeducated on Resident Rights. The HFA or her designee will interview 10 residents weekly for 6 weeks and until 100% compliance is achieved regarding staff treatment of residents, then 10 residents per month for 4 months and until 100% compliance is maintained. During the next election cycle, The HFA or her designee will round with activities staff at least twice, prior to the election, to ensure residents are offered the opportunity to vote.<br>4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted | 12/29/2023 |

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| | 1c. A Quarterly Minimum Data Set (MDS) assessment, dated 9/4/23, indicated Resident H was cognitively intact.<br><br>An interview was conducted with Resident H on 11/29/23 at 2:16 p.m. She indicated some nurses are "hateful." She had spoken to one of the nurses regarding propping her feet up due to swelling in her feet. She didn't feel she was being mean about it, but she really wanted assistance with getting her feet up. The nurse did not assist and stated to her in a hateful tone, she was speaking mean to her and left the room. She called and told her family about the attitude of that nurse. The family then called and spoke to that nurse. The nurse reported to her family she was the one that was being mean. After, the resident stopped a male staff person coming down the hallway, and he assisted with raising her bed. The resident indicated that's all she wanted assistance with. "I don't want to be fussing and arguing with the staff."<br><br>1d. A Quarterly Minimum Data Set (MDS) assessment, dated 11/15/23, indicated Resident EE was moderately impaired.<br><br>An interview was conducted with Resident EE on 11/29/23 at 2:34 p.m. She indicated there are long delays in call light response times by the staff. The staff turn their name badges around, so the residents' are unable to identify who assist them. One evening the week of Thanksgiving, a staff member had stated to her that she had put her call light on 3 times in the past 15 minutes, and she wasn't going to keep coming into her room to answer her call light.<br><br>1e. A Quarterly Minimum Data Set (MDS) assessment, dated 10/18/23, indicated Resident | | accordingly. | |

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| | DD was severely impaired.<br><br>An interview was conducted with Resident DD's Representative on 11/29/23 at 4:11 p.m. The resident's family had come in to visit Resident DD. Resident DD was observed sitting in the dining room with her dinner tray in front of her, but not eating. A staff member was sitting next to the resident eating a meal. At that time, the staff member requested the family assist the resident with her dinner meal while the staff member sat there eating.<br><br>1f. A quarterly Minimum Data Set (MDS) assessment, dated 8/9/23, indicated Resident G was moderately cognitive impaired.<br><br>An interview was conducted with Resident G on 11/30/23 at 9:32 a.m. He indicated one day the week of Thanksgiving, he was told by a nurse the CNA staff were arguing about who was going to come down to his room to feed him. The nurse stated "aides don't want to feed you," so she had come to assist him.<br><br>2. During the resident council meeting conducted on 11/28/23 at 2:30 p.m., the council indicated some residents were not given the opportunity to vote for the November 7, 2023 election for the mayor. Resident B indicated she had wanted to vote, but was unable to do so. She had asked about it and was told she needed to get down to activities, because they were doing it right then. She was never told when or where to go to vote. At that time, a CNA staff member was pushing her down to the activities, and then she was told by another staff member it was too late to vote. She missed out on voting that day.<br><br>An interview was conducted with the Resident | | | |

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| | Council President (RCP) on 11/29/23 at 11:48 a.m. she indicated the process in place for residents to have the opportunity to vote was not organized, and some residents missed out on the opportunity. She can recall being told about the election a few weeks prior the election was coming, but no follow up was done to where, when or what to do if a resident chose to vote. She had asked the Assistant Executive Director (AED) when and where, and if she had not asked the AED she wanted to vote; she believed she would not have gotten to do it.<br><br>An interview was conducted with AD at 12/1/23 at 11:30 a.m. She indicated she had a few weeks prior her activity staff and herself went to each resident room and asked if they would like to participate in voting in the election for mayor. All the residents denied wanting to participate in voting due to it was for the mayor, and they didn't know who was running. The residents voiced since the election was not to vote for the president they did not wish to vote. Since she did not have anyone that wanted to vote; she did not make arrangements for anyone to come to the facility. The AD indicated the activities staff asked the residents verbally about voting. She was unable to provide any documentation the activities staff spoke to all the residents in the facility about voting.<br><br>An interview was conducted with the Executive Director (ED) and the AED on 12/1/23 at 2:03 p.m. They had heard from the AD there was no residents wished to vote for the election. The AED indicated the day before the election there was a couple of residents that inquired about voting. He called and received by email applications for absentee ballots for those residents that decided to vote. ED and AED went around that day to all the residents rooms and | | | |

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| | asked verbally all the residents if they wanted to vote. AED and ED was unable to provide documentation they asked all the residents to vote.<br><br>The AED provided residents' applications for absentee ballots filled out to vote on 12/1/23 at 2:30 p.m. Resident B did fill out an application for absentee ballot for November 7, 2023 election.<br><br>An interview was conducted with Resident B with AED on 12/1/23 at 2:45 p.m. She indicated she was unable to vote that day. She was told by staff it was too late when she was headed down there. AED was unsure why she was unable to vote that day.<br><br>A Voting and Absentee Ballots policy was provided by the ED on 12/1/23 at 12:19 p.m. It indicated "...It is the policy of this facility to assist and inform all residents of any upcoming elections and offer assistance in obtaining needed materials to vote, however the resident must make all voting choices on his/her own accord. Procedures -...2. Determine which residents wish to vote and compile a list of names. 3. Provide assistance to ensure that the residents are currently listed with the local voter's registration office. 4. Periodically reassess residents' interest in active voting. 5. Request absentee ballots and check to ensure that each resident receives his/her ballot...9. Coordinate assistance at polls as per residents' needs or requests."<br><br>A Resident Rights policy was provided by the ED on 12/1/23 at 12:19 p.m. It indicated "...The resident has right to exercise his or her rights as a citizen or resident of the facility and as a citizen of the United States...Dignity. The facility must promote care for residents in a manner and in an | | | |

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| | environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality..."<br><br>This citation relates to complaint IN00411851.<br><br>3.1-3(t) | | | |
| F 0565 SS=E Bldg. 00 | 483.10(f)(5)(i)-(iv)(6)(7)<br>Resident/Family Group and Response<br>§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.<br>(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.<br>(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.<br>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.<br>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.<br>(A) The facility must be able to demonstrate their response and rationale for such response.<br>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. | | | |

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| | §483.10(f)(6) The resident has a right to participate in family groups.<br><br>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.<br>Based on interview and record review, the facility failed to follow up with resolutions to grievances reported in resident council for 3 of 3 resident council minutes reviewed. (Residents' B, C, D, E, F, G, J, K, L, M, N, P, Q, R, S, T, V, W, X, Y, Z, BB, and CC)<br><br>Findings include:<br><br>The September 2023, October 2023, and November 2023 Resident Council Minutes were provided by the Executive Director on 11/28/23 at 1:10 p.m. The minutes indicated the following grievances discussed:<br><br>September 2023 Resident Council Minutes:<br>A resident stated she wanted her name removed from the scheduled exercise class on the activity's calendar.<br>A resident had not received her prizes she won from bingo activity.<br><br>October 2023 Resident Council Minutes:<br>Old business:<br>Nursing: Staff talking about residents in the hallway and the conversations are overheard by residents.<br>Activities: Residents want their winnings after playing bingo.<br>Kitchen: Residents requesting breakfast for dinner<br>Housekeeping: Request for staff utilize bleach to | F 0565 | The facility will ensure this requirement is met through the following corrective measures:<br>1. No residents were harmed. Grievances from those resident council meetings will be reviewed and followed-up on at this time.<br>2. All residents have the potential to be affected. See below for corrective measures.<br>3. The policies related to resident council and grievances were reviewed and no changes are indicated at this time. Activities staff and Department Heads will be educated on those policies. The HFA or her designee will review all resident council concerns/grievances and ensure appropriate follow-up has been provided in a timely manner monthly to ensure 100% compliance is achieved and maintained indefinitely.<br>4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly. | 12/29/2023 |

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| | clean rooms.<br>New business:<br>Nursing: Certified Nursing Aides (CNA)s leave without finishing their jobs.<br>Maintenance: Gnats flying in the dining room.<br><br>November 2023 Resident Council Minutes:<br>Old Business:<br>Nursing: Staff are on their phones a lot.<br>Kitchen: Food not appealing, residents' want breakfast for dinner, and residents' want to invite dietitian at the next meeting<br>Activities: Resident wants her name removed from the exercise class on the activity calendar and a resident had not received her prizes from bingo.<br>New business:<br>Nursing: CNAS in resident's room looking out window while resident sleeping.<br>Staff are not available at nurse's station when residents need help.<br><br>A resident council meeting was conducted on 11/28/23 at 2:30 p.m. The residents that attended the meeting was the following: B, C, D, E, F, G, J, K, L, M, N, P, Q, R, S, T, V, W, X, Y, Z, BB, and CC. The resident council indicated the council meets monthly, and the Activities Director (AD) attends the meetings. The AD documents the content discussed in the meetings. During the meetings, grievances are reported, but they do not receive any follow up with resolutions to their grievances discussed in the meetings. The council indicated they do not feel the staff are respectful. Some staff use foul language and are on their personal cell phones during care. They do not respond to the call lights timely. The staff will come into the residents' rooms turn off their call lights and then immediately leave the room without providing the service that was needed. | | | |

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| | An interview was conducted with the Resident Council President on 11/29/23 at 11:48 a.m. She indicated grievances discussed in the resident council monthly meetings are turned in to the appropriate person by the AD. The council does not receive follow up with resolutions to grievances/concerns discussed in the council meetings.<br><br>An interview was conducted with the Activities Director on 12/1/23 at 11:30 a.m. She indicated she does sit in and write down the discussions at the monthly resident council meetings. After the meetings, she fills out the grievance forms and gives the forms to the appropriate department the grievances are referring to. She does not provide follow up to the grievances that were discussed in the council.<br><br>The September 2023 and October 2023 resident council grievances were provided by the Executive Director on 12/1/23 at 2:00 p.m. The following grievances were the following:<br><br>September 2023:<br><br>A resident council grievance dated 9/22/23 indicated the council had concerns with staff gossiping, talking on cell phones in rooms, and call light response times. The conclusion to the investigation of the concern indicated "no specific details regarding staff or hallway provided. Staff education provided. Upon observation not able to confirm concern." The resident response to resolution indicated "no further concerns note."<br><br>A resident council grievance dated 9/22/23 indicated the grievance was "the residents want breakfast once a month for dinner." The | | | |

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| | conclusion to the investigation of the concern indicated "The dietary department provides a resident choice meal monthly that is chosen during resident council. The request for a breakfast meal to be provided for dinner will be provided for the October 2023 resident choice meal...The resident/resident representative response to resolution: No further concerns..."<br><br>October 2023:<br><br>A grievance by Resident F dated 10/20/23 indicated a resident was asked to leave the resident council meeting and Resident F did not feel it was right. During investigation, the resident was rude and yelling out during resident council meeting and was asked to leave. The conclusion to the investigation the resident apologized for her behavior.<br><br>The Executive Director did not provide any additional grievances that were reported by the resident council in September 2023, October 2023 or November 2023.<br><br>A Resident Council policy was provided Executive Director on 12/1/23 at 12:19 p.m. It indicated "..Purpose: to establish guidelines for assisting residents with the development and facilitation of a Resident Council in order to voice concerns, make recommendations, and participate in resolution of concerns...Policy: It is the policy of the facility to encourage and support a Resident Council for the purpose of protecting and preserving resident rights and to afford residents a forum to voice and discuss alleged concerns, resident rights or other problems and to participate in the resolution. The Resident Council shall also be encouraged to make recommendations regarding facility operations, | | | |

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| | quality of life issues and resident care...Any suggestions, concerns or view of the Resident Council presented to the Administrator or other facility staff will be reviewed and acted upon. The Administrator/Executive Director will respond to all written recommendations and concerns of the council, in writing, and in accordance with the facility grievance policy..."<br><br>A grievance policy was provided by the Nurse Consultant on 12/4/23 at 2:30 p.m. It indicated "...Policy: It is the policy of this facility to thoroughly investigate all grievances and provide a prompt resolution regarding the resident's rights. The facility respects the resident's/resident representative's right to file a grievance and can do so without the fear of reprisal or mistreatment..."<br><br>This citation relates to complaint IN00421422.<br><br>3.1-3(l) | | | |
| F 0656 SS=D Bldg. 00 | 483.21(b)(1)(3)<br>Develop/Implement Comprehensive Care Plan<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and | | | |

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| | psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed. | | | |
| | Based on interview and record review, the facility failed to ensure a resident had a care plan to address his seizure diagnosis for 1 of 5 residents reviewed for unnecessary. (Resident 74)<br><br>Findings include: | F 0656 | The facility will ensure this requirement is met through the following corrective measures:<br>1. Resident 74 was not harmed and his plan of care was reviewed and revised to include diagnosis of seizures. | 12/29/2023 |

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| | The clinical record for Resident 74 was reviewed on 11/30/23 at 9:55 a.m. His diagnoses included, but were not limited to: bilateral above knee amputation, type 2 diabetes mellitus, and congestive heart failure.<br><br>The 9/21/23 Quarterly MDS (Minimum Data Set) Assessment indicated he had a BIMS (brief interview for mental status score) of 15, indicating he was cognitively intact.<br><br>An interview was conducted with Resident 74 on 11/30/23 at 10:00 a.m. He indicated he went to the hospital because he had a seizure. The seizure was a few days after falling backwards in his wheel chair and hitting his head. He was now taking medication to address his seizures and hadn't had any since.<br><br>The 9/5/23 hospital notes read, "...presented on 9/5/2023 c/o [complaints of Seizures (Seizure today during rehab [rehabilitation]at ECF [extended care facility,] EMS [emergency medical services] report postictal [period that begins when a seizure subsides and ends when the patient returns to baseline] upon arrival, 2nd seizure en route resolved with 5 mg Versed [medication used to treat anxiety and cause drowsiness...] Assessment/Plan 1. Seizures: Presented from facility after having a seizure. He also seized en route to ED [emergency department....]a. New this morning, patient reports having fallen and hit his head twice in the past 2 weeks (most recently on Sunday.) b. EEG [electroencephalography-recording of brain activity] results pending. c. Cont [Continue] Keppra d. Seizure precautions."<br><br>The physician's orders and December, 2023 MAR (medication administration record) indicated he | | 2. All residents have the potential to be affected. Residents care plans will be reviewed to ensure necessary diagnosis are addressed in his/her plan of care.<br>3. The policies related to comprehensive care plans and care plan revisions were reviewed and no changes were indicated. Licensed nursing staff will be educated on these policies. The DON or her designee will audit 5 random resident care plans weekly for 6 weeks and until 100% compliance is achieved to ensure care plans include appropriate diagnosis, then 5 per month for 4 months and until 100% compliance is maintained.<br>4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly. | |

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| | was receiving 500 mg of levetiracetam (anticonvulsant medication) twice a day for seizures, effective 9/7/23.<br><br>The 9/22/23 neurology note indicated he had a past medical history of seizures and was currently taking 500 mg of Keppra (name brand for leviteracetam) twice a day without issue.<br><br>Resident 74's care plans did not address his seizure diagnosis.<br><br>An interview was conducted with the NC (Nurse Consultant) on 12/5/23 at 12:40 p.m. She reviewed Resident 74's care plans and 9/22/23 neurology note and indicated he did not currently have a care plan to address his seizure diagnosis, but he should, and she was going to create it now.<br><br>The NC provided the Comprehensive Care Plans policy on 12/5/23 at 1:35 p.m. It read, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment."<br><br>3.1-35(a) | | | |
| F 0657<br>SS=D<br>Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to-- | | | |

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| | (A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. | | | |
| | Based on interview and record review, the facility failed to ensure a resident's care plan included non-pharmacological interventions for pain management and ensure care plan meetings were completed quarterly and when a resident had a significant change for 3 of 24 residents' care plans reviewed. (Residents' 30, 57 and G)<br><br>Findings include:<br><br>1. The clinical record for Resident 30 was reviewed on 11/29/23. Resident 30's diagnoses included, but not limited to, diabetes type II, pain in right shoulder, pain in left shoulder, generalized muscle weakness, and other reduced mobility.<br><br>During a resident council meeting held on 11/28/23 at 2:11 p.m., Resident 30 indicated, she | F 0657 | The facility will ensure this requirement is met through the following corrective measures:<br>1. Resident 30 has been evaluated by the physiatrist and goes to the pain clinic monthly. Her pain assessment has been completed and her plan of care revised. Residents 57 has had a care plan meeting. No residents were harmed.<br>2. All residents have the potential to be affected. A review was conducted to ensure residents have a current pain assessment completed and an appropriate care plan in place as indicated. A review was conducted to ensure | 12/29/2023 |

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| | can't always make it down to the activity room for activities related to her pain.<br><br>An interview with Resident 30 conducted on 11/29/23 at 9:56 a.m. indicated, she has arthritis pain and requested for her physician to increase her dose of pain medication however, the physician had explained she was on a high dose of pain medication already. Resident 30 indicated, her pain medication does not always relieve her pain enough to go to activities or meetings.<br><br>A MDS (Minimum Data Set) note dated 10/30/2023 at 11:10 a.m. indicated, "Patient states medications are somewhat effective in managing pain".<br><br>Resident 30's last pain evaluation was completed on 5/18/23.<br><br>Resident 30's care plan for pain was reviewed on 12/4/23. A care plan dated 11/22/17, indicated, Resident 30 was at risk for chronic pain related to osteoarthritis and included, but no limited to, interventions such as, pain medications will be administered as ordered and requested, observe to determine if she was experiencing non-verbal signs of pain, and to decrease the external stimulation as much as possible. A care plan initiated 11/4/22 indicated, Resident 30 was currently prescribed an opioid medication. Interventions included, but not limited to, "teach me and I will participate in non-pharmacological approaches to pain reduction". Resident 30's care plans did not contain person-centered non-pharmacological approaches to be attempted (other than to decrease external stimuli) to decrease her pain, nor did the care plan address a re-evaluation of the effectiveness of the intervention(s) after attempting | | residents have had a care plan meeting within the last quarter.<br>3. The policies related to pain management and care plan meetings have been reviewed and no changes are indicated. Licensed nursing staff will be educated on the pain management policy and social services staff educated on the care plan meeting policy. The DON or her designee will audit 5 random residents weekly and until 100% compliance is achieved to ensure pain assessments are completed timely and pain management care plans are in place and include appropriate non-pharmacological interventions for 6 weeks, then 5 per month for 4 months and until 100% compliance is maintained. The HFA or her designee will audit 5 random residents per week to ensure care plan meetings are held timely and until 100% compliance is achieved for 6 weeks, then 5 random residents per month for 4 months and until 100% compliance is maintained.<br>4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly. | |

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| | non-pharmacological approaches nor after pain medication was administered.<br><br>A Pain policy received on 12/4/23 at 12:10 from DON (Director of Nursing) indicated, the purpose was "To establish guidelines to measure a resident's level of pain. To provide optimal comfort through a pain control plan, which is established with the members of the health care team...1. Residents will have a pain evaluation completed upon admission, quarterly, and when the resident experiences new pain in a different location...3. Residents will have pain assessed routinely with each dose of pain medication given...7. The pain scale will be used to determine the effectiveness of pain interventions...9. The resident will have a care plan developed for their pain control with established interventions, and this will be reviewed on a quarterly basis and as needed..."<br><br>2. The clinical record for Resident 57 was reviewed on 12/4/23. Resident 57's diagnoses included, but not limited to, Parkinson's disease, history of falling, difficulty in walking, and cognitive communication deficit.<br><br>Resident 57 had a significant change MDS completed on 10/9/23 related to being placed on hospice.<br><br>An interview with CDSS (Corporate Director of Social Services) conducted on 12/5/23 at 10:22 a.m. indicated, a "care plan meeting should be completed within 14 days after a resident has a significant change" MDS completed. In a later interview on the same day at 10:54 a.m., she indicated, Resident 57 had not had a care plan meeting since September of 2023, but should have had a care plan meeting since the significant | | | |

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| | change.<br><br>A Comprehensive Care Plan policy received on 12/5/23 indicated, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident...that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs...The comprehensive care plan will describe, at a minimum, the following:<br>a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being...<br>f. Resident specific interventions that reflect the resident's needs and preferences..."<br><br>A Care Plan Revisions Upon Status Change policy received on 12/5/23 indicated, "The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change." 3. The clinical record for Resident G was reviewed on 11/30/23 at 9:43 a.m. The resident's diagnosis included, but was not limited to, cord compression (pressure on spinal cord). The resident was admitted to the facility on 3/17/23.<br><br>A quarterly Minimum Data Set (MDS) assessment, dated 8/9/23, indicated Resident G was moderately cognitive impaired.<br><br>An interview was conducted with Resident G on 11/30/23 at 9:43 a.m. He indicated he had not had any care plan meetings.<br><br>A care conference summary dated 3/20/23 was provided by the Executive Director on 12/1/23 at 9:49 a.m. It indicated a care plan meeting had been conducted with the resident's family. | | | |

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| | The medical record did not indicate any additional quarterly care plan meetings were conducted with the resident nor his family.<br><br>An interview was conducted with Social Services Director 2 on 12/1/23 at 3:43 p.m. He indicated Resident G had only had a care plan meeting on admission. He should have had additional care plan meetings. He has been reaching out to residents and their families to catch up.<br><br>A care plan meeting and invitations policy was provided by the Assistant Director of Nursing on 12/5/23 at 9:18 a.m. It indicated "...Policy: It is the policy of this facility to invite residents and/or resident representative(s) to resident care plan meetings. Responsible: Social Services Director (SSD)/Designee; MDS Coordinator. Procedure: 1. The SSD/Designee will obtain a list of proposed dates for resident care plan meetings. 2. SSD/Designee will send a standard letter to the Resident Representative or place a call to schedule the care plan meeting and will alert the resident within 72 hours of the meeting where the meeting will take place and at what time. 3. The SSD/Designee will document that the letter was sent or the phone call was made and the response received from the resident or resident representative. 4. The Resident and/or the Resident Representative will sign the care plan to verify the attendance at the care plan meeting and it will be documented in the Care Plan meeting note that they attended. 5. If the Resident and/or Resident Representative decline the invitation to attend the care plan meeting, they will be offered a copy of the care plan and sign that they received it. If they do not want a copy of the care plan it will be documented in the Care Plan meeting note that they declined to attend and declined a copy of the care plan..." | | | |

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| | 3.1-35(a)<br>3.1-35(b)<br>3.1-35(c)<br>3.1-35(d)(2)(B) | | | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>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.<br>Based on observation, interview, and record review, the facility failed to: administer a resident's morning medications timely for 1 of 3 residents reviewed for ADLs (Activities of Daily Living) (Resident EE); adequately document a resident's behaviors per the facility's behavior documentation policy for 1 of 5 residents reviewed for unnecessary medications (Resident EE); ensure a resident's pain was managed per the facility's pain management policy; coordinate care for a resident on hospice services (Resident 57) for 1 of 1 residents reviewed for hospice; and perform neurochecks following a resident's unwitnessed fall with head injury (Resident 57) for 1 of 3 residents reviewed for accidents.<br><br>Findings include:<br><br>1. The clinical record for Resident EE was reviewed on 11/30/23 at 2:28 p.m. Resident EE's diagnoses included, but not limited to, chronic obstructive pulmonary disease (COPD), | F 0684 | The facility will ensure this requirement is met through the following corrective measures:<br>TIMELY MEDICATION ADMINISTRATION-<br>1. Resident EE received her medications late without adverse effects.<br>2. All residents have the potential to be affected.<br>3. The policy on medication administration was reviewed and no changes are indicated.<br>Licensed staff will be educated on this policy. The DON or her designee will review medication administration timeliness twice weekly for 6 weeks and until 100% compliance is achieved to ensure medications are administered timely and, if not, proper notification and documentation is | 12/29/2023 |

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| | congestive heart failure (CHF), diabetes type II, depression, anxiety, and chronic kidney disease.<br><br>An interview with Resident EE conducted on 12/1/23 at 10:35 a.m. indicated, she had not received her morning medications as of yet.<br><br>An interview with Resident EE conducted on 12/1/23 at 11:37 a.m. indicated, she had received her morning medications and the nurse had applied lotion to her legs.<br><br>An interview with DON (Director of Nursing) conducted on 12/5/23 at 1:03 p.m. indicated, when administering a medication, for it to be considered on time, the medication can be administered one hour prior to the administration time and/or up to an hour after the administration time on the MAR.<br><br>A December 2023 MAR (medication administration record) for Resident EE's current medications with administration times was provided by ADON (Assistant Director of Nursing) on 12/5/23 at 1:20 p.m. According to Resident EE's December 2023 MAR, the following medications were to be administered at 8 a.m. daily: allopuinol (for gout), amlodipine (for hypertension), cholecalciferol (vitamin D3), escitalopram (an antidepressant), polyethylene glycol (a stool softener), and a mulitvitamin. According to Resident EE"s December 2023 MAR, the following medications were to be administered at 9 a.m. daily: Lasix (a diuretic), omeprazole (decreases stomach acid), Prostat (a supplement), hydralazine (used to treat hypertension), buspirone (used to treat anxiety/depression), and acetaminophen. On the 2023 December MAR for Resident EE, the above mentioned medication's administration on 12/1/23 did not have a circle/mark nor an explanation | | made per policy; then twice monthly for 4 months and until 100% compliance is maintained.<br>4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.<br>BEHAVIOR DOCUMENTATION-<br>1. Resident EE was not harmed. See below for corrective measures.<br>2. All residents with behaviors have the potential to be affected. See below for corrective measures.<br>3. The policy related to behavior management was reviewed and no changes are indicated. Licensed nursing staff and social services staff will be educated on this policy. The Social Services Director or his designee will review 5 random residents weekly and until 100% compliance is achieved to ensure behavior documentation and follow-up is completed when indicated, then 5 per month for 4 months and until 100% compliance is maintained.<br>4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.<br>PAIN MANAGEMENT-<br>1. Resident 30 has been evaluated by the physiatrist and goes to the pain clinic monthly. Her pain assessment has been | |

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| | documented as to why they were administered late.<br><br>A Medication Administration policy received on 12/5/23 at 1:20 p.m. from ADON (Assistant Director of Nursing) indicated, "Medication(s) are to be administered no sooner than sixty (60) minutes prior and no later than sixty (60) minutes after scheduled time i. Medication(s) ordered for specific times or before/after meals should be administered based on those times...Document any scheduled medication(s) that is withheld, refused, or given at a different time than scheduled i. MAR/eMAR should have the licensed nurse/authorized personnel initials circled/marked for the medication(s) with and [sic, an] explanation documented in the appropriate designated area on MAR/eMAR..."<br><br>2. A physician's order for Resident EE dated 11/29/23 indicated, to give one tablet of Wellbutrin SR (an antidepressant) 100 mg once a day.<br><br>According to Resident EE's clinical record, she was also prescribed escitaloproam oxalate (an anti-depressant) 20 mg for depression.<br><br>Resident EE's care plan dated 4/15/20, revised on 10/24/23 indicated, she was at risk for side effects related to the use of antidepressants and antianxiety medications. Interventions included, but not limited to, the use of psychotropic medications will be reviewed quarterly by a pharmacist and the interdisciplinary team to ensure the need for continued use and the appropriateness for a gradual dose reduction and the facility will observe for changes in my behaviors and revise/update my care plan as needed. | | completed and her plan of care revised.<br>2. All residents have the potential to be affected. A review was conducted to ensure residents have a current pain assessment completed and an appropriate care plan in place as indicated.<br>3. The policy related to pain management has been reviewed and no changes are indicated. Licensed nursing staff will be educated on the pain management policy. The DON or her designee will audit 5 random residents weekly and until 100% compliance is achieved to ensure pain assessments are completed timely and pain management care plans are in place and include appropriate non-pharmacological interventions for 6 weeks, then 5 per month for 4 months and until 100% compliance is maintained.<br>4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.<br>HOSPICE COORDINATION-<br>1. Resident 57 was not harmed. Hospice was contacted and provided updated hospice documentation. The plan of care was revised to include hospice coordination.<br>2. All resident receiving hospice services will be reviewed to ensure hospice documents are provided and remain up to date and the | |

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| | Resident EE care plan dated 4/9/20 and revised on 2/23/23 indicated, she was at risk of having signs and symptoms of depression like sad mood, tearfulness, and isolation. Interventions included, but not limited to, the facility will observe for changes in my depression symptoms.<br><br>Resident EE's behavior monitoring task documentation for the last 60 days was provided on 12/4/23 at 12:10 p.m. by DON. Under the task of behavior monitoring, it included which behavior symptoms were exhibited, what triggered the behavior, and which behavior interventions were used. According to this documentation, Resident EE had no behavior symptoms from 10/1/23 until present with the exception of 11/18/23 at 8:19 p.m. where she was observed frequently crying.<br><br>A quarterly MDS assessment completed on 11/15/23 indicated her PHQ9 was "0" with no behaviors. The PHQ9 indicated the severity of depression. A score of 0-4 is none.<br><br>A review of Resident EE's social services behavior notes was conducted on 12/1/23 at 2:19 p.m. There weren't any other social services behavior notes as per the facility's behavior documentation policy other than the one near the end of November/beginning of December.<br><br>An interview with SSD (Social Services Director) conducted on 12/1/23 at 2:33 p.m. indicated, he had made the one behavior note in Resident EE's chart related to finding out that on 11/18/23 she was tearful and perhaps that was the reason Resident EE's psychologist added another anti-depressant. He indicated, he just sees her when she is due for an assessment which is done | | plan of care is shows that coordination.<br>3. The policy related to hospice coordination of care was reviewed and no changes are indicated. Licensed nursing staff will be educated on this policy. The DON or her designee will audit 4 random hospice binders and plans of care weekly for 6 weeks and until 100% compliance is achieved to ensure binders are up to date along with the hospice plan of care then 5 per month for 4 months and until 100% compliance is maintained.<br>4. The findings of these audits will be presented during the facility's monthly QAPI meeting and the plan of action adjusted accordingly.<br>NEUROLOGICAL CHECKS-<br>1. Resident 57 suffered no adverse effects.<br>2. All residents with possible head injuries have the potential to be affected. See below for corrective measures.<br>3. The policy related to fall investigations was reviewed and no changes are indicated. Licensed nursing staff will be educated on this policy. The DON or her designee will review all accidents to ensure neurochecks are completed. The reviews will be completed daily, Monday through Friday, indefinitely to ensure 100% compliance.<br>4. The findings of these reviews | |

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| | quarterly. The note he wrote in November 2023 had not indicated an increase in signs/symptoms of depression but rather just the diagnoses related to it.<br><br>A follow-up evaluation note from Resident EE's behavioral health services group dated 6/22/23 indicated, "Patient denied feeling depressed... no behavioral assessment have been completed in 30/60 days...no psychotropic medication changes are recommended at this time".<br><br>A follow-up evaluation note from Resident EE's behavioral health services group dated 8/1/23 indicated, "Patient indicated she has been in good spirits...no behavioral assessment have been completed in 30/60 days. Patient believes her mood is stable at this time...no psychotropic medication changes are recommended at this time".<br><br>A follow-up evaluation note from Resident EE's behavioral health services group dated 11/27/23 indicated, "Patient's affect appeared sad/down. She was sitting in her room after breakfast with her door shut, lights off, and curtains down...Patient admitted feeling increasingly sad, down, and depressed...denied any specific triggering events...admitted to crying often...no behavioral assessments have been completed in 30/60 days...Plan: 1. Start Wellbutrin SR..."<br><br>A Protocol for Behavior Documentation policy was received on 12/4/23 at 12:10 p.m. from DON indicated, "The CNA's [sic, certified nursing assistants] will document behaviors in POC [sic, point of care] when behaviors occur. The CNA will notify the nurse of the behavior. The nurse or social service will complete the Behavior Sheet upon being notified of or witnessing a | | will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly. | |

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| | behavior....Social Services will follow-up documentation of behaviors under progress notes utilizing the Behavior Note...Social Services will complete a progress note at the end of the 2 weeks of routine documentation with the determination of whether or not a behavior management program is needed. The Behavior Management Team Review will be utilized...Copies of the behavior management plan will be kept in a binder at nurses station if desired to allow access to all staff to the interventions for the resident on the behavior management program...Behavior care plans will be initiated by Social Services, they will include the behavior symptoms and interventions for the symptoms specific to the resident."<br><br>3. The clinical record for Resident 30 was reviewed on 11/29/23. Resident 30's diagnoses included, but not limited to, diabetes type II, pain in right shoulder, pain in left shoulder, generalized muscle weakness, and other reduced mobility.<br><br>During a resident council meeting held on 11/28/23 at 2:11 p.m., Resident 30 indicated, she can't always make it down to the activity room for activities related to her pain.<br><br>An interview with Resident 30 conducted on 11/29/23 at 9:56 a.m. indicated, she has arthritis pain and requested for her physician to increase her dose of pain medication however, the physician had explained she was on a high dose of pain medication already. Resident 30 indicated, her pain medication does not always relieve her pain enough to go to activities or meetings.<br><br>A MDS (Minimum Data Set) note dated 10/30/2023 at 11:10 a.m. indicated, "Patient states medications are somewhat effective in managing pain". | | | |

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Resident 30's last pain evaluation was completed on 5/18/23.

Resident 30's November 2023 MAR (medication administration record) indicated, on the following dates, her pain rating (0 to 10, 10 being worst pain ever experienced) prior to receiving her Norco pain medication was a 5 or above at some point in the day: 11/11, 11/2, 11/3, 11/6, 11/7, 11/8, 11/9, 11/11, 11/12, 11/14, 11/15, 11/16, 11/17, 11/20, 11/21, 11/22, 11/23, 11/25, 11/26, 11/27, 11/28, 11/29, and 11/30. No re-evaluations of her pain after receiving her pain medication was documented. On the following dates, she had a pain rating of 5 or higher two/three times in the day prior to her pain medication being administered: 11/16, 11/20, 11/23, 11/25, 11/26, 11/28, and 11/30.

Resident 30's care plan for pain was reviewed on 12/4/23. A care plan dated 11/22/17, indicated, Resident 30 was at risk for chronic pain related to osteoarthritis and included, but no limited to, interventions such as, pain medications will be administered as ordered and requested, observe to determine if she was experiencing non-verbal signs of pain, and to decrease the external stimulation as much as possible. A care plan initiated 11/4/22 indicated, Resident 30 was currently prescribed an opioid medication. Interventions included, but not limited to, "teach me and I will participate in non-pharmacological approaches to pain reduction". Resident 30's care plans did not contain person-centered non-pharmacological approaches to be attempted (other than to decrease external stimuli) to decrease her pain, nor did the care plan address a re-evaluation of the effectiveness of the intervention(s) after attempting

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| | non-pharmacological approaches nor after pain medication was administered.<br><br>A Pain policy received on 12/4/23 at 12:10 from DON (Director of Nursing) indicated, the purpose was "To establish guidelines to measure a resident's level of pain. To provide optimal comfort through a pain control plan, which is established with the members of the health care team...1. Residents will have a pain evaluation completed upon admission, quarterly, and when the resident experiences new pain in a different location...3. Residents will have pain assessed routinely with each dose of pain medication given...7. The pain scale will be used to determine the effectiveness of pain interventions...9. The resident will have a care plan developed for their pain control with established interventions, and this will be reviewed on a quarterly basis and as needed..."<br><br>4. The clinical record for Resident 57 was reviewed on 12/4/23. Resident 57's diagnoses included, but not limited to, Parkinson's disease, history of falling, difficulty in walking, and cognitive communication deficit.<br><br>Resident 57 had a significant change MDS completed on 10/9/23 related to being placed on hospice.<br><br>An observation of Resident 57's hospice binder was conducted on 12/5/23 at 10:40 a.m. Inside Resident 57's hospice binder were some handwritten nursing and nursing aide notes, as well as chaplain notes. The binder did not contain a signed consent for hospice services between Resident 57 and/or representatives and the hospice nor a hospice plan of care with interventions indicating the care or services they | | | |

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| | will provide for Resident 57. At the same time as the observation, ADON was unable indicate which days the hospice provider came to the facility as she was unable to locate a schedule for Resident 57's hospice.<br><br>A Coordination of Hospice Services policy was received on 12/5/23 at 12:02 p.m. from ADON. It indicated, "when a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental, and psychosocial well-being...The plan of care will identify the care and services that each entity will provide in order to meet the needs of the resident and his/her expressed desire for hospice care...The facility will communicate with hospice and identify, communicate, follow and document all intervention put into place by hospice and the facility. The facility will monitor and evaluate the resident's response to the hospice care plans...The plan of care will include directives for managing pain and other uncomfortable symptoms and will be revised and updated as necessary..."<br><br>A Comprehensive Care Plan policy received on 12/5/23 indicated, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident...that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs...The comprehensive care plan will describe, at a minimum, the following:<br>a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being...<br>f. Resident specific interventions that reflect the resident's needs and preferences..." | | | |

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| | 5. A fall note for Resident 57 was dated 11/20/2023 at 2:26 p.m. It indicated, Resident 57 had an unwitnessed fall his room near the bathroom door. The back of his head was bleeding. The fall was unwitnessed and had hit the back of his head which was found to be bleeding. He was sent to the local emergency room for treatment. He was not admitted to the hospital but rather later returned to the facility.<br><br>A nurse note dated 11/21/23 at 1:53 p.m. indicated, Resident 57's vital signs were within normal limits, no signs/symptoms of pain, his neurochecks were within normal limits, and was resting in his recliner.<br><br>A review of Resident 57's electronic charting for neuro-assessments was completed on 12/4/23 at 4:02 p.m. and indicated, no other neurochecks had been completed following his fall on 11/20/23 despite his fall being unwitnessed.<br><br>The most recent fall risk assessment for Resident 57 was completed in May 2023 and at that time his fall risk was low.<br><br>An interview with DON conducted on 12/4/23 at 4:40 p.m. indicated, neurochecks should have been completed for Resident 57 following his fall on 11/20/23.<br><br>A Fall Investigation and Risk Evaluation policy received on 12/1/23 at 9:52 a.m. from ED (Executive Director)indicated, "Residents will be evaluated at a minimum upon admission, quarterly, and with a significant change in the resident that may change their risk for falls...4. The assessment of the resident after al fall should include...c. Neuro checks if the fall was unwitnessed or an injury to | | | |

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| | the head is suspected or observed..."<br><br>This citation relates to complaint IN00411851.<br><br>3.1-25(b)(3)<br>3.1-43(a)<br>3.1-37(a) | | | |
| F 0689 SS=D Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, interview, and record review, the facility failed to timely implement a resident's fall intervention; update a resident's care plan with identified safety interventions to prevent accidents; and appropriately implement a safety intervention to prevent accidents for 2 of 3 residents reviewed for accidents. (Residents 74 and L)<br><br>Findings include:<br><br>1. The clinical record for Resident 74 was reviewed on 11/30/23 at 9:55 a.m. His diagnoses included, but were not limited to: bilateral above knee amputation, type 2 diabetes mellitus, and congestive heart failure.<br><br>The at risk for falls care plan, revised 10/11/23, indicated he was at risk for falls related to him being a bilateral amputee and a history of falling. | F 0689 | The facility will ensure this requirement is met through the following corrective measures:<br>1. Resident 74's plan of care was reviewed and revised to include anti-tippers to his wheelchair. Resident L's care plan was reviewed and revised as well, to include her power chair, adjusting her power chair controls during transport, and padding to her bed. The bed was visualized to ensure the pool noodles were placed correctly.<br>2. All residents who have experienced an accident or fall have the potential to be affected. Falls/accidents from the past 30 days will be reviewed to ensure resulting interventions are | 12/29/2023 |

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| | The 9/21/23 Quarterly MDS (Minimum Data Set) Assessment indicated he had a BIMS (brief interview for mental status score) of 15, indicating he was cognitively intact.<br><br>An interview was conducted with Resident 74 on 11/30/23 at 10:00 a.m. He indicated he fell backwards in his wheel chair twice, and hit his head, because he didn't have any anti-tippers (optional safety anti-tilt mechanism to prevent a wheelchair from tipping over backwards) on his wheel chair. The facility did not put anti-tippers on his wheel chair until his daughter came to the facility and complained about it. He stated, "I don't have legs, so I'm top heavy, and fall backwards." One of the times was with a transportation service person, who let him fall. The other time was when being weighed in the hallway. He told the staff member he tipped over easily, but she said not to worry, because "I got you." The CNA (Certified Nursing Assistant) pushed him up on the scale and "sure enough," the wheel chair tipped backwards. He fell and hit his head, and the CNA fell too. He had a headache after the second fall. He did not have anti-tippers on his wheelchair either time. Now that he had anti-tippers, he didn't have any problems with falling backwards. He had a seizure a few days after the second fall. The physician at the hospital told him the seizure was "most likely because I hit my head." He'd since been on anticonvulsant medication and hadn't had any subsequent seizures.<br><br>The 8/16/23, 12:13 p.m. fall note read, "Time of fall; location of fall; vital signs: approximately around noon, writer notified by [name of transportation company] driver that resident had fell outside in the van. 136/80 [blood pressure,] 80 [pulse,] 16 | | appropriate, care planned and visualized to ensure they are in place.<br>3. The policy related to Accidents/Fall Investigation and risk evaluation was reviewed and no changes are indicated. Licensed nursing staff will be educated on this policy. The DON or her designee will review all accidents to ensure the investigation is thorough, resulting intervention is appropriate, assessment and care plan are reviewed/revised accordingly, and visually inspect as indicated to ensure the interventions are in place. The reviews will be completed daily, Monday through Friday, indefinitely to ensure 100% compliance.<br>4. The findings of these reviews will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly. | |

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| | [respirations,] 98.1 [temperature,] 96% RA [oxygen saturation-room air.] Description of fall: Resident fell backwards, in the wheelchair while being transported up the ramp, resulting in hitting his head. c/o [complains of] dizziness reported. Range of motion; mental status, neurochecks if unwitnessed or hit head; injuries: Upper extremities WNL [within normal limits,] resident hit his head, mental status WNL Immediate intervention: neuro assessment perform, v/s [vital signs] Physician notification; family (responsible party notification: MD, DON [Director of Nursing,] emergency contact."<br><br>The 8/17/23 Fall IDT [Interdisciplinary Team] Note read, "Summary of the fall: Resident fell backwards, in the wheelchair while being transported up the ramp, Root cause of fall: isolated incident Intervention and care plan updated: Transportation company to be educated on safe transfers."<br><br>The 8/21/23 nurse's note, written by the ADON (Assistant Director of Nursing,) read, "Narrative: Phoned [name of transportation company] and spoke with rep. [representative] advised that I was following up on fall incident that occurred on 8/16 and offered to provide wheelchair ramp safety education. Rep attempted to transfer to manager. Manager was unavailable at this time. Writer was provided with email to forward education information and advised that manager will follow up with me once available. Educational tools emailed to [email address to transportation company."]<br><br>There was no subsequent nurse's note referencing follow up with the manager at the transportation company. | | | |

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| | An interview was conducted with the ADON on 12/1/23 at 11:22 a.m. She indicated transportation staff was who pushed Resident 74 up the ramp, into their van. The facility staff went outside to assess him after the fall, but none of the facility staff saw the actual fall. Resident 74 was okay and still wanted to go to his appointment. From what she recalled being told, the transportation driver moved to the side when Resident 74 fell backwards and hit his head. They didn't consider anti-tippers to his wheel chair as an intervention afterwards, because "it wouldn't have stopped the fall, so we just did education." She spoke to the manager of the company and sent over information on how to safely roll up a ramp.<br><br>On 12/5/23 at 1:43 p.m., an interview was conducted with the manager of the transportation company used during Resident 74's 8/16/23 fall. She indicated the facility staff sent over education on how to safely roll a resident up a ramp in their wheel chair, but their staff already knew how to do that, as this was what they did all day long. They had video footage of Resident 74's fall. The driver was pushing Resident 74 up the ramp in his wheel chair. Once the driver began strapping the wheel chair into the van, the front 2 wheels of the wheel chair came up off the floor and the wheel chair started to roll backwards, as Resident 74 was "kind of top heavy." The driver caught Resident 74 and assisted him to the ground. The driver was behind Resident 74 the whole time. This occurred while securing the back part of the wheel chair to the van. The driver never made it to the front of the wheel chair to secure it, because the front wheels lifted up before he made it to the front. Since this happened in the parking lot of the facility, facility staff came to assist with picking him up. It might have been helpful to have anti-tippers, "especially with someone with no | | | |

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| | legs."<br><br>The 9/3/23, 11:46 a.m. fall note read, "Time of fall; location of fall; vital signs: CNA attempting to get residents weight, pushed wheelchair up incline and wheelchair flipped backwards and resident and CNA fell on floor. Description of fall: CNA attempting to get residents weight, pushed wheelchair up incline and wheelchair flipped backwards and resident and CNA fell on floor. Range of motion; mental status, neurochecks if unwitnessed or hit head; injuries: ROM [range of motion] WNL, alert and oriented, neuros and v/s initiated. Immediate intervention: weights to be completed via hoyer<br>Physician notification; family (responsible party notification: MD, DON, and fam [family] notified."<br><br>The 9/3/23 fall assessment read, "Nursing Description: CNA attempting to get residents weight, pushed wheelchair up incline and wheelchair flipped backwards and resident and CNA fell on floor. Resident Description: Resident stated that CNA wheeled him up the wheelchair scale and the wheelchair and himself fell backwards hitting his head....Other Info-resident bilateral amputee making wheelchair top heavy."<br><br>The 9/5/23 Fall IDT Note read, "Summary of the fall: CNA attempting to get residents weight, pushed wheelchair up incline and wheelchair flipped backwards and resident and CNA fell on floor. Root cause of fall: Intervention and care plan updated: OT TO EVAL RES FOR W/C [wheel chair] POSITIONING."<br><br>The 9/5/23 Change of Condition assessment indicated he had a seizure in the morning and a second uncontrolled seizure lasting over a minute. He was sent to the emergency room. | | | |

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The 9/5/23 hospital notes read, "...presented on 9/5/2023 c/o [complaints of] Seizures (Seizure today during rehab [rehabilitation]at ECF [extended care facility,] EMS [emergency medical services] report postictal [period that begins when a seizure subsides and ends when the patient returns to baseline] upon arrival, 2nd seizure en route resolved with 5 mg Versed [medication used to treat anxiety and cause drowsiness...] Assessment/Plan 1. Seizures: Presented from facility after having a seizure. He also seized en route to ED [emergency department....]a. New this morning, patient reports having fallen and hit his head twice in the past 2 weeks (most recently on Sunday.) b. EEG [electroencephalography-recording of brain activity] results pending. c. Cont [Continue] Keppra d. Seizure precautions."

The 9/6/23, 3:52 p.m. nurse's note read, "Narrative: Residents daughter and advised that resident would be returning from the hospital within the couple of days and wanted to request a careplan to address some concerns. Advised that I would have social services reach out to schedule a meeting."

The 9/7/23, 4:16 p.m. nurse's note indicated his admission assessment for his return to the facility was completed. There were no progress notes referencing anti-tippers or wheel chair adjustments between 9/7/23 and 9/11/23.

The 9/11/23 multidisciplinary care conference summary read, "Nursing Summary 1. Problems/Concerns-Daughters wanted to know what interventions were in place to keep resident from falling out of wheelchair....Restorative Care/PT [physical therapy]/ OT [occupational

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| | therapy] 1. Problems/Concerns-Resident still receiving OT/PT. Therapy has updated precautions and interventions since most recent hospitalization related to a seizure/fall. Therapy has ordered anti-tippers for resident's wheelchair. Therapy also recommends obtaining his weights via the Hoyer lift instead of on a scale. Staff to accompany resident to all appointments and transportation staff to load resident with 2 person assist to prevent any future falls."<br><br>An interview was conducted with PT 12 on 12/5/23 at 9:38 a.m. She indicated Resident 74 was on caseload during both his 8/16/23 and 9/3/23 falls. She heard he fell with transportation, but therapy did not do an analysis of his 8/16/23 fall with transportation, as no one asked her about looking at his wheelchair after the 8/16/23 fall with transportation. She didn't didn't know much about the first fall, whether it had something to do with the person pushing him or whether the chair tipped backwards, "but I wasn't informed, so." She thought anti-tippers needed to be in place after falling backwards, and she didn't know why they weren't implemented after the first fall. Resident 74 was a "bigger guy," had gained a lot of weight and the anti-tippers could have been placed after the 8/16/23 fall. She was present at the 9/11/23 care plan meeting and his daughter was asking about wheelchair adjustments and that's when the anti-tippers were suggested. They asked maintenance to add anti-tippers because his center of gravity was much different. They ended up putting those on that day.<br><br>2. The clinical record for Resident L was reviewed on 11/29/23 at 2:00 p.m. Her diagnoses included, but were not limited to, hemiplegia, hemiparesis, and morbid obesity. | | | |

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| | The 11/10/23 Quarterly MDS (Minimum Data Set) Assessment indicated she had a BIMS (brief interview for mental status score) of 15, indicating she was cognitively intact.<br><br>An interview was conducted with Resident L on 11/29/23 at 2:03 p.m. She indicated she had an appointment one day, and the CNA (Certified Nursing Assistant) who was supposed to go with her was unable to go, so the facility van driver, Van Driver 14, was going to take her. Van Driver 14 told her she needed to get up and dressed to get there on time. At the time, her power wheelchair was new. They were "rushing, rushing, rushing." When getting into the van, Van Driver 14's foot got stuck underneath her wheel chair. There was something sticking out inside of the van. Her old wheelchair fit past this piece with no issues, but her new chair didn't, and it "tore up my leg." She had to get 17 stitches. Normally, Van Driver 14 guided her verbally on what she needed to do with her wheel chair, but this time, he didn't do that. When Van Driver 14 reached over to strap her wheelchair into the van, he accidentally hit her arm, which caused her to accidentally hit the button on her chair to make it go forward, causing her to hit the piece sticking out with her left leg. There was blood everywhere after getting out of the van. She went to the hospital and "never hurt so bad in my life." Shortly after the van accident, she also had to get 28 stitches in her right leg from another incident in her room. Resident L showed pictures of the stitches in her legs on her cell phone.<br><br>The 10/9/23, 10:03 a.m. nurse's note read, "Narrative: Resident was in the facility van for an appointment. She hit her knee while trying to navigate her electric chair. Her Left knee is open and heavily bleeding. Writer and other staff | | | |

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| | applied pressure to wound and wrapped it tightly to slow the bleeding. Area was not able to be measured at the time. Resident was transported to [name of local hospital] via ambulance, for treatment and evaluation. Face sheet and orders were sent. Family was notified of incident via phone."<br><br>The 10/9/23 incident analysis indicated on 10/9/2023, an environmental screen was completed. No sharp or protruding objects were noted in the van or on resident's wheel chair. On 10/12/2023, Resident L was provided education by the ADON (Assistant Director of Nursing.) She educated resident to allow bus driver to assist with safe repositioning of her wheel chair on the van and allow the bus driver to provide instructions on how to adjust wheelchair while in the van.<br><br>An interview was conducted with Van Driver 14 on 12/4/23 at 12:11 a.m. He indicated he began working at the facility 5 months after they opened as a CNA, and started driving the van 3 years ago. He recalled the incident on the van with Resident L. She rolled up inside the bus, but didn't cut her chair off. She went backwards a bit, then forward and hit the stationary chair inside the van with her left leg and that's how she "opened her leg." He was behind her wheel chair at the time, getting ready to strap in her wheel chair. When he got to the front of her wheel chair, he saw the blood coming from her left leg, and told her she had to get back out of the van. He didn't see her leg actually hit the stationary chair inside the van, just saw her go forward, so that must be when she hit it.<br><br>An observation of the facility van was made with Van Driver 14 on 12/4/23 at 12:20 p.m. There were | | | |

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| | 2 stationary seats, one on each side of the van, directly behind the driver and front passenger seats. Van Driver 14 pointed to the seat behind the driver's seat and indicated that was the seat on which she hit her leg. It was a vegan leather type material. Van Driver 14 indicated, if you had fragile skin, the material was hard enough to tear it. When she got in, she was going kind of fast and her wheel chair speed wasn't turned down low. Since the incident, he now made sure she and other residents had their chair turned down to the slowest speed prior to getting onto the ramp. He would rather for them to go slower than for them to have an accident. Neither Resident L nor Van Driver 14 made sure of that that day.<br><br>The 10/9/23 through 10/11/23 hospital notes read, "...presented as a trauma 1 due to a bleeding left lower extremity laceration with a tourniquet placed in the field. Patient states that she was initially on her way to a doctor's appointment earlier this morning when she cut her leg on a chair in the transport van taking her from her ECF [extended care facility] to her appointment. States that she did not fall, hit her head, or lose consciousness. She initially presented to OSH [outside hospital] where the laceration was closed primarily and no imaging was obtained. Peer outside documentation the wound was hemostatic, and the patient returned to her ECF. EMS [emergency medical services] was called later this afternoon due to concern that the left lower extremity laceration was continuing to bleed. Upon arrival of EMS it was noted that the patient's wound dressing from earlier was saturated in blood and there was bleeding noted to be coming from the incision that was closed by suture, and due to concern for high amount of bleeding a tourniquet was placed high on the left lower extremity. The patient received 100 mcg of fentanyl in transit due | | | |

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| | to pain she experienced after the tourniquet was placed. She remained hemodynamically stable in transit. Upon arrival in the trauma Bay ATLS primary and secondary survey were conducted with revealed a large assumed to be deep laceration on the distal LLE [lower left extremity]which was closed with suture but had blood coming from the wound between sutures. The tourniquet was taken down at 1836 (6:36 p.m.) with no significant change in blood output from the incision. Distal pulses were present bilaterally after tourniquet was taken down. approximately 5-6 sutures were removed from the laceration to explore the wound and source of bleeding, and bedside cautery and suture ligation was used to gain hemostatisis in the wound. The bleeding from the laceration appeared to be venous in nature and was appropriately stopped with cautery and suture ligation, and wrapped in pressure dressing."<br><br>Resident L's care plans, including the assistance with ADLs (activities of daily living) and skin condition care plans, did not reference ensuring her motorized wheel chair was turned down to the lowest speed when getting into the facility van and turned off once inside. Her ADL care plan, last reviewed 11/27/23, indicated she used a manual wheelchair, as she exceeded the weight limit for use of her power chair, and was not updated to include her current use of a power chair.<br><br>The 10/12/23, 4:53 p.m. nurse's note read, "Pt. [Patient] returned from hospital this evening. Drsg. [Dressing] remains c/d/i [clean/dry/intact] to LLE. No bleeding noted. Pt. denies pain or discomfort. 72 hr f/u [follow up] continues for readmission. v/s [vital signs] noted and remain stable. | | | |

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| | An interview and observation was conducted with Resident L on 12/4/23 at 10:51 a.m. She indicated she was in her room and threw a pillow onto her bed, but the pillow began to fall off the bed, so she rolled up to catch it, but didn't catch it, and when she backed up from the bed, she heard the blood dripping from her right leg. Her right leg hit the bar underneath the side of her bed. Resident L pointed to the white bars along the underside of her bed. She was in the room by herself at the time this occurred. She thought the facility needed to put something, maybe a rubber piece, over the white bars along the underside of her bed where she hit her leg.<br><br>The 11/6/23, 8:18 p.m. incident analysis read, "Nursing Description: resident screaming for this nurse to come quick. Resident Description: resident stated that she was throwing a pillow onto the bed and her leg was caught under the bed....11/6/2023-this writer summoned to resident room, upon entering copious amount of blood on the floor and coming from resident right lower extremity. Area cleanse pressure applied, 911 call call director of nursing, unit manager, family and doctor's office called. 911 arrived escorted resident to emergency room. 11/9/2023-Environmental screen completed. No sharp protruding objects noted. Resident legs have been wrapped with Kerlix and ace/coban to keep in place and are serving as a protectant at this time. Derma savers are on order to assist with further leg protections. Staff education began regarding use of derma savers once they arrive and the importance of encouraging resident to allow staff to apply a form of protection for her lower extremities."<br><br>The 11/6/23 Emergency Department note read, | | | |

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| | "...pt[patient] was in her wheelchair reaching down for a pillow when her r [right] fell down and got cut on the bedframe. pt has an open laceration to r shin...ED Disposition: Other: [Name of physician] at the bedside for laceration repair."<br><br>The 11/10/23 wound note indicated a laceration to right shin after repair in emergency wound...Patient bumped her leg into something while in wheelchair, was sent to emergency room for evaluation and repair. There are multiple interrupted style sutures in place reapproximating the flap to edges."<br><br>An interview was conducted with the DON (Director of Nursing) and NC (Nurse Consultant) on 12/4/23 at 12:55 p.m. The NC indicated after Resident L's van accident, they educated drivers on adjusting the speed of her power chair, but the intervention didn't make it's way onto a care plan. When informed of Resident L wanting padding for the bars on the underside of her bed where she hit her leg, the NC indicated they could get pool noodles to cover the bars. The DON indicated when she spoke with Driver 14, he informed her he instructed Resident L to hold on, but she went into the van anyway.<br><br>The ADL care plan, revised 11/27/23, had an intervention for polyethylene foam to left, right and foot of rail on bed, initiated 12/4/23 by the DON.<br><br>An interview and observation was made with Resident L in her room on 12/5/23 at 12:00 p.m. There were red foam noodles on the foot of her bed, but nothing along the bars on the underside of the bed where Resident L hit her leg or as indicated in the care plan. She was unaware the red noodles had been placed on the foot of her | | | |

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|---|---|---|---|
| | 155628 | A. BUILDING 00<br>B. WING | 12/05/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| CREEKSIDE HEALTH AND REHABILITATION CENTER | 3114 EAST 46TH STREET<br>INDIANAPOLIS, IN 46205 |

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| | bed. Resident L indicated the noodles needed to on the side where she hit her leg.<br><br>An interview was conducted with the ED (Executive Director) on 12/5/23 at 12:35 p.m. She indicated the Assistant ED placed the noodles on the foot of her bed yesterday and was supposed to do the sides too. She called the ED at this time and informed him he needed to put noodles on the sides as well. After getting off the phone, the ED indicated the Assistant ED misunderstood the instructions yesterday, but would do the sides now.<br><br>The Fall Investigation and Risk Evaluation policy was provided by the ED on 12/1/23 at 9:52 a.m. It read, "9. The Interdisciplinary Team will review the fall and determine the root cause to the extent possible. 10. Update the care plan with new intervention(s) as indicated."<br><br>3.1-45(a)<br>3.1-45(b) | | | |
| F 0698 SS=D Bldg. 00 | 483.25(l)<br>Dialysis<br>§483.25(l) Dialysis.<br>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.<br><br>Based on interview and record review, the facility failed to check assess a dialysis fistula as ordered by the physician and to complete post dialysis assessments timely for 1 of 1 resident reviewed for dialysis (Resident 36). | F 0698 | The facility will ensure this requirement is met through the following corrective measures:<br>1. Resident 36 was not harmed.<br>2. All residents receiving dialysis services have the potential to be affected. See below for corrective | 12/29/2023 |

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| | Findings include:<br><br>The clinical record for Resident 36 was reviewed on 12/1/23 at 2:10 p.m. The Resident's diagnosis included, but were not limited to, chronic kidney disease and anemia.<br><br>A care plan, last revised 8/12/22, indicated Resident 36 had end stage kidney disease and required dialysis. The goal was for him to remain free from infection, The approaches included that he would attend dialysis on scheduled days and times, initiated 10/20/23, and that his AV (connection of artery and vein) fistula was in his left upper arm, initiated 10/20/23.<br><br>A physician's order, dated 1/18/23, indicated the check the bruit (sound of blood flow) and thrill (vibration felt) of dialysis fistula every shift.<br><br>A physician's order, dated 2/21/23, indicated he was to receive hemodialysis on Monday, Wednesday, and Friday.<br><br>A Quarterly MDS (Minimum Data Set) Assessment, completed 11/4/23, indicated Resident 36 was severely cognitively impaired and received dialysis services.<br><br>The November and December 2023 TAR (Treatment Administration Record) did not contain documentation that the bruit and thrill were checked on the following days:<br>11/2/23- night shift,<br>11/4/23- evening and night shifts,<br>11/5/23- evening shift,<br>11/10/23- evening shift,<br>11/16/23- evening shift,<br>11/17/23- evening and night shift,<br>11/18/23- evening shift, | | measures.<br>3. The policy related to dialysis services was reviewed and no changes are indicated. Licensed nursing staff will be educated on this policy. The DON or her designee will review all residents receiving dialysis twice weekly for 6 weeks and until 100% compliance is achieved to ensure pre/post dialysis assessments are completed on dialysis days and bruit/thrill checks are completed every shift, then weekly thereafter. to ensure 100% compliance is maintained.<br>4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly. | |

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| | 11/19/23- evening shift,<br>11/20/23- night shift,<br>11/21/23- evening shift,<br>11/23/23- evening and night shift,<br>12/1/23- night shift, and<br>12/4/23- evening shift.<br><br>The clinical record for Resident 36 did not contain post dialysis assessments on 11/21/23, 11/27/23, and 11/29/23.<br><br>During an interview on 12/05/23 at 8:47 a.m., LPN (Licensed Practical Nurse) 3 indicated that normally a pre dialysis assessment was completed prior to him going to dialysis and sent with him to the dialysis center. The nurse was to complete a post dialysis assessment when he returned. LPN 3 believed the fistula was checked each shift.<br><br>On 12/1/23 at 3:24 p.m., the Executive Director provided the Dialysis policy, last revised April 2022, which read "...Residents receiving hemodialysis will receive appropriate monitoring and care from the facility and the dialysis provider in order to coordinate care...Monitoring of the dialysis fistula will be completed by the nurse assigned to the resident...1. Listen using a stethoscope for the bruit and lightly palpate for the thrill once each shift. 2. Document the presence or absence of the bruit and thrill on the treatment record each shift... pre-dialysis assessments will be completed before dialysis...post dialysis form will be completed after dialysis..."<br><br>3.1-37(a) | | | |
| F 0761<br>SS=D<br>Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br>§483.45(g) Labeling of Drugs and Biologicals | | | |

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| | Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>Based on observation, interview, and record review, the facility failed to ensure medications stored in the facility's medication carts were not expired and/or had current orders for their use and vacu-tainers used for blood collection were not expired for 2 of 4 medication rooms and 4 of 8 medication carts reviewed.<br><br>Findings include:<br><br>1. An observation of a medication cart on the 400 hallway with LPN (Licensed Practical Nurse) 3 was conducted on 12/5/23 at 11:13 a.m. Inside the | F 0761 | The facility will ensure this requirement is met through the following corrective measures:<br>1. Residents 62 and 49 were not harmed. The expired medication was removed and destroyed per facility protocol and new medication obtained. The expired blood collection tubes were disposed of.<br>2. All residents have the potential to be affected. All medication carts and medication rooms were audited and expired items | 12/29/2023 |

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| | medication cart was a bottle of Tylenol 325 mg tablets for Resident 62. The bottle of Tylenol tablets indicated, the expiration date was 11/4/23.<br><br>An interview with LPN 3 conducted at the same time as the observation, indicated, the expired medication should have been removed from the medication cart.<br><br>2. An observation of a medication cart on the 100 hallway with LPN 10 was conducted on 12/5/23 at 11:50 a.m. Inside the medication cart was a bottle of Chloroseptic throat spray 1.4% for Resident 49. A review of Resident 49's current medication orders with LPN 10 conducted at the same time as the observation, indicated, Resident 49 did not have a current physician's medication order for Chloroseptic throat spray.<br><br>3. An observation of the 100 hallway medication room was conducted on 12/5/23 with LPN 10 at 11:54 a.m. In a cabinet inside the medication room was a plastic bag containing blood specimen tubes and tourniquets. Upon review of the yellow-topped blood specimen tubes, it was observed that two of the tubes had an expiration date of 10/31/23.<br><br>A Guidelines for Medication Storage and Labeling policy received on 12/5/23 at 12:30 p.m. from DON (Director of Nursing) indicated, "Medication and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier...All discontinued, outdated or deteriorated medication will be destroyed or sent back to the pharmacy.."<br><br>3.1-25(b)<br>3.1-25(o) | | replaced and/or disposed of per facility policy.<br>3. The policy related to medication storage was reviewed and no changes are indicated.<br>The DON or her designee will audit all medication carts and medication rooms weekly for 6 weeks and until 100% compliance is achieved to ensure no expired or discontinued medications are in circulation and expired supplied are discarded, then twice monthly for 4 months to ensure compliance is maintained.<br>4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly. | |