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| | 155809 | A. BUILDING 00<br>B. WING | 09/23/2024 |

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| GREY STONE HEALTH & REHABILITATION CENTER | 10445 DUPONT OAKS BLVD<br>FORT WAYNE, IN 46845 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00443443 and IN00443537.<br><br>Complaint IN00443443 - No Federal/state deficiencies are related to the allegations.<br><br>Complaint IN00443537 - Federal/state deficiencies related to the allegations are cited at F690.<br><br>Survey dates: September 17, 18, 19, 20 and 23, 2024.<br><br>Facility number: 012935<br>Provider number: 155809<br>AIM number: 201207690<br><br>Census Bed Type:<br>SNF: 13<br>SNF/NF: 76<br>Total: 89<br><br>Census Payor Type:<br>Medicare: 3<br>Medicaid: 67<br>Other: 19<br>Total: 89<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed September 25, 2024 | F 0000 | October 10, 2024<br>Indiana State Department of Health<br>Department of Health and Human Services<br>Centers for Medicare & Medicaid Services<br><br>To whom it may concern,<br>Grey Stone Health and Rehabilitation, CMS Certification Number **155809** has received the 2567. Enclosed is our Plan of Correction for all of the deficiencies we received during our Survey process. We ask that our Plan of Correction be reviewed and accepted as we strive to continue operating in compliance with CMS. We are also requesting desk review approval to place us back into compliance as quickly as possible.<br>Thank you for your consideration in this matter.<br><br>Sincerely,<br>Maria Diaz, Administrator<br>Grey Stone Health and Rehabilitation<br>maria.diaz1@saberhealth.com<br>260-471-4770 | |
| F 0686<br>SS=G<br>Bldg. 00 | 483.25(b)(1)(i)(ii)<br>Treatment/Svcs to Prevent/Heal Pressure Ulcer | | | |

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

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

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| | Based on observation, interview, and record review, the facility failed to ensure services were effectively provided to identify, monitor, and treat an area of facility-acquired skin impairment and failed to ensure interventions were implemented to provide effective pressure relief to the wound for a resident admitted without skin impairment for 1 of 4 residents reviewed for pressure injuries. (Resident 243) This deficient practice resulted in the facility-acquired skin impairment deteriorating to a stage three pressure injury with infection that required antibiotic therapy.<br><br>Findings include:<br><br>Resident 243's record was reviewed on 9/17/24 at 10:46 AM. Diagnoses included unspecified focal traumatic brain injury with loss of consciousness status unknown, type 2 diabetes mellitus with diabetic polyneuropathy, and paresthesia of skin.<br><br>A hospital discharge summary, dated 9/1/24 at 12:25 PM, indicated no skin rashes or lesions were present on Resident 243's skin.<br><br>An admission assessment, dated 9/1/24 at 5:52 PM, indicated Resident 243's skin was warm, dry, and intact, had normal color and turgor with two abrasions noted on the left knee. No pressure ulcers were indicated on the admission skin assessment. A section of the admission assessment labeled care plan included selections of "continue current care plan", "initiate care plan" and "plan of care updated". None of the selections indicated a care plan was initiated, or interventions were implemented.<br><br>A Braden Scale assessment, dated 9/1/24 at 5:52 PM, included in the admission assessment | F 0686 | **F686**<br>**1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>Resident was discharged on 9/19/24.<br><br>**2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?**<br><br>Current resident and new admits with pressure ulcers will have a skin alteration audit along with identified corrections will be completed by the Director of Nursing or designee.<br><br>**3.What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**<br><br>The Director of Nursing or designee will have an in-service/education with Licensed nurses on Pressure Injury Prevention and Treatment Policy, | 10/15/2024 |

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| | indicated Resident 243 had a slightly limited ability to respond meaningfully to pressure or discomfort, his skin was occasionally moist, and required a linen change about once a day. The assessment indicated Resident 243 was bedfast, was able to make frequent slight position changes, and had adequate meal intakes. The assessment indicated friction and shear were not an apparent problem. Intervention and care plan actions were blank with no interventions selected for pressure ulcer prevention.<br><br>A weekly skin assessment, dated 9/2/24 at 2:09 PM, was blank with no indication whether skin conditions were present or not.<br><br>A skilled nursing note, dated 9/3/24 at 2:34 PM, indicated skin impairment was present, but no corresponding wound assessment was available for review. The type, characteristics, and location of skin impairment was not specified on the assessment.<br><br>A skilled nursing note, dated 9/4/24 at 4:23 PM, indicated Resident 243's skin was intact with no impairment.<br><br>No skilled nursing notes, progress notes or wound assessment records for 9/5/24 were available for review.<br><br>A skilled nursing note, dated 9/6/24 at 3:42 AM, indicated Resident 243's skin was intact with no impairment.<br><br>No skilled nursing notes, progress notes or wound assessment records for 9/7/24 were available for review.<br><br>A skilled nursing note, dated 9/8/24 at 1:51 AM, | | and the Clean Dressing Change Policy.<br><br>**4.How the corrective action(s) will**<br>**be monitored to ensure the deficient**<br>**practice will not recur, i.e., what**<br>**quality assurance program will be**<br>**put into place?**<br><br>The Director of Nursing or designee<br>will be complete random audits of pressure ulcers utilizing the Skin Alteration audit tool. This audit<br>will be completed Weekly for 4 weeks,<br>then monthly for 5 months.<br><br>**5.By what date the systemic changes**<br>**for each deficiency will be completed?**<br><br>All audits, in-servicing, and systemic<br>Changes will be in effect by October<br>22, 2024. | |

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| | indicated skin impairment was present, but no corresponding wound assessment was available for review. The type, characteristics, and location of skin impairment was not specified on the assessment.<br><br>Resident 243's current admission Minimum Data Set (MDS) assessment, dated 9/8/24, indicated his Basic Interview for Mental Status (BIMS) score was 12 (mild cognitive impairment). The MDS indicated Resident 243 was dependent on staff to roll back and forth in bed and move from a lying to sitting position in bed. The MDS indicated Resident 243 did not have recorded occurrences of rejection of care. The MDS indicated he was at risk for development of pressure ulcers and had no current pressure ulcers.<br><br>The comprehensive plan of care, dated 9/3/24 through 9/9/24, did not include documentation to indicate a plan of care to provide pressure relief to the left elbow skin impairment was developed.<br><br>Resident 243's current care plan, initiated 9/9/24, titled "Skin Integrity? indicated Resident 243 was at risk for skin breakdown related to incontinence, impaired mobility, diabetes mellitus, and indicated the resident had a problem of risk for skin breakdown. Interventions included: remove the headboard from the bed and place an air mattress; assess for presence of risk factors, treat, reduce, and eliminate factors to extent possible; avoid shearing resident's skin during positioning, transferring, and turning; conduct a systematic skin inspection, pay particular attention to bony prominences; keep clean and dry as possible; minimize skin exposure to moisture; keep linen dry and wrinkle free; pressure reducing cushion to wheelchair; pressure reducing mattress to bed; report any signs of skin breakdown(sore, tender, | | | |

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| | or broken areas); and use moisture barrier product to perineal area.<br><br>A skilled nursing note, dated 9/9/24 at 10:38 PM, indicated Resident 243's skin was intact with no impairment.<br><br>A progress note, dated 9/10/24 at 8:55 AM, indicated Nurse Practitioner (NP) 5 had been notified of an open area on the left elbow NP 4 had addressed earlier and a bandage was in place.<br><br>A Wound Management Detail Report, dated 9/10/24 at 10:11 AM, indicated the facility-acquired skin impairment on the left elbow was a Stage III (three) pressure ulcer measured 2.0 centimeters (cm) length (L) by 1.8 cm width (W) by 0.0 cm depth (D), had light exudate (drainage), 20 precent granulation tissue and 80 percent slough (necrotic tissue). The report indicated the ulcer had well defined wound edges and edema (swelling) of the skin surrounding the wound.<br><br>A skilled nursing note, dated 9/10/24 at 10:53 AM, indicated skin impairment was observed but no corresponding wound assessment was available for review. The type, and location of skin impairment was not specified on the assessment.<br><br>A progress note, dated 9/10/24 at 11:26 AM, indicated NP 4 had been notified of a skin tear on the left elbow by nursing staff. She indicated the left elbow wound had full thickness loss, with 80 percent slough in the wound bed, 20 percent granulation tissue and a small amount of serosanguinous exudate (blood-tinged drainage) with blanchable redness surrounding the area. NP 4 provided orders to cleanse the wound, pat dry, apply Medi-honey to the wound bed, cover with a foam dressing, change every other day and as | | | |

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| | needed upon soilage or dislodgement.<br><br>The Centers for Medicare and Medicaid Services (CMS) Long-Term Care (LTC) Facility Resident Assessment Instrument (RAI) User's Manual Version 1.18.11 October 2023 Section M0300C, page M-13, indicated, " ...Stage 3 [three] Pressure Ulcer ...Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss."<br><br>Untimed Physician orders, dated 9/10/24, indicated Resident 243's pressure sore should be measured with progress documented weekly.<br><br>Untimed Physician's orders, dated 9/10/24, indicated an air mattress was ordered.<br><br>A Treatment Administration Record (TAR), dated September 2024, indicated beginning 9/10/24 at 2:00 PM, through 9/18/24, staff should change Resident 243's position every two hours or more often, and pressure should be avoided to the affected area.<br><br>A skilled nursing note, dated 9/11/24 at 9:23 AM, indicated a skin impairment was observed and indicated Resident 243 had no orders for any type of dressing. No description of the left elbow ulcer or assessment details were available for review.<br><br>A skilled nursing note, dated 9/12/24 at 11:25 PM, indicated a skin impairment was observed and indicated Resident 243 had no orders for any type of dressing. No description of the left elbow ulcer or assessment details were available for review.<br><br>No skilled nursing notes, progress notes or wound assessment records for 9/13/24 were | | | |

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| | available for review.<br><br>No skilled nursing notes, progress notes or wound assessment records for 9/14/24 were available for review.<br><br>A skilled nursing note, dated 9/15/24 at 7:00 AM, indicated skin was intact without impairment, and Resident 243 had no orders for any type of dressing.<br><br>The September 2024 TAR indicated the resident should have an air mattress and staff should measure and document wound progress weekly. The record did not include documentation to indicate staff measured the left elbow wound or the wound progress was evaluated between 9/10/24 and 9/17/24.<br><br>A skilled nursing note, dated 9/16/24 at 3:59 AM, indicated a skin impairment was observed, but Resident 243 had no orders for any type of dressing. No description of the left elbow ulcer or assessment details were available for review.<br><br>A Braden Scale assessment, dated 9/16/24 at 12:58 PM, indicated Resident 243 had very limited ability to feel or communicate pain, had very moist skin, required linen change at least once a shift, and was chairfast with very limited ability to make frequent or significant changes in position. The assessment indicated Resident 243 had adequate meal intakes, and shearing and friction were a problem. The assessment indicated Resident 243 was at high risk for skin breakdown. The assessment indicated no interventions or care plan changes were made to increase pressure relief for Resident 243's left elbow.<br><br>A skilled nursing note, dated 9/17/24 at 12:20 AM, | | | |

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| | indicated a skin impairment was observed, but Resident 243 had no orders for any type of dressing. No description of the left elbow ulcer or assessment details were available for review.<br><br>A Wound Management Detail Report, dated 9/17/24 at 10:38 AM, indicated a Stage III pressure ulcer on the left elbow measured 2.0 cm (L) by 1.5 cm (W) by 0.0 cm (D), moderate serous (clear) exudate and 80 percent covered by slough. The left elbow ulcer had well defined wound edges and edema (swelling) of the skin surrounding the wound.<br><br>A progress note, dated 9/17/24 at 11:41 AM, indicated NP 4 determined there was a decline in the left elbow ulcerated area with evidence of cellulitis. She indicated an antibiotic would be started to treat the cellulitis. No description of the left elbow ulcer or assessment details were documented in the notes.<br><br>Physician's orders, dated 9/17/24, indicated to give doxycycline hyclate (an antibiotic) 100 milligrams twice daily for ten days.<br><br>An untimed progress note, dated 9/18/24, indicated an ABD pad may be substituted for the foam dressing ordered to the left elbow due to foam dressing not being available one time only.<br><br>During an observation on 9/18/24 at 10:25 AM, Resident 243 was observed lying on his back in bed with his left arm propped on a pillow and covered with a sheet. Registered Nurse (RN)2 entered the room carrying an abdominal (ABD) pad and a package of Medi-honey (a treatment to dissolve dead tissue in a wound). She indicated she was not prepared, returned a few minutes later carrying a bottle of wound cleanser and was | | | |

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| | accompanied by the Infection Preventionist (IP). She approached the resident with the wound cleanser when the IP prompted her to don a gown prior to beginning the procedure. After donning the gown and gloves, RN 2 pulled the sheet back and cleansed the wound. The tip of Resident 243's elbow had a nickel-sized, brown centered, round wound surrounded on all edges by yellow slough with bright red skin surrounding the immediate edges and swollen, pink skin surrounding two to three inches of the arm. RN 2 performed hand hygiene, changed her gloves and applied a piece of Medi-honey to the wound bed, touching the wound bed with her gloved hand in the process. She then picked up the dressing, placed it on the wound, secured it in place without performing hand hygiene use or applying clean gloves after touching the wound bed.<br><br>According to medihoney.com an article, titled Manufacturer's Guideline, dated January 2024, indicated Medi-honey was used to promote a moist wound environment to aid and supports autolytic debridement (dissolves dead tissue).<br><br>During an interview on 9/18/24 at 10:25 AM, Resident 243's wife indicated he had an infected left elbow, and the nurse was going to return to the room to perform a dressing change within the next few minutes. Resident 243's wife indicated she was concerned about Resident 243's elbow because she reported to the nurses that it had looked infected and was warm to touch several days before a Nurse Practitioner saw it and ordered an antibiotic.<br><br>During an interview on 9/18/24 at 10:45 AM, the IP indicated hand hygiene should be done before each procedure, after removing any dressing, and after wound care is complete. She indicated she | | | |

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| | would have to review the policy to see if hand hygiene and glove change is required after touching the wound during the packing of a treatment product.<br><br>During an interview on 9/19/24 at 10:22 AM, CNA 3 indicated the facility did not use a written reporting system for CNA staff to notify the nurse of skin concerns. She indicated she informed her nurse verbally sometime during her shift over that weekend and she believed the nurses were aware of the area on the elbow prior to that because it had been there for a while. She could not recall when she first observed the area on the elbow. She indicated the area looked like a scab but could not recall the size or what the skin around it looked like.<br><br>During an interview, on 9/19/24 at 1:18 PM, Nurse Practitioner 5 indicated on 9/10/24 an unidentified CNA asked if she needed to order a bandage for Resident 243's left elbow. She indicated the elbow had an area around the size of the end of her thumb (about the size of a dime) with slough in the center. She indicated it did not appear to be a result of a skin tear. She indicated the area was positioned on a pressure point and was the result of pressure. She indicated she was not aware of any skin impairment on the left elbow prior to that encounter.<br><br>A current policy titled Clean Dressing Change Policy, dated 3/10/24, provided by the IP on 9/18/24 at 1:00 PM, indicated hand hygiene and donning new gloves should occur if a wound is touched during the assessment process.<br><br>A current policy titled Skin and Wound Care Best Practices, last revised 6/10/22, provided by the IP, on 9/18/24 at 3:07 PM, indicated pressure | | | |

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| | reduction and redistribution should be provided to residents determined to be at risk. The policy indicated full body skin assessments should be conducted upon admission, with a second full body assessment conducted within the first 24 hours of admission. Staff should complete a Weekly Skin Check and review nursing assistant's shower sheet skin reviews. The policy indicated pressure injuries and wounds should be treated with evidenced based interventions as ordered by the provider.<br><br>3.1-40(a)(1)<br>3.1-40(a)(2) | | | |
| F 0689<br>SS=D<br>Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br><br>Based on interview, and record review the facility failed to ensure interventions were followed to prevent falls for 1 of 24 residents reviewed (Resident 22).<br><br>Findings include:<br><br>During an interview on 9/17/24 at 2:13 PM, Resident 22 indicated she had been in the facility for about a month and was concerned because she fell 3 times since she was admitted. She indicated she had just fallen the evening before during a transfer with the sit to stand lift. She indicated her knees gave out during the transfer and as her body lowered toward the bed, the bed moved away because the wheels were not locked, causing the staff to lower her to the floor.<br><br>Resident 22's record was reviewed on 9/20/24 at 10:15 AM. Diagnoses included drug-induced polyneuropathy, repeated falls, unsteadiness on | F 0689 | **F689**<br>**1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>Resident was discharged on 9/24/24.<br><br>**2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?**<br><br>Current resident and new admits who have a risk of falls will be reviewed by the Director of Nursing or designee to ensure Fall | 10/15/2024 |

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| GREY STONE HEALTH & REHABILITATION CENTER | 10445 DUPONT OAKS BLVD<br>FORT WAYNE, IN 46845 |

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| | feet, and muscle weakness, generalized.<br><br>Resident 22's current Admission Minimum Data Set (MDS), dated 8/25/24, indicated her Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact). The MDS indicated the resident needed substantial assistance transferring from a chair to a bed and bed to chair.<br><br>Resident 22's current care plan titled "At risk for falls ..." indicated the resident had a problem of being at risk for falls, with a goal date of 11/26/24. Interventions included keep bed in lowest position with brakes locked, and obtaining a physical therapy consult for transfer training. The care plan did not indicate to use any type of lift for transfer or the number of staff required for transfer.<br><br>During an interview on 9/20/24 at 10:54 AM, the therapy director indicated upon admission and as needed, therapy staff evaluates a resident's transfer status and gives recommendations to nursing. She indicated therapy had recommended nursing transfers with Resident 22 be conducted using a Hoyer (full-body mechanical lift). She indicated therapy had not at any time approved the nursing staff to use the sit to stand lift without therapy assistance since admission.<br><br>Resident 22's current care plan titled "Resident requires staff assistance to complete ADLS (activities of daily living)" with a goal date of 11/26/24 indicated therapy recommendations should be followed.<br><br>A therapy note, dated 9/9/24, Physical Therapy Assistant (PTA) 7 performed a sit to stand transfer with nursing staff. The note indicated Resident 22 was able to maintain a standing | | interventions<br>are in place per plan of care.<br><br>**3.What measure will be put into**<br>**place and what systemic changes**<br>**will be made to ensure that the deficient practice does not recur?**<br><br>The Director of Nursing or designee<br>will have an in-service/education with<br>nurses and aides on the Fall Prevention<br>and Management Policy.<br><br>**4.How the corrective action(s) will**<br>**be monitored to ensure the deficient**<br>**practice will not recur, i.e., what**<br>**quality assurance program will be**<br>**put into place?**<br><br>The Director of Nursing or designee<br>will complete random audits of residents who have had a fall utilizing<br>the Fall audit tool. This audit will be<br>completed Weekly for 4 weeks, then monthly for 5 months.<br><br>**5.By what date the systemic** | |

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| | position for around 10 seconds. The note indicated Resident 22 used the sling for increased support and displayed limited standing tolerance.<br><br>A physician's order, dated 9/10/24, indicated staff may use a Hoyer lift when fatigue was present.<br><br>Progress notes, dated 9/17/24 at 1:57 AM, indicated at 8:30 PM, Resident 22 was transferring using the stand-up lift, the bed locks were not activated and the bed slid away causing the resident to slide down to the floor.<br><br>In an interview on 9/20/24 at 11:01 AM, Certified Nurse Aide (CNA) 6 indicated a resident's transfer status should be found on the care plan. She indicated Resident 22 had been using a sit to stand lift but changed to a Hoyer lift around a week prior because her legs were too weak to use a sit to stand lift. CNA 6 indicated she had no knowledge of a Kardex or care card to direct staff care of the residents.<br><br>In an interview on 9/20/24 at 11:08 AM, the Director of Nursing (DON) indicated transfer status was found on the Kardex for CNAs and therapy recommendations should be followed. She indicated Resident 22's bed should have been locked prior to her transfer.<br><br>A current policy titled Mechanical Lift Policy dated 7/1/24 provided by the DON indicated a resident's transfer status should be determined upon admission, quarterly, and as needed with any change in the resident's transfer ability. The policy indicated the decision should be based on nursing judgement or therapy recommendation.<br><br>3.1-45(a)2 | | **changes for each deficiency will be completed?**<br><br>All audits, in-servicing, and systemic Changes will be in effect by October 22, 2024. | |

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| F 0690 SS=D Bldg. 00 | 483.25(e)(1)-(3)<br>Bowel/Bladder Incontinence, Catheter, UTI<br><br>Based on observation, interview and record review, the facility failed to ensure nephrostomy incision care was provided for 1 of 2 residents reviewed (Resident Z).<br><br>Findings include:<br><br>A report to the Indiana Department of Health indicated Resident Z's nephrostomy dressing had not been changed since the resident's admission to the facility on 9/3/24.<br><br>Resident Z's record was reviewed on 9/18/24 at 4:01 PM. Diagnoses included prostate cancer, bladder cancer, bone cancer, end stage kidney disease, urinary tract infection (UTI) and artificial openings of the urinary tract status of bilateral (both sides) nephrostomy (tube surgically place into the kidney) tubes.<br><br>Resident Z's physician orders did not include orders for nephrostomy tube site care.<br><br>An Admission Observation, dated 9/3/24 at 11:36 PM, indicated Resident Z was occasionally incontinent (unable to control) of urine and occasionally used a urinal. Resident Z did not have a urinary catheter (drainage tube). Resident Z did not have any surgical incisions.<br><br>A Skilled Nursing Note, dated 9/7/24 at 11:44 PM, indicated Resident Z had a urinary catheter. Resident Z did not have a surgical incision.<br><br>A Skilled Nursing Note, dated 9/8/24 at 5:41 PM, indicated Resident Z did not have a urinary catheter. Resident Z had surgical incisions for | F 0690 | **F690**<br>**1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>Resident Z had orders obtained for nephrostomy care by the Staff Development Coordinator on 9/20/24.<br>Resident Z suffered no ill effects.<br><br>**2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?**<br><br>Current resident and new admits with nephrostomy tubes will be audited to ensure orders are in place as appropriate. This audit will be completed by the Director of Nursing or designee.<br><br>**3.What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**<br><br>The Director of Nursing or | 10/15/2024 |

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| | bilateral nephrostomy tubes. The incisions were intact and well approximated. The resident did not have any dressing change orders. The physician and family had been notified of the skin condition.<br><br>A progress note, dated 9/11/24 at 4:31 PM, indicated Resident Z's daughter had voiced concern related to a nephrostomy tube being displaced 2 inches. The daughter was offered verbal assurance the nephrostomy tube was fine since it was still draining, and the nursing staff would monitor the tube. Resident Z's nephrostomy tube exchange scheduled for 9/30/24 was entered and transportation was notified.<br><br>A Skilled Nursing Note, dated 9/14/24 at 12:48 AM, indicated Resident Z did not have a urinary catheter. Resident Z did not have a surgical incision.<br><br>A Skilled Nursing Note, dated 9/17/24 at 2:25 AM, indicated Resident Z did not have a urinary catheter. Resident Z did not have a surgical incision.<br><br>A Skilled Nursing Note, dated 9/19/24 at 1:13 PM, indicated Resident Z had a urinary catheter. The resident had an order for a dressing and the dressing was dry and intact.<br><br>Resident Z's Care Plan, dated 9/4/24, indicated the resident had nephrostomy tubes to divert urine. The target goal was to avoid skin breakdown and maintain proper drainage through 12/4/24. Interventions included reporting complications and stoma (opening) care as needed. The Care Plan did not indicate Resident Z required dressing changes of the nephrostomy tube insertion sites.<br><br>In an interview on 9/19/24 at 11:37 AM, the | | designee<br>will have an in-service/education with<br>Nurses and C.N.As on the Nephrostomy/<br>Urostomy Care Procedure.<br><br>**4.How the corrective action(s) will<br>be monitored to ensure the deficient<br>practice will not recur, i.e., what<br>quality assurance program will be<br>put into place?**<br><br>The Director of Nursing or designee<br>will complete random audits of residents with Nephrostomy tubes utilizing the Nephrostomy audit<br>tool. This audit will be completed Weekly for 4 weeks,<br>then monthly for 5 months.<br><br>**5.By what date the systemic changes<br>for each deficiency will be completed?**<br><br>All audits, in-servicing, and systemic<br>Changes will be in effect by October<br>22, 2024. | |

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| | Director of Nursing (DON) indicated they were not aware of Resident Z's nephrostomy care needs as they had worked in the facility for less than 1 week. The DON was made aware the resident did not have physician orders for nephrostomy care. The DON was made aware Resident Z's hospital discharge summary did not include dressing change instructions. The DON indicated the nursing staff should have contacted the physician for dressing change orders. The DON indicated the nurses were responsible for dressing changes. The DON indicated they did not know if the nurses or the nurse assistants were responsible for emptying the nephrostomy drainage bags.<br><br>On 9/19/24 at 11:52 AM, the DON provided Resident Z's Kardex (care plan summary for nurse assistants). A care plan approach, dated 9/18/24, indicated the resident had nephrostomy tubes.<br><br>In a phone interview on 9/19/24 at 11:59 AM, Resident Z's daughter indicated Resident Z had nephrostomy (drains kidneys) tubes in both kidneys. Resident Z's daughter indicated they had cared for Resident Z at home for 18 months prior to the resident's hospitalization. The daughter indicated they were instructed at the hospital to change the nephrostomy dressing every 3 or 4 days. The daughter indicated they did not believe Resident Z's dressing had been changed since they had been admitted to the facility. The daughter indicated Resident Z had been hospitalized for a severe kidney infection. The daughter indicated they would change the dressing but was told the nurse would do the dressing changes.<br><br>In an interview on 9/20/24 at 11:43 AM, Resident Z's daughter indicated they were concerned | | | |

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| | about the condition of the right nephrostomy tube. The daughter indicated the right sutures had gotten caught on the bed during a therapy transfer pulling the nephrostomy tube out approximately 2 inches.<br><br>During an observation on 9/20/24 at 11:43 AM, A tan, plastic covered adhesive bandage was observed at the right nephrostomy site. The right nephrostomy tube bandage was missing a quarter sized portion of the tan, plastic covering. The right nephrostomy tube bandage was labeled 9/1/24. The right nephrostomy tube sutures were hanging freely below the bandage. A tan adhesive bandage was also observed at the left nephrostomy site. The left nephrostomy tube bandage was observed to be creased and the label was not legible.<br><br>In a phone interview on 9/20/24 at 3:03 PM, Resident Z's urology nurse indicated the resident's nephrostomy tube insertion sites should be cleansed with soap and water and covered with drain sponges every 3 to 7 days. The urology nurse indicated the loose sutures were not harmful if the tube was draining properly. The urology nurse indicated nephrostomy tubes were sutured internally, and the external sutures were for reinforcement.<br><br>On 9/23/24 at 11:13 AM, Certified Nurse Aide (CNA) 9 assisted Resident Z with leaning forward in their wheelchair. The right nephrostomy tube bandage was observed to be missing a quarter sized portion of the tan, plastic covering. The right nephrostomy tube bandage was labeled 9/1/24. CNA 9 indicated they could not read the date on the left nephrostomy tube bandage. The left nephrostomy tube bandage was observed to be creased, and the label was not legible. | | | |

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| | An undated current facility policy, provided by the DON on 9/23/24 at 1:10 PM, indicated wounds were to be assessed and new dressings applied as ordered by the physician.<br><br>A current facility policy, dated 1/27/11 and revised 12/14/21, provided by the DON on 9/23/24 at 1:10 PM, indicated the nurse should review all referring facility information to determine appropriate admission orders. The physician should review and confirm the orders. The nurse should document the date, time, and the confirming physician's name.<br><br>A current facility policy, dated 1/27/11 and revised 6/27/24, indicated the nurse may contact the physician to request additional orders based on the resident's medical treatment needs.<br><br>This citation relates to Complaint IN00443537.<br><br>3.1-41(a)(1) | | | |
| F 0755 SS=D Bldg. 00 | 483.45(a)(b)(1)-(3)<br>Pharmacy<br>Srvcs/Procedures/Pharmacist/Records<br>Based on observation, interview and record review, the facility failed to ensure a prescribed medication was provided for 1 of 4 residents reviewed (Resident 64).<br><br>Findings include:<br><br>On 9/19/24 at 9:11 AM, Licensed Practical Nurse (LPN) 8 was observed preparing medication for Resident 67. LPN 8 was unable to locate the medication Xtandi (a cancer medication) in the medication cart. The medication was not available in the facility medication dispensary machine. | F 0755 | **F755**<br>**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>Resident discharged on 9/20/24.<br><br>**2.How other residents having the potential to be affected by the** | 10/15/2024 |

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| | In an interview on 9/19/24 at 9:19 AM, LPN 8 indicated in the event of an unavailable medication, the resident's prescribing physician and the pharmacy should be notified.<br><br>Resident 67's record was reviewed on 9/19/24 at 10:30 AM. Diagnoses included bone cancer, prostate cancer and bladder cancer.<br><br>Resident 67's Admission Minimum Data Set, (MDS) dated 11/23/23, indicated the resident's Brief Interview for Mental Status (BIMS) score was 3 (severe cognitive impairment).<br><br>Resident 67's Medication Administration Record (MAR), dated 9/1/24 through 9/19/24, indicated the resident was to be administered Xtandi 1 time a day beginning on 9/11/24. The MAR indicated the resident had been administered Xtandi on 9/12/24, 9/14/24, 9/17/24 and 9/18/24. The MAR indicated the resident had not been administered Xtandi on 9/13/24 due to the medication being on order. The MAR indicated Resident 67 had not been administered Xtandi on 9/15/24, but no reason for the medication not being administered was documented. The MAR indicated Resident 67 had not been administered Xtandi on 9/16/24 due to the medication being unavailable.<br><br>Resident 67's progress notes, dated 9/11/24 through 9/18/24 did not indicate the pharmacy or the prescribing physician had been notified of Xtandi being unavailable.<br><br>In an interview on 9/19/24 at 11:37 AM, the Director of Nursing (DON) indicated Resident 67's wife was to supply Xtandi to the facility. The DON indicated 9/19/24 was the first day the medication had been unavailable. The DON | | **same deficient practice will be identified and what corrective action(s) will be taken?**<br><br>Current resident and new admits who provide their own medications will have a medication availability audit tool completed by the Director of Nursing or designee to ensure medications are available.<br><br>**3.What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**<br><br>The Director of Nursing or designee will have an in-service/education on our policy for Medication Shortage/ Unavailable Medications to all Licensed nurses.<br><br>**4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br><br>The Director of Nursing or designee | |

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| | indicated Resident 67's wife did not supply a dose for 9/19/24 as the resident was to be discharged on 9/19/24.<br><br>A current facility policy, dated 12/1/07 and revised on 8/1/24, provided by the DON on 9/19/24 at 11:20 AM indicated the facility should notify the resident's physician if a medication is unavailable from the pharmacy. The policy indicated the nurse should document the circumstances surrounding the missed on the MAR and in the progress notes if a missed dose is unavoidable.<br><br>3.1-25(a) and (b)(1) and (c) | | will be performing the Medication Availability audit tool for residents who supply their own medications. This audit will be completed Weekly for 4 weeks, then monthly for 5 months.<br><br>**5.By what date the systemic changes for each deficiency will be completed?**<br><br>All audits, in-servicing, and systemic Changes will be in effect by October 22, 2024. | |