STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00398310. Complaint IN00398310 - No deficiencies related to the allegations are cited. Survey dates: February 21, 22, 23, 24, 27 and 28, 2023. Facility number: 000057 Provider number: 155132 AIM number: 100266570 Census Bed Type: SNF/NF: 107 Total: 107 Census Payor Type: Medicare: 22 Medicaid: 67 Other: 18 Total: 107 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 9, 2023.	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Survey Revisit on or after 03/30/2023.	
F 0641 SS=E Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview, and record review, the facility failed to accurately code the Minimum Data Set (MDS) for 4 of 6 residents	F 0641	*what corrective action(s) will be accomplished for those residents found to have been affected by*	03/30/2023

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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	reviewed for MDS accuracy (Residents 34, 40, 69 and 102). Findings include: 1. A comprehensive record review was completed on 2/23/23 at 12:35 p.m. for Resident 34. He admitted to the facility on 12/20/22. His diagnoses included but were not limited to, after care of joint replacement surgery, unspecified atrial fibrillation, encephalopathy, acute pyelonephritis, urinary retention, GERD (gastro-esophageal reflux disease), undifferentiated schizophrenia, and restlessness with agitation. Resident 34 had a notice of Pre-Admission Screening and Resident Review (PASSR) level II outcome in his medical record. The notification was dated 12/2/22 and indicated he had a diagnosis of schizophrenia. Resident 34's comprehensive MDS, dated 12/26/22, indicated that he did not require a level II assessment. 2. A comprehensive record review was completed on 2/22/23 at 10:40 a.m. for Resident 40. She admitted to the facility on 12/20/20. Her diagnoses included, but were not limited to, aftercare following joint replacement surgery, COPD (chronic obstructive pulmonary disease), panic disorder, emphysema, major depressive disorder, hyperlipidemia, other anxiety disorders, repeated falls, and muscle weakness. Resident 40 had a notice of PASRR level II outcome in her medical record. The notification was dated 5/13/21 and indicated she had a diagnosis of major depression, anxiety disorder and panic disorder.		*the deficient practice;* MDS assessments were reviewed, modified and retransmitted for residents 34, 40, 69, and 102. Residents had no negative outcomes. *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;* All in house residents with Level 2, will be reviewed to ensure that most recent MDS was accurate. MDS will be modified and retransmitted as needed. MDS Coordinator and MDS Coordinator Assistant were educated regarding accurate assessments on or before 03/30/2023. *what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* A list of in-house residents with PASSAR Level 2 was developed. SSD to update list of residents with PASSAR Level 2. This report will be reviewed and updated daily and will serve as a reference when completing section A 1500 of the MDS. MDS Coordinator and MDS Coordinator Assistant were educated regarding accurate assessments on or before 03/30/2023. *how the corrective action(s) will be*	

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	Resident 40's comprehensive MDS, dated 1/16/23, indicated she did not require a level II assessment. 3. A comprehensive record review was completed on 2/22/23 at 10:18 a.m. for Resident 69. He admitted to the facility on 7/11/18. He had the following diagnoses, but not limited to COPD (chronic obstructive pulmonary disease), generalized anxiety disorder, agoraphobia with panic disorder, GERD (gastro-esophageal reflux disease), hyperlipidemia, sleep apnea, osteoarthritis of the hip, tobacco use, and acute hepatitis C. Resident 69 had a care plan, dated 8/20/19, indicating he was determined to be mentally ill per the PASRR level 2 assessment. Level 2 diagnosis were major depression and PTSD (post-traumatic stress disorder). Resident 40's MDS assessment, dated 7/3/22, diagnosis section of the MDS lacked documentation of PTSD on the assessment. On 2/28/23 at 10:39 a.m., the MDS Coordinator indicated she corrected Residents 34, 40, and 69's MDS assessments to reflect the accuracy of PASRR outcomes and diagnoses. 4. On 2/27/23 at 03:59 p.m., the closed medical record was reviewed for Resident 102. A nurses' progress note, dated 12/12/22 at 11:33 a.m., indicated Resident 102 had discharged from the facility by private car with her family to home. Resident 102 discharged from the facility fully clothed with shoes on. The resident's family member reviewed and signed the discharge paperwork and copies were sent with the resident. The resident inventory sheet was signed, and all belongings accounted for. Resident 102 was sent home with a 3 day supply of medication.		*monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.* MDS/designee will complete MDS accuracy QAPI tool This audit will be completed weekly x 4 weeks, monthly x 6 months then quarterly until continued compliance is maintained for two consecutive quarters. Results of these audits will be reviewed by QAPI committee.	

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	A review of the discharge Minimum Data Set (MDS) assessment, dated 12/12/22, indicated Resident 102 had been discharged to an acute hospital. On 2/28/23 at 9:50 a.m., during an interview, the MDS coordinator indicated Resident 102 had come to the facility from an acute hospital, she had discharged home. The discharge MDS assessment had been coded wrong. The facility followed the Resident Assessment Instrument (RAI) Manuel for coding of the MDS. On 2/28/23 at 1:14 p.m., the Administrator provided a current policy titled, "RESIDENT ASSESSMENT (RAI)," dated 10/2019. This policy indicated, "It is the policy of (Name of Corporation) to ensure MDS assessments accepted into the QIES ASAP [automated system for payment] system accurately reflects the resident's identification, location, overall clinical status, and payment status. If inaccuracies are identified processes will be followed to ensure the information is corrected...." 3.1-31(i)			
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-			

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	(i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. Based on record review and interview, the facility failed to ensure a new resident had a baseline care plan initiated to identify problems related to pain and insomnia (Resident 204) for 1 of 22 residents	F 0655	*what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* Baseline care plan was initiated	03/30/2023

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	reviewed for care planning. Findings include: On 2/27/23 at 2:55 p.m., Resident 204's medical record was reviewed. The resident's admission date was 2/24/23. The diagnoses included, but were not limited to, rhabdomyolysis (a breakdown of muscle tissue that releases damaging protein into the blood), laceration of the head, chronic heart failure, neuropathy (nerve pain), pain in left hip, sacroiliitis (a painful condition that effects one or both sacroiliac [joints at base of the spine] joints that results in lower back pain), primary insomnia, and a wedge compression fracture of the fourth lumbar (back) vertebra (bone of spine). Resident 204's care plans did not include a care plan for pain management or insomnia. Resident 204's Admission pain, observation report, was dated 2/24/23 and showed "In Progress." None of the questions had been answered on the Pain Interview. On 2/27/23 at 3:45 p.m., Resident 204's care plans and admission pain assessment were requested. On 2/28/23 at 9:00 a.m., the Administrator provided copies of all of Resident 204's care plans and Admission Pain Assessment Interview. The pain assessment had been completed by the Minimum Data Set (MDS) Coordinator on 2/27/23 at 4:02 p.m. Resident 204's care plans, dated 2/27/23, created by the MDS Coordinator, included, but was not limited to, "Resident is at risk for pain related to: Rhabdomyolysis, laceration to the head, neuropathy, sacroiliitis, wedge compression		on 2/24/23 and was updated to reflect a pain and insomnia care plan for Resident 204. Resident 204 had no negative outcomes with pain and insomnia adequately treated. *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;* New residents have the potential to be affected by deficient practice. MDS/designee will complete base line care plan audit for residents that have admitted in last 30 days. Educated provided to licensed staff regarding base line care plan on or before 3/30/2023. *what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* Education provided to licensed staff on or before 3/30/23. Pain and insomnia have been added to the base line care plan for new residents. *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; and by what date the systemic changes for each deficiency will be completed.* *After submitting an acceptable Plan of Correction, if it is*	

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	fracture of the fourth lumbar vertebra." The goal, with a target date of 5/27/23, indicated Resident will be free from adverse effects of pain. A second care plan, dated 2/27/23, created by the MDS Coordinator indicated, "Resident is at risk for adverse side effects related to use of psychotropic medication, antidepressant, and hypnotic." The goal, with a target date of 5/27/23, indicated, "Will have no adverse side effects." On 2/28/23 at 11:43 a.m., during an interview, in his room, Resident 204 indicated he did not get all his medication until yesterday. They did not have his ambian (for sleep), norco (for pain), or the lyrica (for nerve pain). They finally had given him generic medicine for his sleeping medication, and it helped last night. He had trouble sleeping, had been taking that for years. He fell 5 years ago and landed on his leg. The orthopedic surgeon had put a plate and rod in his leg. He has been on lyrica and norco for the past 5 years. He had pain the whole time he was at the facility since admission. When he asked about it they indicated it took several days to get all the medicine from pharmacy. They said it was the hospital's fault and there was a problem with not having all the prescriptions to get the medicines from pharmacy. They gave him pain medicine last night, for the first time, and it helped. He indicated "I'm getting ready to ask for some more now." On 2/28/23 at 10:12 a.m., the Regional Clinical Consultant (RCC) provided a current policy, dated as revised 10/19, titled, "IDT Comprehensive Care Plan Policy." This policy indicated, "It is the policy of this facility that each resident will have a comprehensive person-centered care plan based on comprehensive assessment...Create an organized, resident-centered review on a routine		*determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.* Baseline care plan QA tool will be completed weekly times 4 weeks, monthly times 6 months, and then quarterly until compliance is maintained for two consecutive quarters. Results of these audits will be reviewed by QAPI committee.	

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	basis to improve communication with residents...." 3.1-30(a)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (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. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, interview, and record review, the facility failed to ensure a resident had a new and/or revised comprehensive care plan to address a new diagnosis for 1 of 22 residents reviewed for care planning (Resident 59), and	F 0657	*what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* Care plan has been updated for	03/30/2023

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	failed to revise a resident's care plan to include fall interventions for 1 of 22 residents reviewed for care planning (Resident 95). Findings include: 1. On 2/23/23 at 1:30 p.m., Resident 59's medical record was comprehensively reviewed. She had been a long-term care resident and resided on the secured memory care unit since 10/29/2020. She had previously lived at two separate Assisted Living (AL) facilities before she was admitted to long-term care. She had active diagnoses which included but were not limited to, dementia and psychotic disorder with hallucinations due to known physiological condition, and on 6/4/2022 a new diagnosis of Herpes viral vulvovaginitis (HSV) was added. Her physician's orders were reviewed and revealed she took Valacyclovir, an antiviral medication, on a regular basis, every other day. A nursing progress note, dated 7/28/21 at 3:17 p.m., indicated Resident 59 returned from her private doctor with a new order for an antiviral medication to complete a course over 7 days and to follow up in November. A nursing progress note, dated 8/5/21 at 9:01 p.m., indicated Resident 59 had completed her antiviral course with no issues. After her follow up in November, a nursing progress note dated 11/4/21 at 8:26 p.m., indicated,		resident 59 to include genital herpes. Care plan has been updated regarding placement of bed for resident 95. Neither resident has had any negative outcomes. *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;* All residents have the potential to be affected by deficient practice. Audit that appropriate diagnosis are care planned and that fall interventions are on care plan for all residents. Education provided to IDT regarding updating and revising care plans on or before 3/30/23 *what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* Education provided to IDT regarding updating and revising care plan on or before 3/30/23. IDT to review appointment paperwork next business day to audit diagnosis codes and update care plan. IDT to audit room moves to ensure all interventions are correct. *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; and by what date*	

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	Resident 59 remained on Valtrex (an antiviral medication) for HSV. Her comprehensive care plan lacked documentation of new and/or revised interventions related to her genital herpes diagnoses. Although she had comprehensive care plan which addressed her as being at risk for skin breakdown due to her cognition and incontinence, the care plan lacked revision to include a diagnoses of genital herpes or for increased monitoring due to outbreaks, rashes and//or flare ups. During an interview on 2/23/23 at 2:54 p.m., Resident 59 indicated, she had lived at the facility almost three years. She had resided on memory care for a long time, but she was excited that she would soon move to a new private room on the other side of the facility. She indicated since she started taking a daily medication, she had not had any more problems with her genital herpes. During an interview on 2/23/23 at 3:05 p.m., the Memory Care Support Specialist (MCSS) indicated Resident 59 was going to move off the memory care unit to a private room as she was no longer considered a risk for elopement and displayed no exit seeking behaviors. When Resident 59 first moved in he didn't even know she had genital herpes, but she kept getting a rash. They sent her to her doctor which was when she got the new diagnosis and she had been on medicine for it since with no concerns. 2. On 2/22/23 at 2:15 p.m., Resident 95 was sitting in her wheelchair with her right arm in a sling. Her bed was not against the wall. On 2/24/23 at 3:15 p.m., Resident 95 was sitting up in her wheelchair with her right arm in a sling. Her		*the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.* Care plan updating QA tool to be completed weekly times 4 weeks, monthly times 6 months, and quarterly until compliance has been maintained for two consecutive quarters. Results of these audits will be reviewed by QAPI committee	

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	bed was not against the wall. A comprehensive record review was completed on 2/24/23 at 11:26 a.m. for Resident 95. She admitted on 1/18/23 after sustaining a fractured right arm. Her diagnoses included, but were not limited to, other displaced fracture of upper end of right humerus, dementia, Alzheimer's disease with late onset, asthma, major depressive disorder, anemia, GERD (gastro-esophageal reflux disease), muscle weakness, unsteadiness on her feet, and pain of her right shoulder. Her orders included to have her bed against the wall, dated 1/18/23. Her care plan had a problem dated 1/19/23 for Resident 95. It indicated she was at risk for falls due to lack of understanding one's physical and cognitive limitations, history of falls, advanced age, incontinent, on two or more high risk medications, needs assistance with mobility and has an unsteady gait (walking). The goal, dated 5/1/23, indicated her fall risk factors would be reduced to avoid significant fall with injury. The care plan did not address an intervention to have the bed against the wall. On 2/28/23 at 10:12 a.m., the Regional Clinical Specialist provided a copy of current facility policy titled, "IDT [interdisciplinary team] Comprehensive Care Plan Policy," revised 10/2019. The policy indicated, "It is the policy of this facility that each resident will have a comprehensive person-centered care plan developed based on comprehensive assessment. The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning including medical,			

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	nursing, mental and psychosocial needs ...Care plan problems, goals and interventions will be updated based on changes in resident assessment/condition, resident preferences or family input ...." 3.1-35(d)(2)(B)			
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to prevent the potential for accidents by maintaining safe hot water temperatures in the secured memory care unit. This deficient practice had the potential to effect 26 of 26 residents who resided on the memory care unit (Residents 24, 53, 54, 88, and 59). Findings include: On 2/22/23 at 9:45 a.m., Resident 24 was observed. She was seated in a recliner chair in the memory care TV lounge area. Her eyes were closed, her head was bowed, and she appeared to be asleep. During an interview on 2/22/23 at 9:50 a.m., Certified Nursing Assistant (CNA) 20 indicated Resident 24 was not a resident on the secured memory care unit, but that since her admission, a couple days prior, she had trial days on the unit	F 0689	*what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* Mixing valve was replaced on water heater. Water temperatures are within appropriate parameters. Residents had no negative effects. *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;* 26 residents had the potential to be affected by deficient practice. Water temperatures will be monitored weekly and recorded to ensure temperatures are within appropriate parameters. Education provided Maintenance Director and	03/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

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	due to her confusion and behaviors. Particularly, the night before, she had been found in her bathroom. She had left the bathroom sink running until it overflowed and wandered around the unit. Staff brought her to memory care early that morning and she seemed to have settled down. When asked if there were other residents on the memory care unit who would run the water and forget that it was on, CNA 20 indicated Resident 24 was "notorious" for it. Resident 24 would often clog up her toilet or sink with paper towels, turn on the water and forget it was running until the sink overflowed. On 2/22/23 at 10:00 a.m., Resident 24's bathroom hot water temperature was checked. After the water ran for approximately 2 minutes, steam was visible and rose to fog the mirror. An initial temperature check registered the water temperature at 125 degrees Fahrenheit (F). Two additional rooms were sampled for hot water temperatures at opposite ends of the memory care unit: Residents 53 and 54's room had the initial water temperature register at 126 degrees F. Residents 88 and 59's room had the initial water temperature register at 131 degrees F. On 2/22/23 at 10:45 a.m., the Administrator (ADM) was made aware of the hot water temperatures. The ADM indicated the Maintenance Director (MD) had been off work since the previous Thursday for medical reasons and was not anticipated to return until recovered. In the meantime, the ADM, Housekeeping Supervisor (HKS) and a Regional Maintenance Support Technician (RMST) were responsible for maintaining daily and as needed responsibilities.		back up maintenance team on appropriate water temperatures on or before 3/30/23. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* Water temperatures will be monitored weekly and recorded to ensure temperatures are within appropriate parameters. Education provided Maintenance Director and back up maintenance team on appropriate water temperatures on or before 3/30/23. *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; and by what date the systemic changes for each deficiency will be completed.* *After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.* ED/designee to randomly check water temperatures using TELS management tool. Water temperatures will be monitored and recorded weekly times 4 weeks, monthly times 6 months, and quarterly until compliance has been maintained for two	

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	On 2/22/23 at 10:50 a.m., the ADM and HKS were accompanied to the memory care unit to re-check the water temperatures. The HKS indicated she had worked in the facility for 8 years and was familiar with the residents. Upon entering Resident 24's room, the HKS indicated, she had often had to clean up after Resident 24 when she clogged the toilet or sink with paper towels and had collaborated with the nursing staff to come up with the idea of placing a doorbell alarm to the top of the bathroom door, which sounded upon entrance to alert staff that Resident 24 may need assistance in the bathroom. On 2/22/23 at 10:55 a.m., the HKS re-checked the water temperatures in room noted above. She indicated the temperatures should be between 116-120, not to exceed 120 degrees F. Resident 24's room, the temperature registered 134 degrees F. Residents 53 and 54's room, the temperature registered 131 degrees F. Residents 88 and 59's room, the temperature registered 136 degrees F. On 2/22/23 at 11:00 a.m., the ADM indicated all water use on the memory care unit would be suspended until the temperatures could be stabilized, however, all resident showers were already taking place off the unit, as the memory care unit shower room was under construction at that time. The ADM indicated she suspected the problem was the new hot water tank which had been installed back in December after several plumbing issues. She indicated she would also call the service who installed the hot water tank and have a technician out by the end of the day. On 2/22/23 at 2:15 p.m., a third check of the hot		consecutive quarters. Results of these audits will be reviewed by QAPI committee.	

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	155132	A. BUILDING 00 B. WING	02/28/2023

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	water temperatures was conducted with the HKS for the memory care unit. In the rooms noted above, the water temperatures did not exceed 100 degrees F. The HKS indicated, it was better to run a little colder than too hot, but she and the equipment technician were still working on adjustments. On 2/23/23 at 12:45 p.m., an equipment service technician from a local plumbing service and repair company indicated he had been out all morning working with the HKS to adjust the hot water tank. He indicated there were three components to the adjustments which involved precise calibration of the hot water valve, cold water valve and the mixing valve. He indicated the water was not running over 120 degrees F any longer, but they were making final adjustments to maintain temperatures between 116-120 degrees F. On 2/22/23 at 11:30 a.m., the ADM provided copies of the MD hot water temperature monitoring logs. She indicated, and the logbook documentation gave instructions; Hot water temperatures were randomly checked on each unit at least once a week. The logs for the previous 4 weeks in the memory care unit were all within safe operating temperatures. The logbook documentation instructions indicated, "..Ensure patient room water temperatures are between 105 [degrees] and 115 [degrees] F (or specified by state requirements) ... Indiana - 100-120 degrees F." On 2/22/23 at 3:00 p.m., the ADM indicated all resident on the memory care unit were at risk due to the hot water temperatures given their mental capacities. At that time, she provided a copy of current facility policy titled, "Resident Rights," dated 3/2017. The policy indicated, " ...Safe			

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	Environment: You have a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely ...." 3.1-45(a)			
F 0690 SS=E Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must			

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	ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to ensure urinary catheter bags were kept off the floor for 2 of 4 residents reviewed for urinary catheters (Resident 18 and 41). Findings include: 1. During an observation on 2/22/23 at 10:02 a.m., Resident 18 was lying in her bed. She indicated she had a supra-pubic catheter to drain her bladder. The catheter collection bag was lying on the floor. On 2/22/23 at 3:15 p.m., a comprehensive record review was completed for Resident 18. She had the following diagnoses, but not limited to COPD (chronic obstructive pulmonary disease), sacral spina bifida with hydrocephalus (occurs when the bones in the spine do not properly form and hydrocephalus is extra fluid in and around the brain), paraplegia, major depressive disorder, neuromuscular dysfunction of the bladder, anxiety, constipation, and tobacco use. Resident 18's care plan dated 10/29/20, indicated she required a supra-pubic urinary catheter related to neuromuscular dysfunction of the bladder and she is at risk for infection. The goal dated, 3/5/23, indicated her catheter care would be managed appropriately as evidence by not exhibiting signs of urinary tract infection or urethral trauma. An intervention dated 10/29/20 indicated not to allow the tubing or any part of the drainage system (bag) to touch the floor.	F 0690	*what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* Residents 18 and 41 do not have catheter bag touching the floor. Resident 41 has been provided with wash basin as a barrier when resting in bed. Residents have had no negative outcomes. *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;* Any resident that has a catheter has the potential to be affected by deficient practice. Staff provided education regarding catheter bag placement on or before 3/30/23. *what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* Staff provided education regarding catheter bag placement on or before 3/30/23. Unit Manager/designee will check urinary drainage bag is appropriately placed during resident care rounds daily. *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; and by what date*	03/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	02/28/2023

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	2. During an observation on 2/24/23 at 9:42 a.m. Resident 41 was wheeling himself down the hall. His catheter bag was dragging on the floor. During an observation 2/24/23 at 10:08 a.m., Resident 41 was sitting next to the nurse's cart and LPN 10 as she passed her medication. Resident 41's catheter bag was halfway full and was lying on the ground under his wheelchair. At this time, LPN was interviewed about Resident 41's catheter bag lying on the ground. She did not respond and addressed Resident 41 indicating she needed to reposition his catheter bag. On 2/27/23 at 10: 55 a.m., a comprehensive medical record review was completed for Resident 41. He had the following diagnoses but not limited to unspecified spina bifida with hydrocephalus, infection and inflammatory reaction due to indwelling catheter, essential hypertension, low potassium, pain and muscle weakness. Resident 41's care plan included a problem with a date of 3/30/21 indicating he required an indwelling catheter related to obstructive and reflux uropathy (disease of the urinary system), and that he is at risk for infection. The care plan addressed Resident 41 will hang his catheter bag on his wheelchair above his bladder. The goal dated 5/21/23 indicated he will have catheter care managed appropriately as evidenced by not exhibiting signs of urinary tract infection or urethral trauma. An intervention dated 3/30/21 indicated not to allow the catheter tubing or any part of the drainage system (bag) to touch the floor. The ED (Executive Director) provided a policy titled, "Indwelling Urinary Catheters-Suprapubic		*the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.* Catheter QA tool to be completed weekly times 4 weeks, monthly times 6 months, and then quarterly until compliance is maintained for two consecutive quarters. Results of these audits will be reviewed by QAPI committee.	

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	155132	A. BUILDING 00 B. WING	02/28/2023

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	or Urethral," with no date. The policy did not address the positioning or placement of catheter bags. 3.1-41(a)(1)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, interview, and record review, the facility failed to properly place and change a gauze/transparent dressing for a PICC line (peripherally inserted central catheter) for 1 of 1 resident reviewed for a vascular access device (Resident 154). Findings include: On 2/23/23 at 8:41 a.m., a PICC line was observed in Resident 154's left upper arm. It had gauze applied at the insertion site and was covered with a transparent dressing dated 2/9/23 and initialed, "AB." On 2/23/23 at 1:00 p.m., Resident 154's PICC line to the left upper arm was observed a second time, and remained dated 2/9/23 and initialed, "AB." On 2/24/23 at 3:53 p.m., Resident 154's record was reviewed. She admitted to the facility on 2/7/23 with active diagnoses, which included, but were limited to infection and inflammatory reaction due to indwelling urethral catheter, peripheral vascular disease (disease of the blood vessels), presence	F 0694	*what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* Residents PICC line dressing was changed. Residents PICC line dressing order was updated. Resident had no negative outcomes *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;* Residents with PICC line have the potential to be affected by deficient practice. Current PICC lines were audited to ensure the dressings had been changed timely. Education provided to licensed staff regarding PICC lines on or before 3/30/23. *what measures will be put into place and what systemic changes will be made to ensure that the*	03/30/2023

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	155132	A. BUILDING 00 B. WING	02/28/2023

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	of vascular implants and grafts (artificial medical device in the body), diabetes mellitus (blood sugar disorder), and acute myocardial infarction (heart attack). A nursing progress note, dated, 2/8/23 at 9:18 a.m., indicated the nurse notified a family member and Resident of new PICC being placed. They informed the nurse she had an axillary-femoral bypass graft AFBG) (tubing from the axillary artery to the femoral artery to allow more blood flow) on her left side and showed the nurse the scar in her forearm. The provider was notified and ordered a peripheral line placed. Nurse charted, unable to start the peripheral vascular (PV) line. Provided indicated to contact the hospital to confirm the location of the AFBG and to start the antibiotic upon confirmation. A nursing progress note, dated, 2/9/23 at 1:01 p.m., indicated orders were obtained to remove the right upper extremity (RUE) PICC line and place it in the left upper extremity (LUE). Awaiting stat arterial doppler for RUE to verify integrity of AFBG. A nursing progress note, dated, 2/9/23 at 3:03 p.m., indicated, the pharmacy had come to remove the current PICC line (RUE) and place it in the LUE. A physician's order, dated 2/8/23, gave instructions for the nurse to initial every shift that the PICC line site was free of warmth, redness or swelling. A physician's order, dated 2/8/23, gave instructions to change transparent dressing, as needed, if integrity of the dressing was compromised (wet, loose, or soiled).		*deficient practice does not recur;* Education provided to licensed staff regarding PICC lines on or before 3/30/23. Unit Manager/designee will check date of PICC line dressing during resident care rounds daily. *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; and by what date the systemic changes for each deficiency will be completed.* *After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.* Parenteral QA tool will be completed weekly times 4 weeks, monthly times 6 months, and quarterly until compliance is maintained for two consecutive quarters. Results of these audits will be reviewed by QAPI committee.	

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	The record lacked documentation of a physician's order to monitor/maintain the dressing until 2/17/23. A physician's order, dated, 2/17/23, gave instructions to change PICC line dressing every 7 days with transparent dressing. The nurse was to measure (in centimeters) the PICC catheter length (from insertion site to catheter hub) and the nurse was to measure the upper arm circumference (10 cm above antecubital fossa) (inside the elbow), once a day, every 7 days. A physician's order, dated 2/8/23, gave instructions to give piperacillin-tazobactam (an antibiotic medication) 3.375 gram reconstituted solution, every 8 hours by IV, due to infection and inflammatory reaction due to indwelling urethral catheter with an end date of 2/17/23. A nursing progress note, dated, 2/10/23 at 3:10 a.m., indicated Resident 154 had a vascular access device, PICC line, in her LUE. A nursing progress note, dated, 2/12/23 at 1:48 a.m., Resident 154 continued on antibiotic therapy for UTI (urinary tract infection) and wounds. A nursing progress note, dated, 2/14/23 at 9:48 a.m., Resident 154 continued on antibiotic therapy for UTI. A nursing progress note, dated, 2/25/23 at 12:28 a.m., Resident 154 continued on IV antibiotics, PICC line flushed well. A physician's order, dated 2/24/23 at 3:18 p.m., gave instructions to give meropenem 1 gram reconstituted solution, every 8 hours by IV.			

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	Resident 154's Treatment Administration Record (TAR) for the month of February was reviewed and revealed: a. On 2/17/23 at 5:11 a.m., Licensed Practical Nurse (LPN) 25 charted on 2/16/23, the order was not completed. b. On 2/17/23 at 1:29 p.m., LPN 26 charted the order was not completed. The piperacillin-tazobactam antibiotic was ordered on 2/8/23 but was not started until 2/9/23 at 10:00 p.m., LPN 27 charted it was due to the PICC line needing to be place in the LUE. The PICC line was inserted in the LUE on 2/9/23. The TAR indicated the PICC line dressing was not changed until 2/24/23 by LPN 27. On 2/27/23 at 11:56 a.m., Resident 154's care plan, dated 2/9/23, indicated she had IV access and was at risk for infection/complications due to her PICC line. The goal was to keep her free from complications associated with IV access. An approach to the issue was to change the dressing as ordered. During an interview, on 2/24/23 at 11:04 a.m., with the Administrator, Director of Nursing Services (DNS), and the Regional Clinical Consultant (RCC) present, the only statement proffered as to why Resident 154 did not get her PICC line dressing order until 2/17/23 and the dressing was not changed until 2/24/23, was by the RCC. She indicated maybe the resident refused. A current policy, titled, "Central Vascular Access Device (CVAD) Dressing Change," dated 6/1/21, was provided by the Administrator, on 2/24/23 at 12:18 p.m. A review of the policy indicated, "			

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	155132	A. BUILDING 00 B. WING	02/28/2023

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	...The nurse is responsible and accountable for obtaining and maintaining competence with infusion therapy within his or her scope of practice ...Central vascular access devices (CVADs) include peripherally inserted central catheter (PICC) ...The catheter insertion site is a potential entry site for bacteria that may cause a catheter-related infection ...Perform sterile dress changes ...at least weekly ...what a transparent dressing is applied over a sterile gauze dressing it is considered a gauze dressing and is changed upon admission ...every two days ...." 3.1-47(a)(2)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record review, the failed to ensure a resident with difficulty sleeping due to acute and chronic pain received medications, prescribed by the physician, to control pain and aid in ability to sleep, when they did not follow up after admission to obtain written prescriptions for the pharmacy to provide the prescribed medications (Resident 204) for 1 of 1 residents reviewed for pain. Findings include: On 2/27/23 at 2:55 p.m., Resident 204's medical record was reviewed. The resident's admission date was 2/24/23. The diagnoses included, but were not limited to, rhabdomyolysis (a breakdown of muscle tissue that releases damaging protein into the blood), laceration of the head, chronic heart failure, neuropathy (nerve pain), pain in left hip, sacroiliitis (a painful condition that effects one or both joints at base of the spine, that results in lower back pain), primary insomnia, and a wedge compression fracture of the fourth lumbar (back) vertebra (bone of spine). The admission Minimum Data Set (MDS) assessment, dated 12/24/23, indicated Resident 204's Brief Interview for Mental Status (BIMS) assessment was 15 out of 15 which was	F 0755	*what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* One of one resident was affected by deficient practice. Resident's narcotic medication order was ordered and received. Resident's pain is being effectively controlled. *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;* Any new resident with narcotic orders has the potential to be affected by deficient practice. Availability of medications was verified for residents admitted within the last seven days. Education provided to licensed staff regarding ordering narcotic medications on or before 3/30/23. *what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* Education provided to licensed staff regarding ordering narcotic	03/30/2023

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	cognitively intact. On 2/27/23 at 8:58 a.m., during a random medication pass observation, with Registered Nurse (RN) 18, she was observed as she prepared and passed morning medications to Resident 204. The resident received the following medications, from RN 18: 81 milligrams (mg) aspirin, 20 mg furosemide (a diuretic), 25 mg metoprolol (for blood pressure), 20 mg omeprazole (for acid reflux prevention), and Miralax (for bowels) 17 gram (gm) in water. Resident 204 had an order for lyrica (pregabalin) 25 mg capsule, twice a day for pain in left hip. The medication was not available in the medication cart. She marked the medication administration record not given, medication unavailable. RN 18 told Resident 204, when she administered his other medications, the lyrica for his pain had still not arrived from the pharmacy, she would have to call them. The resident indicated they had told him it was not available; he needed all his medication. Upon returning to the hall, RN 18 opened the narcotic book and indicated there were no narcotic sheets in the book for Resident 204. The locked narcotic drawer contained no narcotic medications for him either. RN 18 then went to the nurses' station desk and phoned the pharmacy. After talking to the pharmacy, she indicated they had told her when the resident admitted to the facility they required paper prescriptions for all narcotic medications. None had been faxed over to the pharmacy, so they were unable to supply the medication. Without the pharmacy authorization she could not obtain the medication from the facility's emergency supply, either. She would have to call the physician to obtain written prescriptions for		medications on or before 3/30/23. DNS/designee will verify orders and medications are available for resident use within 24 hours of admission. *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; and by what date the systemic changes for each deficiency will be completed.* *After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.* Pharmacy Services and recommendations QA tool will be completed weekly for 4 weeks, monthly for 6 months, then quarterly until compliance is maintained for two consecutive quarters. Results of these audits will be reviewed by QAPI committee.	

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	the narcotic medications. A review of Resident 204's MAR indicated lyrica (pregabalin) was not administered on 2/24/23 at 9:03 p.m., due to not available. It was not administered on 2/25/23 at 7:13 a.m. or 5:00 p.m., because it was not available. It was not administered on 2/26/23 at 6:49 a.m., because it was not available. It was not administered on 2/27/23 at 11:38 a.m., because it was not available. The record indicated Resident 204 received lyrica on 2/26/23 at 5:00 p.m., by Licensed Practical Nurse (LPN) 13. The record reflected Resident 204 had an order for hydrocodone-acetaminophen 7.5-325 mg prn (as needed). This medication, also a narcotic pain medication, was not charted on the MAR as ever having been administered. Resident 204 had an order for zolpidem (a narcotic sleeping pill) 5 mg at bedtime prn (as needed). On 2/28/23 at 10:10 a.m., during an interview, the Regional Clinical Consultant (RCC) indicated traditionally the hospital should have sent prescriptions for medications, then they would have been faxed to pharmacy. If they did not send a written prescription the facility needed to contact the doctor to obtain one. If the medication was not available at medication pass the nurse should not have charted it as given. She was going to contact the nurse, LPN 13, who documented it as given on Sunday 2/26/23 evening. The MAR would have to be corrected because the medication was not available. Resident 204's care plans did not include a care plan for pain management or insomnia. Resident			

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	204's Admission pain, observation report, was dated 2/24/23 and showed "In Progress." None of the questions had been answered on the Pain Interview. On 2/27/23 at 3:45 p.m., Resident 204's care plans and admission pain assessment were requested. On 2/28/23 at 9:00 a.m., the Administrator provided copies of Resident 204's care plans and Admission Pain Assessment Interview. The pain assessment had been completed by the MDS (Minimum Dataset) Coordinator on 2/27/23 at 4:02 p.m. Resident 204's care plans, dated 2/27/23, created by the MDS Coordinator, included, but was not limited to, "Resident is at risk for pain related to: Rhabdomyolysis, laceration to the head, neuropathy, sacroiliitis, wedge compression fracture of the fourth lumbar vertebra." The goal, with a target date of 5/27/23, indicated Resident will be free from adverse effects of pain. A second care plan, dated 2/27/23, created by the MDS Coordinator, indicated, "Resident is at risk for adverse side effects related to use of psychotropic medication, antidepressant, and hypnotic." The goal, with a target date of 5/27/23, indicated, "Will have no adverse side effects." On 2/28/23 at 11:43 a.m., during an interview, in his room, Resident 204 indicated he did not get all his medication until yesterday. They did not have his ambian (for sleep), norco (for pain), or the lyrica (for nerve pain). They finally had given him generic medicine for his sleeping medication, and it helped last night. He had trouble sleeping, had been taking that for years, fell 5 years ago landed			

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	155132	A. BUILDING 00 B. WING	02/28/2023

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	on his leg. The orthopedic surgeon put a plate and rod in his leg. He has been on lyrica and norco for the past 5 years. He had pained the whole time he was here (at the facility) since admission. When he asked about it they indicated it took several days to get all the medicine from pharmacy. They said it was the hospital's fault, there was a problem with not having all the prescriptions to get the medicines from pharmacy. They gave him pain medicine last night, for the first time, and it helped. He indicated "I'm getting ready to ask for some more now." 3.1-25(g)(2)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose			

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	reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, interview, and record review, the facility failed to ensure an approved psychiatric diagnosis was included in a resident's (Resident 82) comprehensive medical record for the use and indication of antipsychotic medications and failed to ensure ongoing monitoring for improving/worsening symptoms were documented to justify the medications continued use for 1 of 5 resident reviewed for unnecessary medications. Findings include: During an observation on 2/21/23 at 1:48 p.m., Resident 82 was sitting up in a Geri chair (a	F 0758	*what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* One of five residents were affected by this deficient practice. Physician ordered GDR on psychotropic medications. Resident was successfully off psychotropic medications with no adverse effects. *how other residents having the potential to be affected by the same deficient practice will be identified and what corrective*	03/30/2023

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	recliner on wheels) with the legs elevated. Her eyes were closed. She was unresponsive to verbal stimuli. During an observation on 2/22/23 at 10:02 a.m., Resident 82 was sitting up in a Geri chair with the legs elevated. Her eyes were closed. She did not respond to verbal stimuli or touch. During an observation on 2/23/23 at 3:41 p.m., Resident 82 was sitting up in a Geri chair with the legs elevated. She opened her eyes when her name was called. She did not verbally respond. During an observation on 2/27/23 at 9:23 a.m., Resident 82 was sitting up in a Broda chair (a recliner chair on wheels). She was unresponsive to verbal stimuli. An interview was conducted with RN 8 on 2/23/23 at 2:30 p.m. RN 8 indicated she was not familiar with Resident 82 due to being a float nurse. An interview was conducted with UM 9 (Unit Manager) on 2/23/23 at 2:38 p.m. UM 9 indicated Resident 82 had not been awake much and did not eat much since transferring to her unit. UM 9 had not reviewed Resident 82's admission orders because she had admitted to another unit. When UM 9 reviewed Resident 82's medication, she indicated she would notify the physician due to resident's sedation. During an interview with LPN 16 on 2/27/23 at 9:30 a.m., she indicated Resident 82 did not eat breakfast, indicating she would not open her mouth. During an interview with Resident 82's family representative on 2/27/23 at 9:35 a.m., he indicated		*action(s) will be taken;* Residents receiving psychotropic medications have the potential to be affected by this deficient practice. Audit of resident with psychotropic medications will be completed to ensure proper diagnosis. Education provided to IDT in regards to psychotropic medications and proper diagnosis on or before 3/30/23. *what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* Education provided to IDT in regards to psychotropic medications and proper diagnosis on or before 3/30/23. Upon admission IDT review, psychotropic medications will be reviewed for appropriate diagnosis, if diagnosis is not appropriate, provider will be contacted for follow up. *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; and by what date the systemic changes for each deficiency will be completed.* *After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of*	

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	he was concerned about Resident 82's drowsiness and poor appetite. A telephone interview was conducted with the Pharmacist on 2/27/23 at 2:05 p.m. The Pharmacist indicated she reviewed Resident 82 when she admitted and did not make any recommendations. She did not know what her thought process was at the time of the review. On 2/15/23, the Pharmacist indicated on her Pharmacist Observation there were irregularities and to see her report. The Pharmacist did not send the report from 2/15/23 until 2/27/23 due to being on vacation. She indicated Resident 82 received an order to decrease Seroquel and they are doing a gradual dose reduction. An interview was conducted with the NP (Nurse Practitioner) on 2/27/23 at 3:02 p.m. The NP indicated Resident 82 admitted with the discharge plan of going to an assisted living. The plan was to get Resident 82 out of the facility quickly. The NP indicated Resident 82 was diagnosed with COVID-19 upon admission to the facility. The NP indicated that around 2/13/23, Resident 82 was tested for a UTI (Urinary Tract Infection) and was treated for a UTI. The NP indicated Resident 82's sedation and poor food and fluid intake was likely due to the diagnoses of COVID-19 and UTI, not adverse drug reactions to olanzapine and Seroquel usage. A comprehensive record review was completed on 2/23/23 at 3:50 p.m. Resident 82 had the following diagnoses, but not limited to encounter for other orthopedic aftercare, unspecified fracture of right femur, unspecified fall, generalized osteo arthritis, essential hypertension, hyperlipidemia, unspecified dementia, unspecified severity with other behavioral disturbance, Alzheimer's disease		*correction with the updated plan of correction date.* Unnecessary Medication QA tool will be completed weekly times 4 weeks, monthly times 6 months, and quarterly until compliance is maintained for two consecutive months. Results of these audits will be reviewed by QAPI committee.	

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	with early onset, peripheral vascular disease, hypothyroidism, unspecified anxiety, and pain in the right hip. Resident 82 had orders for Zyprexa Zydis (olanzapine) 10mg daily for unspecified dementia, unspecified severity, with other behavioral disturbance. She received Seroquel 50 mg two times daily for unspecified dementia with unspecified severity, with other behavioral disturbance. It was reduced to Seroquel 25 mg two times daily on 2/23/23. An observation was completed by the Pharmacist on 1/23/23 at 2:53 p.m. It indicated, based on the information available at the time of the review, and assuming the accuracy and completeness of such information, it is my professional judgement that as such time, the resident's medication regimen contained no new irregularities." An observation was completed by the Pharmacist on 2/15/23 at 1:45 p.m. It indicated, "see report for any noted irregularities." On 2/28/23 at 10:00 a.m., the ED (Executive Director) provide a consultation report from the pharmacist. The report indicated Resident 82 received two or more antipsychotics. The report indicated, "Antipsychotics have a BOXED WARNING for increased mortality in older adults with psychosis related dementia. Additionally, they are associated with other potentially serious adverse effects including movement disorders, metabolic abnormalities, and orthostatic hypotension." The pharmacist recommended a gradual dose reduction to decrease olanzapine to 5mg daily, with then goal of discontinuation. Resident 82's care plan, dated 1/31/23, indicated			

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	she was at risk for side effects related to use of psychotropic medication, antipsychotic. The goal of the care plan was resident 82 would have no adverse side effects. Interventions included to administer medications as ordered, observed for effectiveness, document side effects as observed and notify MD (medical doctor), observe for side effects: antipsychotic medications: dizziness, dry mouth, indigestion, drowsiness, constipation, impaired balance, weight gain, tremors, abnormal involuntary movements, and pharmacist to review medications routinely. Resident 82's record revealed her weight on 1/23/23 was 122.4 pounds. Her weight on 2/20/23 was 116.0 pounds. Her food and fluid records indicated she refused to accept supplements and meals on several occasions. On 2/16/23, she refused dinner due to her condition and refused to accept any fluids. Her nutrition care plan, dated 1/23/23, indicated she was not motivated to feed herself. The goal indicated she would increase her intake to 75-100 percent of her meals and would not experience weight loss. A policy was provided by the ED on 2/24/23 at 9:30 a.m., titled "Nursing Admission/Return Admission Policy and Procedure," with a date of 3/2010. The policy indicated, " ...Physician Orders, transcribe the routine medication orders to include dosage, route, frequency, and the diagnosis to support the use, ask if the resident/representative understands the medication names, reason for use and why they should be continued after discharge from the facility. Explain the importance of managing medications to avoid adverse drug events or re-hospitalization, admission medication regimen review completed upon admission or as close to admission as possible, per policy ...."			

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	3.1-48(b)(1)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §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. §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. Based on observation and interview, the facility failed to ensure medications were properly secured, and also failed to waste or destroy unused medications, according to federal guidelines, when a nurse threw medications into the trash can and then poured medication down a sink drain for 3 of 5 random medication administration observations.	F 0761	*what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* Medication cart was locked. Medication cup was taken off cart. Medication cards were placed in medication cart. Residents had no	03/30/2023

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	Findings include: On 2/27/23 at 8:47 a.m., during a random observation, a medication cart was observed outside room 409, unattended. The cart was unlocked. There were no staff members observed in the hall. The nurse was not within eyesight of the medication cart. A plastic medication cup was on the cart with applesauce and a spoon in it. Medications, several pills of different colors were mixed in the applesauce. There were 6 medication cards, containing medications, turned upside down on cart for Resident 97. On 2/27/23 at 8:50 a.m., Registered Nurse (RN) 18 came out of Resident 20's room. During an interview, she indicated she had prepared Resident 20's medications in applesauce, but she did not want to take them that way. RN 18 then indicated "I'm just going to start over." She threw the cup of applesauce and medications into the trash can on the side of the medication cart. She then pushed the medication cart to the front hallway, next to the nurses' station. She put all the medication cards in the drawer and locked it. She threw the trash bag in the soiled utility room trash. A review of Resident 20's morning administered medications, from the MAR (Medication Administration Record) indicated RN 18 had given the following morning medications: Tylenol 500 mg 2 tabs , Allegra (for allergies) 180 mg, amlodipine (for blood pressure) 5 mg, Eliquis(blood thinner) 5 mg, I-caps (supplement		negative outcomes. *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;* All residents have the potential to be affected by deficient practice. Education provided to licensed staff regarding proper medication storage and disposal by 3/30/23. *what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* Education provided to licensed staff regarding proper medication storage and disposal by 3/30/23. Drug buster container added to each medication cart for drug disposal. *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; and by what date the systemic changes for each deficiency will be completed.* *After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.* Medication administration skills validation check with be	

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	155132	A. BUILDING 00 B. WING	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	for vision) 180 10-2 mg, losartin (for blood pressure) 50 mg, potassium chloride 20 meq, sodium chloride 1,000 mg, sotalol (for a heart irregular rhythm) 120 mg, and torsemide (diuretic) 10 mg. On 2/27/23 at 8:58 a.m., during a random medication observation, RN 18 was observed as she prepared medications for Resident 204. She took a bottle of Miralax from the medication drawer and poured into a plastic medication cup. The powder heaped up over the cup. She then shook the cup over the trash can, to level it off at the top edge of the cup, which was above the 30 ml mark. She then poured the powder into a cup of water, and carried it, with other medications to the resident's room. Resident 204 indicated he did not want the Miralax because his bowels were "OK." RN 18 took the MiraLAX which she had mixed in a cup of water and poured it down the sink in the resident's bathroom. On 2/27/23 at 9:15 a.m., during an interview, RN 18 indicated, when they waste narcotics they use a drug buster system, and 2 nurses have to witness. Non-narcotics they usually just throw into the "red box", but she could not put a cup of applesauce in there. On 2/28/23 at 9:10 a.m., the Administrator provided a current policy, dated revised 1/1/13, titled, "General Dose Preparation and Medication Administration." This policy indicated, "...Dispose of unused medication portions in accordance with facility policy...Discard used medication supplies...in accordance with facility policy...." On 2/28/23 at 10:25 a.m., upon request for "The		completed on all shifts daily for one week, weekly for 2, every other week for 2 weeks, and monthly for six months by DNS/designee. Results of these audits will be reviewed by QAPI committee.	

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	Facility Policy," during an interview, the Director of Nursing Services (DNS) indicated the facility policy said to make medications inaccessible. If the nurse put them into the trash and took trash to the soiled utility they were then inaccessible. It was ok to put medications in the trash if they are not accessible. 3.1-25(m) 3.1-25(o)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observations, interview, and record review, the facility failed to ensure infection control procedures were followed by staff in the main dining room while assisting residents with	F 0812	*what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*	03/30/2023

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	eating for 5 of 5 randomly observed residents during a dining services observation, (Residents 9, 159, 163, 305, and one unidentified resident). Findings include: On 2/21/23 at 12:25 p.m., Licensed Practical Nurse (LPN) and Unit Manager (UM) 4 were observed in the Moving Forward dining room. LPN 4 moved Resident 159's walker with her bare hands and did not wash or gel her hands before she moved Resident 163's walker. Resident 163 was prepared to leave the dining room. LPN 4 walked with Resident 163 to her room. On 2/21/23 at 12:31 p.m., UM 4 indicated, LPN 4 should have performed hand hygiene before she touched Resident 163's walker. On 2/21/23 at 12:36 p.m., Certified Nursing Aide (CNA) 5 was observed as she touched Resident 305's arm. She did not perform hand hygiene before she returned to assist an unidentified resident with her meal. On 2/21/23 at 12:37 p.m., CNA 6 was observed as she touched the arm of her chair with her left hand, then continued to assist Resident 9 with her meal. She pulled Resident 9's hand away from the resident's face with her potentially contaminated left hand. CNA 6 touched both arms of her chair with both bare hands and continued to assist Resident 9 with eating. On 2/21/23 at 12:42 p.m., CNA 6 was observed as she touched the arm of her chair with her left hand and pulled her chair closer to the table, then continued to assist Resident 9 with her meal. On 2/23/23 at 12:45 p.m., CNA 5 was observed as		Residents had no negative outcomes. *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;* All residents that eat in dining room have the potential to be affected by the deficient practice. Education provided to staff regarding proper hand hygiene during meal services on or before 3/30/23. *what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* Education provided to staff regarding proper hand hygiene during meal services on or before 3/30/23. Assigned manager will observe and direct staff for proper hand hygiene during meal service. ED/designee will observe and direct staff for proper hand hygiene during meal service weekly. *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; and by what date the systemic changes for each deficiency will be completed.* *After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as*	

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	she touched and fixed her hair. She failed to perform hand hygiene before she removed Resident 305 clothing protector, unlocked her wheelchair and took her to the nurse's station. On 2/21/23 at 12:48 p.m., CNA 6 was observed as she stood up, moved an empty chair with her bare hand, did not perform hand hygiene and continued to assist Resident 9 with their meal. During an interview, on 2/24/23 at 11:11 a.m., the Infection Preventionist, (IP) indicated staff have been instructed to hand gel and hand washing between touching residents. During an interview, on 2/24/23 at 11:12 a.m., Regional Clinical Consultant (RCC) indicated basic hand hygiene is needed after touching a resident, their chair, or environment. A current policy, titled, "Hand Hygiene Policy," dated 12/2021, was provided by the Administrator on 2/24/23 at 11:15 a.m. A review of the policy indicated, " ...Indications for Hand-rubbing but not limited to: Before having director contact with a resident and/or equipment ...After each resident contact and after contact with a resident's belongings, environmental surfaces, touching items on the floor, and resident care equipment ...." 3.1-21(i)(3)		*possible. The facility will need to submit an amended plan of correction with the updated plan of correction date*. Meal observation QA tool to be completed weekly times 4 weeks, monthly times 6 months, then quarterly until compliance is maintained for two consecutive quarters. Results of these audits will be reviewed by QAPI committee.	