STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 00 B. WING	05/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIARCLIFF HEALTH & REHABILITATION CENTER	5024 WESTERN AVENUE SOUTH BEND, IN 46619

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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 IN00352288, IN00350263, IN00351334, IN00353319 and IN00351757. Complaint IN00352288 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00350263 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00351334 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00353319 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00351757 - Substantiated. No deficiencies related to the allegations were cited. Survey dates: May 23, 24, 25, 26, 27 & 28, 2021 Facility number: 013420 Provider number: 155831 AIM number: 201293620 Census Bed Type: SNF/NF: 56 Total: 56 Census Payor Type: Medicare: 3 Medicaid: 44 Other: 9 Total: 56	F 0000		

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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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed on June 7, 2021.			
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to			

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	participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. Based on interview and record review, the facility failed to ensure Resident Council grievances were acknowledged and resolved in a timely manner. The deficit practice had the potential to affect 5 of 5 residents who regularly attended resident council meetings and had unresolved concerns. Finding include: On 5/24/21 at 2:48 P.M., the Resident Council President was interviewed. During the interview, she indicated there had been several grievances brought up by members of the Resident Council during the past several months that had not been resolved. Some of the concerns included, but were not limited to, cold food, showers not given, staffing, medications and treatments not always done, and missing laundry. She indicated the facility had a new Activity Director that was assisting the Resident Council with meetings but that there were no meeting minutes nor written responses to their concerns completed. On 5/24/21 at 3:15 P.M., the Activity Director was interviewed. She indicated she had been new to the position since October 2020. She had not kept meeting minutes but thought she might have written down some of the information that Resident Council had shared. She had no specific form she used to write down concerns for specific departments and did not have written responses to those concerns. She indicated Resident	F 0565	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully requests paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Minutes from the past 90 days of resident council minutes will be reviewed for resident concerns. Concerns will be documented on the facility concern forms and addressed and responded to. Administration will request a meeting with the resident council to discuss the concerns and resolutions for review. **How other residents having the potential to be affected by the**	06/25/2021

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	Council members always had the same concerns-"staffing, food, and laundry". When questioned, she indicated she had shared the concerns with the administration staff numerous times during daily morning meetings. On 5/25/21 at 2:05 P.M., during a Resident Council meeting, 5 residents who routinely attended the meetings indicated concerns with the following issues: lack of staffing and use of agency staff; cold food and delay in passing room trays; call lights not being answered/ignored, or if answered, being told the staff member would return but then never would come back; and missing clothing items that were never found or replaced. All 5 residents indicated they "rarely" received a response back from administration regarding their concerns and never received written responses. On 5/28/21 at 11:10 A.M., the Activity Director provided copies of some hand written notes from Resident Council meetings which indicated the following: -November 5, 2020: Staffing and call light "still issues"; food still cold; clothes missing; clothes shrinking; poor teamwork; residents having to wait for care in the mornings due to lack of towels; and lost clothing. -January 20, 2021: "all 3 meals cold"; laundry items missing for more than "3 weeks"; towels are in short supple; rude and disrespectful staff; and issues with agency staff on night shift. -February 2021: "48 minute wait for food-food cold"; missing clothing items-residents would like to look through clothing items in the laundry to try and find their missing clothing; not enough staff to do laundry; staff are disrespectful; residents not getting enough towels. There were no other Resident Council notes		**same deficient practice will be identified and what corrective actions(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Activity Director will be educated on proper documentation of Resident Council meetings and disbursement of concerns will be given to departments for resolution. Concerns will be reviewed in morning IDT meetings and addressed. Resolutions for any concerns will be expected for review with a goal of 5 business days or less. Activity Director will present the resolutions to the Resident Council President for review and presented at the next scheduled Resident Council meeting or at a time designated by Resident Council. **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:** Resident Council minutes, concerns and resolutions will be reviewed each month for completion and acceptance by the Resident Council at the regular QAPI committee meeting. Results of the audits will be	

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	provided to review. On 5/28/21 at 11:41 A.M., the Administrator was interviewed. During the interview, he indicated that he had not attended any resident council meetings for several months. He indicated it was the responsibility of the Social Service Director (SSD) to follow up on Resident Council concerns/grievances as well as individual grievances, however, the facility's SSD had left their employment a few weeks prior and they were actively searching for a new one. He indicated the Activity Director was responsible for assisting the Resident Council with their meetings and their concerns should be documented on a form that should have a response to the concern documented. 3.1-3(l)		reviewed by the QAPI committee and the plan will be adapted or adjusted as needed to maintain compliance. **By what date the systemic changes will be completed:** 6/25/2021	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be			

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	required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on interview and record review, the facility failed to ensure a care plan related to a fractured arm was in place for 1 of 4 residents reviewed for accidents and failed to ensure a care plan was in place for a mental illness for 1 of 5 residents reviewed for unnecessary medications. (Resident 20 & 22) Findings include: 1. A clinical record review was completed, on 5/24/2021 at 9:58 A.M., and indicated Resident 20's diagnoses included but were not limited to: diabetes, vasuclar dementia and adult failure to	F 0656	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully request*	06/25/2021

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	thrive. A nurses note, dated 5/17/2021, indicated Resident 20 "...having a fracture arm from her fall on 5/14, also that she had been seen in ER at [local hospital] and to f/u [follow up] with orthopedic surgeon in office this week...." Resident 20's medical record indicated no care plan had been created following her fall with a fractured arm. During an interview, on 5/27/2021 at 4:33 P.M., the Administrator indicated when a resident falls and has a fracture, there should be a care plan for treatment documented. 2. A record review was conducted on 5/28/21, at 11:33 A.M., for Resident 22 and indicated she admitted on 8/14/2020 and diagnoses included, but were not limited to, schizophrenia, anxiety, depression and bipolar disorder. A quarterly MDS (Minimum Data Set) assessment, dated 3/26/21, indicated Resident 22 was cognitively intact and received and an antipsychotic and antianxiety medication for 7 days of the look back period. The physician's orders indicated Resident 22 received Saphris 5 mg (milligrams) tablet daily for schizophrenia, started on 8/15/21, trazodone 25 mg tablet at bedtime for generalized anxiety disorder, started on 12/17/2020, depakote 500 mg every morning and at bedtime for bipolar disorder, started on 12/7/2020, trifluoperazine 10 mg two times a day for schizophrenia, started on 3/18/21, lorazepam 1 mg three times a day for anxiety, started on 8/14/2020 and trihexyphenidyl 2 mg three times a day for schizophrenia, started 8/14/2020.		*paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** R-20's care plan was revised to address fracture. R 22's care plan has been updated to address targeted behaviors associated with R22's diagnosis of schizophrenia. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** Residents with new fractures and residents with behaviors associated with diagnosis of schizophrenia. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Care plans for residents with new fractures will be updated. Care plans for residents with behaviors associated with diagnosis of schizophrenia will be reviewed and revised if necessary to assure targeted behaviors are specifically addressed. **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**	

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	No specific care plan with targeted behaviors related to schizophrenia was present for review. During an interview on 5/28/21, at 2:59 P.M., the DON (Director of Nursing) indicated a care plan should be present for schizophrenia and the staff should be monitoring for behaviors related to her schizophrenia. A policy was provided by the Director of Clinical Operations, on 5/28/21 at 3:56 P.M., titled, "Care Planning-Interdisciplinary Team", revised September 2013, and indicated the policy was the one currently being used by the facility. The policy indicated "...Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident...." 3.1-35(a)		**into place:** The DON or designee will complete audits of care plans for residents with new fractures and residents with diagnosis of schizophrenia to assure care plans address the fracture and to address targeted behaviors associated with the diagnosis of schizophrenia. Audits will be completed weekly x 6 weeks then monthly for 2 months. Results of the audits will be reviewed with the QAPI committee for further recommendations. **By what date the systemic changes will be completed:** 6/25/2021	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			

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	Based on observation, record review and interview, the facility failed to ensure a resident had appropriate interventions in place to prevent the development of a pressure ulcer, follow physician's orders for wound care, complete timely skin assessments, and update resident care plans for 2 of 3 residents reviewed for pressure ulcers. (Resident 14 & Resident 35). Findings Include: 1. On 5/24/21 at 12:22 P.M., the clinical record for Resident 14 was reviewed. Diagnoses included, but were not limited to, diabetes, peripheral vascular disease, and open wound to the right ankle. An annual MDS (Minimum Data Set) assessment, dated 3/11/21, indicated the resident had a BIMS score of 15 which signified she had no cognitive impairment. Resident 14 had no behaviors or refusal of care. She had a stage 3 pressure ulcer (full thickness tissue loss) and had no venous, arterial, or diabetic ulcers present. A CAA (Care Area Assessment) dated 3/25/21, indicated the resident had an alteration in skin integrity and had a healing stage 3 pressure ulcer to her right ankle. She was seen weekly by the wound doctor and had boots applied while in bed for prophylaxis. The resident had a diagnosis of peripheral vascular disease and neuropathy. A care plan, dated 6/17/20 and revised on 3/3/21, indicated the resident had a pressure ulcer to her right lateral ankle. The goal was for the wound to show signs of healing. Interventions were: encourage resident to not wear her slippers that rub on her foot, encourage her not to wear shoes without socks, measurements weekly, medications	F 0686	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully request paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** R-14's treatment plan has been reviewed and revised. R-35's treatment and care plan has been reviewed and revised. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** Residents with pressure injuries have the potential to be affected. All residents with pressure injuries will be reviewed to assure ordered treatments are being performed and documented, interventions are in place to prevent the development of pressure ulcers, skin assessments are completed timely and care plans are updated.	06/25/2021

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	and treatments as ordered, refuses to wear different shoes, and weekly wound rounding with in-house wound doctor. On 5/23/21 at 11:56 A.M., Resident 14 was observed seated in a w/c (wheelchair) in her room. She indicated she had a sore on her right outer ankle which was due to her shoes rubbing. She was supposed to wear different shoes but hadn't gotten any. On 5/24/21 at 2:16 P.M., the resident was observed walking in the hallway with restorative aids. She wore Birkenstock sandels without socks. At 2:34 P.M., Resident 14 was observed seated back in her room in her w/c and was wearing her sandals. There was a dressing to her right outer ankle that was dated 5/21/21. She wore no other bandages or dressings to her feet or calves. On 5/25/21 at 3:20 P.M., Resident 14 was observed seated in her w/c in her room. A brown opened box sat on her bed. She indicated she wasn't sure what was in the box but thought it was some type of bandage for her ankle. She pointed to an open box of bandages that were sitting on her walker seat and indicated she was supposed to put these on her ankle. Her right ankle wound was covered with a dressing. A Physician order, dated 2/24/21 at unknown time, was for Medihoney Wound/Burn Dressing Gel-Apply to right lateral ankle topically daily in the afternoon for wound-and cover with border gauze. A Wound Evaluation and Management Summary, dated 5/18/21 at unknown time, indicated the resident had been seen by the wound physician for a wound on her right lateral ankle. The wound		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Licensed Nursing staff will receive in-service education with topics including but not limited to: · Completion and documentation of ordered treatments · Following physician orders for treatments · Monitoring interventions are implemented per plan of care **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:** The DON or designee will conduct audits of residents with pressure injuries to assure ordered interventions are implemented and pressure injury treatments are completed and documented, and care plans are updated if there is a decline in wound healing. These audits will be completed weekly for 8 weeks, then monthly for 3 months. Results of the audits will be presented to the QAPI committee for review and recommendations. **By what date the systemic changes will be completed:** 6/25/2021	

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	measured 0.5 cm X 0.4 cm. and the surface area was 0.20 cm. The summary indicated when the physician visited, the resident was found to be wearing the wrong dressing-she had a Xeroform dressing on, dated 5/17/21, which should have been a honey dressing. The physician ordered the correct dressing to be applied which was Medihoney-apply once daily and cover with a gauze island dressing. Physician recommendations were for the EZ boot (pressure relieving boots) to be worn in bed and chair to off-load her wound; elevate her legs, and diabetic shoes due to diabetic foot ulcers-may need referral to podiatry. The summary indicated the resident's wound to her right lateral ankle had improved as evidenced by decreased surface area. A TAR (Treatment Administration Record) for May 2021, indicated by lack of nurse initials and observation of her dressing, dated 5/21/21, the resident's wound dressing to her right lateral ankle had not been changed on 5/22, 5/23, 5/24, or 5/25/21. A Wound Evaluation and Management Summary, dated 5/25/21 at unknown time, indicated the resident had been seen by the wound physician for a wound on her right lateral ankle. The wound measured 0.6 cm X 0.4 cm. and the surface area was 0.24 cm. The wound physician spoke with the wound care nurse and the resident about the lack of wound healing. She was going to try using Collagen for 3 times a week. The resident was encouraged to elevate her legs throughout the day. Physician recommendations were for the EZ boot to be worn in bed and chair to off-load her wound; elevate her legs, and diabetic shoes due to diabetic foot ulcers-may need referral to podiatry.			

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	On 5/25/21 at 3:36 P.M., QMA 4 (Qualified Medication Aide) was interviewed and indicated the wound nurse had been in and changed Resident 14's orders. The resident was just supposed to wear a dressing to cover and protect her ankle but no longer had a treatment. She indicated she was not aware of the resident having an EZ boot on during the night and didn't think the resident wore one. On 5/25/21 at 3:50 P.M., the Director of Clinical Operations was interviewed about the resident's diabetic shoes and why she wasn't wearing them or if she even had them. She indicated the order for diabetic shoes should have been discontinued but gave no further information about the shoes. When questioned about the dressings in the resident's room, she indicated dressings were sent to the resident's directly and that she would go and get them and take them to the nurses station for nursing staff to change. 2. A clinical record review was completed, 5/27/2021 at 10:59 A.M., and indicated Resident 35's diagnoses included but were not limited to: traumatic subdural hemorrhage, cerebral infarction and Alzheimers disease. A care plan, dated 10/23/2020, indicated "... [Resident 35's name] has an actual skin risk r/t[related to] Edema to bilateral lower extemities...." and there had not been any updates to the care plan since 10/23/2020. A physicians order, dated 12/18/2020, indicated "...EZ [pressure eliminating boot] Boot to be worn in bed and chair to off-load wound to right lateral ankle every shift for wound...." A form, titled "Weekly Wound Observation", dated 3/10/2021, indicated Resident 35 had a			

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	155831	A. BUILDING 00 B. WING	05/28/2021

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	pressure ulcer to his right lateral ankle, measuring "...0.5 x 0.5 x not measurable cm [centimeters]....", and the overall impression was documented as improving. A form, titled "Weekly Wound Observation", dated 3/16/2021, indicated Resident 35's pressure ulcer to his right lateral ankle, measuring "...1.3 x 1 x not measurable cm....", and the overall impression was documented as worsening. A form, titled "Weekly Wound Observation", dated 3/30/2021, indicated Resident 35's pressure ulcer to his right lateral ankle, measuring "...0.9 x 0.6 x not measurable cm....", and the overall impression was documented as improved. A TAR [treatment administration record], indicated "...EZ Boot to be worn in bed and chair to off-load wound to right lateral ankle every shift for wound....", dated 5/1/2021 - 5/31/2021, and indicated Resident 35's EZ boots were not documented as applied on 5/14/2021 during the night shift, 5/20/2021 & 5/21/2021 on day shift, 5/24/2021 on night shift and 5/25/2021 on day and evening shift. A TAR, dated 5/1/2021 - 5/31/2021, indicated Resident 35 was to be administered "...Medihoney Wound/Burn Dressing Gel (Wound Dressing) Apply to right lateral ankle topically one time a for wound cleaner pat dry, apply medihoney, cover with bdr[border dressing] gauze...." and indicated this dressing change was not completed on 5/20/2021 and 5/25/2021. Resident 35's care plan indicated his interventions had not been timely updated following the worsening of his pressure ulcer.			

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	During an observation, on 5/26/2021 at 10:26 A.M., Resident 35 rated his pressure ulcers to his ankle at a 5 on a 0/10 pain scale. He was observed to have a scab area the size of a dime to his right ankle with a dark surrounding area, the size of a silver dollar. On 5/26/2021 at 10:30 A.M., Resident 35's ankle was observed without a dressing in place. On 5/27/2021 at 2:53 P.M., Resident 35 was observed lying in his bed, asleep, without his boots on. On 5/27/2021 at 4:24 P.M., Resident 35 was observed in the hallway by the nurses station without his EZ boots on and his ankle dressing not in place. During an interview, on 5/27/2021 at 4:25 P.M., the Corporate Nurse indicated Resident 35 should have his boots on while in the wheelchair and in the bed, as ordered. A policy was provided by the Administrator, on 5/28/2021 at 3:32 P.M., titled "Pressure Ulcers/Skin Breakdown - Clinical Protocol", dated April 2018, and indicated this was the policy currently used by the facility. The policy indicated "...b. Current approaches should be reviewed for whether they remain pertinent to the resident/patient's medical conditions, are affected by factors influencing wound development or healing, and the impact of spectifc treatment choices made by the resident/patient or a substitute decision-maker...." 3.1-40(a)(1) 3.1-40(a)(2)			

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F 0689 SS=G 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 record review and interview, the facility failed to ensure a Resident, who utilized a wheelchair as her main mode of transportation, was properly secured in the facilities transportation bus, while being transported to and from an appointment, resulting in the resident sliding out of the wheelchair onto the floor of the bus and fracturing her ankle when the bus driver had to break hard to avoid an accident. This deficient practice affected 1 of 1 residents reviewed for accidents. (Resident C) Finding includes: During an interview with Resident C, on 5/24/2021 at 1:30 P.M., she indicated she fell out of her wheelchair during transportation from a doctor's appointment and fractured her ankle. She indicated she was strapped into the transportation van but fell onto the floor and sat on her ankle and subsequently breaking it. A Reportable Incident, dated 4/22/2021, indicated "...Brief Description of Incident: 4/22/2021 Facility transportation driver [name of driver] notified the facility that when transporting Resident (BIMs 15) [Brief Interview for Mental Status score, which	F 0689	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully request paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident C remains in the facility and facility continues to monitor healing of the fractured ankle. Resident C has continued to use facility transportation after event with no further incidents. **How other residents having the potential to be affected by the**	06/25/2021

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	indicated Resident is cognitively intact] he had to brake hard to avoid an accident and resident slid from chair to the floor of the van. Resident was transferred to the hospital by 911 for evaluation and treatment...Type of Injury: 4/22/2021 Hospital notified facility that resident had a fractured ankle...Immediate Action Taken: 4/22/2021 Resident is own responsible party. Physician notified. Driver returned to facility to demonstrate procedure of securing w/c [wheelchair] and seat belt. Driver returned to duties after demonstration of proper securing procedures...Follow up: 4/30/2021 Resident returned from hospital with left ankle fracture. Facility will continue to follow physicians orders and monitor though healing. No further concerns or incidents noted with transportation, driver was successful in demonstrating proper securing of wheelchair. Noted that seat belt and shoulder strap were placed on resident, but placement was above waist line so when bus stopped, resident slid forward under the seatbelt, then sitting on the floor. When resident sat on the floor, she also sat on her ankle resulting in a fracture. Facility did not substantiate any findings of intentional abuse or neglect ...." During an interview with Transportation Driver 11 on 5/26/2021 at 2:30 P.M., he indicated he had been the driver who transported Resident C to her doctor's appointment on 4/22/2021, on the way back from that appointment another driver cut him off and he had to brake hard to avoid getting into an accident and that when he slammed on his brakes Resident C slid down onto the floor and landed on her leg and broke her ankle. The Transportation Driver then demonstrated how he secured the resident into the seat and indicated the belt was secured on her upper waist, above the wheelchair arms, not below and on her lower		**same deficient practice will be identified and what corrective actions(s) will be taken:** Residents who use their wheelchair as a seat in a motor vehicle have the potential to be affected by the alleged deficient practice. Facility drivers will be educated on the proper placement of wheelchair tie down straps and proper placement of lap/shoulder straps when securing a resident in the van. Return demonstrations will be performed and documented for the drivers employee file. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Administrator/designee will complete random observations of wheelchair residents for proper securing and placement of seat belt devices. Observations will be random and with a frequency of 1xweek for 4 weeks and monthly for a minimum of 2 months with 100% compliance. Any findings of noncompliance will require complete retraining of driver and successful return demonstration before proceeding. Results of observations will be reviewed by the QAPI committee for further recommendations. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	waist. During an interview with the Executive Director of the facility on 5/27/2021 at 11:30 A.M., he indicated the facility had reported an incident in which a resident had slid out of their wheelchair onto the floor landing on her leg and subsequently breaking her ankle. The driver, he indicated, had her secured with the seat belt and shoulder strap but the placement of it was above her waistline. The facility did education with him and he did a return demonstration and returned to duty and the facility has had no further incidents. The Executive Director indicated there was no policy or procedure for securing a resident. "Best Practices For Using a Wheelchair as a Seat in a Motor Vehicle" (January 2008) was retrieved on 5/28/2021 from the Wheelchair Transportation Safety website at www.umtri.umich.edu. The guidance indicated "...8. Insist that the seat belt not loop over the arm rests or cover any devices mounted on the chair, such as an augmentative communication device or lap tray. Explanation: The seat belt protects the rider only when it fits snug and low across the pelvis. The farther away from the body it is, the less protection it can give...." This Federal tag is related to Complaint IN00352288. 3.1-45(a)		**assurance program will be put into place:** Maintenance Director/designee will present to the facility QAPI committee observation results. All new drivers will be required to complete the training before starting duty as a driver. Refresher training will be required a minimum of semi-annually for all drivers going forward and documentation of training and results will be presented to the QAPI committee for review and recommendations. **By what date the systemic changes will be completed:** 6/25/2021	
F 0697 SS=G Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with			

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	professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview and record review, the facility failed to ensure a resident was adequately medicated for pain prior to and during dressing changes with extensive wounds that required daily dressing changes for 1 of 1 residents reviewed for pain, resulting in the resident having increased anxiety and pain prior to and during dressing changes (Resident 31). Findings include: On 5/24/21 at 1:59 P.M., the clinical record for Resident 31 was reviewed. Diagnoses included, but were not limited to, congestive heart failure, obesity, and stage 4 (Full thickness tissue loss with exposed bone, tendon or muscle) pressure wound to the left lateral shin. The resident was confined to bed and received hospice services. A quarterly MDS (Minimum Data Set) assessment, dated 4/16/21, indicated the resident had a BIMS (Brief Interview Mental Status) score of 11 which signified he had moderately impaired cognition. He required extensive assistance with 2 staff members for bed mobility. He had no behaviors, rejection of care, or mood indicators but did complain of occasional pain when questioned. Care plans indicated the following: -Resident had pain and discomfort at times related to poor mobility due to obesity, relied on staff to help him reposition, and had a diagnosis of gout (last revised on 3/21/2019). The goal was to remain free from pain. Interventions were to assist	F 0697	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully request paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** R 31 remains in the facility and is monitored to assure medication for pain is received prior to facility staff completion of dressing changes as well as interventions for pain and anxiety are implemented during dressing changes. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** Residents receiving dressing changes have the potential to be affected. The facility has identified	06/25/2021

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	with ADL's (care), document effectiveness or not of the medications, ensure call light is within reach, monitor daily for physical symptoms associated with pain, offer comfort measures and pain medications and offer pain medications as prescribed and monitor adverse reactions. -Resident has a terminal prognosis related to heart failure and utilizes hospice services (8/2/2019). The goal was the resident's pain would be managed at a level acceptable to him and his personal care needs would be met. Interventions included, but were not limited to, coordinate care with the facility and hospice to ensure an effective plan of care, hospice and facility CNA (Certified Nursing Assistant) to coordinate ADL's: shower, skin care, grooming, etc, hospice nurses and home health aids visit 2 times/week, hospice and facility nurse to monitor the resident's pain level and report ineffective pain control to the physician, and treatment to pressure ulcers per physician orders. -Resident has elected a DNR (Do Not Resuscitate) code status (2/7/2019). Interventions included, but were not limited to, keep the resident comfortable and pain free per physician orders. -Resident has a behavior problem related to anxiety and exhibits yelling out during care and will accuse staff of hurting him before they touch him to do treatments (Revised 1/14/20). Interventions included, but were not limited to, anticipate and meet the residents needs, assure the resident throughout care that staff are trying to make sure he has no pain, and monitor behavior episodes and attempt to determine the underlying cause. On 5/23/21 at 11:38 A.M., Resident 31 was		all residents with dressing changes and will assure interventions are in place to address pain or potential pain with dressing change. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Nursing staff will receive in-service education including but not limited to: · Pain management prior to dressing changes · Monitoring for and interventions for pain and anxiety during dressing changes. **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:** The DON or designee will conduct dressing change observations to assure residents have received ordered pain medication prior to dressing change and any pain and/or anxiety the resident may experience during dressing changes is addressed using appropriate interventions. These observations will be conducted Weekly for 6 weeks then monthly for 2 months. Results of the audits will be presented to the QAPI committee for review and recommendations. **By what date the systemic**	

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	observed lying in his bed. His legs were spread apart with a wedge in between them at the end of the bed. He complained of his feet hurting and indicated "feels like someone took a ball bat to my feet". On 5/25/21 at 10:15 A.M., the resident was observed lying in bed with the head of the bed up at almost 90 degrees. He was lying in poor alignment and laid diagonally across the bed with his head and neck bent forward and lolling over to the right side. His left leg laid near the left side of the bed. At 2:42 P.M., Resident 31 was observed lying in bed. He laid diagonally across the bed with his head and neck bent forward and lolling over to the right side. His left leg remained near the left side of the bed. The resident indicated he "hurt" on his left leg and that it needed to be moved. At 2:50 P.M., 2 staff members came into the room and told the resident they were going to change and reposition him. The room to the door was closed but the resident could be heard in the hallway yelling that he hurt and for staff to "stop" and not to touch him. On 5/27/21 at 11:20 A.M., LPN 2 (Licensed Practical Nurse) was observed getting ready to go into Resident 31's room. She had a treatment cart with her and indicated she was going to give the resident his scheduled Tylenol for pain and then was going to change his dressings. At 11:29 A.M., the Director of Clinical Operations, DON (Director of Nursing), LPN 2 and 2 CNA's were in the resident's room to change his dressings. The resident indicated he "needed to poop" but couldn't. The dressings to his left calf were removed. The DON removed 1/2 of the dressing to the left calf which had dried red and brown		**changes will be completed:** 6/25/2021	

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	fluids on it and which stuck to the wounds. The wounds started bleeding. She then used normal saline to moisten the remaining 1/2 dressing and removed it. The resident had a chronic wound to his calf that had 3 large open areas which were bordered by thick yellow slough. There were several pinpoint areas of bleeding and a large amount of bleeding from the large open area nearest to his knee which appeared after the dressing was removed. There were multiple dime sized areas of black tissue on the calf and the skin surrounding the wounds had thick, yellow scales. LPN 2 applied a large amount of medihoney to an ABD pad and placed it on his calf-then wrapped it with a kerlix dressing. Resident 31 yelled throughout the procedure and stated "it hurts" and "stop, stop". He begged staff not to "cut me down there" (resident has had necrotic tissue "cut" away from the wound in the past). The resident was then assisted to turn over where he was found to have 2 large foam dressings attached to his buttocks and upper thighs which were partially covering his anus making it difficult to have a bowel movement. Both foam pads had dried stool along the edges farthest away from his anus. LPN 2 pulled each foam pad off quickly and the resident yelled over and over that it hurt. He then had an extremely large bowel movement as soon as the dressing was removed. The area on his buttocks was cleaned of stool and his bottom and upper back of his thighs were observed to be excoriated with several open areas that were now bleeding. His entire bottom and back of his thighs were non-blanchable and were purple to black in color. There was a skin fold on the back of his left thigh that appeared to have yellow slough in the crease and there was an open area on the back of his right thigh that had undefined edges and appeared as beefy red, "ground meat" skin. The skin on his buttocks and upper back of his thighs			

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	had a foul, sweaty odor after being cleansed of BM. The resident continued to yell in pain to his bottom and his knee and again, stated for staff not to cut him down there. LPN 2 then reapplied the sticky foam pad to each side of his buttocks and thighs and he was positioned onto his back. Resident 31 stopped yelling in pain after staff no longer touched him. On 5/27/21 at 2:15 P.M., Hospice RN 9 was interviewed. During the interview, she indicated she had cared for the resident the past year. She indicated Resident 31 had had wounds since being admitted to hospice in 2019. The wounds were chronic and would heal and then reopen again. He was followed by hospice and the facility's wound doctor who visited each week. RN 9 indicated, in the recent past, she would look at his wound with the wound doctor and unit manager each week and his wounds would be measured and changes made to his treatments if needed. She and other hospice staff came into visit the resident and bathe and change his dressings on Tuesdays and Thursdays. RN 9 was aware the resident's dressing had been changed earlier but they were soiled and needed changed again. She and hospice CNA 10 were observed to turn Resident 31 over. RN 9 gently and slowly removed the foam pads from his buttocks. When questioned, she indicated his wounds looked worse than when she had seen them last on Thursday, 5/20/21. There was no bleeding noted to the open areas on his buttocks and upper thighs. She indicated, if staff pulled the sticky foam dressing off too quickly, it would tear his skin and make him bleed. She applied new foam pads to his buttocks and thighs and he was assisted to lie back on his back. During the procedure, Resident 31 yelled out in pain however, hospice staff were successful for short			

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moments in diverting his attention. RN 9 indicated the resident always yelled out when moved and touched and was on a pain management program.

A physician order, dated 11/23/2020, was for Morphine Sulfate solution 20 mg (milligrams)/ml (milliliter)-give 0.25 ml by mouth every 2 hours as needed for pain. Give a PRN (as needed) dose at 9:00 a.m. before wound care.

Review of the MAR (Medication Administration Record) and TAR (Treatment Administration Record) indicated the following:

-March 2021: The TAR indicated behavior monitoring for behaviors of yelling out during care and expressions of discomfort before being touched. His wound care with dressing changes were scheduled for 9:00 a.m. each day. The TAR indicated the resident had behaviors on day shift 1 time during the entire month which was on 3/31/21. The MAR indicated there was no Morphine Sulfate given prior to the dressing changes scheduled at 9:00 a.m.

-April 2021: The TAR indicated behavior monitoring for behaviors of yelling out during care and expressions of discomfort before being touched. His wound care with dressing changes were scheduled for 9:00 a.m. each day. The TAR indicated the resident had behaviors on day shift on 4/11, 4/13, 4/16, 4/17, 4/18 x3, 4/20 x3, 4/29 x3, and 4/30/21 x5. The MAR indicated he was only given a PRN dose of Morphine Sulfate on 4/23/21 at 2:12 a.m. The resident had no behaviors recorded on that day.

-May 2021: The TAR indicated behavior monitoring for behaviors of yelling out during

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	care and expressions of discomfort before being touched. His wound care with dressing changes were scheduled for 9:00 a.m. each day. The TAR indicated the resident had behaviors on day shift on 5/1 x2, 5/2 x3, 5/4 x3, 5/14 x4, 5/15 x4, 5/16 x4, 5/17 x4 and 5/21/21. The MAR indicated there was no Morphine Sulfate given prior to the dressing changes scheduled at 9:00 a.m. On 5/28/21 at 3:32 P.M., the Administrator provided a current copy of the facility policy titled "Pain Assessment and Management" which stated the following: "Purpose is to help staff identify pain and develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain...Pain management is a multidisciplinary care process that includes the following: Assessing the potential for pain, Effectively recognizing the presence of pain...Addressing the underlying causes of the pain...." 3.1-37(a)			
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---			

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	§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 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 record review and interview, the facility failed to ensure a resident receiving psychotropic medications had appropriate side effect monitoring and appropriate behavior monitoring in place for targeted behaviors for 1 of 5 residents	F 0758	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement*	06/25/2021

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	reviewed for unnecessary medications. (Resident 22) Findings Include: A record review was conducted on 5/28/21, at 11:33 A.M., for Resident 22 and indicated she admitted on 8/14/2020 and her diagnoses included, but were not limited to, schizophrenia, anxiety, depression and bipolar disorder. A quarterly MDS (Minimum Data Set) assessment, dated 3/26/21, indicated Resident 22 was cognitively intact and received and an antipsychotic and antianxiety medication for 7 days of the look back period. The physician's orders indicated Resident 22 received Saphris 5 mg (milligrams) tablet daily for schizophrenia, started on 8/15/21, trazodone 25 mg tablet at bedtime for generalized anxiety disorder, started on 12/17/2020, depakote 500 mg every morning and at bedtime for bipolar disorder, started on 12/7/2020, trifluoperazine 10 mg two times a day for schizophrenia, started on 3/18/21, lorazepam 1 mg three times a day for anxiety, started on 8/14/2020 and trihexyphenidyl 2 mg three times a day for schizophrenia, started 8/14/2020. The MAR for March 2021 indicated Resident 22 had side effect monitoring for antianxiety and antipsychotic medications, but there were X's documented for the entire month. The order indicated to document if observed, the number of times on MAR and document in progress notes. The MAR for April 2021 indicated Resident 22 had side effect monitoring for antianxiety and antipsychotic medications, but there were X's		*by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully request paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** R 22 remains in the facility. R 22's care plan has been revised to address specific target behaviors related to her diagnosis of schizophrenia and she is monitored for side effects of medications used to treat her diagnosis of schizophrenia. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** Residents receiving psychotropic medications have the potential to be affected. Residents receiving psychotropic medications have been identified and plan of care reviewed and revised as necessary to address monitoring for side effects of psychotropic medications and targeted behaviors. **What measures will be put into place or what systemic**	

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	documented for the entire month. The order indicated to document if observed, the number of times on MAR and document in progress notes. The MAR for May 2021 indicated Resident 22 had side effect monitoring for antianxiety and antipsychotic medications, but there were X's documented for the entire month. The order indicated to document if observed, the number of times on MAR and document in progress notes. Psychology progress notes, dated 3/25/21, indicated Resident 22 had seen the behavioral health services LCSW (Licensed Clinical Social Worker) the note indicated Resident 22 could be restless and agitated, reported she was engaged to a gentleman at her previous assisted living facility. She reported she had felt unloved by her parents, physically abused by her first husband, threatened death with a machete by a man living in her home. The progress note indicated her delusions were non-distressful, persecution, not distressful at this time, but distressful in the past and her perceptions: delusions, non-distressful. Psychology progress notes, dated 4/15/21 , indicated Resident 22 had seen the behavioral health services FNP-C (Certified Family Nurse Practitioner) and indicated Resident 22's delusions were non-distressful, persecution, not distressful at this time, but distressful in the past and her perceptions: delusions, non-distressful. The nursing staff were to continue to monitor mood, behaviors, sleep and appetite and document accordingly. Psychology progress notes, dated 4/19/21, indicated Resident 22 had seen the LCSW. The LCSW indicated staff reports that the resident frequently talks to herself. The resident reported		**changes will be made to ensure that the deficient practice does not recur:** The facility will review residents during the monthly behavioral team meeting to assure monitoring for side effects of medication and targeted behaviors are completed and documented. **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:** The DON or designee will audit the records of residents receiving psychotropic medications to assure targeted behaviors and medication side effect monitoring are completed and documented. These audits will be conducted for randomly selected residents receiving psychotropic medications each week for 6 weeks; then randomly selected residents each month for 3 months. Results of the audits will be presented to the QAPI committee for review and recommendations **By what date the systemic changes will be completed:** 6/25/2021	

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	she was waiting for alternate placement and shared about her fiance from the assisted living. The resident indicated she was having set backs in getting married. The report indicated her delusions were non-distressful, persecution, not distressful at this time, but distressful in the past and her perceptions: delusions, non-distressful. Psychology progress notes, dated 5/6/21, indicated Resident 22 had seen the FNP-C and indicated staff reports resident talks to herself and the report indicated her delusions were non-distressful, persecution, not distressful at this time, but distressful in the past and her perceptions: delusions, non-distressful. The nursing staff were to continue to monitor mood, behaviors, sleep and appetite and document accordingly. Psychology progress notes, dated 5/14/21, indicated Resident 22 had seen the Psychologist. He indicated staff confirmed delusional thoughts of getting married and the resident reported to him that "she observed her roommate sucking her own breasts" and he had reported it to the facility social worker. He indicated she was preoccupied about discharging the facility and getting married during their session. A psychosocial progress note, dated 2/18/21, indicated the behavioral team met to discuss Resident 22's recent behaviors, but do not indicate what they were. A psychosocial progress note, dated 4/15/21, indicated the behavioral team met to discuss Resident 22's recent behaviors and indicated she had no new behaviors. A psychosocial progress note, dated 5/20/21,			

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	indicated the behavioral team met to discuss Resident 22's recent behaviors and indicated she had no recent behaviors. A nursing progress note, dated 5/12/2021 at 6:31 P.M., indicated resident had refused to eat dinner and had refused breakfast and lunch earlier in the day. The resident indicated "I am not hungry go give that food to the kids at the boarder,you cant force me to eat when I am not hungry, I have snacks in this drawer I can eat, and actually you are disturbing me, I need to be packing because I am leaving in a few days I have found an apartment am about to get married". The care plan, for Resident 22, indicated no specific care pan with targeted behaviors related to schizophrenia was present for review. Behavior monitoring, for Resident 22 indicated no specific targeted behaviors were being documented related to her schizophrenia. During an interview on 5/28/21, at 2:59 P.M., the DON (Director of Nursing) indicated a care plan should be present for schizophrenia and the staff should be monitoring for behaviors related to her schizophrenia. During an interview on 5/28/21, at 4:33 P.M., the DON indicated she wasn't sure of what the "X" on the side effect monitoring sheet meant, but thought it just was not addressed. She indicated she expected staff to put a number of times a side effect was observed and document in the progress notes. A policy was provided by the Director of Clinical Operations, on 5/28/21 at 3:50 P.M., titled, "Medication Therapy", revised April 2007, and			

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	indicated the policy was the one currently being used by the facility. The policy indicated "...A description of the behavioral symptoms...targeted and individualized interventions for the behavioral and/or psychosocial symptoms; the rationale for the interventions and approaches; specific and measurable goals for targeted behaviors; and how the staff will monitor for effectiveness of the interventions...The IDT will monitor for side effects and complications related to psychoactive medications...." 3.1-48(a)(3)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5 percent. A medication pass observation revealed 2 errors out of 26 opportunities resulting in a 7.69% error rate (Resident 43 and Resident 54). Findings include: 1. On 5/26/21 at 9:20 A.M., during a medication pass, RN 7 (Registered Nurse) was observed to administer Resident 43, Fluticasone Propionate (nasal spray used to treat rhinitis [sneezing, runny, stuffy, itch nose]) Suspension 50 MCG/ACT 2 sprays in each nostril. The order was for Fluticasone Propionate Suspension 50 MCG/ACT 1 spray in each nostril. 2. On 5/28/21 at 8:41 A.M., during a medication	F 0759	*This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *This facility respectfully request paper compliance for this citation.* **What Corrective action(s) will be accomplished for those residents found to have been**	06/25/2021

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	pass, QMA 8 (Qualified Medication Aid) was observed to administer Resident 54, Meloxicam (non-steroidal anti-inflammatory medication) 15 mg 1 tablet by mouth. The Meloxicam was in a pharmacy packaged container with the name of the medication, dose, route, and day and time to be given which read 5/28/21 at 9:00 a.m. On 5/28/21 at 11:00 A.M., during reconciliation of Resident 54's medications, there was no active physician's order for Meloxicam found in the resident's EHR (Electronic Health Record). Review of the MAR (Medication Administration Record) for May 2021, did not indicate an order for Meloxicam. There was a discontinued physician order for Meloxicam 15 mg tablet-give 1 tablet by mouth daily which was dated 7/23/2020. RN 3 was notified of the medication error and was observed to look at the resident's pharmacy packaged medications for 5/29, 5/30, and 5/31/21. All 3 days had Meloxicam 15 mg tablets-1 tablet by mouth to be given at 9:00 a.m. each day. RN 3 indicated the DON (Director of Nursing) was going to contact the physician for notification and further orders. On 5/28/21 at 11:29 A.M., the Director of Clinical Operations provided a current copy of the facility policy titled "Adverse Consequences and Medication Errors which stated that a 'medication error' was defined as the preparation or administration of drugs or biologicals which were not in accordance with physician orders, manufacturer specifications or accepted professional standards and principles of the profession providing services; examples of medication errors included: Unauthorized drug-a drug that is administered without a physician's order...."		**affected by the deficient practice:** The resident sample list provide to the facility does not include resident 43. The resident sample list provided to the facility does not include resident 54 **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** All residents receiving medications administered by qualified staff have the potential to be affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Staff qualified to administer medications will receive in-service education including but not limited to: · Safe medication administration practices and following prescriber orders · Accepting therapeutic interchange orders · Medication variance reporting **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:** The DON, pharmacy consultant or designee will conduct random	

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	3.1-48(c)(1)		observation of staff qualified to perform medication administration 2 times per week for 3 weeks, then weekly for 3 weeks then monthly for 2 months. Results of these observations will be shared with the QAPI committee for further discussion and recommendation. **By what date the systemic changes will be completed:** 6/25/2021	