STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155483	A. BUILDING 00 B. WING	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF RISING SUN, THE	405 RIO VISTA LN RISING SUN, IN 47040

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 12, 13, 17, and 18, 2023 Facility number: 000405 Provider number: 155483 AIM number: 100273800 Census Bed Type: SNF/NF: 42 Total: 42 Census Payor Type: Medicare: 10 Medicaid: 26 Other: 6 Total: 42 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 20, 2023.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Law. The Facility's date of alleged compliance is February 2, 2023. The Facility is respectfully requesting paper compliance for all deficiencies in this POC.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure residents that self-administered medications were appropriately assessed for self-administration for 2 of 10 residents reviewed for medication administration. (Residents 146 and 23)	F 0554	It is the policy of the Facility to respect resident rights to self-administer medications and follow policy for assessments, as well as review with IDT, and obtain/follow MD orders as needed.	02/02/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brenda Bannon	Administrator	02/09/2023

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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	Findings include: 1. On 01/17/23 at 11:21 A.M., Resident 146 was observed in his room sitting in his wheelchair. The nebulizer was running, and the resident was holding a nebulizer mouthpiece up to his face. The nurse was not present in the resident's room. On 01/17/23 at 11:41 A.M., the resident was observed in his room sitting in his wheelchair. The nebulizer was running, and the resident was holding a nebulizer mouthpiece up to his face. The resident's nurse, LPN (Licensed Practical Nurse) 8 was not in the resident's room, she was at the nurses' station giving report while the treatment was running. On 01/17/23 at 3:59 P.M., LPN 3 administered the resident's wound treatment and began the nebulizer treatment. She indicated she liked to stay in the room with the resident while the nebulizer treatment was running. The resident had a recent diagnosis of pneumonia, and she wanted to ensure the resident received the full treatment. The resident's clinical record was reviewed on 01/18/23 at 2:32 P.M. An Admission MDS (Minimum Data Set) assessment, dated 01/12/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, acute respiratory failure with hypoxia, atrial fibrillation, heart failure, post COVID-19, and pulmonary fibrosis. The resident required extensive staff assistance with most ADLs (Activities of Daily Living), but only required supervision with eating. The resident's current MD orders included an open ended order, with a start date of 01/10/23, for administration of a DuoNeb solution four times a day for respiratory failure. The resident's record lacked documentation of a medication		DON and/or designee assessed resident number 146 and 23. Assessments completed by 2-1-2023. All residents have potential to be affected. DON and/or designee in-serviced nursing staff on administering nebulizer and inhalers and residents requesting to self administer. Nursing in-service completed 2-1-2023. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. The DON and/or designee will audit 5 residents for self administration of meds per week x's 4 weeks, then 3 residents per week x's 4 weeks, then 1 resident per week for 4 weeks, then monthly x's 3 months. Observations/audits will be conducted on random shifts to monitor corrections. If the facility is within compliance at the end of 6 months, then monitoring can be stopped. At the monthly QAPI meetings, monitoring will be reviewed, and any concerns will be addressed as they are identified. If necessary,	

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	self-administration assessment. The current, undated facility policy, titled "Nebulizer Medication Administration Guidelines" was provided by the RDO (Regional Director of Operations) on 01/18/23 at 1:25 P.M. The policy indicated, "...Licensed personnel required to stay at bedside if resident is unable to self-administer medication..." 2. On 01/12/23 at 11:40 A.M., Resident 23 was observed sitting in a chair in his room. A handheld albuterol inhaler was laying on his overbed table. On 01/18/23 at 8:11 A.M., the resident was sitting on the side of his bed. RN 2 entered his room and administered his oral medications and a nasal spray. A handheld inhaler was laying on his bedside table. During an interview on 01/18/23 at 9:58 A.M., the resident indicated they've been leaving the inhaler at bedside for him since last year when he had some respiratory trouble. He had never used one before that. He took two puffs, probably two or three times a week. The resident's clinical record was reviewed on 01/17/23 at 2:36 P.M. A Discharge MDS assessment, dated 12/21/22, indicated the resident's short term memory was okay and he was independent with decision making. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease with acute exacerbation. The resident's current MD orders included an open ended order, with a start date of 01/04/23, for an Ipratropium-Albuterol inhaler to be used every four hours as needed for shortness of breath. The resident's record lacked		an action plan will be written by the committee. The Administrator and/or designee will monitor the action plan until resolution is obtained.	

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	documentation of a medication self-administration assessment. During an interview on 01/18/23 at 12:26 P.M., RN 4 indicated if a resident wanted to self-administer medications, they would assess the resident on their ability to do so. If the resident could take their medications on their own safely, they would get a physician's order for medication self-administration. She was not sure on the exact time frame, but residents would be re-evaluated for self-administration every so many months or if there was a change in their condition. The current, undated facility policy titled "SELF-ADMINISTRATION OF MEDICATIONS BY RESIDENTS" was provided by the RDO on 01/18/23 at 1:25 P.M. The policy indicated, "...Self-administration medications will be encouraged if it is...safe for the resident...ordered by the attending physician...the Interdisciplinary Team determines the resident's ability to self-administer medications by means of a skill assessment...A physician's order is obtained...Update the resident's care plan quarterly or as indicated..." 3.1-11(a)			
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and			

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	resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation, interview, and record review, the facility failed to protect residents' information related to the disposal of resident meal tickets for 3 of 4 residents who ate in the main dining room. (Residents 11, 25, 38) Findings include: During an observation on 01/18/23 at 12:10 P.M., while serving lunch, CNA (Certified Nurse Aide) 6 disposed of a meal ticket in the trash can by the dining room door.	F 0583	It is the policy of this facility to provide privacy and confidentiality for personal and medical records for all residents. Resident number 11, 25, and 38 had no negative outcome for deficient practice. CNA number 6 in-serviced on confidentiality of medical records. All residents have potential to be affected.	02/02/2023

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	During an interview on 01/18/23 at 12:13 P.M., CNA 5 indicated the meal tickets should be placed in the shred box not in the trash can. During an observation on 01/18/23 at 12:14 P.M., there were three meal tickets in the dining room trash can. The meal tickets retrieved from the trash can included the following resident information: name, room number, allergies, dislikes, preferences, and specialized equipment and diets. During an interview on 01/18/23 at 2:20 P.M., the DON (Director of Nursing) indicated any paperwork containing resident information should be shredded prior to disposal. The current "Notice of Privacy Practices" policy, with an effective date of September 2016, was provided by the Regional Director of Operations on 01/18/23 at 1:25 P.M. The policy indicated "...Your [protected health information] is information about you (the resident) created by us (the facility)...We are required by law to maintain the privacy of your protected health information..." 3.1-3(o)		(A) DON and/or designee in-serviced nursing staff on Policy and Procedure for privacy/confidentiality by 2-1-2023. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated (B) DON and/or designee will monitor the dining room for protection of health information 5 x's per week x 4 weeks, then 3 x per week for 4 weeks, then monthly x 4 months. Observations/audits will be conducted on random shifts to monitor corrections. If the facility is within compliance at the end of 6 months, then monitoring can be stopped. At the monthly QAPI meetings, monitoring/audits will be reviewed, and any concerns will be addressed as they are identified. If necessary, an action plan will be written by the committee. The Administrator and/or designee will monitor the action plan for a minimum of 6 months and/or until resolution is obtained.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care			

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	Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to follow manufacturer's guidelines related to insulin pen usage for 1 of 12 residents reviewed for quality of care (Resident 12) Findings include: During a medication administration observation on 01/17/23 at 3:22 P.M., LPN (Licensed Practical Nurse) 3 cleaned the tip of the Novolog insulin pen, applied the needle, held the pen sideways, and primed the pen with two units of insulin. She dialed the pen to the correct sliding scale dose and went into Resident 12's room to administer the insulin. She administered the insulin in the right side of the resident's abdomen. During a medication administration observation on 01/18/23 at 11:33 A.M., RN 4 cleaned the tip of the Novolog insulin pen, applied the needle, held the pen sideways, and primed the pen with two units of insulin. She dialed the pen to the correct sliding scale dose, went into Resident 12's room to administer the insulin. She administered the insulin in the left side of his abdomen. During an interview on 01/18/23 at 11:38 A.M., RN 4 indicated she held the pen sideways when she primed it and should have held the pen with the needle pointing up.	F 0684	It is the policy of this facility to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Resident # 12 was assessed related to deficient practice and no negative outcome. LPN # 3 and RN # 4 were in-serviced on priming insulin pens. DON and/or designee re-educated all licensed nursing staff per in-service on proper use of insulin pens by 2-1-2023. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. DON and/or designee will audit insulin administration 5 x's per week for 4 weeks, then 3 x's per week for 4 weeks, then weekly for 4 weeks, then monthly x's 3 months.	02/02/2023

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	The clinical record for resident 12 was reviewed on 01/18/23 at 03:16 P.M., A Quarterly MDS (Minimum Data Set) assessment, dated 11/08/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, liver cirrhosis and diabetes. During an interview on 01/18/23 at 11:40 A.M., the DON (Director of Nursing) indicated she was unaware of a specific policy for insulin pens. At 3:22 P.M., she indicated Resident 12 had no adverse effects related to the insulin pen having been primed incorrectly. The current Novolog package insert, with a revised date of 01/2019, was provided by the DON on 01/18/23 at 12:10 P.M. The insert indicated, "...Before each injection...Turn the dose selector to select 2 units. With the pen pointing up, tap the insulin to move the air bubbles to the top...Press the button all the way in...A drop of insulin should appear at the needle tip..." 3.1-47(a)(1)		Observations/audits will be conducted on random shifts to monitor corrections. If the facility is within compliance at the end of 6 months, then monitoring can be stopped. At the monthly QAPI meetings, monitoring/audits will be reviewed, and any concerns will be addressed as they are identified. If necessary, an action plan will be written by the committee. The Administrator and/or designee will monitor the action plan at a minimum of 6 months and/or until resolution is obtained.	
F 0690 SS=D 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-			

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	(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 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 provide appropriate urinary catheter care for 1 of 3 residents reviewed for urinary tract infections. (Resident 23) Findings include: On 01/12/23 at 11:40 A.M., Resident 23 was in his room sitting in his recliner. Catheter tubing was observed hanging from the bottom of the resident's pant leg, and a drainage bag containing dark yellow urine was hanging on the resident's walker. The resident indicated the catheter was fairly new and he had it because he had kidney stones. He recently completed antibiotics for a urinary tract infection.	F 0690	It is the policy of this facility to ensure that a 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. It is also the facility policy to ensure that Residents who are incontinent of bladder receive appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. Resident # 23 was assessed and	02/02/2023

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	On 01/18/23 at 11:45 A.M., CNA (Certified Nurse Aide) 7 was observed as she provided urinary catheter care for the resident. The CNA entered the room and obtained the resident's permission to provide care. She gathered her supplies and placed them on the overbed table. With her bare hands she moved the resident's catheter drainage bag and hung it on the side of the bed. The CNA then donned gloves, grabbed the bed controller to adjust the bed and then hung the controller on the side of the resident's waste basket. She bumped the overbed table and the resident's inhaler fell on the floor. The CNA picked the inhaler up and placed it back on table. She retrieved the bed controller from the side of the waste basket, repositioned the resident's bed again, and then hung the controller back on the waste basket. She removed the blanket that was covering the resident and cleansed, rinsed, and dried the resident's perineal area and urinary catheter insertion site. When she was finished, she instructed the resident to reposition himself while she applied a new brief and assisted the resident with pulling his pants back up. The CNA then removed her gloves, grabbed the bed controller, adjusted the bed, and hung the controller back on the waste basket. She bagged the soiled linen and trash, disposed of the bags in the appropriate containers, and took the basin the utility room to be sanitized. During an interview on 01/18/23 at 11:58 A.M., CNA 7 indicated she should have performed hand hygiene before she entered the resident's room. She should have changed her gloves after she adjusted the bed and picked the inhaler off the floor. The resident's clinical record was reviewed on 01/17/23 at 2:36 P.M. A Discharge MDS (Minimum		no negative outcome related to deficient practice. CNA # 7 educated on catheter care. All residents with a foley catheter have potential to be affected. DON and/or designee in-serviced nursing staff on catheter care by 2-1-2023. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated DON and/or designee will audit catheter care 5 x's weekly x 4 weeks, 3 x's weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months. Staff will be re-educated with any further findings. Observations/audits will be conducted on random shifts to monitor corrections. If the facility is within compliance at the end of 6 months, then monitoring can be stopped. At the monthly QAPI meetings, monitoring will be reviewed, and any concerns will be addressed as they are identified. If necessary, an action plan will be written by the committee. The Administrator and/or designee will monitor the action plan x's 6 months minimum, and/or until resolution is	

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	Data Set) assessment, dated 12/30/22, indicated the resident had a short-term memory problem but was but independent with decision making. The resident had an indwelling urinary catheter. The diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease), and urinary tract infection in the last 30 days. A Progress Note, dated 01/05/23 at 1:26 P.M., indicated the resident was re-admitted to the facility from a hospital on 01/04/23. The resident would continue to receive Levofloxacin (an antibiotic) for a urinary tract infection. The current, undated facility policy titled "Policy and Procedure Indwelling Urinary Catheter Care" was provided by the Regional Director of Operations on 01/18/23 at 1:25 P.M. The policy indicated, "...To cleanse and maintain hygiene...obtain second staff member as needed...wash hands and don gloves..." 3.1-41(a)(2)		obtained.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident			

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	preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to notify the physician of a dietician recommendation, monitor supplement intake, and follow physician orders for obtaining weights for 2 of 3 residents reviewed for nutrition. (Residents 17 and 30) Findings include: 1a. During an observation on 01/12/23 at 12:15 P.M., Resident 17 was sitting in her room eating her lunch. The clinical record for Resident 17 was reviewed on 01/17/23 at 10:03 A.M. A Quarterly MDS (Minimum Data Set) Assessment, dated 10/10/22, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, anemia, hypertension, non-Alzheimer's dementia, malnutrition, anxiety, and depression. A "Nutritional Risk Quarterly Review", dated 10/04/22, indicated the resident weight on 09/06/22 was 115 pounds. The Summary of Nutritional Review, indicated the resident was overall stable from a nutritional standpoint as evidence by stable weight, intact skin, and adequate food and fluid intake. The resident was at risk for compromise in nutrition and hydration status due to advanced age, chronic disease, including dementia and dysphagia; need for a mechanically-altered diet; low BMI (Body Mass	F 0692	It is the policy of this facility to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's condition demonstrates that this is not possible or resident preferences indicate otherwise. Resident number 17 and 30 weights were obtained. All other residents with weekly weights and dietary recommendations have the potential to be affected by this deficient practice. A 30 day look back was completed on dietary recommendations, orders, and care plans updated accordingly, and a 30 day look back of weekly weights completed. MD notified of any significant changes. Administrator will in-service Dietary manager and Nurse Managers on dietary recommendations by 2-1-2023.	02/02/2023

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	Index) for advanced age of 18.6; polypharamcy; and abnormal labs. A recommendation was made for house shakes, three times a day to promote a healthy weight gain and ensure adequate by mouth intake. The clinical record lacked indication that the physician had been notified of the recommendation. A Weight Summary, indicated the resident had the following weights: - 08/24/22, 120.4 - 09/06/22, 115 - 10/12/22, 113.4 - no documented November weight - 12/08/22, 111.0 - 12/19/22, 111.5. During an interview on 01/18/23 at 11:35 A.M., the RD (Registered Dietician) indicated the resident was nutritionally compromised. She required a mechanically-altered diet and was on supplements for weight loss. When she made a recommendation the facility would have to send it to the physician and they either agree or disagreed. The facility would then place an order if the MD had agreed to it. She would monitor the residents EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) to ensure the resident was consuming the supplements and the amount consumed. During an interview on 01/18/23 at 11:50 A.M., the Dietary Manager indicated that when the RD came to the facility she would make recommendations and the facility would send those to the MD. The would either agree or disagree. An order would be		Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated DON and or designee will review weekly weights and dietary recommendations weekly x's 6 months. Observations/audits will be conducted on random shifts to monitor corrections. If the facility is within compliance at the end of 6 months, then monitoring can be stopped. At the monthly QAPI meetings, monitoring will be reviewed, and any concerns will be addressed as they are identified. If necessary, an action plan will be written by the committee. The Administrator and/or designee will monitor the action plan at a minimum of 6 months and/or until resolution is obtained.	

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	written if they agreed with the recommendation. During an interview on 01/18/23 at 11:57 A.M., the DON (Director of Nursing) indicated when the RD made a recommendation it would be discussed in the weekly SWAT meeting. The recommendations would be sent to the MD. There should have been a progress note that the MD was notified of the recommendation and if he agreed or disagreed with the recommendation. 1b. An open-ended physician's order, with a start date of 12/15/22, indicated the resident was to have power pudding, twice a day. The December 2022 and January 2023 EMAR/ETAR lacked documentation of the amount of power pudding the resident had consumed on the space provided. During an interview on 01/18/23 at 10:23 A.M., RN 4 indicated when a resident received supplements it would be documented on the EMAR/ETAR. They should be documenting how much the resident consumed. If it was a liquid they would document the cc (cubic centimeter) amount consumed and for puddings they should document the % (percentage) amount consumed. The current, undated, facility policy titled, "Supplement Administration", was provided by the Regional Director of Operations on 01/18/23 at 1:27 P.M. The policy indicated, "...To ensure that resident supplements are administered in a timely manner and documentation is completed to substantiate administration... 2. During an observation on 01/17/23 at 11:37 A.M., Resident 30 was in his room sitting in his wheelchair. He was awake and alert with no signs or symptoms of distress.			

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The clinical record was reviewed on 01/18/23 at 10:19 A.M. An Annual MDS assessment, dated 12/29/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, hemiplegia, hypertension, and malnutrition. The resident had received a diuretic medication for seven of the seven days during the review period.

The EMAR/ETAR for November and December 2022, was provided by the Regional Director of Operations on 01/18/23 at 1:58 P.M., and included the following physician's orders:

- Weight, Check and record weekly, on day shift, every Wednesday, with a start date of 06/22/22. The record lacked a weight entry or a refusal to be weighed on the following dates:
- 11/16/22,
- 11/23/22,
- 11/30/22,
- 12/07/22, and
- 12/21/22.

- Lasix (a diuretic/water pill) Tablet 40 mg (milligrams), twice a day for edema, with a start date of 06/22/22, and
- hydrochlorothiazide (a diuretic/water pill) Tablet 12.5 mg, once daily for hypertension, with a start date of 06/22/22.

The Progress Notes were provided by the Regional Director of Operations on 01/18/23 at 1:58 P.M. The record lacked documentation the resident refused to be weighed or was out of the facility at the times the weights were not documented.

During an interview on 01/18/23 at 10:34 A.M., RN

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	2 indicated the staff came together as a team to obtain residents' weights. The CNAs (Certified Nurse Aides) generally weighed the residents, wrote them down on a sheet of paper and the nurses would put the weights in the computer. The resident would be on weekly weights for his malnutrition. The paper Daily Unit Management Forms, where the CNAs would have documented the resident's weights, as identified by the Regional Director of Operations, were provided on 01/18/23 at 12:00 P.M. The records lacked documentation of the resident's weights or any refusals to be weighed. The current undated S.W.A.T. (Skin and Weight Assessment Team) Program policy was provided by the ADON (Assistant Director of Nursing) on 01/18/23 at 11:48 A.M. The policy indicated, "...PURPOSE...To identify those residents at nutritional risk for related medical concerns...It is the policy of this facility to assess the nutritional status of each resident. SWAT is designed to aggressively review and address those residents exhibiting significant weight change...These residents will be monitored through this team effort on a weekly basis, involving all applicable disciplines to best cater to the improvement of the resident's nutritional status..." 3.1-46(a)(1)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the			

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	facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, interview, and record review, the facility failed to appropriately manage a resident's enteral tube feeding for 1 of 1 resident reviewed. (Resident 43) Findings include: During an observation on 01/13/23 at 10:06 A.M., Resident 43 was lying in bed in her room and connected to her enteral feeding pump. The bottle of nutritional supplement hanging on the pump apparatus was dated 01/11/23, and running continuously at 45 ml (milliliters) per hour. There were no resident's initials, nurse's initials, or time documented on the bottle as to when it was initiated into service. During an observation on 01/13/23 at 10:56 A.M., the resident was lying in bed in her room and connected to her enteral feeding pump. The bottle of nutritional supplement hanging on the pump apparatus was dated 01/11/23, and running continuously at 45 ml per hour. There were no	F 0693	It is the policy of this facility to ensure that a resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding. Resident # 43's enteral feeding container and tubing was removed and new tube feeding hung on 1/17/2023, resident assessment completed and no negative outcome from this deficient practice. No other residents are affected at this time. DON and/or designee will in-service the nursing staff on enteral feeding and dating/initialing by 2-1-2023.	02/02/2023

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	resident's initials, nurse's initials, or time documented on the bottle as to when it was initiated into service. During an observation on 01/13/23 at 2:49 P.M., the resident was lying in bed in her room and connected to her enteral feeding pump. The bottle of nutritional supplement hanging on the pump apparatus was dated 01/11/23, and running continuously at 45 ml per hour. There were no resident's initials, nurse's initials, or time documented on the bottle as to when it was initiated into service. During an observation on 01/17/23 at 9:49 A.M., the resident was lying in bed in her room and connected to her enteral feeding pump. The bottle of nutritional supplement hanging on the pump apparatus was dated 01/17/23, and running continuously at 45 ml per hour. There were no resident's initials, nurse's initials, or time documented on the bottle as to when it was initiated into service. During an interview and observation on 01/18/23 at 9:37 A.M., the ADON (Assistant Director of Nursing) indicated the resident was admitted to the facility with the enteral feeding tube in place. The nutritional supplement bottle was good for 24 hours. The staff changed the bottle and the tube running from the bottle every 24 hours on the night shift, 10:00 P.M. to 6:00 A.M. The staff were supposed to write a date and the time the bottle and tubing were put into service on the bottle and the tube. It was the facility policy to change it every 24 hours. The resident's enteral feeding apparatus was observed with the ADON. The bottle was labeled with the current date, 01/18/23, the time the bottle was initiated into service, the resident's initials, and the nurse's initials.		Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated DON and/or designee will audit enteral feedings for proper labeling and information 5 x's per week x 4 weeks, 3 x's per week for 4 weeks, weekly x's 4 weeks, then monthly x's 3 months. Observations/audits will be conducted on random shifts to monitor corrections. If the facility is within compliance at the end of 6 months, then monitoring can be stopped. Any findings will result in re-education for staff identified. At the monthly QAPI meetings, monitoring will be reviewed, and any concerns will be addressed as they are identified. If necessary, an action plan will be written by the committee. The Administrator and/or designee will monitor the action plan x's 6 months minimum and/ or until resolution is obtained.	

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The clinical record was reviewed on 01/18/23 at 9:50 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 12/29/22, indicated the resident was rarely/never understood. The diagnoses included, but were not limited to, cerebral palsy and malnutrition. The resident had a feeding tube. The resident was admitted to the facility on 12/22/22.

The EMAR/ETAR (Electronic Medication Administration / Electronic Treatment Administration Record) for January 2023, was provided by the Regional Director of Operations on 01/18/23 at 2:50 P.M., and included the following physician's order:

- Weight, Check and record weekly, on day shift, every Wednesday, for four weeks, with a start date of 12/28/22.

The record lacked a weight entry or a refusal to be weighed on the following dates:
- 01/04/23, and
- 01/11/23.

During an interview on 01/18/23 at 11:41 A.M., the ADON indicated residents who were newly admitted or readmitted to the facility were placed on S.W.A.T. (Skin Weight Assessment Team) for four weeks. If their weights were unstable they would stay on S.W.A.T. until their weights were stable for four weeks. S.W.A.T. included monitoring weekly weights.

The current ENTERAL TUBES: CONTINUOUS (PUMP) FEEDINGS policy was provided by the Regional Director of Operations on 01/18/23 at 10:00 A.M. The policy indicated, "...Label container and tubing with resident's name, date,

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	formula, rate and time formula was initiated..." The current undated S.W.A.T. Program policy was provided by the ADON on 01/18/23 at 11:48 A.M. The policy indicated, "...PURPOSE...To identify those residents at nutritional risk for related medical concerns...It is the policy of this facility to assess the nutritional status of each resident. SWAT is designed to aggressively review and address those residents exhibiting significant weight change...These residents will be monitored through this team effort on a weekly basis, involving all applicable disciplines to best cater to the improvement of the resident's nutritional status...Indicators determining implementation of S.W.A.T. monitoring...Tube feeding..." 3.1-46(a)(1) 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.			

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	§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 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 record review, interview, and observation, the facility failed to ensure a resident received the physician prescribed medication for 1 of 6 residents reviewed for pharmacy services. (Resident 30) Findings include: During an observation on 01/17/23 at 11:37 A.M., Resident 30 was in his room sitting in his wheelchair. The clinical record was reviewed on 01/18/23 at 10:19 A.M. An Annual MDS (Minimum Data Set) assessment, dated 12/29/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, hemiplegia, hypertension, anxiety, depression, and psychotic disorder. The EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) for January 2023, was provided by the Regional Director of Operations	F 0755	It is the policy of this facility to provide pharmaceutical services, including procedures that ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident. Resident number 30 was assessed and no negative outcome found. All residents have potential to be affected. DON and/or designee will In-service with licensed nurses and QMAs on medication administration to include signing EMAR/ETAR by 2-1-2023. Additionally, any employee who fails to comply with the points of	02/02/2023

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	on 01/18/23 at 1:58 P.M. The record lacked documentation the resident had received or refused the following medications, leaving blanks on the record, on the following dates and times: - Lasix Tablet 40 MG (Milligrams), give 1 tablet by mouth two times a day of edema with a start date of 06/22/22. - 01/03/23 at 1:00 P.M. - Metformin Tablet 500 MG, give 2 tablets by mouth two times a day for diabetes with a start date of 06/27/22. - 01/01/23 at 5:00 P.M., and - 01/03/23 at 5:00 P.M. - Depakote Tablet 250 MG, give 1 tablet by mouth three times a day for mood stabilizer with a start Date of 10/04/22. - 01/01/23 at 5:00 P.M., and - 01/03/23 at 1:00 P.M. and at 5:00 P.M. - Tizanidine Tablet 2 MG give 1 tablet by mouth three times a day for muscle spasms with a start date of 08/24/22. - 01/01/23 at 5:00 P.M., and - 01/03/23 at 1:00 P.M. and at 5:00 P.M. During an interview on 01/18/23 at 10:34 A.M., RN 2 indicated when staff administered medications, they documented it on the EMAR/ETAR. If a resident refused a medication the staff documented the refusal in the EMAR/ETAR. There was a code they could use that would show up in the box on the EMAR. Technically there should not be blanks on the EMAR/ETAR. The Progress Notes were provided by the Regional Director of Operations on 01/18/23 at 1:58 P.M. The record lacked documentation the		the in-service may be further educated and/or progressively disciplined as indicated. DON and/or designee will audit EMAR/ETAR 5 x's per week x 4 weeks, 3 x's per week for 4 weeks, weekly x's 4 weeks, then monthly x's 3 months for completion to substantiate administration of medications. Observations/audits will be conducted on random shifts to monitor corrections. If the facility is within compliance at the end of 6 months, then monitoring can be stopped. At the monthly QAPI meetings, monitoring will be reviewed, and any concerns will be addressed as they are identified. If necessary, an action plan will be written by the committee. The Administrator and/or designee will monitor the action plan x's 6 months at minimum and/or until resolution is obtained.	

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	resident refused medications or was out of the facility at the times the medications were not documented. The current undated Electronic Health Record Documentation policy was provided by the Regional Director of Operations on 01/18/23 at 1:58 P.M. The policy indicated, "...Purpose...A medical record is maintained for each resident to provide a permanent record of the care provided..." The current undated Medication Administration policy was provided by the Regional Director of Operations on 01/18/23 at 1:58 P.M. The policy indicated, "...Purpose...To ensure that resident medications are administered in a timely manner and documentation is completed to substantiate administration...Licensed professional nurses administer medications according to times documented on the Medication Administration Record..." 3.1-25(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or			

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	§483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on observation, record review and interview, the facility failed to follow physician orders related to hold parameters on medications for 1 of 6 residents reviewed for unnecessary medications. (Resident 4) Findings include: During an observation on 01/17/23 at 9:53 A.M., Resident 4 was sitting in the common area with other residents. He had no concerns and was awaiting to participate in exercise. The clinical record for Resident 4 was reviewed on 01/17/23 at 1:41 P.M. A Quarterly MDS (Minimum Data Set) Assessment, dated 11/15/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, stroke, hypertension, diabetes, and renal insufficiency. A Progress Note, dated 11/10/22 at 9:45 A.M., indicated the resident was returning to the facility from a hospital stay. A Hypertension Care Plan, started 11/29/17, included, but was not limited to, an intervention to give the medications as ordered. An open-ended physician's order, with start date	F 0757	It is the policy of this facility to ensure that resident's drug regimen is free from unnecessary drugs. Resident number 4 was assessed with no negative outcome related to deficient practice. MD made aware of medication administered outside of parameters. All residents with parameters have potential to be affected by this deficient practice. 100% audit of all current MARS to indentify all residents with similar med orders that require BP and or pulse taken with assessment before administration of med by 2-1-2023. MD made aware. DON and/or designee will in-service licensed nurses and QMAs on medication administration to include parameters and holding as ordered by 2-1-2023.	02/02/2023

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	155483	A. BUILDING 00 B. WING	01/18/2023

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	of 11/10/22, indicated the staff were to administer Carvedilol 3.125 mg, 1 tablet, twice a day for hypertension. They were to hold the medication if the resident's heart rate was less than 60. The clinical record including the November 2022, December 2022, and January 2023 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) lacked documentation that the resident's heart rate was assessed prior to administrator for the following dates and times: - 11/10/22 at 8:00 P.M., - 11/11/22 at 8:00 A.M., - 11/12/22 at 8:00 P.M., - 11/13/22 at 8:00 A.M. and 8:00 P.M., - 11/14/22 at 8:00 A.M., - 11/16/22 at 8:00 A.M. and 8:00 P.M., - 11/17/22 at 8:00 A.M. and 8:00 P.M., - 11/18/22 at 8:00 P.M., - 11/19/22 at 8:00 A.M. and 8:00 P.M., - 11/20/22 at 8:00 A.M. and 8:00 P.M., - 11/21/22 at 8:00 P.M., - 11/22/22 through 11/26/22 at 8:00 A.M. and 8:00 P.M., - 11/27/22 at 8:00 P.M., - 11/28/22 through 12/01/22 at 8:00 A.M. and 8:00 P.M., - 12/02/22 at 8:00 P.M., - 12/03/22 at 8:00 A.M. and 8:00 P.M., - 12/04/22 at 8:00 P.M., - 12/05/22 at 8:00 P.M., - 12/06/22 through 12/10/22 at 8:00 A.M. and 8:00 P.M., - 12/11/22 at 8:00 P.M., - 12/12/22 through 12/20/22 at 8:00 A.M. and 8:00 P.M., - 12/21/22 at 8:00 P.M., - 12/22/22 through 12/24/22 at 8:00 A.M. and 8:00		Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. DON and/or designee will audit EMAR 5 x's per week x 4 weeks, 3 x's per week for 4 weeks, weekly x's 4 weeks, then monthly x's 3 months for holding medications when outside parameters. Observations/audits will be conducted on random shifts to monitor corrections. If the facility is within compliance at the end of 6 months, then monitoring can be stopped. At the monthly QAPI meetings, monitoring will be reviewed, and any concerns will be addressed as they are identified. If necessary, an action plan will be written by the committee. The Administrator and/or designee will monitor the action plan x's 6 months minimum and/or until resolution is obtained.	

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	P.M., - 12/25/22 at 8:00 P.M., - 12/26/22 through 12/27/22 at 8:00 A.M. and 8:00 P.M., - 12/28/22 at 8:00 P.M., - 12/29/22 at 8:00 A.M. and 8:00 P.M., - 12/30/22 at 8:00 P.M., - 12/31/22 at 8:00 A.M. and 8:00 P.M., - 01/01/23 at 8:00 A.M. and 8:00 P.M., - 01/02/23 at 8:00 P.M., - 01/03/23 at 8:00 A.M. and 8:00 P.M., - 01/04/23 at 8:00 P.M., - 01/05/23 at 8:00 P.M., - 01/06/23 through 01/10/23 at 8:00 A.M. and 8:00 P.M., - 01/11/23 at 8:00 P.M., - 01/12/23 through 01/16/23 at 8:00 A.M. and 8:00 P.M., and - 01/17/23 at 8:00 A.M. An open-ended physician's order, with a start date of 12/25/22, indicated the staff were to administer hydralazine 10 mg, 2 tablets, twice a day. They were to hold the medication if the resident's blood pressure was less than 130/80. The January 2023 EMAR/ETAR indicated the medication was given outside of the parameters on the following dates and times: - 01/12/23 at 5:00 P.M., the blood pressure was 118/72, - 01/16/23 at 8:00 A.M. the blood pressure was 118/66, and - 01/16/23 at 5:00 P.M., the blood pressure was 124/62. During an interview on 01/17/23 at 2:50 P.M., RN 2 indicated the resident received a regular diet and needed assistance with all activities of daily			

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	living. The resident had just been switched to a mechanical lift for transfers. If a resident's medication had hold parameters she would obtain the vital signs, document them in the EMAR/ETAR and the medication would be given if within the acceptable parameters. If the vital signs were outside the parameters, the medication would not be given. A check on the EMAR would indicate the medication was given. The current, undated, facility policy titled, "PHYSICIAN ORDERS-(FOLLOWING PHYSICIAN ORDERS)", was provided by the Regional Director of Operations on 01/17/23 at 3:37 P.M. The policy indicated, "...It is the policy of the facility to follow the orders of the physician..." The current, undated, facility policy titled, "Medication Administration", was provided by the Regional Director of Operations on 01/17/23 at 3:37 P.M. The policy indicated, "...To ensure that resident medications are administered in a timely manner and documentation is completed to substantiate administration..." 3.1-48(a)(3)			
F 0912 SS=D Bldg. 00	483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq Ft/Resident §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; Based on observation, interview, and record review, the facility failed to provide at least 80 square feet per resident for 2 of 28 resident rooms. (Rooms 5 and 7)	F 0912	It is the policy of the facility to ensure that all residents reside in rooms that meet the required square feet of living space for residents in resident rooms. The	02/02/2023

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	Findings include: Review of the facility documentation of room size certification, provided by the Administrator, on 01/12/23 at 11:15 A.M., indicated the following room sizes, as observed on facility tour, provided less than 80 square feet per resident: 1. Room 5, SNF/NF (Skilled Nursing Facility/Nursing Facility), was 217 sq ft, had the capacity for 3 beds, and equaled 79.3 sq ft per resident. During an observation of Room 5 on 01/12/23 at 11:35 A.M., each resident had adequate space to move about the room and store their belongings. The room measurements were confirmed. 2. Room 7, SNF/NF, was 224 sq ft, had the capacity for 3 beds, and equaled 74.6 sq ft per resident. During an observation of Room 7 on 01/12/23 at 11:38 A.M., each resident had adequate space to move about the room and store their belongings. The room measurements were confirmed. These room sizes were verified by the Maintenance Director on 01/12/23 at 11:45 A.M. During an interview on 01/18/23 at 10:09 A.M., the Regional Director of Operations indicated he would only use the beds as a last option and would like to continue the room waiver. 3.1-19(l)(2)(A) 3.1-19(l)(3) 3.1-19(l)(8)		rooms cited in the survey will only be used for residents as a last resort and will only be used for the shortest amount of time possible. Currently rooms 3,4,5, and 7 remain occupied by 1 or 2 residents. In the past, the facility has had a waiver related to this physical plant concern. Residents residing in these rooms have the potential to be affected by this finding. The management who make room assignments (DON, ADON, SSD, MDS, ACT, HSK, Maintenance are aware per review with Administrator on 1/27/23 that these rooms are to be used as a last resort with 3 residents and for the shortest time possible due to the square footage space concerns. Staff who fail to observe this practice will be further educated and/or progressively disciplined as indicated. If it is ever necessary to place 3 residents in the effected rooms, the Administrator and/or designee will monitor these rooms daily to see that they are only being used for 3 residents as a last resort and for the shortest amount of time possible. This monitoring will	

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			continue ongoing until 3 residents are no longer residing in one room. If ever the rooms are being utilized for 3 residents, the space will be monitored to ensure the space accommodated meets the resident's needs.	