STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. BUILDING 00 B. WING	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(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 the Investigation of Complaints IN00378660, IN00379466, IN00380446, IN00382277, and IN00382310. Complaint IN00378660 - Substantiated. Federal/state deficiencies related to the allegations are cited at F550, F580, and F684. Complaint IN00379466 - Substantiated. Federal/state deficiencies related to the allegations are cited at F550 and F727. Complaint IN00380446 - Substantiated. Federal/state deficiencies related to the allegations are cited at F550, F690, F693, F727, F755, F761, and F921. Complaint IN00382277 - Substantiated. Federal/state deficiencies related to the allegations are cited at F550 and F689. Complaint IN00382310 - Substantiated. Federal/state deficiencies related to the allegations are cited at F550. Unrelated deficiency is cited. Survey dates: June 15, 16, and 17, 2022 Facility number: 000366 Provider number: 155469 AIM number: 100288900 Census Bed Type: SNF/NF: 95 Total: 95	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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	Census Payor Type: Medicare: 14 Medicaid: 58 Other: 23 Total: 95 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/27/22.			
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or			

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	her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observations, record review, and interview, the facility failed to ensure a resident's dignity was maintained, related to the resident lying in bed without a top sheet or blanket and dried stains and food crumbs on the bed, for 1 of 5 residents reviewed for dignity. (Resident H) Findings include: Resident H was observed on 6/15/22 at 6:15 a.m. lying in bed, eyes closed. There was no top sheet or cover over her. The bottom sheet had a dried reddish brown substance next to the left leg on the bottom sheet and there were food crumbs present on the lower part of the bed on the bottom sheet. During an interview on 6/15/22 at 6:38 a.m., the Corporate Regional Director indicated she would get someone in to care for the resident. On 6/15/22 at 7:04 a.m., a staff member entered the room and placed a cover over the resident. On 6/15/22 at 9:53 am., the bed linens had been	F 0550	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center'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.* **1) Immediate actions taken for those residents identified:** Resident H was provided care at the time of notification. Linens were changed at the time of care.	07/10/2022

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	changed. Resident H's record was reviewed on 6/16/22 at 3:23 p.m. The diagnoses included, but were not limited to, dementia. A Significant Change Minimum Data Set assessment, dated 4/26/22, indicated a severely impaired cognitive status, required extensive assistance of one for bed mobility, transfers occurred only once or or twice with assistance of one, was an extensive assistance of one for hygiene and was dependent for bathing. This Federal tag relates to Complaints IN00378660, IN00379466, IN00380446, IN00382277, and IN00382310. 3.1-3(t)		**2) How the facility identified other residents:** No other residents were found to have been affected. **3) Measures put into place/ System changes:** Director of Nursing or designee will educate staff on Resident Rights/ Exercise of Rights before July 10th, 2022. All staff educated on Resident Rights upon hire, annually and on an as needed basis. **4) How the corrective actions will be monitored:** Dignity rounds will be completed at least 3x/week at varied times to ensure dignity is maintained, including but not limited to providing ADL's for residents with impaired cognitive status, resident's needing extensive assistance for bed mobility, resident's needing assistance with hygiene and bathing and resident's needing assistance with transfers. The Director of Nursing or designee will be responsible for oversight of these audits.	

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			The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 7/10/22**	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must			

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	ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Bases on record review and interview, the facility failed to notify residents' Physicians of a change in condition and medication not administered as ordered and also failed to notify the resident's Responsible Party of the medication not being administered, for 2 of 7 residents reviewed for Physician and Responsible Party notification. (Residents M and D) Findings include: 1. Resident M was interviewed on 6/15/22 at 9:41 a.m. He stated he was sick on the past Monday (6/13/22) and he felt like his blood sugar had	F 0580	*This Plan of Correction is the center'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*	07/10/2022

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	dropped. He reported it to the nurse, and she had not responded for a 1/2 hour. An investigation into the incident indicated the resident's blood sugar had been 59 and his skin was cold and clammy. Glucagon (used to treat low blood sugars) was given and after 15 minutes the blood sugar was 133. Resident M's record was reviewed on 6/16/22 at 4:42 p.m. The diagnoses included, but were not limited to, diabetes mellitus. There was no Physician's Orders for the Glucagon. There was no documentation of the low blood sugars, an assessment, follow up assessment, or treatment of the low blood sugar and no documentation the Physician had been notified of the incident. An undated facility policy for treatment of hypoglycemia, received from the RN Consultant as current on 6/17/22 at 9:17 a.m., indicated the Physician was to be contacted if the blood sugar was below 60 unless there were specific call parameters. No further information was provided by the facility when informed the Physician had not been notified of the low blood sugar upon exit on 6/17/22 at 12:30 p.m. 2. Resident D's record was reviewed on 6/15/22 at 1:44 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, gastro-esophageal reflux disease, and vascular dementia. A Physician's Order, dated 4/23/22, indicated		*federal and state law.* **1) Immediate actions taken for those residents identified:** Resident M's record and orders have been updated and Physician/responsible parties notified. Resident D's records and orders have been updated and Physician/responsible parties notified. **2) How the facility identified other residents:** Audit was completed for change in condition notification since 6/20/22 to ensure appropriate parties were notified of change in condition or a need to alter treatment. **3) Measures put into place/ System changes:** Licensed nurses will be re-educated regarding notifying resident or resident representative/Physician with a significant change and a need to alter treatment. **4) How the corrective actions will be monitored:**	

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	lansoprazole suspension (used for heartburn) 3 milligrams per ml (milliliter), 10 ml's twice a day through the feeding tube was to given for heartburn. The Medication Administration Record (MAR), dated 6/2022, indicated the lansoprazole had not been given at 6 a.m. as ordered on June 3, 7, 9, and 16, 2022 and at 5 p.m. on June 12, 14, and 15, 2022. The MAR indicated the lansoprazole had been administered on June 13 at 6 a.m. and 5 p.m. and June 15 at 6 a.m. There was a lack of documentation that indicated the resident's Physician and Responsible Party had been notified of the medication not being administered as ordered. During an interview on 6/17/22 at 10:35 a.m., the Assistant Director of Nursing indicated the Physician had just been made aware of the medication not being given and had placed the medication on hold until it arrived at the facility. The facility policy on Physician and family notification, dated 11/13/18 and received from the RN Consultant, indicated the Physician and family/Responsible Party would be notified in a timely, efficient, and effective manner for all medical care problems. They would be notified of, but not limited to, a significant change and a need to alter treatment. This Federal tag relates to Complaint IN00378660. 3.1-(a)(2) 3.1-(a)(3)		Director of Nursing or designee will review documentation at least 3x/week to ensure appropriate notifications were documented for change in condition, change in treatment plan, and/or transfer to hospital. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 7/10/22**	

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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 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			

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	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 record review and interview, the facility failed to develop a Care Plan for diabetes mellitus, hypoglycemia and/or hyperglycemia, for 1 of 11 residents reviewed for Care Plans. (Resident M) Finding includes: Resident M was interviewed on 6/15/22 at 9:41 a.m. He stated he was sick on the past Monday (6/13/22) and he felt like his blood sugar had dropped. Resident M's record was reviewed on 6/16/22 at 4:42 p.m. The diagnoses included, but were not limited to, diabetes mellitus. There was no Care Plan for the diabetes mellitus, hypoglycemia, and/or hyperglycemia. No further information was provided by the facility when informed there had been no documentation of an assessment, follow up assessments, and treatment of the low blood sugar with medication without an order upon exit on 6/17/22 at 12:30 p.m. 3.1- 35(a)	F 0656	The facility requests paper compliance for this citation. *This Plan of Correction is the center'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.* **1) Immediate actions taken for those residents identified:** Resident M's care plan was reviewed, and medication ordered and documented per physician order. **2) How the facility identified other residents:** All residents had the potential to be affected by the alleged deficient practice.	07/10/2022

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			3) Measures put into place/ System changes: Staff will be re-educated on the importance of developing and implementing a comprehensive care plan and documenting on the clinical records any residents' treatment refusals and assessments completed. Director of Nursing or Designee will audit comprehensive care plans and treatment documentation 5 times weekly for 4 weeks, and 2x weekly thereafter to ensure comprehensive care plans and treatment documentation were completed to ensure compliance. **4) How the corrective actions will be monitored:** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 7/10/22**	

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F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care 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 record review and interview, the facility failed to ensure a resident received treatment and care in accordance with professional standards, related to treatment, assessment, and documentation of a change in condition, for 1 of 11 residents reviewed for quality of care.(Resident M) Findings include: Resident M was interviewed on 6/15/22 at 9:41 a.m. He stated he was sick on the past Monday (6/13/22) and he felt like his blood sugar level had dropped. He reported it to the nurse, and she had not responded for a 1/2 hour. An investigation of the incident indicated a signed statement by Nurse 3, dated 6/15/22, was received. She indicated she had just administered her 9 p.m. medications, and the resident was sleeping in the hall. She checked the resident's blood sugar level and it was 59 (normal 70-99), and his skin was cold and clammy. Glucagon (used to treat low blood sugar levels) was given and after 15 minutes the blood sugar was 133. Resident M's record was reviewed on 6/16/22 at 4:42 p.m. The diagnoses included, but were not	F 0684	The facility requests paper compliance for this citation. *This Plan of Correction is the center'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.* **1) Immediate actions taken for those residents identified:** The physician was made aware that resident M received medication that was not ordered by the physician. Resident M did not have a negative outcome.	07/10/2022

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	limited to, diabetes mellitus. A Significant Change Minimum Data Set assessment, dated 5/6/22, indicated an intact cognitive status and no behaviors. There was no Care Plan for the diabetes mellitus or hypoglycemia. There was no Physician's Order for the Glucagon. There was no documentation of the low blood sugar level, assessment, follow up assessment, or treatment of the low blood sugar level located in the record. During an interview on 6/15/22 at 10:36 a.m., the Administrator indicated she had not been aware of the incident. An undated facility policy for treatment of hypoglycemia, received from the RN Consultant as current on 6/17/22 at 9:17 a.m., indicated hypoglycemia was to be treated with small amount of food such as orange juice, regular soda, skim milk, and a blood sugar check was to be repeated in 10-15 minutes if there was a mild reaction and the resident was conscious. If there was a moderate reaction, with drowsiness, profuse perspiration, and/or blood sugar of 30-50, 4 ounces of orange juice followed by food was to be given. If the resident was unable to swallow, notify the Physician and prepare glucagon from the emergency drug kit for administration as ordered. All findings, interventions, and Physician notifications were to be documented in the clinical record. No further information was provided by the facility when informed there had been no		**2) How the facility identified other residents:** All residents who receive medications have the potential to be affected by the alleged deficiency. Review of resident's orders/diagnoses to be completed prior to July 10th, 2022 to ensure appropriate documentation, orders and assessments are in place. **3) Measures put into place/ System changes:** Staff will be re-educated on assessments, significant changes, documentation, physician and responsible party notifications. **4) How the corrective actions will be monitored:** Director of Nursing or designee will complete 3 medication/diagnosis order audits per week to ensure that medications are being administered as ordered. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155469	A. BUILDING 00 B. WING	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(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
	documentation of an assessment, follow up assessments, and treatment of the low blood sugar with medication without an order upon exit on 6/17/22 at 12:30 p.m. This Federal tag relates to Complaint IN00378660. 3.1-37		**months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 7/10/22**	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a Care Planned intervention to prevent injury due to a fall was in place, related to the bed not being in low position for 1 of 3 residents reviewed for fall interventions. (Resident H) Finding includes: On 6/15/22 at 6:15 a.m., Resident H was observed lying in bed. There were no rails or bolsters on the bed. The bed was raised approximately 32 inches from the floor. On 6/15/22 at 7:04 a.m., she remained in bed and the bed was raised approximately 32 inches from the floor.	F 0689	The facility requests paper compliance for this citation. *This Plan of Correction is the center'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.*	07/10/2022

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	On 6/15/22 at 9:53 a.m., she remained in bed and the bed was in the lowest position, which was approximately 5 inches off the floor. On 6/15/22 at 12:52 p.m., the resident remained in bed and the bed was raised approximately 32 inches from the floor On 6/15/22 at 2 p.m., incontinent care was provided from the staff and the bed was lowered to the lowest position. CNA 1 indicated the resident would reposition herself on her back if she was turned to her side. On 6/16/22 at 8:36 a.m., the resident was in bed and the bed was raised approximately 32 inches from the floor. Resident H's record was reviewed on 6/16/22 at 3:23 p.m. The diagnoses included, but were not limited to, dementia. A Significant Change Minimum Data Set assessment, dated 4/26/22, indicated a severely impaired cognitive status, required extensive assistance of one for bed mobility, transfers occurred only once or or twice with assistance of one, and had no falls. A Care Plan, dated 5/26/21, indicated a risk for falls. The interventions included to keep the bed in the lowest position with the brakes locked. A fall reduction program policy, received from the RN Consultant as current and dated 2/12/21, indicated all resident would receive adequate supervision and assistive devices to aid in the prevention of falls. This Federal tag relates to Complaint IN00382277.		**1) Immediate actions taken for those residents identified:** Resident H's bed placed in the lowest position to ensure resident's fall intervention plan is in place. **2) How the facility identified other residents:** All residents who utilize fall interventions have the potential to be affected by the alleged deficiency. A fall risk audit was completed to ensure that all interventions were in place **3) Measures put into place/ System changes:** Staff will be re-educated on falls, fall interventions and prevention. **4) How the corrective actions will be monitored:** Director of Nursing or designee will complete rounds on 3 residents at least once a day 5 times per week to ensure that residents have their fall interventions in place. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of**	

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	3.1-45(a)(2)		**90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 7/10/22**	
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- (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.			

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	§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, record review, and interview, the facility failed to ensure a resident with a urinary catheter and a history of urinary tract infections (UTIs) received the proper care and services related to improper catheter bag positioning for 1 of 3 residents reviewed for catheters. (Resident G) Finding includes: During observations on 6/15/22, the following was observed: At 6:06 a.m., Resident G was lying in bed with closed eyes. The urinary catheter bag was on the floor on the left side of the bed. The bedside table wheel was on the catheter bag. At 9:52 a.m., the resident remained in bed and the urinary catheter bag remained on the floor with the bedside table wheel on the catheter bag. At 11:51 a.m., he was sitting in a wheelchair, there was liquid on the floor underneath the chair. The urinary catheter bag contained yellow urine and there was urine dripping from the drainage tube, which was touching the floor. Nurse 2 indicated she had just been in the room and had not noticed the liquid on the floor. At 11:59 a.m., he remained in the wheelchair and	F 0690	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center'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.* **1) Immediate actions taken for those residents identified:** Resident G's urinary catheter bag was changed and catheter care was completed per physician order. Urinary drainage bag is not touching the floor and the tubing is not obstructed. **2) How the facility identified other residents:**	07/10/2022

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	was eating lunch. The catheter drainage tubing remained touching the floor and urine continued to drip out of the tube. At 12:21 p.m., the urinary drainage tube continued to touch the floor and urine dripped from the drainage tube. At 12:26 a.m., Nurse 2 entered the room to change the urinary drainage bag and indicated the drainage tube was not closed all the way and was dripping urine. She indicated the catheter bag needed changed and then changed the bag. Resident G's record was reviewed on 6/16/22 at 2:34 p.m. The diagnoses included, but were not limited to, end stage renal disease and on 3/5/22 urinary tract infection was added. A Significant Change Minimum Data Set assessment, dated 4/25/22, indicated an intact cognitive status and had an indwelling urinary catheter. A Care Plan, dated 7/12/21, indicated an indwelling urinary catheter was present due to end stage renal disease and neuromuscular dysfunction of the bladder. The interventions included to keep the catheter system closed as much as possible and position the bag below the level of the bladder. A facility policy for urinary catheter care, dated 2/14/19 and received from the RN Consultant as current, indicated the urinary drainage bags and tubing would be positioned to prevent them from touching the floor. The urinary catheter bag could be placed in a vinyl bag to prevent contact with the floor.		All residents with orders for catheters have the potential to be affected by this alleged deficient practice. Audit of current residents with indwelling catheters was completed to ensure appropriate treatment and services are provided. **3) Measures put into place/ System changes:** Nurses re-educated on catheter care and ensuring that catheters are free from obstruction and that the drainage tube is closed properly. The director of nursing or designee will complete weekly audits on all residents with catheters to ensure that urinary drainage bags and tubing would not be touching the floor. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends	

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	This Federal tag relates to Complaint IN00380446. 3.1-4(a)(2)		or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 7/10/22**	
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 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 record review and interview, the facility failed to ensure a resident received enteral feeding and water flushes through the gastrostomy tube (g-tube) (feeding tube) as ordered by the Physician, for 2 of 3 residents reviewed for g-tubes. (Residents D and J) Findings include:	F 0693	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of*	07/10/2022

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	1. Resident D's record was reviewed on 6/15/22 at 1:44 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, gastro-esophageal reflux disease, and vascular dementia. A Significant Change Minimum Data Set (MDS) assessment, dated 4/29/22, indicated the cognitive status was unable to be assessed, was dependent on one staff for eating, received 51% or more of nutrition and 501 cubic centimeters (cc's) or more of fluids from a feeding tube A Care Plan, dated 5/12/21, indicated she was totally dependent on a feeding tube for nutrition and hydration. The interventions included, the feeding and water flushes would be administered as ordered. The Physician's Orders, dated 4/22/22, indicated the enteral feeding was Glucerna 1.2 and was to infuse at 70 cc's an hour. The feeding was to be turned off at midnight and restarted at 4 a.m. The feeding tube was to be flushed with 400 cc's of water every four hours. The Medication Administration Record (MAR), dated 6/2022, indicated the 400 cc water flush had not been completed on June 7, 2022 on day shift, June 3 and 10, 2022 on evening shift, and June 13, 2022 on night shift. The MAR, dated 6/2022, indicated the Glucerna 1.2 and 400 cc's of the water flush every four hours was not infused on June 2 and 10, 2022 on evening shift, June 7, 2022 on day shift, and June 13 and 15, 2022 on night shift. There was no intake for June 7, 2022. The total feeding intake per shift (580 cc's over 8		*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.* **1) Immediate actions taken for those residents identified:** Resident D is receiving enteral feeding and water flushes through the gastrostomy tube as ordered by the physician. Resident J is receiving enteral feeding and water flushes through the gastrostomy tube as ordered by the physician. **2) How the facility identified other residents:** All residents who receive tube feeding have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** The nursing staff will be re-educated on proper setting and documentation of Enteral Feedings by the DON/designee by 7/10/22. Random audits 3 times a week a	

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	hours at 70 cc's an hour), indicated 280 cc's of feeding on day shift on June 4, 5, 6, 8, 10, 11, 12, and 13, 200. On evening shift, June 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, and 15, 2022 the total feeding intake was 280 cc's. There was no intake for June 2 and 10, 2022. There was no feeding intake for June 13 and 15, 2022 on night shift. During an interview on 6/16/22 at 10:58 a.m., the Assistant Director of Nursing (ADON) indicated she was unable to say if the feedings and the flushes had been administered as ordered at the correct rate on the above dates. She indicated 280 cc's would not be the correct amount of feeding delivered at 70 cc's an hour. 2. Resident J's record was reviewed on 6/16/22 at 3:52 p.m. The diagnoses included, but were not limited to, stroke A Quarterly MDS assessment, dated 4/13/22, indicated a severely impaired cognitive status, was dependent on one staff for eating, and received 51% or more of nutrition and 501 cc's of fluids from a feeding tube. A Care Plan, dated 1/27/17, indicated she was dependent on a feeding tube for nutrition and fluids and would receive adequate nutrition and hydration through the feeding tube. The Physician's Orders, dated 1/4/22, indicated Glucerna 1.2 was to be administered at 65 cc's an hour with 200 cc's of water flushes every shift. A Physician's Order on 1/5/22, indicated the feeding was to be turned off at midnight and restarted at 4 a.m.		various time will be completed by DON/designee to ensure proper settings and documentation. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 7/10/22**	

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	The Medication Administration Record (MAR), dated 6/2022, indicated the 200 cc water flush had not been completed on June 3 and 7, 2022 on day shift, June 6, 2022 on evenings, and June 13 & 14, on night shift. The MAR, dated 6/2022, indicated the Glucerna 1.2 had not been administered on June 3 and 7, 2022, on June 6, 2022 on evening shift, and June 11, 12, 13, and 14, 2022 on night shift. The total feeding intake per shift, (65 cc's an hour for 8 hours is 520 cc's) was 260 cc's on June 6, 2022 on day shift, 100 cc's on June 12, 2022 on day shift, 1300 cc's on day shift on June 13, 2022, 260 cc's on June 1, 2022 on evening shift. No intake was documented on June 11, 2022 on night shift. A facility policy, titled, "Gastrostomy Tube - Feeding and Care", dated 8/3/20, and received as current from the RN Consultant, indicated the nutrition and fluids would be provided as per the Physician's Orders. This Federal tag relates to Complaint IN00380446. 3.1-44(a)(2)			
F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility			

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	must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on record review and interview, the facility failed to ensure a Registered Nurse (RN) was scheduled in the facility for at least 8 consecutive hours a day, 7 days a week. This had the potential to affect 95 of 95 residents who resided in the facility. Finding includes: The Nursing Staff Schedules, dated May 22-June 18, 2022, were reviewed on 6/17/22 at 8:56 a.m. The schedules indicated there was no RN coverage on May 22, 25, 26, 30, and 31, 2022 and June 4, 5, 8, 9, 13, and 14, 2022. During an interview on 6/16/22 at 4:30 p.m., the Corporate Regional Director indicated the facility had hired two RN's, one never came to work and the other had just started working at the facility. This Federal tag relates to Complaints IN00379466 and IN00380446. 3.1-17(b)(3)	F 0727	The facility requests paper compliance for this citation. *This Plan of Correction is the center'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.* **1) Immediate actions taken for those residents identified:** Facility reviewed labor assignments and ensured Registered Nurse (RN) was scheduled in the facility for at least 8 consecutive hours a day, 7 days a week. **2) How the facility identified other residents:** All residents have the potential to	07/10/2022

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			be affected by this alleged deficient practice. **3) Measures put into place/ System changes:** Director of Nursing, Administrator, HR and Staff coordinator were educated on the importance of ensuring RN coverage is provided daily for at least 8 consecutive hours. **4) How the corrective actions will be monitored:** An audit tool will be developed to ensure that RN coverage is present on a daily basis to ensure compliance. Administrator or designee is responsible for this audit **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 7/10/22**	
F 0755 SS=D	483.45(a)(b)(1)-(3) Pharmacy			

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Bldg. 00	Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services 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 and interview, the facility failed to ensure a resident was provided with routine medication in a timely manner by the contracted Pharmacy, related to a medication not available to be administered as ordered by a Physician for resident, for 1 of 3 residents	F 0755	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of	07/10/2022

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	155469	A. BUILDING 00 B. WING	06/17/2022

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	reviewed for medications. (Resident D) Finding includes: Resident D's record was reviewed on 6/15/22 at 1:44 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, gastro-esophageal reflux disease, and vascular dementia. A Physician's Order, dated 4/23/22, indicated lansoprazole suspension (used for heartburn) 3 milligrams per ml (milliliter), 10 ml's twice a day through the feeding tube was to given for heartburn. The Medication Administration Record (MAR), dated 6/2022, indicated the lansoprazole had not been given at 6 a.m. as ordered on June 3, 7, 9, and 16, 2022 and at 5 p.m. on June 12, 14, and 15, 2022. The MAR indicated the lansoprazole had been administered on June 13 at 6 a.m. and 5 p.m. and June 15 at 6 a.m. The Nurses' Progress notes, dated 6/12/22 at 6:33 p.m., 6/14/22 at 8:26 p.m., and 6/15/22 at 5:43 p.m., indicated the medication was not available and the facility was waiting on the medication to be delivered from the Pharmacy. During an interview on 6/16/22 at 10:58 a.m., the Assistant Direction of Nursing indicated she was unsure where the lansoprazole medication was obtained from since it was documented as given on June 13 and 15, 2022. During an interview on 6/17/22 at 10:35 a.m., the Assistant Director of Nursing, indicated the lansoprazole had been re-ordered on 6/9/22. She indicted she called the Pharmacy on 6/16/22 and		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. 1) Immediate actions taken for those residents identified: The physician was made aware that resident D's medications were not given as ordered. Resident D did not have a negative outcome. 2) How the facility identified other residents: All receive medications have the potential to be affected by the deficiency.	

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	they informed her the order had expired. She informed the Pharmacy the order had not expired. The Pharmacy was to send it last evening and they had not sent the medication. When the Pharmacy was notified again, they indicated the insurance would not pay for the medication. The facility was now paying for the medication until approval was obtained from the insurance company. A facility policy, titled, "Ordering And Receiving Non-Controlled Medications From The Dispensing Pharmacy", dated 10/27/14, and received from the RN Consultant as current, indicated medications would be dispensed from the pharmacy on a timely basis. The same day delivery would be delivered for all orders received by noon. This Federal tag relates to Complaint IN00380446. 3.1-25(a)		A medication audit for the last 14 days was completed to identify any medications given after the time they were ordered by the physician. 3) Measures put into place/ System changes: Staff will be re-educated the process re-ordering medications 4) How the corrective actions will be monitored: Director of Nursing or will complete medication administration audit daily to ensure that medications are available. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90%	

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			compliance or greater is achieved x3 consecutive months.¿ The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 of compliance/10/2022	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse,			

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	except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review, and interview, the facility failed to ensure a medication was stored in a locked medication storage area, related to an unlabeled medication observed at a resident's bedside, for 1 of 18 resident rooms observed for medications at the bedside/storage. (Resident E) Finding includes: During the initial tour of the facility on 6/15/22 at 5:15 a.m. through 6 a.m., there was a bottle of Milk of Magnesia (MOM) (laxative) observed on Resident E's bedside dresser. During an observation on 6/15/22 at 7:21 a.m., a CNA was in the room providing care. The MOM bottle remained on the bedside dresser. During an observation and interview on 6/15/22 at 11:27 a.m., the resident had a family member present and they indicated the bottle of MOM was brought in and a dose was given to the resident by them. The bottle of MOM remained on the bedside dresser. The bottle of MOM remained on the bedside dresser during observations on 6/16/22 at 8:41 a.m. and 9:09 a.m. During an interview on 6/16/22 at 9:09 a.m., Nurse 1 indicated the bottle of MOM should not have been left at the bedside and she was unsure why it had been placed there. Resident E's record was reviewed on 6/16/22 at	F 0761	The facility requests paper compliance for this citation. This Plan of Correction is the center'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. 1) Immediate actions taken for those residents identified: The medication was removed from Resident E's bedside. 2) How the facility identified other residents:	07/10/2022

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	10:48 a.m. The diagnoses included, but were not limited to, stroke. There were no Physician's Orders for the Milk of Magnesia for Resident E. A medication storage policy, dated 10/2014, and received as current from the Corporate Nurse Consultant, indicated all nurses and aides were required to report to the Charge Nurse on duty any medications found at the bedside not authorized for bedside storage and to give the unauthorized medications to the Charge Nurse to be returned to the family. This Federal tag relates to Complaint IN00380446. 3.1 -25(m)		All receive medications have the potential to be affected by the deficiency. 3) Measures put into place/ System changes: Staff will be re-educated on proper storage of medications 4) How the corrective actions will be monitored: IDT will continue to complete Angel Rounds daily and identify any medications left at bedside. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months.¿ The QA Committee will identify any trends or patterns and make	

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			recommendations to revise the plan of correction as indicated. 5 of compliance/10/2022	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review, and interview, the facility failed to ensure the residents' environment was functional and sanitary, related to a wheel missing from an over bed table, soiled linen in hallways uncovered and stored close to clean linen, over flowing trash container in the hallway, and urine on floor not sanitized timely, for 2 of 31 residents (Residents G and E) and 2 of 4 hallways observed. (Cherry Lane and Apple Lane) Findings include: 1. During an observation on 6/15/22 at 11:51 a.m., Resident G was sitting in a wheelchair, there was liquid on the floor underneath the chair. The urinary catheter bag had urine dripping from the drainage tube. Nurse 2 indicated she had just been in the room and had not noticed the liquid on the floor.	F 0921	The facility requests paper compliance for this citation. This Plan of Correction is the center'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.	07/10/2022

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	On 6/15/22 at 11:59 a.m., the resident was observed rolling his wheelchair in and out of the urine on the floor. He was eating lunch and only had socks on his feet. On 6/15/22 at 12:26 p.m., Nurse 2 was observed entering the resident's room and indicated she was going to change the urinary catheter bag. On 6/15/22 at 12:34 p.m., Resident G indicated the urinary catheter bag had been changed. He then wheeled himself out of the room. Nurse 2 exited the room and the urine remained on the floor. On 6/15/22 at 12:50 p.m., Housekeeper 1 went to the room and indicated she smelled urine. She indicated no one had told her the floor needed cleaned, she always came to recheck the rooms. She then cleaned and sanitized the floor. 2. Resident E's room was observed on 6/15/22 at 7:21 a.m., 7:57 a.m., 11:27 a.m., and 6/16/22 at 8:41 a.m. and 9:09 a.m. The over the bed table was missing a wheel and would tilt with movement of the table. The Administrator and Corporate Regional Director was informed on 6/16/22 at 1:15 p.m. 3. Random observations of the hallways indicated the following: On 6/15/22 at 5:27 a.m., there was an uncovered cart filled with soiled linen sitting in the hallway of Cherry Lane. On 6/16/22 at 8:28 a.m. there was a trash barrel		1) Immediate actions taken for those residents identified: Resident G's floor was cleaned and is free of urine. Resident over the bed table has been repaired. Soiled linen carts that did not have covers have been replaced with carts that have lids. 2) How the facility identified other residents: All residents who reside in the facility have the potential to be affected by the alleged deficient practice. 3) Measures put into place/ System changes: All staff will be educated on the use of the Maintenance Request Form by the DON/designee by 7/10/22. Angel Rounds will be completed by and they will document on the Daily Manager Rounds Checklist daily areas needing repairs. The sheets will be reviewed daily in the morning	

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	sitting in the hallway of Cherry Lane. The barrel was overflowing with plastic soiled trash bags. The top of the barrel could not seal and fell from the trash bag heap to the floor. On 6/16/22 at 9:36 a.m., there was an uncovered cart filled with soiled linen sitting next to the clean linen cart on Cherry Lane. On 6/16/22 at 11:15 a.m., there were 2 carts filled with soiled linen sitting in the Cherry Lane Hallway. One of the soiled carts was sitting next to the clean linen cart. The Assistant Director of Nursing acknowledged the observation. On 6/17/22 at 8:45 a.m., there was an uncovered cart filled with soiled linen in the hallway on Apple Lane. On 6/17/22 at 8:49 a.m., there was an uncovered cart filled with soiled linen sitting in the hallway of Cherry lane next to the Medication Cart. A soiled linen policy, dated October 2018 and received from the Assistant Director of Nursing as current, indicated the soiled linen would be handled and transported according to best practices for infection prevention and control. The soiled linen should be placed in a bag or container at the location where it was used. This Federal tag relates to Complaint IN00380446. 3.1-19(e)		and afternoon meetings and Maintenance Requests will be completed. The Administrator will review the Maintenance Requests daily with the Maintenance Department to ensure repairs are completed. The Administrator/designee will complete the Environment Quality Assurance Worksheet 5 rooms weekly x 8 weeks and monthly ongoing. 4) How the corrective actions will be monitored: p paraid="726862373" paraeid="{eb3914d5-676e-4033-b102-02e39ab453ec}{36}" >The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved.¿ The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated Date of compliance: 7/10/22	