STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 00 B. WING	12/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00423804. Complaint IN00423804 - Federal/State deficiencies related to the allegations are cited at F561. Survey dates: December 11, 12, 13, 14, 15, 2023 Facility number: 000245 Provider number: 155354 AIM number: 100290800 Census Bed Type: SNF/NF: 63 Total: 63 Census Payor Type: Medicare: 5 Medicaid: 40 Other: 18 Total: 63 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 21, 2023.	F 0000	**Plan of Correction Statement** Preparation and or execution of this plan of Correction general or any other corrective action set forth herein, in particular, does not constitute an admission or agreement by Newburgh Healthcare of the facts alleged or the conclusions set forth in the Statement of Deficiencies. The Plan of Correction and specific corrective actions are prepared and / or executed solely because of provisions of Federal and / or State law.	
F 0550 SS=E 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,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kitty Cabell	RN/DON	01/17/2024

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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	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 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 observation, interview, and record review, the facility failed to ensure dignity was respected for 1 of 1 residents reviewed for dignity and 3 of 3 random observations. (Resident 53,	F 0550	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	01/15/2024

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	Resident 20, Resident 31, Resident F) Findings include: 1. On 12/13/23 at 8:06 A.M., CNA (Certified Nurse Aide) 21 was observed in Resident 20's room assisting the resident to eat breakfast. CNA 21 was standing in front of the resident who was sitting in her wheelchair and was using her cell phone. On 12/13/23 at 10:58 A.M., Resident 20's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease and COVID-19. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 9/21/23, indicated the resident's mental status could not be assessed because the resident was rarely or never understood, and required total assistance of 1 (one) staff for eating. A current late loss ADL (Activities of Daily Living) care plan, revised 4/26/23, included an intervention of "see Nurse Aide assignement [sic] sheet for details on staff assist needed". The most recent CNA Assignment Sheet, dated 12/11/23, indicated the resident was a "feed". 2. On 12/14/23 at 8:13 A.M., CNA 21 was observed sitting in a recliner in Resident 53's room using her cell phone. The resident was sitting in a recliner next to her. An empty breakfast tray was on the bedside table in front of the resident. On 12/14/23 at 10:05 A.M., Resident 53's clinical record was reviewed. Diagnosis included, but was not limited to, vascular dementia without		**practice;** All staff will be in-serviced on resident's rights and treating residents with dignity and will put emphasis on addressing residents in a respectful manner, timely response to requests for assistance and or care. The Staff Development Coordinator will include this in-service training with the orientation of all new employees. The facility will utilize a process to interview all residents about dignity and choices as well as update individual preferences. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected. All residents will be interviewed in regard to being treated with dignity/respect and choices. Any concerns shall be reported to the administrator. In-service shall be provided to staff, including identified nurses, on both Dignity/Respect and Choices. All staff will be in-serviced on resident's rights and treating residents with dignity and will put emphasis on addressing residents in a respectful manner, timely response to requests for	

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	behavioral disturbance. The most recent quarterly MDS Assessment, dated 9/3/23, indicated the resident's mental status could not be assessed because the resident was rarely or never understood, and required extensive assistance of 1 (one) staff for eating. A current nutrition care plan, revised 12/7/23, indicated that the resident was at nutritional risk related to requiring assistance at meals. The most recent CNA Assignment Sheet, dated 12/11/23, indicated the resident was a "feed". 3. In an anonymous interview on 12/11/23 at 11:57 A.M., it was indicated an unidentified CNA was on their phone while assisting to transfer Resident 31 to and from the restroom using a hoyer lift. On 12/13/23 at 11:27 A.M., Resident 31's clinical record was reviewed. Diagnoses included, but were not limited to, non traumatic intracerebral hemorrhage and muscle weakness. The most recent admission MDS Assessment, dated 9/12/23, indicated the resident had severe cognitive impairment and required extensive assistance of 2 or more staff for toileting. Current physician orders included, but was not limited to: Hoyer lift total assist x 2 staff for transfers, dated 9/6/2023 On 12/14/23 at 10:03 A.M., the Administrator indicated staff should not be using their cell phones in the hallway, in resident rooms, or in resident care areas. 4. On 12/13/23 at 8:53 A.M., Resident F indicated		assistance and or care. The Staff Development Coordinator will include this in-service education with the orientation of all new employees. The facility will utilize a process to interview all residents about dignity and choices as well as update individual preferences. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Activity Director will poll residents monthly during Resident Council meeting on Dignity and Respect concerns. Any concerns expressed will be reported to the administrator. This will be monitored daily through condition changes, care plan changes and individual sample interviews. This plan of correction will be utilized as one of our performance improvement practices. Results will be discussed monthly in the performance improvement meeting to ensure continued compliance. The DON/Designee will be responsible to monitor process. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and**	

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	while speaking with a Certified Nurse Aide (CNA) the previous night, she felt as though she was disrespected. Resident F indicated the CNA had come into the room, and the resident asked if she would turn her. The CNA indicated to the resident there was not enough time or staff to assist her. The resident asked the CNA if she was aware that state was in the building for the week, and the CNA told the resident "don't you dare threaten me with state". Resident F indicated the CNA was rude. On 12/15/23 at 10:34 A.M., a current Cell Phones policy, undated, indicated "There are to be absolutely no cell phones in the hallways, in resident common areas, in resident rooms, shower rooms, dinning [sic] rooms or in any room resident care occurs". On 12/15/23 at 10:28 A.M., a current Resident Rights policy, dated 8/18/17, indicated "Employees shall treat all residents with kindness, respect, and dignity" 3.1-3(a) 3.1-3(p)(4) 3.1-3(t)		This plan of correction will be utilized as one of our performance improvement practice. Results will be discussed monthly in the performance improvement meeting to ensure continued compliance. The DON/Designee will be responsible to monitor process.	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including			

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	sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on observation, interview, and record review, the facility failed to promote and facilitate resident self-determination related to bathing for 1 of 3 residents reviewed for Activities of Daily Living (ADLs). A resident's preference for showers and to have hair washed three times a week was not honored. (Resident F) Findings include: On 12/11/23 at 10:09 A.M., Resident F indicated she had requested her hair to be washed three times a week (twice by staff and once by the beauty shop), and it was not being done. She indicated she had currently gone two weeks without her hair being washed. Resident F indicated she would rather take showers, but staff was currently only providing bed baths. Resident F indicated staff did not wash her hair with every bed bath.	F 0561	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No resident has requested their hair be washed with each bed bath. Resident F was showered per their preference. This resident care plan was updated to reflect the resident currents shower preference and frequency. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to	01/15/2024

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	On 12/12/23 at 12:39 P.M., Resident F's clinical record was reviewed. Diagnosis included, but were not limited to, morbid obesity, anxiety, and depression. The most recent state optional and quarterly MDS (minimum data set) Assessment, dated 11/6/23, indicated no cognitive impairment, no rejection or refusals of care, and impairment on one side of the upper extremities, and impairment on both sides of the lower extremities. Resident F required extensive assistance of two staff with bed mobility, and total dependence of two staff with transfers and toileting. Resident F's shower record from 11/14/23 through 12/13/23 indicated no showers had been given, only bed baths. The record indicated the resident had refused having hair washed on 12/12/23. On 12/13/23 at 8:53 A.M., Resident F indicated she did not refuse to have her hair washed the previous day, as no one had asked if she wanted her hair washed. On 12/13/23 at 8:35 A.M., the weekly shower schedule sitting on the nurses station was reviewed. Resident F was not listed on the schedule. On 12/13/23 at 12:40 P.M., the CNA assignment form indicated Resident F was to have a bed bath daily. The form lacked preference on having hair washed. On 12/14/23 at 10:00 A.M., a grievance form, dated 12/8/23, was reviewed. The form indicated Resident F explained "she wants things done at certain times and the time requests were not being met" The planned resolution indicated to wash hair on Tuesday and Sunday, and hair dresser to		be affected by the alleged deficient practice. The Activity Director will continue to interview all residents for updated preferences for bathing . Their care plan will be update appropriately. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** DON/Designee will audit shower sheets daily during Clinical Meeting to ensure all scheduled showers were given. Any missed showers will be followed up with staff and resident for reason of refusal. All nursing staff will be Inservice by DON/Designee on Resident Rights, including ensuring all residents are showered per their preference. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The Director of Nursing or designee will monitor the bathing sheets daily for 30 days in clinical meeting for both units. The bathing sheets will be reviewed for patterns of refusals or other reasons for the task not being performed. Resident preferences will be reviewed and updated as	

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	wash on Thursdays. On 12/14/23 at 9:04 A.M., CNA 27 indicated Resident F was supposed to have her hair washed on Tuesdays, Thursdays, and Sundays. She indicated first shift gave Resident F a bed bath daily, and second shift was responsible for the shampooing three times a week. On 12/15/23 at 10:28 A.M., a current Resident Rights policy, dated 8/18/17, indicated "Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: ... self-determination" This citation relates to Complaint IN00423804. 3.1-3(a)		needed. Findings will be reviewed monthly with the Quality Assurance Performance Team on an ongoing basis with a goal of reducing the monitor to 3 times a week by the Director of Nursing or designee. The assigned nurse will continue to monitor daily on their shift.	
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			

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	(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 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).			
	Based on interview and record review, the facility failed to ensure notification of change for 1 of 1 resident reviewed for elevated blood pressure. The physician was not notified timely of a resident's decline in condition. (Resident 31) Finding includes: On 12/13/23 at 11:27 A.M., Resident 31's clinical	F 0580	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The resident's record was reviewed with the documenting staff nurse.	01/15/2024

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	record was reviewed. Diagnoses included, but were not limited to, nontraumatic intracerebral hemorrhage and hypertension. The most recent admission MDS (Minimum Data Set) Assessment, dated 9/12/23, indicated the resident had severe cognitive impairment with no behaviors. The clinical record indicated Resident 31 had a history of stroke. Resident 31 was admitted to the facility on 9/5/23 following a hemorrhagic stroke with right hemiparesis. The Resident was sent to the hospital on 9/23/23 for a CVA (cerebrovascular accident). Current physician orders included, but was not limited to: Clonidine HCl (an antihypertensive medication) oral tablet 0.1 MG (milligram) - Give 1 tablet by mouth every 4 hours as needed for SBP (systolic blood pressure) above 160 and/or DBP (diastolic blood pressure) above 95, dated 9/5/2023 Monitor resident for sudden numbness, weakness of face, arm, or leg. Monitor for s/s (signs and symptoms) confusion, trouble speaking, seeing in one or both eyes, trouble walking, dizziness, loos [sic] of balance or coordination, or sudden severe headache. Any symptoms, call MD (Medical Doctor), dated 9/29/23. The most recent CVA/Stroke care plan, dated 9/18/23, included, but was not limited to, the following interventions: Monitor vital signs as ordered and PRN (as needed). Notify MD of significant abnormalities. Monitor/document/report PRN for neurological deficits: level of consciousness, visual function changes, aphasia, dizziness, weakness,		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by this alleged practice. Nursing staff is to notify physician and family of any change of condition and document such change in a timely manner. This will be monitored by the Director of Nursing/Designee. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Licensed staff will review the policy regarding Change of Condition, Notification of Change in Condition including potential symptoms of stroke and expected outcomes of initial physician's orders. The Interdisciplinary Team (IDT) will review during clinical start up for any change of conditions and to ensure proper notification to physician and family has occurred in a timely manner. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	restlessness. Progress notes included, but were not limited to: On 11/21/2023 at 4:30 A.M., "Call light is ringing. Wife is at bedside and says "Something's wrong, he's never like this". Resident breathing heavily and face is somewhat red and flushed. Checked vitals, Pulse 67, R (respirations) 20, SpO2 (oxygen saturation) 97% room air, Temp (temperature) 97.7. B/P (blood pressure) 182/84." On 11/21/2023 at 4:35 A.M., an administration order note indicated 1 tablet of clonidine was given. On 11/21/2023 at 5:05 A.M., the follow-up for effectiveness was marked as "unknown". A note indicated "Resident's wife rang the call light again. Checked resident's B/P and it was up a little bit about 188/88. Explained it had just been 30 minutes. Will check later. Resident seems a little less anxious." On 11/21/2023 at 6:40 A.M., "Resident's blood pressure remains high. About 172/88. Pulse is 82. Respirations are 18. Resident breathing less labored. Resident has been speaking often with non-intelligent phrases but mixes some understandable with it. Resident's wife asks what was his blood pressure?" [sic] Explained what it was and resident's wife states "Oh, no that's not good" "He grabbed my hearing aid and pulled it out of my ear." "Did he have a stroke?" "Oh, no. [sic] "Will he have to go to the hospital?" Resident then interjected and said "No, I'm not going there." Explained that resident's vitals are within normal range and we can continue to monitor his vitals here. Will check later. Right now resident remains in stable condition."		**into place; and** To ensure compliance the Director of Nursing (DON) /designee will be responsible for the completion of notification to responsibly party/family member and physician or Nurse Practitioner (NP). Any trends will be reported to QAPI monthly times 6 months then quarterly thereafter.	

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	On 11/21/2023 at 8:23 A.M., "Assessed resident r/t (related to) wife states something is wrong, resident does not feel good. Face noted to be flushed, unable to put words together. Placed call to [name of Doctor] office, spoke with nurse [name of nurse], informed resident noted to have slurred speech, unable to put words together, nurse sqeeuzed [sic] hands, right hand weakness noted. Received n.o. (new order) per [name of Doctor] Send to [name of hospital] ER (emergency room) to eval (evaluate) and treat. Wife [name of wife] here at facility, et (and) notified. BP160/114 R18 P (pulse) 72 T (temperature) 97.8 O2 sat (saturation) 95%RA (room air)". On 11/21/2023 at 8:30 A.M., "Placed call to [name of ambulance] to transport resident to [name of hospital] ER." On 11/21/2023 at 8:45 A.M., [name of ambulance] here at facility to transport resident to [name of hospital] ER." On 11/21/2023 at 8:50 A.M., "Resident left facility with [name of ambulance] to transport to [name of hospital] ER." On 11/21/2023 at 2:25 P.M., "Placed call to [name of hospital], nurse stated resident admitted with stroke and UTI (urinary tract infection)." On 11/24/23, a Nurse Practitioner Note indicated "Patient has returned from hospital after being there for 2 days at [name of hospital]. He went d/t (due to) patient exhibiting signs of a stroke. His vital signs when he left were BP160/114, R18, P72, T97.8, O2 sat 95%RA ... Wife states that he had a change on his MRI (magnetic resonance imaging) of his brain from prior exam. Staff report the MRI of his brain showed a new left infarct. Patient's			

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	neurological symptoms have return to his baseline. He has had a CVA in the past with residuals of coordination issues, memory deficits, and persistent right-sided weakness. Patient's outcomes are more compromised with hypertension, hyperlipidemia, anemia, Parkinson's disease, and neurogenic bladder." The clinical record showed the resident's baseline systolic blood pressure for November prior to the hospitalization on 11/21/23 ranged from 114-154. Hospital discharge paperwork, dated 11/23/23, indicated the resident was hospitalized with a diagnosis of stroke and UTI (urinary tract infection). On 12/13/23 at 2:22 P.M., LPN (Licensed Practical Nurse) 5 indicated call orders for blood pressure were a nurse judgement and that she would call for anything over a SBP of 150 or a DBP of 90. At that time, she indicated if a PRN antihypertensive medication was given, blood pressure should be rechecked after an hour, and the MD should be notified if there is no improvement or if the blood pressure remains elevated. On 12/15/23 at 8:32 A.M., a current Change in a Resident's Condition policy, dated 2001, indicated "Our facility shall promptly notify...his or her Attending Physician...of changes in the resident's medical/mental condition ... The nurse will notify the resident's Attending Physician or physician on call when there has been a...significant change in the resident's physical/emotional/mental condition ... A "significant change" of condition is a major decline or improvement in the resident's status that...will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions".			

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	3.1-5(a)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as			

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	provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, interview, and record review, the facility failed to ensure PRN (as needed) antianxiety medications were evaluated every 14 days for 2 of 2 residents reviewed for ADL (Activities of Daily Living) and 1 of 1 resident reviewed for dialysis (Resident 265, Resident 48, Resident F). Findings include: 1. On 12/14/23 at 9:18 A.M., Resident 265's clinical record was reviewed. Resident 265's diagnosis included, but was not limited to, anxiety disorder. The most recent admission MDS (Minimum Data Set) Assessment, dated 11/4/23, indicated Resident 265 was cognitively intact and received an antianxiety medication during the 7 day look back period. Current physician orders included, but was not limited to: Lorazepam (an antianxiety medication) Oral Tablet 0.5 MG (milligrams) - Give 1 tablet by mouth as needed for anxiety three times a day as needed, dated 11/27/2023	F 0758	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident's # 48 and # 265 and Resident F will have orders updated to reflect changes in the administration of the medication not to exclude continuation for 14 days. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Residents will continue to be reviewed monthly by the consultant pharmacist and nursing. New orders will be reviewed by the nurse manager and or the Director of Nursing. **What measures will be put into place and what systemic changes will be made to**	01/15/2024

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	The November 2023 MAR (medication administration record) indicated Resident 265 received lorazepam on 11/28, 11/29, and twice on 11/30. The December 2023 MAR indicated Resident 265 received lorazepam on 12/2, 12/3, three times on 12/4, twice on 12/6, 12/7, twice on 12/8, 12/9, 12/10, twice on 12/11, 12/12, and twice on 12/13. The clinical record lacked documentation of clinical rational by a physician for the lorazepam given greater than 14 days.2. On 12/12/23 2:12 P.M., Resident 48's clinical record was reviewed. Diagnoses included, but were not limited, to cerebral palsy, metabolic encephalopathy, and major depressive disorder. The current quarterly MDS (Minimum Data Set) Assessment indicated Resident 48 was severely cognitively impaired and needed extensive assistance to perform activities of daily living. Physicians ordered included but were limited to: Diazepam Gel 20 mg (milligrams), insert 15 mg rectally as needed for greater than 5 minutes seizure activity dated 6/10/21. The clinical record lacked a 14-day assessment for PRN medications.3. On 12/12/23 at 12:39 P.M., Resident F's clinical record was reviewed. Diagnosis included, but were not limited to, anxiety. The most recent quarterly MDS Assessment, dated 11/6/23, indicated no cognitive impairment, and had received an antianxiety medication. Current physician orders included, but were not limited to: Ativan Oral Tablet 0.5 MG (milligram) (an		**ensure that the deficient practice does not recur;** An audit will be completed of current resident medication orders to ensure there are no current PRN psychotropic medication orders for our residents that are ordered beyond 14 days without a rational for continued use from the attending physician or prescribing practitioner. Any opportunities will be corrected by the Administrative Nurses. Licensed Nursing staff (RNs & LPNs) will be re-educated on the intent of F 758, related to ensuring that any PRN order for psychotropic medication received from the attending physician or prescribing practitioner will include a rational and or the need to revise order. It will be the responsibility of the charge nurse to notify the attending physician or prescribing practitioner that a rational will be required to continue the PRN psychotropic medication beyond the 14 days. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Physician orders are reviewed daily M-F at the morning clinical meeting. During this order review the Administrative Nurses will review any PRN psychotropic medication orders to ensure there	

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	antianxiety medication) 1 tablet by mouth every 6 hours as needed for anxiety, dated 11/16/23. (original order dated 8/11/21 and discontinued 11/16/23) Resident F's Medication Administration Record (MAR) for November 2023 and December 2023 indicated the following dates Ativan was given as needed: 11/3/23 11/6/23 11/7/23 11/10/23 11/12/23 11/16/23 11/19/23 11/26/23 (twice) 11/30/23 12/2/23 (twice) 12/4/23 (twice) 12/6/23 12/8/23 The clinical record lacked a rationale to indicate the duration of the PRN (as needed) order for Ativan beyond 14 days documented by the physician or prescribing practitioner. On 12/15/23 at 10:02 A.M., Licensed Practical Nurse (LPN) 29 indicated she was aware that antianxiety medication use required review, but was unsure how often. On 12/14/23 at 11:14 A.M., the Director of Nursing (DON) provided a current Antipsychotic Medication Use policy, revised 11/5/14, that indicated "If antipsychotic medications are administered as PRN dosages repeatedly over several days (14), the Physician should discuss the situation with staff and evaluate the residents		is a 14 day stop date. If the physician has decided that the medication is to be extended this review will ensure that the physician or prescribing practitioner has documented a rational to continue the medication beyond the 14 days. This will be monitored daily for 30 days then revised at the next QAPI meeting.	

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	as needed to determine e whether the use is appropriate and the symptoms are responding to the medication". At that time, the DON indicated the policy was the same for all psychotropic medications, including antianxiety medications. 3.1-48(a)(2)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to provide proper storage of medications in 2 of 2 medication carts and 2 of 2	F 0761	**What corrective action(s) will be accomplished for those**	01/15/2024

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	medication rooms reviewed. Loose pills were observed in medication carts with improperly labeled medications, and the medication refrigerator lacked temperature readings. (West Hall Medication Cart, West Hall Medication Room, East Hall Medication Room) Findings include: On 12/13/23 at 9:17 A.M., the following was observed in one of the two West Hall Medication carts: 1 round white pill with 210 1 blue caplet oblong with number 675 1/2 oblong white pill 1 small round with TP 1 bottle of Valporic Acid opened and not dated bottom drawer was sticky On 12/13/23 at 9:30 A.M., the following was observed in the other West Hall Medication Cart: 1 yellow piece 1 round multicolored brown pill 1 small yellow round pill with heart on it 1 round peach colored pill with letter M 1/2 white pill 1 white pill with the letters CL On 12/14/23 at 10:30 A.M., the following was observed in the East Hall Medication refrigerator: beer - no name boost - no name On the counter next to the refrigerator, the following was observed: unlabeled boost, beer, and a bottle of whiskey. On 12/14/23 at 10:50 A.M., the refrigerator log for the West Hall Medication Room had the following dates documented for the month of December,		**residents found to have been affected by the deficient practice** An audit of all medication carts will be performed to ensure clean, safe storage and labeling of all medications in medication carts **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken** Residents could have the potential to be affected. An audit of all medication carts will be performed to ensure clean, safe storage and labeling of all medications in medication carts **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Items in medication refrigerators were discarded per facility medication disposition/destruction policy. The DON or are delegated staff nurse will complete an audit of medication refrigerators on the East and West units to ensure proper labeling and refrigerator temperature logging. All licensed nurses and QMA's will participate in in-service to review the facility policy for "Medication Storage"	

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	2023: 12/1, 12/2, 12/3, 12/2 and 12/9. All other dates lacked a temperature reading. During an interview on 12/13/23 at 9:25 A.M., LPN Licensed Practical Nurse) 7 indicated loose pills should not have been in the medication carts, and all medication bottles should have been labeled with an open date. During an interview on 12/14/23 at 10:30 A.M., LPN 7 indicated that the beverages in the refrigerator and on the counter were used by residents who had orders for them and should have been labeled with the resident's name. On 12/14/23 at 1:14 P.M., the Administrator provided a current policy "Storage of Medications" dated April 2007, indicated "...drugs ...shall be stored in the packing, containers,... in which they are received... the nursing staff shall be responsible for maintaining medication areas in a clean, and sanitary manner...medications should be ... labeled accordingly." At the same time, a current policy "Refrigerators and Freezers" dated December 2014 indicated "....monthly tracking sheets for refrigerators and freezers will be posted to record temperatures...monthly tracking sheet will include time, temperature, and initials..." 3.1-25(j)(6) 3.1-25(m)		with a specific emphasis on understanding the procedure for documenting daily medication room refrigerator temperatures and when to report in the event the refrigerator temperature falls outside the acceptable parameters. A facility temperature log is located on each medication room refrigerator to document results with each inspection and with instructions if the refrigerator temperature requires adjustment. Temperatures will continue to be checked every 12 hours. The night shift nurse will be responsible for clearing any loose pills from the medication carts on his/ her assigned unit and informing Pharmacy of the unit manager for replacements if pills are identified to belong for a specific resident. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The nurse managers or other designee will be responsible for completing an audit to monitor for compliance. This tool will be completed daily for 4 weeks. Then weekly by the Director of	

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			Nursing or designee. Any concerns identified will be corrected upon discovery and findings documented on quality assurance tracking log. All QA tools and any findings will be reviewed monthly in the facility Quality Assurance meeting to ensure ongoing compliance for a minimum of 3 months . Pharmacy services will continue quarterly audits. Patterns will be identified to determine effectiveness and system changes.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement			

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	based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.			

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	§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observations, interviews and record reviews, the facility failed to properly prevent and/or contain COVID-19 for 7 of 11 residents reviewed for infection control. (Resident 20, Resident 53, Resident 41, Resident 27, Resident 38, Resident 314, Resident 315) Findings include: 1. On 12/13/23 at 8:06 A.M., CNA (Certified Nurse Aide) 21 was observed in Resident 20's room assisting her to eat. CNA 21 was not wearing any PPE and her surgical mask was pulled down around her chin. At that time, the sign outside the resident's room indicated that the resident was on contact precautions for COVID-19. On 12/13/23 at 8:14 A.M., QMA (Qualified Medication Aide) 17 indicated staff should have on gown, gloves, a face shield, and an N95 mask while in COVID-19 rooms. She further indicated CNA 21 needed to have on PPE while in Resident 20's room. At that time, CNA 21 indicated she hung her gown on the back of the door in resident 20's room to reuse later. On 12/13/23 at 10:58 A.M., Resident 20's clinical record was reviewed. Diagnosis included, but was not limited to, COVID-19. The most recent quarterly MDS (Minimum Data	F 0880	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** Nursing staff members cited in the alleged deficient practice were re-educated. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** No residents were found to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Staff will be re-educated on Isolation precautions, proper PPE, handwashing, and cleaning shared equipment between each resident use. Education will occur upon hire, quarterly and as needed. An audit tool will be put in place to monitor PPE usage, handwashing, and cleaning shared resident equipment between use for 4 staff	01/15/2024

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	Set) Assessment, dated 9/21/23, indicated the resident's mental status could not be assessed because the resident was rarely or never understood, and required total assistance of 1 (one) staff for eating. 2. On 12/14/23 at 8:13 A.M., CNA 21 was observed sitting in a recliner in Resident 53's room with her surgical mask pulled down around her chin. The resident was sitting in a recliner next to her. An empty breakfast tray was on the bedside table in front of the resident. On 12/14/23 at 10:05 A.M., Resident 53's clinical record was reviewed. Diagnosis included, but was not limited to, vascular dementia without behavioral disturbance. The most recent quarterly MDS Assessment, dated 9/3/23, indicated the resident's mental status could not be assessed because the resident was rarely or never understood, and required extensive assistance of 1 (one) staff for eating. 3. On 12/13/23 at 7:59 A.M., LPN 5 was observed to take Resident 41's blood pressure prior to giving the resident's morning medication. LPN 5 left the room without cleaning the blood pressure cuff. 4. On 12/13/23 at 8:16 A.M., QMA 3 was observed to take Resident 27's blood pressure prior to giving the resident's morning medication, and left the room without cleaning the blood pressure cuff. At that time, QMA 3 was observed not performing hand hygiene before or after exiting Resident 27's room. 5. On 12/13/23 at 8:33 A.M., QMA 3 was observed going into Resident 38's room, touched the TV remote, took the resident's blood pressure,		members a day Monday through Friday. Review of audits/concerns during daily clinical meeting to address noted concerns. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**: The Staff Development Coordinator/designee and or Director of Nursing will observe hand hygiene and proper PPE with nursing staff. This will include the use of cell phones in isolation rooms. Nursing staff will be re educated regrading cleaning resident areas for food trays This will be monitored daily for 30 days then revised at the next QAPI meeting.	

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	155354	A. BUILDING 00 B. WING	12/15/2023

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	and failed to perform hand hygiene and clean the blood pressure cuff after use. 6. On 12/13/23 at 8:52 A.M., QMA 3 was observed going into Resident 314's room not performing hand hygiene prior to entering room and prior to placing eye drops. 7. On 12/13/23 at 8:39 A.M., during a random observation, a portable urinal that contained a yellow substance was observed sitting on a bedside table next to a food tray and two drink containers. At that time, Resident 315 was observed lying in the bed with the bedside table over him. From 8:39 A.M. until 8:43 A.M., three staff members were observed walking past the room, each looking into the room and greeted the resident. During an interview on 12/13/23 at 9:11 A.M., QMA 3 indicated blood pressure cuffs should be cleaned after each use with a Sani-cloth, and hand hygiene should be performed prior to going into and after coming out of a resident room. On 12/14/23 at 1:00 P.M., the Infection Preventionist (IP) indicated staff should wear an N95 mask, gown, gloves, and face shield while caring for a resident who has COVID-19. She indicated PPE should not be reused. At that time, she indicated all staff and visitors should wear masks at all times until the mask restrictions were lifted. Restrictions would be lifted when no one tested positive for COVID in the last 14 days. She further indicated staff were expected to remove urinals from bedside tables before a resident was served a meal tray, and clean the area. She indicated hand hygiene should be performed before starting, between tasks, before touching a resident, before donning gloves, and afterwards. On 12/14/23 at 2:19 P.M., a current Infection			

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	Control Guidelines policy dated August 2012,was provided and indicated "...the preferred method of hand hygiene is with an alcohol-base hand rub... and should be before and after direct contact with residents, before preparing or handling medications, and after contact with objects in the immediate vicinity of residents..." On 12/14/23 at 2:19 P.M., a COVID-19 Policy and Procedures policy, undated, indicated "HCP (health care professionals) who enter the room of a resident with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use...respirator with N95 filters or higher, gown, gloves, and eye protection". On 12/14/23 at 2:19 P.M., a Standard Precautions policy, revised December 2007, indicated "Standard precautions include the following practices: hand hygiene, gloves, masks, eye protection, face shields, gowns...do not reuse gowns". 3.1-18(b) 3.1-18(l)			
F 9999 Bldg. 00	#1. 3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in	F 9999	**What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice** During the initial onboarding process, all staff will be given the proper and required dementia training within 30 days.	01/15/2024

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	intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. IF the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency repeat testing will depend on the risk of infection with tuberculosis. This State rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure tuberculin skin tests or risk assessments were completed on 3 of 10 employees selected for review. (CNA 15, CNA 38, LPN 22) Findings include: On 12/13/23 at 1:35 P.M., the employee records were reviewed: CNA (Certified Nursing Assistant) 38 lacked the initial 2-step tuberculosis test needed prior to a hire date of 7/5/23. LPN (Licensed Practical Nurse)22 lacked the initial		During the initial onboarding process, all staff will be given Tuberculin skin tests before working in the facility **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken** All residents in the dementia unit have the potential to be affected by the alleged deficient practice. An audit of all employees was completed to identify any staff that is missing the required dementia training. Identified employees were scheduled for the required training to ensure compliance. Audit of all employee files was conducted. All affected staff had a tuberculin skin test scheduled and all staff missing an annual TB assessment were provided with the form to fill out and return with a licensed nurse to review. **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur** Our Staff Development Coordinator	

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	2-step tuberculosis test needed prior to a hire date 11/30/23. CNA 15 lacked an annual tuberculosis risk assessment for 2023. During an interview on 12/14/23 at 2:00 P.M., the interim Infection Preventionist indicated employees are to receive a 2-step TB skin test followed by an annual risk assessment. On 12/15/23 at 12:15 P.M., the DON (Director of Nursing) presented a current policy "Tuberculosis, Employee Screening for" dated July 2010,"indicated all employees shall be screened for tuberculosis(TB)...,using a two-step tuberculin skin test...prior to beginning employment. The need for annual testing will be determined by the annual TB risk Classification..." #2. 3.1-14 PERSONNEL (u) In addition to the required in-service hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This State rule was not met as evidenced by: Based on record review and interview, the facility		or Designee has been educated on the required Dementia training for all new hires. All newly hired employees will have dementia training scheduled with their new employee orientation. All new employees will have a tuberculin skin test prior to working. All department heads have been educated on this process. **How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place** An audit tool will be used monthly x3 and quarterly thereafter to monitor ongoing compliance. Any audit not meeting threshold will be provided to QAPI committee for action plans for further compliance. The administrator will review all new employee files to ensure tuberculin skin tests were administered prior to working in the facility and stored in the employee file. Results will be submitted to QAPI for 3 months for review to ensure compliance goals. QAPI committee reserves the right to modify or extend	

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	failed to provide documentation of staff completing a minimum of 3 hours of dementia-specific training annually and with new hires for 6 of 10 employee records selected for review. (CNA 21, Laundry Aide 32, CNA 15, QMA 3, QMA 25, LPN 29) Findings include: CNA (Certified Nursing Assistant) 21 lacked the 6 hours of dementia-specific training for new employees with a hire date of 3/3/23. Laundry Aide 32 lacked the 6 hours of dementia-specific training for new employees upon hire 4/14/23. LPN(Licensed Practical Nurse) 29 lacked the 3 hours of dementia-specific training for 2023. QMA 3 lacked 3 hours of dementia training for 2023. CNA 15 lacked the 3 hours of dementia-specific training for 2023. QMA 25 lacked the 3 hours of dementia-specific training for 2023. During an interview on 12/14/23 at 2:00 P.M., the interim Infection Preventionist indicated In-services for dementia were done annually and sign in sheets were completed to keep record of the class. She indicated it was facilities responsibility for record keeping of attendance and required hours. On 12/15/23 at 12:15 P.M., the DON (Director of Nursing) presented a current policy "Dementia-Clinical protocol" date March 2015		monitoring times according to outcomes.	

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	indicated..."nursing assistants will receive initial training in the care of residents with dementia and related behaviors. In-services will be conducted at least annually threreafter..."			