STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KOKOMO HEALTHCARE CENTER	429 W LINCOLN RD KOKOMO, IN 46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 30, 31, April 1, 4, and 5, 2022. Facility number: 000127 Provider number: 155222 AIM number: 100291430 Census Bed Type: SNF/NF: 63 Total: 63 Census Payor Type: Medicare: 2 Medicaid: 50 Other: 11 Total: 63 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on April 13, 2022.	F 0000	The Plan of Correction is the center's credible allegation of compliance. Preparation and 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. This plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. The facility respectfully requests a desk review for this plan of correction.	
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			

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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	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 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 observation, interview and record review, the facility failed to develop and implement a comprehensive plan of care for a resident with a pressure ulcer, a resident who required extensive assistance with care, and failed to develop and implement a relevant care plan intervention related to a root cause analysis after a fall for 3 of 18 residents reviewed for care plans.	F 0656	1. 1. Resident #49 has a current plan of care for the resident's deep tissue injury to the left foot, to include a measurable goal and interventions targeted to heal the wound. Resident # 6 has a plan of care regarding the resident's assessed extensive	05/06/2022

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	(Resident 49, 6 and 18) Findings include: 1. The record for Resident 49 was reviewed on 04/04/2022 at 10:34 a.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, acute kidney failure, anemia, muscle weakness and benign prostatic hyperplasia (enlargement of the prostate). A "Wound Evaluation" by the wound nurse practitioner, dated 03/28/2022 at 1:42 p.m., indicated the resident had a suspected deep tissue injury to the left heel measuring 3.67 cm (centimeters) by 4.1 cm in diameter. A review of the current plan of care indicated a problem of "The resident has impaired skin integrity, or at risk for altered skin integrity Immobility" with an initiation date of 02/08/2021. The goal for this problem was "...will not exhibit complications from altered skin integrity (i.e. infection) through next review date." The date of initiation of the goal was "02/08/2021" with a revision date of "01/28/2022". Documentation was lacking a current plan of care for the resident's deep tissue injury to the left foot, to include a measurable goal and interventions targeted to heal the wound. 2. The record for Resident 6 was reviewed on 04/01/2022 at 2:19 p.m. Diagnoses included, but were not limited to, cerebral infarction (stroke), chronic obstructive pulmonary disease, hypertension, anxiety disorder, and hemiplegia (paralysis of one side of the body) and hemiparesis (weakness to one side of the body).		need for assistance with activities of daily living care to include the number of staff the resident required for bed mobility related to his incontinent care and transfers. Resident #18 has an intervention added to the care plan related to sliding off the side of his bed with no injuries. 2. 2. Resident Assessment Coordinator or designee will complete an audit of all residents to validate the comprehensive care plan is current and completed. Any findings will be addressed with the IDT team. 3. 3. Resident Assessment Coordinator or designee will provide education to interdisciplinary team on the Care plan policy. 4. 4.Five care plans will be audited weekly for four weeks, then five will be audited monthly for three months to validate the comprehensive care plan was completed. Findings of all care plan reviews will be reported at the monthly Quality Assurance meeting and the QA committee will determine when compliance is achieved or if ongoing monitoring is required.	

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On 04/01/2022 at 10:03 a.m., Resident 6 was observed to be in bed with an oversized mattress. The bed was in the high position, with the top of the mattress to the floor estimated to have been 3 1/2 feet. The resident had an above the knee amputation to the left lower extremity and limited use of his left arm and hand. Resident 6 indicated at this time, he had sustained a fall from his bed in January 2022 when a CNA (certified nursing assistant) was assisting him with incontinent care. He stated he "rolled over too far" and fell out of bed and on to the floor.

The resident's record indicated he was transferred to the emergency room for treatment of a laceration to his forehead following a fall from bed on 01/21/2022. Progress notes in the record indicated there was one CNA in the room providing incontinent care at the time of the resident's fall. Section G of the resident's current MDS (minimum data set) assessment, dated 12/30/2021, indicated the resident required "extensive assistance" of "two + persons" for bed mobility (how the resident moves to and from lying position, turns side to side, and positions body while in bed) and was totally dependent with assistance of "two + persons" for transfers.

Documentation was lacking a plan of care regarding the resident's assessed extensive need for assistance with activities of daily living care to include the number of staff the resident required for bed mobility related to his incontinent care and transfers.

3. The record for Resident 18 was reviewed on 04/01/22 at 11:31 a.m. Diagnoses included, but were not limited to, muscle weakness, cerebral palsy, Parkinson's disease and difficulty walking.

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A quarterly MDS (minimum data set) assessment, dated 01/13/22, indicated the resident was a one person physical assist when walking in his room and was unsteady but could stabilize with human assistance.

A Post Fall Evaluation, dated 02/15/22 at 3:02 p.m., indicated the resident had an unwitnessed, self-reported fall on 02/14/22 at 12:00 a.m. The resident shared with the Nurse Practitioner he did not feel like it was a "big deal" and he did not let anyone know. The suspected root cause was the resident was trying to get back into bed. He missed the mattress, hit the edge, which caused him to slide.

A fall care plan, initiated on 10/07/20, indicated the intervention put into place on 02/15/22 was to educate the resident to report falls at the time of the fall. No other interventions were initiated.

During an interview, on 04/05/22 at 4:45 p.m., the Corporate Support Crisis Nurse indicated the new intervention was not relevant to the root cause of the resident's fall.

A current facility policy, titled "Plan of Care Overview," dated as revised 7/26/2018 and received on 4/4/22 indicated "...The purpose of this policy the Plan of Care, also Care Plan is the written treatment provided for a resident that is resident-focused and provides optimal personalized care...."

A current facility policy, titled "Accident/Incident: Occurrence Report," dated 10/17/13 and provided by the Corporate Support Crisis Nurse on 04/05/22 at 3:25 p.m., indicated "...All appropriate actions are to be care planned and implemented...."

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	3.1-35(a) 3.1-35(d)(1)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			
	Based on observation, interview and record review, the facility failed to provide treatment and services to promote healing of a pressure wound for 1 of 2 residents reviewed for pressure ulcers. (Resident 49) Finding includes: During the initial tour, on 03/30/2022 at 10:36 a.m., Resident 49 was observed to be lying in bed with his heels lying on the mattress. On 03/31/2022 at 10:52 a.m., and 04/01/2022 at 2:03 p.m., the resident remained lying in bed with his feet directly on the mattress of the bed. During a tour of the unit, on 04/04/2022 at 9:11 a.m., Resident 49 was observed to be lying in bed with his heels directly resting on the mattress of	F 0686	1. 1. Resident # 49 has treatment orders for the left heel implemented beginning 04/01/2022. 2. 2. An audit of all residents with a pressure ulcer will be completed to validate MD treatment orders are implemented timely and nurses are documenting on the TAR when treatments are administered. Any findings will be communicated to the MD, family and resident. 3. 3. All Licensed nurses will be in-serviced on the following: MD orders for pressure ulcers when impaired skin integrity is identified and documentation of skin assessments upon identification.	05/06/2022

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	his bed. The record for Resident 49 was reviewed on 04/04/2022 at 10:34 a.m. Diagnoses included, but were not limited to diabetes mellitus, hypertension, acute kidney failure, anemia, muscle weakness and benign prostatic hyperplasia (enlargement of the prostate). The record indicated the resident had been admitted to the hospital for scheduled prostate surgery on 03/21/2022 and returned to the facility on 03/24/2022. The admission assessment at the time of the resident's readmission to the facility, on 03/24/2022, indicated the resident had no skin concerns. A review of the resident's progress notes indicated the following entry on 03/25/2022: "...New area site details: Right heel - Pressure: Length = 3.6, Width = 4.1, - Stage Suspected Deep Tissue Injury" The progress note indicated the right heel. The injury was to the left heel. A "Wound Evaluation" by the wound nurse practitioner, dated 03/28/2022 at 1:42 p.m., indicated the following: Location of wound: left heel Length: 3.67 cm (centimeters) Width: 4.16 cm Date wound acquired: Prior to admission Acquired inhouse: No Etiology (cause): Pressure Ulcer - Suspected DTI (deep tissue injury) Dressing change frequency: Daily Pressure reducing/offloading: Ensure compliance		4. All C.N.A.s will be educated on the following: Reporting skin/wound concerns to the nurse and implementing pressure ulcer prevention, Turning and Repositioning, and following the plan of care. 4. The DON/designee will audit all admissions in daily clinical morning meeting for treatment orders on admission and completion of the skin assessment. The DON/Designee will audit weekly all residents with a pressure ulcer for treatment orders implemented timely. This audit will be completed weekly in weekly Resident at Risk meeting as an ongoing process of this facility. The DON/Designee will complete an audit of residents with wounds five times a week to validate interventions for pressure reduction are implemented for 30 days, then three times a week for 30 days, then twice a week for 30 days. The DON will report all findings to the QA committee monthly. The QAPI committee will review systematic changes, effectiveness and continued compliance at least one time monthly and determine if ongoing monitoring is required.	

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with turning protocol, wedge/foam cushion for offloading (elevating feet to alleviate pressure to the heels)
Dressing: Skin prep

A review of the resident's physician orders indicated an order of "Cleanse area of L (left) heel with normal saline and apply skin prep daily" was obtained on 04/01/2022 at 5:00 p.m., four days following the wound evaluation identifying the DTI on 03/28/2022.

Resident 49's heels were observed, with the assistance of LPN 3 and LPN 5, on 04/04/2022 at 11:14 a.m. The resident was found lying in bed with his heels laying directly on the mattress. When the resident's gripper socks were removed by the nurse, the left heel was observed to have a suspected deep tissue injury covering the entirety of the left heel. The area measured, by sight, approximately 3.5 x 4 cm in diameter. Approximately 50% of the area was observed to be covered in black eschar tissue and the remainder was dark brown, dark red in color but not quite black. An area of pink tissue extended outward around the perimeter of the entire area. Both LPN 3 and LPN 5 indicated they were unaware of the resident's wound on the heel and stated the treatment to this area was on evening shift.

A current facility policy, titled "Skin Care & Wound Management," dated as last revised 10/05/2021, indicated "...The facility staff strives to prevent resident/patient skin impairment and to promote the healing of existing wounds. The interdisciplinary team works with the resident /patient family and/or family/responsible party to identify and implement interventions to prevent and treat potential skin integrity issues. The

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	interdisciplinary team evaluates and documents identified skin impairments and re-existing signs to determine the type of impairment, underlying condition(s) contributing to it and description of impairment to determine appropriate treatment. Each resident/patient is evaluated upon admission and weekly thereafter for changes in skin condition. Resident/patient skin condition is also re-evaluated with change in condition, prior to transfer to the hospital and upon return from the hospital. Skin care and wound management program includes, but is not limited to: Analysis of facility pressure ulcer data for quality improvement opportunities. Application of treatment protocols based on clinical 'best practice' standards for promoting wound healing. Daily monitoring of existing wounds. Identification of residents/patients at risk for development of pressure ulcers. Implementation of preventions strategies to decrease the potential for developing Pressure ulcers...." 3.1-40(a)(2)			
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to provide adequate supervision for a resident who required assistance	F 0689	1. 1. Resident #6 while receiving care from one CNA, fell from the bed and sustained	05/06/2022

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	of two staff with activities of daily living (ADL's) for 1 of 1 resident reviewed for accidents. (Resident 6) Resident 6 while receiving care from one CNA, fell from the bed and sustained significant injury requiring transport to the emergency room. Finding includes: During an interview, on 04/01/2022 at 10:03 a.m., Resident 6 was observed to be in bed with an oversized mattress. The bed was in the high position, with the top of the mattress to the floor estimated to have been 3 1/2 feet. The resident had an above the knee amputation to the left lower extremity and limited use of his left arm and hand. Resident 6 indicated he had sustained a fall from his bed in January 2022 when a CNA (certified nursing assistant) was assisting him with incontinent care. He stated he "rolled over too far" and fell out of bed and on to the floor. The resident indicated his head hit the frame of his over-the-bed table and he sustained a laceration near his left eye which caused him to be hospitalized. Resident 6 indicated there was "blood everywhere". The record for Resident 6 was reviewed on 04/01/2022 at 2:19 p.m. Diagnoses included, but were not limited to, cerebral infarction (stroke), chronic obstructive pulmonary disease, hypertension, anxiety disorder, and hemiplegia (paralysis of one side of the body) and hemiparesis (weakness to one side of the body). A progress note, dated 01/21/2022 at 3:13 p.m., indicated "...called to room by (name of CNA) that resident had thrown himself out of bed. upon entering the room i seen him on the floor there was blood on floor he was screaming to get him		significant injury requiring transport to the emergency room. Resident # 6 has had his care plan revised to extensive assist of 2 with bed mobility. 2. 2. An audit will be completed of all residents to validate the safest method for bed mobility and repositioning is care planned and communicated to nursing staff. 3. 3.All nursing staff will be in-serviced on locating the Kardex to determine the plan of care for fall interventions and ADL care with emphasis on bed mobility and repositioning when providing care. 4. 4. The DON/Designee will observe ADL care three times a week for eight weeks monitoring for compliance with the resident plan of care with bed mobility, transfers, repositioning and fall interventions. Then twice a week for four weeks. All findings will be reported to the QAPI meeting monthly by the DNS. The QAPI committee will determine if ongoing monitoring is required or if 100% compliance is achieved.	

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up. writer told him to lay still and went to get help aide stayed in room with resident. writer called 911 ...resident would not stop yelling unable find out if he was in pain or had other injuries. ambulance arrived resident lifted to gurney with assist of 5. his left eye was cut and bleeding. resident out to hospital"

A progress note from the nurse practitioner (NP), dated 01/21/2022 at 3:39 p.m., indicated "informed by nurse that resident fell in his room" The note further indicated "He stated that he fell and hit his head on the metal part of the side table" causing a laceration above the eye by the left eyebrow.

A "Post Fall Evaluation," dated 01/21/2022 at 4:41 p.m., indicated Resident 6 sustained a fall from bed which caused a laceration to the left eye area and the resident was transferred to the emergency room. The evaluation indicated the fall was witnessed by a CNA. The evaluation indicated the resident was "non-ambulatory" and "total mechanical lift for transfers" The resident was described to have been in bed at the time of the fall with the bed in "high position".

A review of Resident 6's current MDS (minimum data set) assessment, dated 12/30/2021, section G indicated the resident required "extensive assistance" of "two + persons" for bed mobility (how resident moves to and from lying position, turns side to side and positions body while in bed) and was totally dependent with assistance of "two + persons" for transfers.

During an interview, on 04/05/2022 at 4:31 p.m., the Director of Nursing (DON) indicated when the CNA was cleaning the resident's bottom, the resident made a sudden jump and threw himself out of bed. The DON indicated she was not in the

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	room when the event occurred and was called to the room after the fall. During an interview, on 04/05/2022 at 5:16 p.m., the DON indicated she had no further information to provide regarding the fall and investigation of Resident 6. The CNA assisting the resident at the time of the fall was not present in the facility at the time of the survey. Attempts were made to contact the CNA documented to have been in the room with the resident at time of the resident's fall, however those attempts were unsuccessful. A current facility policy, titled "Accident/Incident: Occurrence Report," dated as last revised on 10/17/2013 and received on 04/01/2022 at 3:49 p.m., indicated "...A report will be completed on every accident and/or incident that involves a resident. To keep the Medical Director aware of all incidents and to monitor safety in the center...All staff assigned to the area are required to complete a witness (non-witness) statement...Occurrence follow-up report to be completed including evaluate causative factors and all appropriate actions are to care planned and implemented...." 3.1-45(a)			
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-			

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	§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.			
	Based on observation, record review and interview, the facility failed to ensure a physician's order included the type of artificial feeding ordered for 1 of 1 resident reviewed for enteral feedings (nutrition received through a tube going directly into the stomach). (Resident 51) Finding includes: During an observation, on 3/31/22 at 12:10 p.m., Resident 51 had a bottle of Vital 1.5 AF (a brand of artificial feeding) hanging on the continuous feeding pump. The feeding was not attached to the resident's G-Tube (gastronomy tube placed through the abdominal wall into the stomach). The resident indicated he stopped the feeding and detached the tubing which went to the continuous feeding pump. The record for Resident 51 was reviewed on 03/31/22 at 12:20 p.m. Diagnoses included, but were not limited to, malignant neoplasm of the base of the tongue, anxiety disorder, weakness and gastro-esophageal reflux disease (acid reflux).	F 0693	1. Resident #51 had a physician's order including the type of artificial feeding ordered on 4/4/2022. 2. An audit of all residents with orders for an enteral feeding has been completed and any resident with an incomplete order for the type of feeding have been clarified with the physician and the order completed. 3. The DON/Designee will educate all nurses on Enteral Nutrition with emphasis on: “A physician/provider's order is required to administer enteral feedings using the pump...The order will reflect solution or formula, rate of infusion, route, total infusion time...Observe the 5 rights of administration for providing the enteral feeding including...Right dose/concentration...Right feeding solution."	05/06/2022

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	A dietary progress note, dated 11/24/22 at 1:34 p.m., indicated to change the EN (enteral nutrition) to Vital AF 1.5 (type of enteral feeding) at 70 ml(milliliter)/hr(hour) continuous. A physician's order, dated 11/29/21, indicated the enteral feeding was ordered continuous for nutrition 70ml/hr for a total of 1689 ml. The physician's order did not have the type of enteral feed. A dietary progress note, dated 2/23/22 at 2:58 p.m., indicated the dietician recommended changing the residents feeding to Vital AF 1.5 bolus (a single dose given all at once) give 1.5 cans (532 ml) at breakfast, lunch and dinner. Resident 51 was to have Vital 1.5 continuously at 55 ml/hr from 12:00 a.m., to 6:00 a.m. A Nutritional Assessment, completed on 3/30/22, indicated the residents current dietary orders were to give 1.5 cans (532 ml) of Vital AF 1.5 bolus through the g-tube at breakfast, lunch and dinner. Vital AF 1.5 at 55 ml/hr from 12:00 a.m., through 6:00 a.m., continuously. During a record review, the MAR (Medication Administration Record) indicated the enteral feed order was being signed off from 11/30/21 through 4/4/22. The physician's order was corrected by the Clinical Support on 4/4/22. During an interview, on 04/04/22 at 9:04 a.m., LPN 3 indicated the resident was on a tube feed. She was not sure what type of tube feeding the resident used. He was being followed by the Dietician and she changed his orders often. During an interview, on 04/04/22 at 2:25 p.m., the Corporate Support Nurse indicated she did not		4. The DON/Designee will audit all admissions with an enteral feeding to validate there is a physician/provider's order to administer enteral feedings. The order will reflect solution or formula, rate of infusion, route, and total infusion time. The DON/Designee will validate RD recommendations for enteral feedings weekly for three months to validate any recommendation needing a change in a physician's order. The findings from these audits will be reported to the monthly QAPI meeting. The QAPI committee will determine if ongoing monitoring is required or if 100% compliance is required.	

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	know how the staff would know which type of tube feeding the resident used. The staff could look through the Registered Dietician notes and they could find out the type of feeding the resident was using. During an interview, on 04/05/22 at 9:28 a.m., LPN 6 indicated she was not aware the physicians order was missing the type of feeding. She just knew what kind of tube feeding the resident was on. A current facility policy, titled "Enteral Nutrition With Continuous Pump," dated as revised 11/23/18 and received from the Clinical Support on 4/5/22 at 9:06 a.m., indicated "...The purpose of this policy is to provide guidance for staff to provide enteral nutrition utilizing the continuous pump for flow and regulation of the feeding. This policy pertains to the use of the enteral pump device for use with enteral feedings and is congruent with other enteral nutritional policies for delivery of feedings via the gastrostomy tube (G-Tube)...The skilled and competent nurse shall set up the pump, regulate the flow technology, and monitor for adverse events to report to the provider/physician...unless specifically stated otherwise for specific medical reasons, enteral feedings should be placed on a pump device for safety and control...A physician/provider's order is required to administer enteral feedings using the pump...The order will reflect solution or formula, rate of infusion, route, total infusion time...Observe the 5 rights of administration for providing the enteral feeding including...Right dose/concentration...Right feeding solution...." 3.1-44(a)(2)			

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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 provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be			

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	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, record review and interview, the facility failed to ensure a resident's psychotropic medication regimen was managed and monitored when 1 of 1 randomly observed resident received the wrong dosage of an anti-anxiety medication. (Resident 26). Finding includes: During an observation of a medication pass, on April 5, 2022 at 9:13 a.m., QMA 8 was observed to prepare and administer one tablet of clonazepam (an antianxiety medication) 0.5 mg (milligram) for Resident 26. The record for Resident 26 was reviewed on April 5, 2022 at 3:32 p.m. A current physician's order indicated to give Clonazepam 0.25 mg one time a day for treatment of anxiety. The date of the physician order was 12/27/2021. During an interview, on April 5, 2022 at 3:42 p.m., the 400 Unit Nurse indicated she remembered the resident used to take clonazepam 0.5 mg at some time in the past, however she believed the medication had been decreased to 0.25 mg. The nurse was unable to recall when the medication	F 0758	1. Resident # 26 was not harmed. Clonazepam 0.25 mg has been delivered from the pharmacy and is being administered to resident #26. 2. An audit will be completed of all residents with orders for psychotropic medication to validate the medication administered matches the physician's orders. 3. The DON/Designee will educate all licensed nurses and QMAs on medication administration. 4. The DON/Designee will observe 3 nurses or QMAs weekly for three months administering medications. The findings of these observations will be reported to the QAPI committee monthly and the QAPI committee will determine if compliance is achieved or if ongoing monitoring is required.	05/06/2022

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	had been decreased. Upon request, the nurse pulled out the medication cards for Resident 26 from the medication cart for review and again verify the clonazepam medication. The cart contained two cards of clonazepam 0.5 mg tablets. 3.1-48(a)(1) 3.1-48(a)(3)			
F 0776 SS=D Bldg. 00	483.50(b)(1)(i)(ii) Radiology/Other Diagnostic Services §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.			
	Based on record review and interview, the facility failed to ensure a resident's radiology procedure was completed timely for 1 of 1 resident reviewed for radiology services. (Resident 32) Finding includes: The record for Resident 32 was reviewed on 3/31/22 at 12:25 p.m. Diagnoses included, but were not limited to, hypertension, anemia, intellectual disabilities, cognitive communication deficit and vitamin B deficiency.	F 0776	1. 1.Resident #32's Radiology Report, received on 4/5/22 at 9:13 a.m., and indicated the resident's right ankle alignment was normal. There was not any fracture or dislocation. The joints spaces appeared well maintained. The soft tissues were unremarkable. 2. 2. An audit will be completed for the past 30 days to validate any physician's order for	05/06/2022

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	A physician's order, dated 3/24/22, indicated to obtain an X-ray (a digital image of the internal composition of a part of the body) of the residents right ankle, including 3 views, one time only for pain. A progress note, dated 4/4/22 at 10:37 a.m., indicated [X-ray company] was called and a stat (urgent) X-ray was ordered for the residents right ankle. A Radiology Report, received on 4/5/22 at 9:13 a.m., from the Clinical Support Nurse indicated the resident's right ankle alignment was normal. There was not any fracture or dislocation. The joints spaces appeared well maintained. The soft tissues were unremarkable. During an interview, on 3/31/22 at 2:31 p.m., Resident 32 indicated her right ankle had been hurting for a while. She took Tylenol and it eased the pain. She could not recall what happened to her ankle. During an interview, on 4/4/22 at 9:04 a.m., LPN 3 indicated she did not remember the resident being in pain or an X-ray being ordered. During an interview, on 4/4/22 at 11:22 a.m., LPN 1 indicated the X-ray for the resident's right ankle was ordered on 3/24/22 and they must have missed it. The X-ray was ordered stat on 4/4/22. A current facility policy, titled "Physicians Orders," dated as revised on 3/2/22 and received by the Corporate Support on 4/5/22 at 6:37 p.m., indicated "...The purpose of this policy is provide guidance for licensed nurses and licensed therapist to accurately document physician and		an X-ray has been completed and the x-ray obtained. Any findings will be reported to the physician, resident, and family. 3. 3. The DON/Designee will educate all licensed nurses on Physicians Orders with emphasis on obtaining diagnostic services. 4. 4. The DON/Designee will audit all physician's orders in am clinical meeting to validate any orders for x-rays or diagnostic services have been obtained and reported to the physician. This will be an ongoing process of this facility in clinical am meeting. Any findings will be reported to the QAPI committee monthly in the monthly QAPI meeting and the QAPI committee will determine when compliance is achieved or if ongoing monitoring will be required.	

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	provider orders as determined by the licensee's Scope of Practice...a provider may give a medical order over the telephone...The nurse that takes the physician order will be responsible for executing the order or provide for safe hand-off to the next nurse...Contact laboratory services, radiology services, pharmacy services, therapy or other outside vendors as required to execute the medical order...the MAR/TAR should automatically be updated with the new orders if a schedule has been assigned...notify internal staff of changes/updates as appropriate...." 3.1-49(g)			
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures			

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	for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.			
	Based on observation, interview and record review, the facility failed to follow up on a dentist appointment made previously resulting in a missed appointment and failed to have a tracking process in place for residents who requested to be seen by ancillary services for 1 of 1 resident reviewed for dental services. (Resident 56) Finding includes: During an observation and interview, on 03/30/22 at 3:05 p.m., Resident 56 was lying in bed watching television. He indicated he had asked several times to be seen by the dentist and nursing or social services have not gotten back to him related to an appointment. The record for Resident 56 was reviewed on 04/01/22 at 11:00 a.m. Diagnoses included, but	F 0791	1.Resident #56 is on the list to be seen by the dentist in April. 2.An audit was completed of all residents to identify any other residents needing dental services. Any findings will be addressed with dental appointments if indicated. 3.The DON/Designee will educate SS and Nursing managers on Dental Services. The facility will assist residents with obtaining routine dental services, emergency dental services, and services to meet the need of each resident. 4.The SS/Designee will complete an audit monthly with nursing to determine if any	05/06/2022

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	were not limited to, stroke, traumatic brain injury, weakness and hemiplegia (paralysis of one side of the body). An annual MDS (minimum data set) assessment, dated 07/23/21, indicated the resident had obvious or likely cavities or broken natural teeth. A current physician's order, dated 03/23/20, indicated the resident could get a dental consult as needed. A current undated care plan indicated the resident wished to be seen by Prev-Med Ancillary services for dental. Interventions included, but were not limited to, appointments are to be scheduled as requested by the resident. During an interview, on 04/05/22 at 4:36 p.m., the MDS Coordinator indicated if a resident had a consent for Prev-Med then the (SSD) Social Service Director would set up their dentist appointments. The resident had a consent signed in January. The SSD had been using email to schedule residents for dental appointments and she did not document this information in the resident's electronic record. At 4:47 p.m., the SSD joined the interview and indicated the dental company generally would send a list to her. The dental company did not come to the facility in January, skipped February, and came in March. She forgot to check to see if the resident was on the dental list so the resident was not seen. She indicated there was not a process in place to keep track of the residents who need ancillary appointments. She only put a note in the electronic record today and had not put a note in previously. She sent the email in January and asked for the resident to be put on the list, then she forgot to follow up in March therefore the		residents need dental services and assist in scheduling dental services. This will be an ongoing practice of the facility. The SS will report to the QAPI committee monthly in the QAPI meeting the findings of the audit. The QAPI committee will determine if ongoing monitoring is required and when 100% compliance is achieved.	

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	resident was still not seen. She also indicated she needed to work on a system to keep track of all the appointments. A current job description, for the Social Service Director position, dated 06/2019, was provided by the Corporate Crisis Nurse on 04/05/22 at 5:10 p.m., indicated "...Jobs Duties & Responsibilities...performs applications for supplemental services to be use...during the facility stay....Serves as the resident's advocate at all times working...to assure that the resident's needs are met at all times...." A current facility policy, titled "Dental Services," dated 02/17/22 and provided by the Corporate Crisis Nurse on 04/05/22 at 5:06 p.m., indicated "...It is the policy of this facility to provide resident centered care that meets the... physical...needs and concerns of the resident....The facility will follow the standard for care according to Dental services located in the State Operations Manual....Procedure: I. The facility will assist the resident in: a. Obtaining routine Dental Services...d. Making appointments.... 3.1-24(a)(1)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.			

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	§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or			

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	155222	A. BUILDING 00 B. WING	04/05/2022

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	(ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on interview and record review, the facility failed to maintain medical records which were complete and accurate as indicated by missing urine output documentation for a resident with a suprapubic catheter (a flexible tube inserted into the bladder through the abdomen to drain urine) for 1 of 3 residents reviewed for catheter care. (Residents 18) Finding includes: The record for Resident 18 was reviewed on 03/30/22 at 11:31 a.m. Diagnoses included, but were not limited to, neuromuscular bladder, Parkinson's disease and cerebral palsy. A physician's order, dated 02/09/21, indicated to measure and record the output from the resident's suprapubic catheter every shift. An undated care plan indicated the resident had a	F 0842	1. 1. Resident #18 has urine output documentation for output in place. 2. 2.An audit was completed of all residents with a catheter to validate output was being recorded. Any findings will be reported to the physician. 3. 3. The DON/Designee will educate all licensed nurses on Clinical Documentation Standards with emphasis on recording urine output for residents with an indwelling catheter. 4. 4. The DNS/Designee will audit the medical record of all residents with an indwelling catheter to verify urine output is being recorded. This audit will be completed three times a week for four weeks, then twice a week for	05/06/2022

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	suprapubic catheter and the output was to be monitored and documented per the facility policy. A TAR (Treatment Administration Record), for 03/22, indicated documentation for the residents output as NA one time for day shift and 8 times for night shift. During an interview, on 04/05/22 at 4:35 p.m., the Director of Nursing indicated it was her expectation for nursing to follow the physician's orders. During an interview, on 04/05/22 at 5:40 p.m., the Corporate Crisis Nurse indicated she did not know what the documented NA meant and she could not provide a policy specifically related to monitoring and documenting urine outputs. A current facility policy, titled "Clinical Documentation Standards," dated 08/31/22 and provided by the Corporate Support Crisis Nurse on 04/05/22 at 3:57 p.m., indicated "...Nurses will follow the basic standard of practice for documentation including but not limited to providing...accurate account of resident information in the medical record...." 3.1-50(a)(1) 3.1-50(a)(2)		four weeks, then weekly for four weeks. The DON/Designee will report all findings from the audits to the QAPI committee monthly in QAPI meeting and the QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring will be required.	
F 9999 Bldg. 00	3.1-14 Personnel (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective	F 9999	1. The Director of Nursing has completed the following: references, 2nd PPD, a job description, general and specific job orientation, and dementia and abuse training.	05/06/2022

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	employees. The facility shall have a personnel policy that considers references. (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. (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. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to provide screening of references for prospective employees for 1 out of 5 new employee files reviewed, to ensure employees received Tuberculosis (TB) annual health assessment for 5 of 5 employee files reviewed for TB annual health assessments, to ensure new employees received a 1st and/or 2nd PPD (Purified Protein Derivative) (a skin test to determine if a person had been exposed to TB) for 4 of 5 new employee files reviewed for 1st and 2nd step TB skin test, ensure new employees received a physical upon hire for 1 of 5 new employee files reviewed for health screens, failed to have job descriptions for 2 of 5 new employee files reviewed for job descriptions, failed to have general orientation and/or specific job orientation information for 5 of 5 new employee files reviewed for general and specific job orientation, failed to provide documentation of dementia and/or abuse training for 10 of 10 employee records reviewed for dementia and abuse training, and failed to		The Activity Director completed the following: annual TB health assessment/education and training for abuse and dementia. LPN 10 completed the following: annual TB health assessment/education and training for resident rights, abuse and dementia. CNA 11 completed the following: annual TB health assessment/education and training for resident rights, abuse and dementia. Cook 12 completed the following: annual TB health assessment/education and training for abuse and dementia. Dietary Aide 13 completed the following: a 1st or 2nd step TB test, specific orientation information and training for dementia and abuse. Activity Leader 14 completed the following: a 1st or 2nd step TB test, a job description, general and specific orientation information and training for dementia. CNA 15 completed the following: general and specific orientation information and training for dementia.	

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	provide documentation of resident rights training for 3 of 10 employee records reviewed for resident rights training. (Director of Nursing, Activity Director 9, LPN 10, CNA 11, Cook 12, Dietary Aide 13, Activity Leader 14, CNA 15, LPN 16 and CNA 17) Findings include: The facilities employee records were reviewed on 04/01/22 at 10:30 a.m., and indicated the following: 1. Employee personnel files for the Director of Nursing did not contain the following: references, 2nd PPD, a job description, general and specific job orientation, and dementia and abuse training. 2. Employee personnel files for Activity Director 9 did not contain the following: annual TB health assessment/education and training for abuse and dementia. 3. Employee personnel files for LPN 10 did not contain the following: annual TB health assessment/education and training for resident rights, abuse and dementia. 4. Employee personnel files for CNA 11 did not contain the following: annual TB health assessment/education and training for resident rights, abuse and dementia. 5. Employee personnel files for Cook 12 did not contain the following: annual TB health assessment/education and training for abuse and dementia. 6. Employee personnel files for Dietary Aide 13 did not contain the following: a 1st or 2nd step TB test, specific orientation information and training		LPN 16 completed the following: a 1st or 2nd step TB test, specific job orientation information and training for resident rights and dementia. CNA 17 completed the following: annual TB health assessment/education and training for abuse and dementia. 2. An audit of all employee files will be completed to validate the following are completed and verification in the employees file: Dementia Care, Resident Rights and Privileges, INDIANA Abuse & Neglect & Misappropriation of Property, at least two references, a physical examination, Two-step Mantoux testing [TB testing] upon hire and annually thereafter. Employee File Checklist (Indiana) to include reference checks. 3. The new Human Resource Manager and IDT have been educated on Employee files and policies to include: Dementia Care, Resident Rights and Privileges, INDIANA Abuse & Neglect & Misappropriation of Property, 1) obtain at least two references...These steps will be conducted by the Human Resource Manager...1) physical examination...2) Two-step Mantoux testing [TB testing] upon hire and annually thereafter. Employee File Checklist (Indiana) to include reference checks. 4. The HRM/Designee will audit all	

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	for dementia and abuse. 7. Employee personnel files for Activity Leader 14 did not contain the following: a 1st or 2nd step TB test, a job description, general and specific orientation information and training for dementia. 8. Employee personnel files for CNA 15 did not contain the following: general and specific orientation information and training for dementia. 9. Employee personnel files for LPN 16 did not contain the following: a 1st or 2nd step TB test, specific job orientation information and training for resident rights and dementia. 10. Employee personnel files for CNA 17 did not contain the following: annual TB health assessment/education and training for abuse and dementia. During an interview, on 04/01/22 at 1:54 p.m., the Executive Director indicated he was aware of the missing documentation in the employee files. He could not provide any of the missing documentation and the facility followed the state and federal guidelines. A current facility policy, titled "Dementia Care, Resident Rights and Privileges" dated 05/30/2019 and provided by the Executive Director on 04/01/22 at 3:31 p.m., indicated "...a. Staff working with those with dementia/dementia-like diagnosis will receive training upon hire....b. Annual staff training for dementia care will be provided...." A current facility policy, titled INDIANA Abuse & Neglect & Misappropriation of Property," dated 05/30/2019 and provided by the Executive Director on 04/01/22 at 3:31 p.m., indicated "...II. Provide		new hires files weekly for completion of Dementia Care, Resident Rights and Privileges, INDIANA Abuse & Neglect & Misappropriation of Property, at least two references, a physical examination, Two-step Mantoux testing [TB testing] upon hire and annually thereafter. Employee File Checklist (Indiana) to include reference checks. This audit will be weekly for 8 weeks, then monthly for 4 weeks. All findings from this audit will be reported to the QAPI committee in the monthly QAPI meeting by the HRM. The QAPI committee will determine when compliance is achieved of if ongoing monitoring is required.	

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	education and training upon hire, annually...." A current facility policy, titled "Hiring," dated 10/01/19 and provided by the Executive Director on 04/01/22 at 3:31 p.m., indicated "...Human Resources Manager is responsible for conducting the following steps: 1) obtain at least two references...These steps will be conducted by the Human Resource Manager...1) physical examination...2) Two-step Mantoux testing [TB testing] upon hire and annually thereafter. An undated facility document, titled "Employee File Checklist (Indiana)," provided by the Executive Director on 04/01/22 at 3:31 p.m., indicated "...1. A. NEW HIRE PAPERWORK...Reference checks...Bill of Resident Right's Acknowledgement...Resident Abuse Policy...General Orientation Checklist...Department specific orientation checklist...Pre-employment physical exam results...Documentation of Mantoux/chest x-ray results.			