STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	03/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00402380, IN00401372, and IN00395092. Complaint IN00402380- Federal/State deficiencies related to the allegations are cited at F697. Complaint IN00401372 - Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00395092 - Federal/State deficiencies related to the allegations are cited at F684. Survey dates: March 1, 2, 3, 6, and 7, 2023 Facility number: 000131 Provider number: 155226 AIM number: 100274910 Census Bed Type: SNF/NF: 69 Total: 69 Census Payor Type: Medicare: 3 Medicaid: 56 Other: 10 Total: 69 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 14, 2023	F 0000		
F 0657 SS=D	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Bldg. 00	§483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to ensure a resident was invited to participate in interdisciplinary care plan meetings for 1 of 1 resident reviewed for care planning (Resident 38). Findings include: The clinical record for Resident 38 was reviewed on 3/1/23 at 2:54 p.m. The Resident's diagnosis	F 0657	**What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** · A care plan was held with resident #94 on 3/10/23 to discuss her clinical status, changes that have taken place due to her recent hospitalizations, and her psycho-social well being. **How will you identify other**	04/07/2023

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	included, but were not limited to, chronic respiratory failure and hypertension. A Quarterly MDS (Minimum Data Set) Assessment, completed 1/18/23, indicated she was cognitively intact. During an interview on 3/1/23 at 2:54 p.m., Resident 38 indicated she had not attended an interdisciplinary care plan meeting for over a year. The clinical record did not contain any interdisciplinary care plan notes for the last 6 months. During an interview on 3/7/23 at 12:08 p.m., CS (Corporate Support) 1 indicated there were no care plan meeting notes present for Resident 38 for the last 6 months and that there was not documentation that she had been invited to care plan meeting during that time frame. On 3/7/23 at 12:36 p.m., the Executive Director provided the IDT (Interdisciplinary Team) Comprehensive Care Plan Policy, last reviewed October 2019, which read "...Resident, resident's representative, or others as designated by resident will be invited to care plan review..." 3.1-35(d)(2)(B)		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents that have a significant change have the potential to be affected by this alleged deficient practice. · An audit was completed to ensure all residents have been invited to a care plan. No other residents were identified to have been affected by this alleged deficient practice. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur**? · Social services director and MDS coordinator will be inserviced on policy regarding care plans in conjunction with significant change MDSs by 4/7/2023. · When a significant change MDS is completed, the social services director or her assistant will invite residents and or their responsible party to a care plan conference to review/ address the significant change. · Care Planning Meeting Rounding Tool will be completed daily x 4 weeks and then monthly x 3 months to ensure compliance is maintained. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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			recur, i.e. what quality assurance program will be put into place? · SSD/ Designee will be responsible for the completion of the Annual POC QAPI Tool weekly x 4 weeks, monthly x 3 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 90% is not achieved, an action plan will be developed to ensure compliance.	
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, interview, and record review, the facility failed to ensure activities provided in the memory care unit was engaging to a cognitive impaired resident for 1 of 1 residents reviewed for activities in the memory care unit. (Resident G) Findings include:	F 0679	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident Q is provided activities of interest · Resident Q's activity log is	04/07/2023

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	The clinical record for Resident G was reviewed on 3/1/23 at 11:00 a.m. The diagnosis included, but was not limited to, dementia. A Quarterly 10/24/22 Minimum Data Set (MDS) assessment, indicated Resident G was severely cognitively impaired. An activities care plan for Resident G dated 2/10/23 indicated "...Resident enjoys the following activities: watching movies with pop corn (classics), listening to music, playing board and card games, patio time, and socializing, family visit. Goals. Resident will participate in the daily cottage programming...Approach... Encourage resident to participate in activities he enjoys, such as watching TV (classics) listening to music, playing board and card games, patio time, and socializing..." An observation was made of activities in the memory care unit dining room on 3/1/23 at 11:13 a.m. The television was on, and Resident G was observed with his head down and eyes closed. On 3/2/23 at 10:55 a.m., the memory care unit dining room was observed. A trivia activity was provided in the dining room. There were several resident's in attendance. The residents in the activity were observed looking down or sleeping. The trivia questions were being answered by the staff in the room without resident participation. On 03/03/23 at 10:59 a.m., an observation was made of the memory care activities held in the dining room. The residents in attendance were not observed participating in the exercise activity. An observation was made of activities held in the memory care dining room on 3/6/23 at 10:00 a.m. A		kept up to date with activities attended **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents who participate in activities have the potential to be affected by the alleged deficient practice. · MCSS/Designee will audit activity program and resident participation to ensure that all residents have engaging activities that meet their preferences. · MCSS/Designee will conduct an inservice with all Nursing and Activities staff related to ensuring staff providing activities to meet the interests of the residents and participation logs are being completed by 4/7/2023. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · MCSS/Designee will conduct an inservice with all Activities staff related to ensuring staff providing activities to meet the interests of the residents and participation logs are being completed by 4/7/2023. · MCSS/Designee will utilize Activities Rounding Tool daily x 4 weeks and monthly x3 months to round daily to ensure activities are occurring that meet the interests	

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	news show was playing on the television, and Resident G was observed sitting in his wheelchair in the corner of the dining room furtherest from the television with head down and eyes closed. There was no observation of staff encouragement for the resident to participate. An observation was made of Resident G on 3/6/23 at 10:35 a.m. An exercise activity was being held, and Resident G had head down and eyes closed. There was no observation of encouragement for resident to participate. An observation was made of activities in memory care unit on 3/6/23 at 11:03 a.m. A talk show was observed on, and Resident G had his head down and eyes closed. There was no observation of staff encouragement for the resident to participate. On 3/6/23 at 11:20 a.m., an observation was made of the activities held in the memory care dining room. A trivia activity was being held. The Activity Assistant 16 was reading from the television the trivia questions in a monotone voice. The questions were unable to be heard by Resident G nor Resident 9. Resident G at that time was observed with head down and eyes closed. There was no observation of staff encouragement for Resident G to participate. An interview was conducted with the Memory Care Facilitator (MCF) and Corporate Support 1 on 3/7/23 at 2:40 p.m. MCF indicated she monitors and determines the activities that are being provided to the residents in the memory care cottage. She utilized a dementia program that was on the television, but it had been down for the past month. She had been pulling from a streaming service a senior trivia activity to take		of the residents. **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?** · MCSS/Designee will be responsible for the completion of the Annual POC QAPI Tool weekly x 4 weeks, monthly x 3 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 90% is not achieved, an action plan will be developed to ensure compliance.	

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	the place of the dementia related trivia activity that was normally used. A "Meaningful Day Wellness Based Daily Template" was provided by the MCF on 3/6/23 at 2:40 p.m. It indicted the curriculum to follow for providing activities in the memory care unit was the following: high energy activities was to be provided between the hours of 7:30 a.m.- 11:30 a.m., mid to high energy activities was to be provided from 12:30 p.m. - 5:00 p.m., and mid to low energy activities was to be provided between 5:30 p.m. through the last activity at 7:00 p.m. The template indicated "...Continuously challenge yourself: 'Am I meeting my residents' needs? Are we creating meaningful moments? What can I do better?' 3.1-33(a) 3.1-33(b)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to provide a resident's supplement, as ordered, to 1 of 1 resident reviewed for nutrition (Resident 61) and to administer medications as ordered for 1 of 6 residents reviewed for unnecessary medications. (Resident G)	F 0684	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Resident G received the supplement ordered; Resident 61	04/07/2023

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	Findings include: 1. The clinical record for Resident 61 was reviewed on 3/1/23 at 11:00 a.m. His diagnoses included, but were not limited to: depression, gastro-esophageal reflux disease, moderate protein-calorie malnutrition, dysphagia, and dementia. He admitted to the facility on 1/9/23. The vitals section of the electronic health record indicated the following weights on the following dates: 2/6/23 at 147 pounds; 1/26/23 at 143 pounds; 1/20/23 at 145 pounds; and 1/12/23 at 145 pounds with a BMI (body mass index) of 20.8. The 1/22/23 registered dietician nutrition review indicated he was receiving 237 ml of Ensure Plus twice daily in between meals with good acceptance of the supplements. His estimated nutritional needs were being met through diet and supplement intake. His weight was stable since admission. His current weight was 145 pounds on 1/20/23, but his usual body weight was 175 pounds. His BMI indicated his weight as healthy, on the low end of the range. The goal was for gradual weight gain to his usual body weight. There were nutritional interventions in place to promote weight gain. The care plan was reviewed and updated. The 1/9/23 nutrition care plan, last revised 2/10/23, indicated he admitted to the facility below his usual body weight of 175 pounds. The goal was for him to experience a gradual weight gain to his usual body weight. An approach was to offer his supplement per order. The physician's orders indicated to administer Ensure plus 237ml, twice a day between meals at		received all medications identified as missing. **How will other residents who have the potential to be affected by the same deficient practice e identified; and what corrective action(s) will be taken:** · All residents have the potential to be affected by the alleged deficient practice. · DNS or Designee will complete a missing medications and supplements audit to see if any other residents were affected by the alleged deficient practice. All missing medications/supplements have been reconciled, results reviewed by Medical Director. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · DNS or Designee will educate all nurses in correctly identifying and immediately replacing any missing medications or supplements and notification of MD and Responsible Party, inservice completed by 4/7/2023 · DNS or Designee will run Administration Compliance Report daily to ensure all medications and supplements have been administered as ordered. · DNS or Designee will review any resident with missing medications or supplements and	

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	10:00 a.m. and 3:00 p.m. from 1/10/23 to 2/21/23; Fibersource 250 ml Twice A Day between 7:00 a.m. and 11:00 a.m. and between 5:00 p.m. and 10:00 p.m. from 2/22/23 to 2/28/23; and Ensure Plus 237 mL twice a day between meals, effective 3/1/23. The January and February, 2023 Dietary Administration History indicated the first Ensure plus order was not administered on the following dates due to being "on order" or "reordered:" twice on 2/6/23, twice on 2/8/23, twice on 2/10/23, twice on 2/13/23, twice on 2/15/23, twice on 2/17/23, twice on 2/18/23, twice on 2/19/23, twice on 2/20/23, and once on 2/21/23 for a total of 19 administrations. It indicated the Fibersource and second Ensure plus order were administered as ordered. An interview was conducted with Family Member 4 on 3/1/23 at 1:48 p.m. She indicated Resident 61 was supposed to get an Ensure protein supplement with each meal, but he was not receiving it. The facility had been giving him a fiber supplement, but he didn't need that, and needed the Ensure instead. An observation of Resident 61 was made on 3/2/23 at 3:20 p.m. He was sitting in his wheel chair in his room with a Fibersource supplement on his bedside table, not an Ensure plus. An interview was conducted with RN (Registered Nurse) 6 on 3/2/23 at 3:22 p.m. She indicated she was told the Fibersource was a generic substitution for the Ensure, so that's what they'd been giving him. RN 6 reviewed Resident 61's supplement orders at this time and indicated the Ensure supplements had been "a hot topic lately," because many of them, including herself, did not realize that Fibersource could be substituted for		notify the Physician and Responsible Party as indicated and ensure replacement of any missing medication. · DNS or Designee will complete eMAR Compliance Tool daily x 4 weeks and then monthly x 3 months to ensure compliance is maintained. **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:** · DNS or Designee will be responsible for the completion of the Annual POC QAPI Tool weekly x 4 weeks, monthly x 3 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 90% is not achieved, an action plan will be developed to ensure compliance.	

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	Ensure. She was uncertain why he currently had Fibersource instead of Ensure or why the order was changed back to Ensure, effective 3/1/23, if Fibersource was a substitute. An interview was conducted with the RD (Registered Dietician) on 3/3/23 at 11:15 a.m. She indicated the facility was having a supply issue with the Ensure. Their supplier claimed to have sent a box of Boost, an Ensure substitute, but they did not have it. Resident 61's Ensure was discontinued on 2/21/23 and the Fibersource started, because of the supply issue. Resident 61 should have received a supplement instead of missing 19 administrations of Ensure plus in February, 2023. Their provider sent her a list of approved supplement substitutes, and Boost was a substitute for Ensure. She was "not really sure," if Fibersource was a substitute for Ensure, but it was the same calorie wise. Fibersource was usually a substitute for Jevity. The RD provided the Supplements and Nourishments policy on 3/3/23 at 2:16 p.m. It read, "It is the policy of this facility to ensure residents receive supplements and nourishments appropriate to their nutritional needs, physician's order, and preferences. PROCEDURE 1. Supplements and nourishments will be available in the facility."2. The clinical record for Resident G was reviewed on 3/1/23 at 11:00 a.m. The diagnosis included, but was not limited to, dementia. A Quarterly 10/24/22 Minimum Data Set (MDS) assessment, indicated Resident G was severely cognitively impaired. A physician order dated 1/6/23 indicated Resident G was to receive 1 drop of artificial tears in both			

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	eyes three times a day. A physician order dated 1/6/23 indicated the resident was to receive 0.4 milligrams of tamsulosin at bedtime. A physician order dated 1/6/23 indicate Resident G was to receive 50 milligrams of trazadone at bedtime. The February 2023 Medication Administration Record indicated the following days Resident G had not received his trazadone and tamsulosin medications as ordered: tamsulosin: 2/1/23 - documented on hold, 2/3/23 - documented on hold, 2/6/23 - documented on hold, 2/7/23 - documented on hold, 2/9/23 - documented on hold, 2/11/23 - documented on hold, 2/12/23 - documented "on hold awaiting pharm [pharmacy], 2/13/23 - documented on hold, 2/20/23 - documented on hold, 2/22/23 - documented on hold, 2/24/23 - documented on hold, 2/26/23 - documented "on hold awaiting awaiting pharm", and 2/28/23 - documented on hold, trazadone: 2/7/23 - documented on hold, 2/9/23 - documented on hold, 2/10/23 - documented on hold, 2/11/23 - on hold "awaiting pharm", 2/12/23 - on hold, and 2/13/23 - on hold, The resident's clinical record did not indicate the medical provider had been notified of unavailable tamsulosin and trazadone. The March 2023 Medication Administration Record indicated the following days Resident G had not received his trazadone, artificial tears and tamsulosin medications as ordered: tamsulosin: 3/1/23 - documented on hold, 3/2/23 - documented on hold, and 3/3/23 - documented on hold, trazadone: 3/3/23 - documented on hold, and 3/4/23 - on hold "awaiting pharmacy to deliver"			

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	artificial tears: 3/3/23 at 8:00 a.m., documented "needs to be reordered...", 3/3/23 at 2:00 p.m. - documented "waiting the order", 3/4/23 at 8:00 a.m., documented "on hold", 3/4/23 at 2:00 p.m., - documented on hold, 3/4/23 at 8:00 p.m., - documented on hold, 3/5/23 at 8:00 a.m., documented "awaiting delivery", 3/5/23 at 2:00 p.m., documented "awaiting pharmacy to delivery", and 3/5/23 at 8:00 p.m., "awaiting delivery". An interview was conducted with the Assistant Director of Nursing Services (ADNS) on 3/6/23 at 2:39 p.m. She indicated the staff should be ordering medications in 7-10 days remaining of a medication supply. An interview was conducted with the Interim Director of Nursing Services (IDNS) on 3/7/23 at 12:33 p.m. The pharmacy had sent last night Resident G's tamsulosin medication, but we are still waiting for his trazadone and artificial tears to be sent from pharmacy. This federal tag relates to Complaint IN00401372 and IN00395092. 3.1-37			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan,			

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	155226	A. BUILDING 00 B. WING	03/07/2023

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	the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure that hand hygiene was performed prior to donning sterile gloves and performing tracheostomy care of 1 of 1 resident reviewed for tracheostomy care (Resident 28). Findings include: The clinical record for Resident 28 was reviewed on 3/1/23 at 11:38 a.m. The Resident's diagnosis included, but were not limited to, chronic respiratory failure and dependence on ventilator. A care plan, dated 9/3/2015, indicated Resident 28 was at risk for respiratory distress related to tracheostomy. The goal was for her to be free of respiratory distress. The approached included, but were not limited to, provide tracheostomy care as ordered, dated 9/3/2015). A physician's order, dated 8/10/22, indicated she was to receive tracheostomy care, per standard of practice, with sterile water, and normal saline every shift. On 3/3/23 at 11:10 a.m., RT (Respiratory Therapist) 7 was observed providing tracheostomy care to Resident 28. RT 7 washed her hands with soap and water and donned non-sterile disposable gloves. She placed the tracheostomy care kit from the drawer onto the bed side table and opened the tracheostomy care kit. She then opened the sterile water, which had been sitting on the bedside table, and poured sterile water into the reservoir in the kit tray. She removed the sterile gloves from the kit and unfolded them. She donned the sterile	F 0695	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Employee was educated immediately regarding correct procedure for donning sterile gloves. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents with Tracheostomy Care and Suctioning are potentially affected. · DNS or Designee will inservice and observe all Respiratory Therapists with return demonstrations on correct donning and doffing of sterile gloves and education on procedure by 4/7/23. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not reoccur?** · DNS or Designee will inservice and observe all Respiratory Therapists with return demonstrations on correct donning and doffing of sterile gloves and education on procedure by 4/7/23. · The DNS or Designee will audit the donning and doffing of gloves utilizing Sterile Glove Donning and Doffing Audit Tool	04/07/2023

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	gloves over her non-sterile gloves. She did not remove her non-sterile gloves or perform hand hygiene prior to donning the sterile gloves. She performed tracheostomy care by wiping around the trach site, cleansing from the tracheostomy outward. She then applied a new gauze to the tracheostomy site. During an interview on 3/3/23 at 11:20 a.m., RT 7 indicated that she normally donned the sterile gloves over her non-sterile gloves when performing tracheostomy care. During an interview on 3/3/23 at 3:30 p.m., Nurse Consultant 2 indicated that the current tracheostomy care policy did indicated to perform hand hygiene prior to donning the sterile gloves. On 3/3/23 at 12:33 p.m., the Executive Director provided the Tracheostomy- Routine Care policy, last updated 3/2019, which read "...4. Wash hands...7. Open sterile water/ saline, if not provided inside kit 8. Open commercial kit using aseptic technique. Empty contents onto drape 9. Aseptically put on sterile gloves and prepare field..." On 3/6/23 at 3:26 p.m., the IDNS (Interim Director of Nursing Services) provided the Hand Hygiene Policy, last revised 12/2021, which read "...5 moments of hand hygiene- a term that describes the hand hygiene opportunities that prevent infection transmission linked to healthcare activities... Before touching a resident... Before Clean/ Aseptic procedure...After body fluid exposure risk...After touching a resident...After touching resident surroundings...Indication for Hand-rubbing but not limited to...After contact with a resident's belongings, environmental surfaces...resident care equipment..."		weekly x 3 months and then monthly thereafter for 3 months to ensure that correct procedure is being followed. **How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place?** · DNS or Designee will be responsible for the completion of the Annual POC QAPI Tool weekly x 4 weeks, monthly x 3 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 90% is not achieved, an action plan will be developed to ensure compliance.	

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	3.1-47(a)(4)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to assess a resident's pain that included location of the pain, intensity of the pain and effectiveness of an as needed (PRN) pain medication, and provide non-pharmacological interventions to address the resident's pain for 1 of 2 residents reviewed for accidents. (Resident B) Findings include: The clinical record for Resident B was reviewed on 3/1/23 at 1:30 p.m. The diagnosis included, but was not limited to, dementia. The Admissions 12/13/22 Minimum Data Set (MDS) assessment, indicated Resident B was cognitively impaired. A pain care plan for Resident B dated 12/5/22 indicated "Resident is at risk for pain related to complaints of back pain, debility, PVD [Peripheral Vascular Disease], dx [diagnosis] depression, dx pain, lumbar fracture...Approach...Assist with positioning to comfort. Document effectiveness of prn medications...Offer non- pharmacological interventions such as quiet environment, rest, shower, back rub, reposition..."	F 0697	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Resident B's pain was assessed, including the location of the pain, intensity of the pain and effectiveness of the as-needed (PRN) pain medication, and any non-pharmacological interventions were offered to address the resident's pain. Resident able to verbalize that pain is controlled. **How will other residents who have the potential to be affected by the same deficient practice be identified; and what corrective action(s) will be taken:** · All residents have the potential to be affected by the alleged deficient practice. · DNS or Designee will complete a Pain Assessment Audit to see if any other residents were affected by deficient practice, with MD and Responsible Party	04/07/2023

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	A physician order dated 12/6/22 indicated Resident B was to receive 5-325 milligrams of hydrocodone every 8 hours as needed. The order was discontinued on 1/18/23. A physician order dated 1/18/23 indicated Resident B was to receive 5-325 milligrams of hydrocodone every 8 hours needed. The order was discontinued on 2/6/23. A physician order dated 2/7/23 indicated Resident B was to receive 5-325 milligrams of hydrocodone every 6 hours as needed. The January 2023 Medication Administration Record (MAR) indicated the following days Resident B had received 5-325 milligrams of hydrocodone, and the intensity of the resident's pain was not assessed on the following days: 1/1/23 at 2:09 p.m., 1/7/23 at 9:16 a.m., and 1/13/23 at 1:00 p.m., The controlled substance record of 5-325 milligrams of hydrocodone for Resident B was provided by the Interim Director of Nursing (IDNS) on 3/2/23 at 2:50 p.m. It indicated the resident had received 5-325 milligrams of hydrocodone on the following days that was not documented on the January MAR that included assessments of intensity, pain location, and effectiveness of the resident's pain medication: 1/2/23 at 8:00 p.m., 1/3/23 at 8:00 p.m., 1/4/23 at 8:00 p.m., 1/5/23 at 8:00 p.m., 1/6/23 at 8:00 p.m., 1/7/23 at 12:00 p.m., 1/8/23 at 12:00 p.m., 1/9/23 at 8:00 p.m., 1/10/23 at 8:00 p.m., and 1/13/23 at 8:00 p.m. The February 2023 MAR indicated the following days Resident B had received 5-325 milligrams of hydrocodone and the intensity of the resident's		being notified of any new interventions or changes required. · DNS or Designee will educate all nurses in correctly assessing pain using location, intensity, offers of nonpharmacological pain interventions and documentation effectiveness of PRN Pain medications. Inservice completed by 4/7/2023. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · DNS or Designee will educate all nurses in correctly assessing pain using location, intensity, offers of nonpharmacological pain interventions and documentation effectiveness of PRN Pain medications. Inservice completed by 4/7/2023. · DNS or Designee will review residents with PRN Pain medications for administration, nonpharmacological interventions, and documentation of effectiveness, utilizing the Pain Assessment/Nonpharmacological Interventions Rounding tool, and notify the Physician and Responsible Party of any concerns. Rounding tool to be utilized daily x 4 weeks and monthly thereafter x 3 months to ensure compliance. **How the corrective action(s)**	

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	pain was not assessed: 2/1/23 at 12:23 p.m., and 2/2/23 at 7:09 a.m. The controlled substance record of 5-325 milligrams of hydrocodone for Resident B was provided by the Interim Director of Nursing (IDNS) on 3/2/23 at 2:50 p.m. It indicated the resident had received 5-325 milligrams of hydrocodone on the following days that was not documented on the February MAR that included assessments of intensity, pain location, and effectiveness of the resident's pain medication: 2/2/23 at 1:00 p.m., 2/26/23 at 8:30 a.m., 2/26/23 at 8:00 p.m., 2/27/23 at 8:05 a.m., 2/27/23 at 8:00 p.m., 2/28/23 at 8:15 a.m., and 2/28/23 at 8:00 p.m. The March 2023 MAR indicated Resident B had not received 5-325 milligrams of hydrocodone as of March 2nd. The controlled substance record of 5-325 milligrams of hydrocodone for Resident B was provided by the Interim Director of Nursing (IDNS) on 3/2/23 at 2:50 p.m. It indicated the resident had received 5-325 milligrams of hydrocodone on 3/1/23 at 1:00 p.m. There was no documented assessment of intensity, location of pain and effectiveness of the resident's pain medication on 3/1/23 at 1:00 p.m. The resident's clinical record did include non-pharmacological interventions that were provided and evaluated for effectiveness to address the resident's pain. An interview was conducted with IDNS on 3/3/23 at 2:54 p.m. The staff are to follow the facility's pain policy. She was unable to provide documentation non-pharmacological interventions were provided by the staff, and if		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · DNS or Designee will be responsible for the completion of the Annual POC QAPI Tool weekly x 4 weeks, monthly x 3 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 90% is not achieved, an action plan will be developed to ensure compliance.	

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	they were effective to address Resident B's pain. A pain management policy was provided by the IDNS on 3/2/23 at 2:50 p.m. It indicated "...Policy: It is the policy of American Senior Communities to provide the necessary care and services to attain or maintain the highest practicable physical. mental, and psychosocial well being, including pain management. Procedure: 1. Residents are assessed for pain upon admission, weekly, and during medication administration as outlined below. 2. The following will be used when assessing pain...IDT [Interdisciplinary Team] Pain interview or PAINAD (Pain Assessment in Advanced Dementia Scale). Ongoing nursing assessment can also be documented in matrix progress notes or matrix vitals. 3. Interviewable Resident - Pain medications will be prescribed and given based upon the intensity of the pain as follows using the verbal descriptive, numerical scale (1-10) or Wong-Baker FACES Scale. Mild = (1-2) Moderate = (3-5) Severe = (6-8) Very Severe, Horrible = (9-10)...4. Non-Interviewable Resident - Pain medications will be prescribed and given upon nursing assessment of the following: non-verbal sounds (crying, whining, gasping, moaning, or groaning), Vocal complaints of pain (that hurts, ouch, stop), Facial expressions (grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth), Protective body movements or postures (bracing, guarding, rubbing or massaging a body part, clutching or holding a body part during movement)...6. Physician orders for pain medication will be prescribed based upon the resident's intensity of pain, for example Tylenol for mild to moderate pain, Vicodin for severe to very severe pain...8. Documentation of administration of ordered PRN pain medication will initialed on the Medication Administration Record (MAR). 9. Additional			

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	information including, but not limited to reasons for administration, and effectiveness of pain medication will be documented on the Medication Administration (MAR), or on the facility specific pain management flow sheet..." This federal tag relates to Complaint IN00402380. 3.1-37(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on interview and record review, the facility failed to ensure a resident had adequate indication for use of an antibiotic, did not receive duplicate antibiotic therapy (Resident 58 and 31), and to	F 0757	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	04/07/2023

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	monitor a resident's medication by not timely obtaining a VPA (valproic acid) lab, as ordered, (Resident 47) for 3 of 5 residents reviewed for unnecessary medications. Findings include: 1. The clinical record for Resident 58 was reviewed on 3/2/23 at 2:39 p.m. Resident 58's diagnoses included, but not limited to, chronic obstructive pulmonary disease, obstructive sleep apnea, chronic kidney disease, diabetes type II, and syncope. A Nurse Practitioner's (NP) note dated 12/13/2022 at 12:01 p.m. indicated, "Patient seen today for acute concern of cough, congestion, wheezing, fatigue, and chest pain. Patient reporting illness on 12/12/22 with STAT [sic, immediate] labs completed, CXR [chest x-ray]. WBC [white blood count] count on 12/12 is 5.1, and CXR was negative as well. Patient reported continued feeling of illness, fatigue, cough, congestion and right sided chest pain when breathing. Sputum is dark yellow in color, with reports of chills at times. Will add Doxycycline 100 mg BID[twice daily] x 7 days for high risk of Pneumonia..." A physician's order dated 12/12/23 indicated, Resident 58 was to have a chest x-ray. The indication for the chest x-ray was wheezing. A physician's order dated 12/14/22 indicated, Resident 58 was to receive 100 mg (milligrams) of doxycycline monohydrate (antibiotic) every 12 hours for fourteen doses (7 days). The indication for the doxycycline's use was URI (upper respiratory infection). Resident 58's December 2022 MAR (medication		**practice:** · Resident 58 and Resident 31 have completed their ordered medications; Valporic Acid Lab test was ordered for Resident 47. Resident's MD and Responsible Parties have been notified. **How will other residents who have the potential to be affected by the same deficient practice e identified; and what corrective action(s) will be taken:** · All residents have the potential to be affected by the alleged deficient practice. · DNS or Designee will complete an audit of all residents receiving and antibiotic to make sure all meet Mc Greer's Criteria; and will audit the Lab Report to make sure all Residents have appropriate Labs as ordered. · DNS or Designee will educate all nurses in correctly administering antibiotics according to Mc Greer's Criteria when new orders are received, and correctly ordering Labs for each new lab order as indicated. Inservice to be completed by 4/7/2023. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · DNS or Designee will educate all nurses in correctly administering antibiotics according	

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	administration record) indication, he had received doxycycline twice daily on the following dates: 12/14/22, 12/15/22, 12/16/22, 12/17/22, 12/18/22, and 12/19/22. An imaging report dated 12/13/23 indicated, Resident 58's chest x-ray did not indicate pneumonia. An interview with IP (Infection Preventionist) was conducted on 3/7/23 at 10:00 a.m. IP indicated, the facility utilizes McGeer's criteria to define a true infection. The McGeer's criteria table used by the facility was observed on 3/7/23. It indicated: "Pneumonia (all 3 criteria must be present) 1. Interpretation of a chest radiograph as demonstrating pneumonia or the presence of a new infiltrate 2. At least 1 of the following respiratory subcriteria: - New or increased cough - New or increased sputum production - O2 saturation <94% on room air or a reduction in O2 saturation of >3% from baseline - New or changed lung examination abnormalities - Pleuritic chest pain - Respiratory rate of =25 breaths/min 3. At least 1 of the constitutional criteria: A. Fever - Single oral temperature >37.8°C (>100°F) OR - Repeated oral temperatures >37.2°C (99°F) or rectal temperatures >37.5°C (99.5°F) OR - Single temperature >1.1°C (2°F) over baseline from any site (oral, tympanic, axillary) B. Leukocytosis - Neutrophilia (>14,000 leukocytes/mm3) OR - Left shift (>6% bands or =1,500 bands/mm3) C. Acute change in mental status from		to Mc Greer's Criteria when new orders are received, and correctly ordering Labs for each new lab order as indicated. Inservice to be completed by 4/7/2023. · DNS or Designee will review Lab Tracking Report and Antibiotic Report for any resident with antibiotics or missing labs during Clinical Meeting and notify the Physician and Responsible Party as indicated. · DNS or Designee will complete Antibiotic Stewardship/Missing Labs Rounding Tool daily x 4 weeks and then monthly thereafter x 3 months to ensure compliance is maintained. **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:** · DNS or Designee will be responsible for the completion of the Annual POC QAPI Tool weekly x 4 weeks, monthly x 3 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 90% is not achieved, an action plan will be developed to ensure compliance.	

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	baseline..." 2. The clinical record for Resident 31 was reviewed on 3/3/23 at 3:12 p.m. Resident 31's diagnoses included, but not limited to, dementia with behavioral disturbances, type II diabetes, chronic kidney disease, and dysphagia (issues with eating/swallowing). A nursing note dated 1/30/2023 at 7:00 p.m. indicated, "Resident has been in bed. Resident c/o[sic, complained of] pain in back. Biofreeze applied and was effective. Resident is alert but not talking much today. [sic, NP's first name] NP was in and gave new order to I&O[sic, in and out] cath[sic, catheter] x[sic, times] 1 now for UA/C&S [sic, urine analysis, culture and sensitivity]. Urine was milky with sediment noted. Strong odor..." A physician's order dated 2/2/23 indicated Resident 31 was to receive 100 mg of Macrobid (antibiotic) every 12 hours for 10 days for a UTI (urinary tract infection). A physician's order dated 2/6/23 indicated for Resident 31 to receive Bactrim DS 800-160 mg (antibiotic) every 12 hours for 10 days for UTI. A urine culture and sensitivity report dated 2/5/23 indicated, Resident 31's urine analysis, culture and sensitivity from 1/30/23 grew two types bacteria. One was Proteus Mirabilis at a level greater then 100,000 CFU/ml (colony forming units per milliliter). The second was Citrobacter Freundii at 60-70,000 CFU/ml. Per the sensitivity report, the box for the use of Macrobid against Proteus Mirabilis was left blank and the box for Bactrim indicated, Proteus Mirabilis was resistant to that antibiotic.			

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	155226	A. BUILDING 00 B. WING	03/07/2023

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	An interview with the facility's pharmacy was conducted on 3/6/23 at 10:16 a.m. They indicated, on Resident 31's urine culture and sensitivity report from 2/5/23, the box indicating the sensitivity of Bactrims use against Proteus Mirabilis being left blank indicated, the antibiotic was not tested against that bacteria therefore, the Bactrim should not be prescribed/used to treat the bacteria Proteus Mirabilis. A NP's note dated 2/6/2023 at 12:31 p.m. indicated, Resident 31 was seen that day for follow-up medical management and review after returning from ED (Emergency room). "Per documentation, patient noted to have decreased appetite on 2/4/23, nursing unable to get patient to drink or eat, family notified, came in to see patient, and requested she be evaluated in ED. Patient was already being treated for UTI. She returned within hours, and was diagnosed with constipation, already receiving Miralax daily. Results for urine culture showed Proteus and CITROBACTER FREUNDII, added Bactrim BID for 10 days, increased Miralax to BID". A review of Resident 31's February 2023 MAR indicated, she received Macrobid and/or Bactrim DS on the following dates and times: Macrobid: - 2/1/23 at 8 p.m. - 2/2/23 at both 8 a.m. and 8 p.m. - 2/3/23 at both 8 a.m. and 8 p.m. - 2/4/23 at 8 a.m. - 2/6/23 at both 8 a.m. and 8 p.m. - 2/7/23 at 8 a.m. - 2/8/23 at both 8 a.m. and 8 p.m. - 2/9/23 at both 8 a.m. and 8 p.m. - 2/10/23 at both 8 a.m. and 8 p.m. Bactrim:			

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	- 2/6/23 at 8 p.m. - 2/7/23 at 8 a.m. - 2/8/23 at both 8 a.m. and 8 p.m. - 2/9/23 at both 8 a.m. and 8 p.m. - 2/10/23 at both 8 a.m. and 8 p.m. - 2/11/23 at both 8 a.m. and 8 p.m. - 2/12/23 at both 8 a.m. and 8 p.m. - 2/13/23 at both 8 a.m. and 8 p.m. - 2/14/23 at both 8 a.m. and 8 p.m. - 2/15/23 at both 8 a.m. and 8 p.m. - 2/16/23 at both 8 a.m. and 8 p.m. An interview with IP (Infection Preventionist) was conducted on 3/7/23 at 10:00 a.m. IP indicated, the facility utilizes McGeer's criteria to define a true infection. The McGeer's criteria table used by the facility was observed on 3/7/23. It indicated, for residents without an indwelling urinary catheter, the diagnosis of UTI in the revised McGeer criteria includes criteria from both 1 and 2. 1. At least 1 of the following subcriteria of signs or symptoms: - Acute dysuria or acute pain, swelling, or tenderness of the testes, epididymis, or prostate Or - Fever or leukocytosis and at least 1 of the following localizing urinary tract subcriteria Acute costovertebral angle pain or tenderness Suprapubic pain Gross hematuria New or marked increase in incontinence New or marked increase in urgency New or marked increase in frequency - In the absence of fever or leukocytosis, then 2 or more of the following localizing urinary tract subcriteria Suprapubic pain Gross hematuria			

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	New or marked increase in incontinence New or marked increase in urgency New or marked increase in frequency One of the following microbiological subcriteria 2. At least 100,000 CFU/ml of no more than 2 species of microorganisms in a voided urine sample At least 100 CFU/ml of any organism in a specimen collected by an in-and-out catheter. According to McGeer's criteria, Resident 31 should have been treated with an antibiotic for the Proteus Mirabilis infection in her urine but, not for the Citrobacter Freundii. An interview with NP was conducted on 3/6/23 at 11:49 a.m. NP indicated, she had been made aware of Resident 31 having foul smelling urine and altered mental status so she ordered a urine culture and sensitivity to be done. She indicated, she did not wait for the sensitivity to come back prior to ordering the Macrobid related to signs/symptoms of an UTI. NP indicated, she was not aware of McGeer's criteria for the definition of a true urinary tract infection nor that the facility was utilizing this criteria. After reviewing the sensitivity reports, she indicated, the Proteus Mirabilis was not treated correctly and going forward, she will order another urine culture and sensitivity and wait for results on sensitivity for required treatment. An Antibiotic Stewardship Program policy was received on 3/1/23 at 2:06 p.m. from ED (Executive Director). The policy indicated, "Purpose of Policy: To provide a collaborative, interdisciplinary system for the optimization of antibiotic use, improving drug selection, slowing emergence of antimicrobial resistance, and			

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	improving resident/patient outcomes through adopting the Center of Disease Control (CDC) core elements for antibiotic stewardship for long term care."3. The clinical record for Resident 47 was reviewed on 3/6/23 at 11:14 a.m. His diagnoses included, but were not limited to: major depressive disorder, schizotypal disorder, dementia with behavioral disturbance, and paraphilia. The physician's orders indicated to administer a 250 mg tablet of Depakote (divalproex sodium-a combination of sodium valproate and valproic acid) twice a day for conversion disorder with seizures or convulsions, starting 11/22/22 through 1/30/23, and starting again on 1/30/23 ongoing. The orders indicated to obtain a valproc acid level [lab to measure the amount of valproic acid in the blood, required to maintain the drug within the recommended therapeutic range] and fax the results to a specific number, effective 12/19/22. The 12/16/22 psychiatry note indicated, "Staff note pt [patient] has no current sexual behaviors and is cooperating with care most of the time...Pt reports depression is a problem for him. Sexual aggression is improving....Order #1: VPA level next lab day and q [every] 3 mos [months....] Depakote; 250 mg PO [by mouth] bid [twice daily] in my professional opinion, dose reduction is contraindicated d/t [due to] high risk of sx [symptom] escalation. mood stabilization....Continue Depakote 250 mg PO bid." There were no VPA lab results in Resident 47's electronic health record dated on or after the above 12/16/22 order. On 3/7/23 at 11:54 a.m., the IDNS (Interim Director of Nursing Services) provided the 12/19/22			

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	Depakote lab result. It read, "Unable to obtain specimen - 1st attempt the phlebotomist was unable to obtain an adequate sample for testing. A second phlebotomist will be sent. Thank you....Nurse to reschedule." An interview was conducted with the IDNS on 3/7/23 at 11:54 a.m. She indicated Resident 47 was originally put on Depakote for moods, then someone documented it was for seizures. The last Depakote lab completed for him was dated 6/27/22, per their pharmacist. She reviewed Resident 61's labs and they did not indicate a 2nd attempt at the Depakote lab, nor did she find any verification there was follow up to a second attempt. Currently, the Assistant DNS was responsible for ensuring labs were done, but she was unsure who was responsible in December, 2022, when the Depakote/VPA lab was ordered. On 3/7/23 at 12:35 p.m., the IDNS provided the most recent VPA lab result for Resident 47. It was dated 6/27/22. The Labs and Diagnostics policy was provided by the IDNS on 3/6/2333 at 3:26 p.m. It read, " It is the policy of [name of facility] to provide or obtain laboratory and diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services." 3.1-48(a)(6)			
F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §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			

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	elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on interview and record review, the facility failed to implement an antibiotic stewardship program which contains protocols to ensure residents who require antibiotics are prescribed the appropriate antibiotic, monitors/re-evaluates the use of antibiotics, provides appropriate indications for use, and failure to adhere to an algorithm for identification of a true infection for 2 of 5 residents reviewed for unnecessary medications. (Residents 58 and 31) Findings include: 1. The clinical record for Resident 58 was reviewed on 3/2/23 at 2:39 p.m. Resident 58's diagnoses included, but not limited to, chronic obstructive pulmonary disease, obstructive sleep apnea, chronic kidney disease, diabetes type II, and syncope. A Nurse Practitioner's (NP) note dated 12/13/2022 at 12:01 p.m. indicated, "Patient seen today for acute concern of cough, congestion, wheezing, fatigue, and chest pain. Patient reporting illness on 12/12/22 with STAT [sic, immediate] labs completed, CXR [chest x-ray]. WBC [white blood count] count on 12/12 is 5.1, and CXR was negative as well. Patient reported continued feeling of illness, fatigue, cough, congestion and right sided chest pain when breathing. Sputum is dark yellow in color, with reports of chills at times. Will add Doxycycline 100 mg BID[twice daily] x 7 days for high risk of Pneumonia..." A physician's order dated 12/12/23 indicated,	F 0881	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 58 is no longer receiving Antibiotic Therapy **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents who are prescribed an antibiotic have the potential to be affected by the alleged deficient practice. · An audit was completed on all residents to ensure all residents currently receiving antibiotic therapy are meeting criteria for a true infection according to McGeers Criteria. Corrective action will be taken as needed. · DNS or Designee will conduct an in-service with all nurses related to the Antibiotic Stewardship Program including the McGeers Criteria by 4/7/2023. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · DNS or Designee will	04/07/2023

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	Resident 58 was to have a chest x-ray. The indication for the chest x-ray was wheezing. A physician's order dated 12/14/22 indicated, Resident 58 was to receive 100 mg (milligrams) of doxycycline monohydrate (antibiotic) every 12 hours for fourteen doses (7 days). The indication for the doxycycline's use was URI (upper respiratory infection). The CDC (Centers for Disease and Control) website at https://www.cdc.gov/antibiotic-use/core-elements/pdfs/core-elements-antibiotic-stewardship-appendix-a-508.pdf, last accessed on 3/9/23, "The Core Elements of Antibiotic Stewardship for Nursing Homes APPENDIX A: Policy and Practice Actions to Improve Antibiotic Use" indicated, "Antibiotic prescribing and use policies...Documentation of dose, duration, and indication. Specify the dose (including route), duration (i.e., start date, end date, and planned days of therapy), and indication, which includes both rationale (i.e., prophylaxis vs. therapeutic) and treatment site (i.e.,urinary tract, respiratory tract), for every course of antibiotics. This bundle of antibiotic prescribing elements should be documented for both nursing home-initiated antibiotic courses as well as courses continued in the nursing home which were initiated by a transferring facility or emergency department." Resident 58's December 2022 MAR (medication administration record) indication, he had received doxycycline twice daily on the following dates: 12/14/22, 12/15/22, 12/16/22, 12/17/22, 12/18/22, and 12/19/22. An imaging report dated 12/13/23 indicated, Resident 58's chest x-ray did not indicate		conduct an in-service with all nurses related to the Antibiotic Stewardship Program including the McGeers Criteria by 4/7/2023. ·IDT will review Antibiotic Stewardship Program with Medical Director and NP, including McGeers Criteria, by 4/7/2023 · DNS/Designee will review antibiotic orders and Infection Control events daily during Clinical Meeting to ensure all residents receiving antibiotic therapy have an appropriate indication for use. · DNS or Designee will complete Antibiotic Stewardship/Missing Labs Rounding Tool daily x 4 weeks and then monthly thereafter x 3 months to ensure compliance is maintained. **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?** · DNS or Designee will be responsible for the completion of the Annual POC QAPI Tool weekly x 4 weeks, monthly x 3 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 90% is not achieved, an action plan will be developed to ensure compliance.	

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	pneumonia. An interview with IP (Infection Preventionist) was conducted on 3/7/23 at 10:00 a.m. IP indicated, the facility utilizes McGeer's criteria to define a true infection. The McGeer's criteria table used by the facility was observed on 3/7/23. It indicated: "Pneumonia (all 3 criteria must be present) 1. Interpretation of a chest radiograph as demonstrating pneumonia or the presence of a new infiltrate 2. At least 1 of the following respiratory subcriteria: - New or increased cough - New or increased sputum production - O2 saturation <94% on room air or a reduction in O2 saturation of >3% from baseline - New or changed lung examination abnormalities - Pleuritic chest pain - Respiratory rate of =25 breaths/min 3. At least 1 of the constitutional criteria: A. Fever - Single oral temperature >37.8°C (>100°F) OR - Repeated oral temperatures >37.2°C (99°F) or rectal temperatures >37.5°C (99.5°F) OR - Single temperature >1.1°C (2°F) over baseline from any site (oral, tympanic, axillary) B. Leukocytosis - Neutrophilia (>14,000 leukocytes/mm3) OR - Left shift (>6% bands or =1,500 bands/mm3) C. Acute change in mental status from baseline..." 2. The clinical record for Resident 31 was reviewed on 3/3/23 at 3:12 p.m. Resident 31's diagnoses included, but not limited to, dementia with behavioral disturbances, type II diabetes, chronic kidney disease, and dysphagia (issues			

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	with eating/swallowing). A nursing note dated 1/30/2023 at 7:00 p.m. indicated, "Resident has been in bed. Resident c/o[sic, complained of] pain in back. Biofreeze applied and was effective. Resident is alert but not talking much today. [sic, NP's first name] NP was in and gave new order to I&O[sic, in and out] cath[sic, catheter] x[sic, times] 1 now for UA/C&S [sic, urine analysis, culture and sensitivity]. Urine was milky with sediment noted. Strong odor..." A physician's order dated 2/2/23 indicated Resident 31 was to receive 100 mg of Macrobid (antibiotic) every 12 hours for 10 days for a UTI (urinary tract infection). A physician's order dated 2/6/23 indicated for Resident 31 to receive Bactrim DS 800-160 mg (antibiotic) every 12 hours for 10 days for UTI. A urine culture and sensitivity report dated 2/5/23 indicated, Resident 31's urine analysis, culture and sensitivity from 1/30/23 grew two types bacteria. One was Proteus Mirabilis at a level greater then 100,000 CFU/ml (colony forming units per milliliter). The second was Citrobacter Freundii at 60-70,000 CFU/ml. Per the sensitivity report, the box for the use of Macrobid against Proteus Mirabilis was left blank and the box for Bactrim indicated, Proteus Mirabilis was resistant to that antibiotic. An interview with the facility's pharmacy was conducted on 3/6/23 at 10:16 a.m. They indicated, on Resident 31's urine culture and sensitivity report from 2/5/23, the box indicating the sensitivity of Bactrims use against Proteus Mirabilis being left blank indicated, the antibiotic was not tested against that bacteria therefore, the			

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	Bactrim should not be prescribed/used to treat the bacteria Proteus Mirabilis. A NP's note dated 2/6/2023 at 12:31 p.m. indicated, Resident 31 was seen that day for follow-up medical management and review after returning from ED (Emergency room). "Per documentation, patient noted to have decreased appetite on 2/4/23, nursing unable to get patient to drink or eat, family notified, came in to see patient, and requested she be evaluated in ED. Patient was already being treated for UTI. She returned within hours, and was diagnosed with constipation, already receiving Miralax daily. Results for urine culture showed Proteus and CITROBACTER FREUNDII, added Bactrim BID for 10 days, increased Miralax to BID". A review of Resident 31's February 2023 MAR indicated, she received Macrobid and/or Bactrim DS on the following dates and times: Macrobid: - 2/1/23 at 8 p.m. - 2/2/23 at both 8 a.m. and 8 p.m. - 2/3/23 at both 8 a.m. and 8 p.m. - 2/4/23 at 8 a.m. - 2/6/23 at both 8 a.m. and 8 p.m. - 2/7/23 at 8 a.m. - 2/8/23 at both 8 a.m. and 8 p.m. - 2/9/23 at both 8 a.m. and 8 p.m. - 2/10/23 at both 8 a.m. and 8 p.m. Bactrim: - 2/6/23 at 8 p.m. - 2/7/23 at 8 a.m. - 2/8/23 at both 8 a.m. and 8 p.m. - 2/9/23 at both 8 a.m. and 8 p.m. - 2/10/23 at both 8 a.m. and 8 p.m. - 2/11/23 at both 8 a.m. and 8 p.m. - 2/12/23 at both 8 a.m. and 8 p.m.			

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	- 2/13/23 at both 8 a.m. and 8 p.m. - 2/14/23 at both 8 a.m. and 8 p.m. - 2/15/23 at both 8 a.m. and 8 p.m. - 2/16/23 at both 8 a.m. and 8 p.m. An interview with IP (Infection Preventionist) was conducted on 3/7/23 at 10:00 a.m. IP indicated, the facility utilizes McGeer's criteria to define a true infection. The McGeer's criteria table used by the facility was observed on 3/7/23. It indicated, for residents without an indwelling urinary catheter, the diagnosis of UTI in the revised McGeer criteria includes criteria from both 1 and 2. 1. At least 1 of the following subcriteria of signs or symptoms: - Acute dysuria or acute pain, swelling, or tenderness of the testes, epididymis, or prostate Or - Fever or leukocytosis and at least 1 of the following localizing urinary tract subcriteria Acute costovertebral angle pain or tenderness Suprapubic pain Gross hematuria New or marked increase in incontinence New or marked increase in urgency New or marked increase in frequency - In the absence of fever or leukocytosis, then 2 or more of the following localizing urinary tract subcriteria Suprapubic pain Gross hematuria New or marked increase in incontinence New or marked increase in urgency New or marked increase in frequency One of the following microbiological subcriteria 2. At least 100,000 CFU/ml of no more than 2 species of microorganisms in a voided urine			

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	155226	A. BUILDING 00 B. WING	03/07/2023

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	sample At least 100 CFU/ml of any organism in a specimen collected by an in-and-out catheter. According to McGeer's criteria, Resident 31 should have been treated with an antibiotic for the Proteus Mirabilis infection in her urine but, not for the Citrobacter Freundii. The CDC (Centers for Disease and Control) website at https://www.cdc.gov/antibiotic-use/core-elements/pdfs/core-elements-antibiotic-stewardship-appendix-a-508.pdf, last accessed on 3/9/23, "Perform antibiotic "time outs." It indicated, "Antibiotics are often started empirically in nursing home residents when the resident has a change in physical or mental status while diagnostic information is being obtained. However, providers often do not revisit the selection of the antibiotic after more clinical and laboratory data (including culture results) become available. An antibiotic "time out" is a formal process designed to prompt a reassessment of the ongoing need for and choice of an antibiotic once more data is available including: the clinical response, additional diagnostic information, and alternate explanations for the status change which prompted the antibiotic start. Nursing homes should have a process in place for a review of antibiotics by the clinical team two to three days after antibiotics are initiated to answer these key questions: · Does this resident have a bacterial infection that will respond to antibiotics? · If so, is the resident on the most appropriate antibiotic(s), dose, and route of administration? · Can the spectrum of the antibiotic be narrowed or the duration of			

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	therapy shortened (i.e., de-escalation)? · Would the resident benefit from additional infectious disease/ antibiotic expertise to ensure optimal treatment of the suspected or confirmed infection?" An interview with NP was conducted on 3/6/23 at 11:49 a.m. NP indicated, she had been made aware of Resident 31 having foul smelling urine and altered mental status so she ordered a urine culture and sensitivity to be done. She indicated, she did not wait for the sensitivity to come back prior to ordering the Macrobid related to signs/symptoms of an UTI. NP indicated, she was not aware of McGeer's criteria for the definition of a true urinary tract infection nor that the facility was utilizing this criteria. After reviewing the sensitivity reports, she indicated, the Proteus Mirabilis was not treated correctly and going forward, she will order another urine culture and sensitivity and wait for results on sensitivity for required treatment. An interview with IP was conducted on 3/7/23 at 10:00 a.m. IP indicated, antibiotic use within the facility gets reviewed against the McGeer's criteria for identification of a true infection and antibiotic use justification. If it does not meet McGeer's criteria, the facility notified the physician and received a rationale. A review of January, February, and March 2023 antibiotic use surveillence indicated, 8 "infections" did not meet McGeers criteria yet were treated with antibiotics. An Antibiotic Stewardship Program policy was received on 3/1/23 at 2:06 p.m. from ED (Executive Director). The policy indicated, "Purpose of Policy: To provide a collaborative, interdisciplinary system for the optimization of			

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	antibiotic use, improving drug selection, slowing emergence of antimicrobial resistance, and improving resident/patient outcomes through adopting the Center of Disease Control (CDC) core elements for antibiotic stewardship for long term care...The facility shall establish key elements for antibiotic prescribing and a system to monitor and manage antibiotic use. Antibiotic stewardshipp refers to a set of commitments and activities designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use."			
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and			

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	(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.			
	Based on interview and record review, the facility failed to timely administer a resident's influenza vaccination for 1 of 5 residents reviewed for vaccination. (Resident 56) Findings include: The clinical record for Resident 56 was reviewed on 3/6/23 at 3:08 p.m. Her diagnoses included, but	F 0883	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 56 had the Flu Vaccine administered as requested **How will you identify other**	04/07/2023

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	were not limited to, chronic respiratory failure, anoxic brain damage, dependence on respirator, and Alzheimer's disease. She was admitted to the facility on 3/1/22. The physician's orders indicated she may have an annual flu vaccine, starting 3/1/22. Her 4/5/22 Admission Agreement included an Influenza Vaccination Consent. The consent indicated she did not have any contraindications to receienving the influenza vaccine and wished to receive the influenza vaccine. It was docusigned by Resident 56 on 4/5/22 at 2:39 p.m. The Preventive Health Care section of the electronic health record indicated she received an influenza vaccine at the facility on 3/3/23. An interview was conducted with the IDNS (Interim Director of Nursing Services) on 3/6/23 at 3:38 p.m. She reviewed Resident 56's clinical record and indicated Resident 61 resided at the facility during flu season, which started in October, 2023, so she was unsure why she didn't receive the flu vaccine until 3/3/23. The Influenza (Flu) Vaccination (Resident) policy was provided by the IDNS on 3/1/23 at 11:06 a.m. It read, "It is the policy of this facility that resident(s) will be offered influenza vaccination to help prevent the development and transmission of influenza....vaccination to prevent influenza is particularly important for persons at risk for severe complications from influenza including residents of long-term care facilities. Routine annual influenza vaccination is recommended for all persons who do not have contraindications....Vaccine should be administered during the current influenza		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents who have consented to having the Influenza vaccine, and have no contraindication to receiving it, have the potential to be affected by the alleged deficient practice. · An audit was completed to ensure all residents that currently reside in the facility that have consented to the Influenza vaccine have had the vaccine administered. · DNS or Designee will conduct an in-service to the Admissions and Clinical team to educate regarding consents for vaccination administration by 4/7/2023. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · DNS or Designee will conduct an in-service to the Admissions and Clinical team to educate regarding consents for vaccination administration by 4/7/2023. ·IDT will review all new admissions at Clinical Meeting utilizing Influenza Consent Rounding Tool daily x 4 weeks and then monthly x 3 months to ensure that consented Residents receive their Influenza vaccine as	

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	season...Vaccine should be ideally administered by the end of October." 3.1-13(a)		requested. **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?** · DNS or Designee will be responsible for the completion of the Annual POC QAPI Tool weekly x 4 weeks, monthly x 3 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 90% is not achieved, an action plan will be developed to ensure compliance.	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to maintain a functional and sanitary environment by not assuring the resident rooms were routinely dusted for 3 of 3 residents observed for environment (Resident 54, 56, and 66), and that the kitchen floor was in good repair with the potential to affect 60 of 69 residents who reside at the facility.	F 0921	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · No residents were affected by the alleged deficient practice, all identified environmental concerns have been repaired	04/07/2023

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	Findings include: 1 a. The clinical record for Resident 66 was reviewed on 3/1/23 at 10:52 a.m. The Resident's diagnosis included, but were not limited to, acute respiratory failure. On 3/2/23 at 1:22 p.m., Resident 66's room was observed. There was a purple fan on the windowsill. The fan grid had a large amount of dust present on the inside of the grid and there were pieces of dust, attached to the grid, which were moving being blown by the wind from the fan. On 3/3/23 at 1:30 p.m., Resident 66's room was observed. The purple fan was on the windowsill and continued to have a large amount of dust present on the inside of the grid. 1 b. The clinical record for Resident 56 was reviewed on 3/6/23 at 9:45 a.m. The Resident's diagnosis included, but were not limited to, acute and chronic respiratory failure and dependency on ventilator. On 3/6/23 at 9:45 a.m., Resident 56's room was observed. There was a box fan sitting on the windowsill. The fan grid had a large amount of grey dust clinging to the gid of the fan. 1c. The clinical record for Resident 54 was reviewed on 3/6/23 at 1:04 p.m. The Resident's diagnosis included, but were not limited to, chronic respiratory failure and tracheostomy. On 3/6/23 at 1:04 p.m., Resident 54's room was observed. There was a layer of dust coating the top of the bed side storage area.		· Resident 54, 56 and 66 had their fans cleaned immediately and Resident 54's bedside storage area was dusted immediately · Repair bids have been requested for repairing floor tiles and baseboards. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice · Maintenance Director has conducted full facility audit to determine where repairs need to be made and repaired accordingly · ED/Designee will conduct an all staff inservice related to Environment including proper work order procedure by 4/7/2023 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · ED/Designee will conduct an all staff inservice related to Environment including proper work order procedure by 4/7/2023 · The ED will make weekly rounds with the Maintenance Director and Housekeeping Supervisor utilizing Environment Rounding tool weekly x 3 months and then monthly x 3 months to ensure the deficient practice does not recur.	

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	2. On 3/7/23 at 9:41 a.m., the ED (Executive Director) provided the pest control log binder. The binder contained pest control visit notes, which indicated the following: On 10/26/22, the kitchen interior had floor tiles and baseboards which were loose or missing. Please repair to eliminate potential pest harborage/ breeding sites. On 11/29/22, the kitchen interior had floor tiles and baseboards which were loose or missing. Please repair to eliminate potential pest harborage/ breading site. On 1/31/23, the kitchen interior had floor tiles and base boards which were loose or missing. Please repair to eliminate potential pest harborage/ breeding site. On 2/23/22, the kitchen interior had loose floor times and missing baseboards separating from the walls which created a gap/ void for insect/ pest to harbor and nest. On 3/7/23 at 11:05 a.m., the facility kitchen was observed with the ED, the HS (Housekeeping Supervisor), and the MS (Maintenance Supervisor). The back door of the kitchen had broken ceramic tiles on the baseboard which exposed the plaster and a rusty piece of metal. The kitchen floor in the area of the serving window and steam table had 2 drains present in the floor. The ceramic tiles around each of the drains had cracks in them. The drain closest to the window had ceramic tiles which were not level and had shifted from the underlying subflooring.		**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?** · DNS or Designee will be responsible for the completion of the Annual POC QAPI Tool weekly x 4 weeks, monthly x 3 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 90% is not achieved, an action plan will be developed to ensure compliance.	

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	The MS indicated he had been aware of the cracked tiles around the floor drain since October 2022. The ED indicated that the floor and the baseboard were in need of repair. On 3/7/23 at 11:20 a.m., the third-floor ventilator unit was observed with the ED, HS, and MS. Resident 54's room was observed to continue to have a layer of dust present on the bedside storage area. Resident 66's room was observed to have a large amount of dust on the grid of the fan, and Resident 56's room was observed to have a large amount of dust stuck to the grid of the fan. The HS indicated that Resident 54's room could use a dusting. The ED indicated that the fans in Resident 56's and 66's rooms should be cleaned. On 03/7/23 at 11:40 a.m., the HS provided the Deep Cleaning Calendar for March 2023 which indicated that high dusting should be done in rooms on Monday of each week and that windows, blinds and air conditioning/ heating units should be cleaned each Friday. 3.1-19(e)			
F 9999 Bldg. 00	3.1-14 Personnel (q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: ...(5) Professional licensure, certification, or registration number or dining assistant certificate or letter of completion if applicable.... (t) A physical examination shall be required for	F 9999	All licensed staff and been reviewed and identified to have current licenses. Facility now has process in place to ensure TBs are in place for all staff	04/07/2023

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	each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method. (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. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure staff had the 2nd step of a 2 step tb (tuberculin) skin test upon hire and a CNA's (Certified Nursing Assistant's) certification was not expired for 3 of 5 staff members reviewed for tb testing and 1 of 106 staff members reviewed for certifications or licenses. (CNA 15, LPN-Licensed Practical Nurse 16, LPN 17, and CNA 18) Findings include: The Employee Records form, licenses and certifications binder, and employee files for CNA 15, LPN 16, and LPN 17 were provided by the BOM (Business Office Manager) on 3/7/23 at 9:15 a.m. The Employee Records form indicated CNA 15 began working at the facility on 12/7/22; LPN 16 began working at the facility on 3/22/22; LPN 17 began working at the facility on 3/22/22; and CNA 18 began working at the facility on 3/15/17.			

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	CNA 15's employee file included an Employee Tuberculin Skin Testing Record. The record indicated she had step 1 of a 2 step tb test on 11/29/22 which was read on 12/1/22. The 2nd step section of the record was blank. LPN 16's employee file included a Targeted Tuberculin Testing Screening Form. The form indicated she had step 1 of a 2 step tb test on 3/10/22 with no read date. The 2nd step section of the form was blank. LPN 17's employee file included a Targeted Tuberculin Testing Screening Form. The form indicated she had step 1 of a 2 step tb test on 3/10/22 with no read date. The 2nd step section of the form was blank. The State of Indiana's license search website found at https://mylicense.in.gov/everification/Search/aspx indicated her CNA certification expired on 8/26/22. On 3/7/23 at 12:47 p.m., the BOM provided a statement on facility letterhead indicating CNA 15, LPN 16, LPN 17, and CNA 18 all worked full time at the facility. An interview was conducted with the BOM on 3/7/23 at 12:47 p.m. He indicated there was no verification of 2nd step tb testing for CNA 15, LPN 16, or LPN 17 and no verification CNA 18 renewed her CNA certification since it expired on 8/26/22.			