STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155246	A. BUILDING 00 B. WING	02/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHESTERTON MANOR	110 BEVERLY DR CHESTERTON, IN 46304

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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 IN00423048 and IN00424678. Complaint IN00423048 - Federal/state deficiencies related to the allegations are cited at F690. Complaint IN00424678 - No deficiencies related to the allegations are cited. Survey dates: February 6, 7, 8, 9, and 12, 2024 Facility number: 000150 Provider number: 155246 AIM number: 100267000 Census Bed Type: SNF/NF: 67 Total: 67 Census Payor Type: Medicare: 3 Medicaid: 46 Other: 18 Total: 67 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/15/24.	F 0000	F 0000 By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective March 20, 2024, for the complaint survey completed February 12, 2024. Chesterton Manor would like to respectfully request a desk review/paper compliance of this plan of correction.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sherrie Lamore	Administrator	03/01/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders for medications, and an assessment to self-administer their own medications, for 3 of 3 residents reviewed for self-administration of medication. (Residents 56, 22, and 54) Findings include: 1. During a random observation on 2/6/24 at 10:24 a.m., two small bottles of Tylenol were observed in a plastic bin containing denture supplies, located on Resident 56's bedside table. During random observations on 2/7/24 at 9:26 a.m., 1:24 p.m., and 3:05 p.m., the bottles of Tylenol remained in the plastic bin. During random observations on 2/8/24 at 9:57 a.m. and 3:04 p.m., the bottles of Tylenol remained in the plastic bin. During a random observation on 2/9/24 at 10:16 a.m., the bottles of Tylenol remained in the plastic bin on the resident's bedside table. The record for Resident 56 was reviewed on 2/7/24 at 1:35 p.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing) and intestinal obstruction. The Quarterly Minimum Data Set (MDS) assessment, dated 12/5/23, indicated the resident was cognitively intact. The resident did not have a current Care Plan related to self administration of medications.	F 0554	F 554 Resident Self-Admin Meds-Clinically Appropriate It is the practice of this facility to ensure that residents are assessed, and physician's orders obtained if determined to be appropriate to self-administer medications. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Medication Self Administration screens were completed for Tylenol for resident 56, Tums for resident 22 and Tums and Albuterol for resident 54. Physicians' orders were obtained to keep medications at bedside for self-administration based on the results of the screens and the information was added to the care plans. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents with medications at bedside have the potential to be affected by the deficient practice. A facility wide audit was completed to ensure medications are not left at bedside that have	03/20/2024

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	A Physician's Order, dated 10/21/23 and listed as current on the February 2024 Physician's Order Summary (POS), indicated the resident was to receive Tylenol 325 milligrams (mg), 2 tablets every 6 hours as needed for pain. There was no order for the resident to self-administer the medication and a Self-Administration of Medication Assessment had not been completed. During an interview on 2/9/24 at 10:42 a.m., the Director of Nursing (DON) indicated the resident's family would bring in medications for him without telling anyone. She indicated the Tylenol would be removed from the resident's room. 2. On 2/9/24 at 12:40 p.m., Resident 22 was observed in a wheelchair in his room watching television. At that time, there was a large bottle of Tums tablets on his dresser. During an interview at that time, the resident indicated he "takes them all the time." On 2/6/24 at 2:13 p.m., on 2/7/24 at 9:30 a.m. and 3:30 p.m., and on 2/8/24 at 9:57 a.m. and 11:08 a.m., the container of Tums was still on his dresser. The record for Resident 22 was reviewed on 2/9/24 at 11:10 a.m. Diagnoses included, but were not limited to, end stage renal disease, type 2 diabetes, dependence on renal dialysis, major depressive disorder, heart failure, and high blood pressure. The 11/25/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact and needed set up help for eating. There was no Care Plan for the resident to self-administer his own medications.		not been assessed by the IDT for self-administration. No further medications were found to be at the bedside of any other residents. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The facility policy on “Self-Administration of Medication” was reviewed by the IDT. An in-service was conducted with all facility nursing staff on the policy. A performance improvement tool has been developed to monitor that any resident with medication in their rooms has been determined clinically appropriate for self-administration of medication, physician orders are present, and a care plan developed. 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: A Quality Assurance tool has been developed and implemented that randomly audits (5) five residents’ rooms to be observed for medication at bedside. If present, a self-administration of	

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	There was no Physician's Order for the Tums, nor was there an order for the resident to self-administer his own medications. There was no Self-Administration of Medication Assessment completed for the resident. During an interview on 2/8/24 at 2:00 p.m., the Director of Nursing indicated there was no Physician's Order for the Tums tablets and there was no Self-Administration of Medication Assessment for the resident to give his own medications. 3. On 2/6/24 at 10:40 a.m., the resident was observed in her room. There was a labeled facility box, which contained a hand held inhaler of Albuterol sulfate, on the resident's bedside table, along with a bottle of Tums. The resident indicated she used the inhaler and Tums when she needed them. On 2/07/24 at 9:08 a.m., Resident 54 was observed in her room. The bottle of Tums and the inhaler were observed on the bedside table. The record for Resident 54 was reviewed on 2/8/24 at 11:00 a.m. Diagnoses included, but were not limited to, hypertension (high blood pressure), heart failure, cancer, respiratory failure, stroke and chronic obstructive pulmonary disease (restricted airway). The Quarterly Minimum Data Set (MDS) assessment, dated 1/22/24, indicated the resident was cognitively intact for daily decision making. The Care Plan, dated 1/22/24, indicated the resident required oxygen therapy due to chronic obstructive pulmonary disease. The interventions were to administer oxygen and puffers as ordered.		medication assessment will be completed, and a physician's order will be obtained if deemed appropriate and information added to the care plan. This tool will be completed by the Director of Nursing and/or her designee weekly times three, then monthly times three and then quarterly times three. In the event any further concerns are identified, the issue will be immediately corrected, and additional training will be initiated. The outcomes will be reviewed through the facility Quality Assurance Program at least quarterly. By what date the systemic changes for each deficiency will be completed: March 20, 2024	

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	A Physician's Order, dated 6/16/23, indicated inhale 2 puffs of Albuterol sulfate (inhaler) orally every 6 hours as needed for wheezing. There was no Physician's Order for the Tums. There was no Care Plan to self-administer her medications. There was no Self-Administration of Medication Assessment completed for the resident. During an interview on 2/8/24 at 10:49 a.m., the Director of Nursing (DON) indicated the resident did not have a Self-Administration of Medication Assessment completed. A policy titled "Self Administration of Medications", dated 12/2016, indicated.."Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so"... 3.1-11(a)			
F 0684 SS=E 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, record review, and interview, the facility failed to ensure areas of	F 0684	F 684 Quality of Care It is the practice of this facility to	03/20/2024

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	bruising were assessed and monitored, for 3 of 4 residents reviewed for skin conditions (non-pressure related), and signs and symptoms of constipation were monitored, for 1 of 1 residents reviewed for constipation. (Residents 56, 22, 166, and 217) Findings include: 1. During a random observation on 2/7/24 at 9:25 a.m., a circular fading reddish/purple bruise was observed on Resident 56's left forearm. During an interview at that time, the resident indicated he noticed the bruise after staff had helped him put on his shirt. The record for Resident 56 was reviewed on 2/7/24 at 1:35 p.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing), intestinal obstruction, weakness, and surgical aftercare following surgery on the digestive system. The Quarterly Minimum Data Set (MDS) assessment, dated 12/5/23, indicated the resident was cognitively intact. He required extensive assistance with bed mobility and transfers. There was no Physician's Order to monitor the bruising to the resident's left forearm. The Weekly Skin Review, dated 1/31/24, indicated the resident's skin was intact. There was no documentation related to bruising. The Weekly Skin Review, dated 2/7/24, indicated the resident's skin was intact. There was no documentation related to bruising. During an interview on 2/9/24 at 1:02 p.m., the		ensure skin impairments and constipation are assessed, monitored, and treated in accordance with professional standards of practice. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A physician's order was obtained for resident 56 on 2/10/24 for monitoring of the bruise on the left forearm. Documentation of the status of the bruise is being completed weekly on a wound evaluation flow sheet. A physician's order was obtained for resident 22 on 2/7/24 for monitoring of the bruises on bilateral lower arms and right toes. Documentation of the status of the bruises, as well as the old skin tear on right arm, is being completed weekly on a wound evaluation flow sheet. A physician's order was obtained for resident 217 on 2/10/24 for monitoring of the bruises on the right and left dorsal hands. Documentation of the status of the bruises is being completed weekly on a wound evaluation flow sheet. A physician's order was obtained for PRN dosing in addition to routine dosing of Polyethylene	

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	Assistant Director of Nursing indicated the resident told her that he had the bruise "for a while." She indicated the bruise should have been identified on the weekly skin assessment. 2. On 2/6/24 at 10:29 a.m., Resident 22 was observed sitting in a wheelchair in his room watching television. At that time, both lower arms were observed with red and purple areas of bruising, and the right arm had an old skin tear that was scabbed. The record for Resident 22 was reviewed on 2/9/24 at 11:10 a.m. Diagnoses included, but were not limited to, end stage renal disease, type 2 diabetes, dependence on renal dialysis, major depressive disorder, heart failure, and high blood pressure. The 11/25/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact. A Care Plan, revised on 4/24/23, indicated the resident had potential for further skin integrity impairment related to vision loss and fragile skin. The approaches were to follow facility protocols for treatment and injury. There was no documentation in Nursing Progress Notes prior to 2/6/24 regarding the bruises on both arms. A Nurses' Note, dated 2/7/24 at 10:27 a.m., indicated the resident was noted with multiple bruises and scabbed areas to his hands, arms, and legs. Physician's Orders, dated 2/7/24 at 10:35 a.m., indicated monitor bruising to bilateral arms and right toes until resolved every day and night shift.		Glycol for constipation for resident 166. A care plan addressing constipation was initiated on 2/22/24. A bowel movement report is being run daily for resident 166 to monitor documentation and PRN medication dosing is offered if no BM every 3 days as per plan of care. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents with skin impairments and problems with constipation have the potential to be affected by the deficient practices. A facility wide skin sweep was conducted to identify residents with any further skin issues. Physician orders for monitoring have been obtained for any residents identified as having skin impairments in the skin sweep and documentation has been completed on a wound evaluation assessment form in the EMR with weekly monitoring. A bowel movement report will be run daily on all residents and the bowel protocol will be offered for any resident who is identified as not having a BM every 3 days. Care plans will be initiated for those residents identified as having problems with constipation.	

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	During an interview on 2/9/24 at 1:15 p.m., the Director of Nursing indicated there was no assessment or documentation of the bruises prior to 2/7/24. 3. During an interview on 2/6/24 at 2:42 p.m., Resident 166 indicated she had trouble with constipation. The record for Resident 166 was reviewed on 2/8/24 at 10:05 a.m. Diagnoses included, but were not limited to, cervical disc degeneration, morbid obesity, anxiety, major depressive disorder, high blood pressure, and seizures. The 12/5/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making and was always incontinent of bowel. There was no Care Plan for constipation. Physician's Orders, dated 1/21/23, indicated Polyethylene Glycol powder, give 17 grams by mouth one time a day for constipation. Dissolve 1 capful (17 GM) in 6-8 ounces of liquid. Physician's Orders, dated 11/30/23, indicated Percocet 5-325 milligrams (mg) (Oxycodone with Acetaminophen), give 1 tablet by mouth every 8 hours as needed for pain. There was no prn (as needed) medication ordered for the resident for constipation. The bowel movements (bm) log for the month of 12/2023, indicated, on 12/20 it was blank and not completed. On 12/21 and 12/22 "0" was entered, on 12/23 it was blank and not completed, on 12/24		What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The facility policies on “Skin and Wound Management” and “Management of Constipation” were reviewed by the IDT. An in-service was conducted with all facility nursing staff on the policies. A performance improvement tool has been developed to assure documentation and monitoring has been completed on any newly identified wounds per the weekly skin assessment or clinical dashboard and all residents with constipation have PRN orders to treat per policy and care plans are in place. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A Quality Assurance tool has been developed and implemented that randomly audits (5) five residents to ensure monitoring orders and a wound evaluation assessment have been completed for any newly identified skin issues and care plans are present for residents identified as having problems with constipation and PRN orders to treat are in place. This tool will be completed by the Director of Nursing and/or	

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	"0" was entered, on 12/25 it was blank and not completed, on 12/26 "0" was entered and on 12/27-12/29/23 were blank and not completed. The bm log for the month of 1/2024, indicated, on 1/15 it was blank and not completed. On 1/16-1/19/24 a "0" was entered. The bm log for the month of 2/2024, indicated a "0" was entered on 2/2, 2/3, 2/4, and on 2/5 the resident had a small bowel movement. On 2/6/24 another "0" was entered. The Medication Administration Record (MAR) for the month of 1/2024, indicated the resident was administered the Percocet on 1/14, 1/19 times 2, 1/21, 1/24, 1/26, and 1/27/24. During an interview on 2/9/24 at 1:30 p.m., the Director of Nursing indicated staff were not documenting in the point of care when the resident had a bowel movement. 4. On 2/6/24 at 10:49 a.m., Resident 217 was observed with multiple bruise like appearances on the right and left dorsal side of her hands. The record for Resident 217 was reviewed on 2/6/24 at 9:15 a.m. Diagnoses included, but were not limited to, chronic ulcer of the left ankle, right below the leg amputation, squamous cell carcinoma of the skin, peripheral vascular disease, and atherosclerotic heart disease. The resident was admitted to the facility on 2/5/24. The Minimum Data Set (MDS) assessment was not completed. A Care Plan, dated 2/6/24, indicated the resident was on anticoagulant therapy of Plavix and Aspirin.		designee weekly times three, then monthly times three, and then quarterly times three. In the event any further concerns are identified, the issue will be immediately corrected, and additional training will be initiated. The outcomes will be reviewed through the facility Quality Assurance Program at least quarterly. By what date the systemic changes for the deficiency will be completed: March 20, 2024	

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	An Admission Nursing Assessment Evaluation, dated on 2/5/24, indicated the resident was admitted with areas of non-pressure ulcers to the left distal ankle. There was an old PEG tube scar, as well as a healed wound to the left foot. There was no documentation of bruise like marks on the right and left hand. A Skin Observation Assessment, dated 2/6/24 through 2/7/24, indicated "no scratches, red areas, discoloration, skin tear, or open areas noted". During an interview on 2/9/24 at 3:21 p.m., the Director of Nursing (DON) indicated she did not see the marks on the resident's hands, and the nurses missed the bruises to her hand on the Admission Assessment. A facility policy titled, "Skin and Wound Management System", provided as current by the Administrator on 2/9/24 at 2:39 p.m., indicated... " An assessment of skin integrity is to be performed on each resident upon admission to the center by completing" ... a.) A head to toe physical evaluation of the skin condition". 3.1-37(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.			

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	§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, record review, and interview, the facility failed to ensure a resident with a suprapubic foley catheter received foley catheter care, and catheter bags and tubing were kept off the floor, for 2 of 3 residents reviewed for catheters. (Residents B and D) Findings include: 1. During an interview on 2/6/24 a 10:55 a.m., Resident B indicated nursing staff were not cleaning around his suprapubic foley catheter. At that time, the resident lifted up the bed linens, so	F 0690	F 690 Bowel/Bladder Incontinence, Catheter, UTI It is the practice of this facility to ensure residents with suprapubic catheters receive catheter care and urinary drainage bags and tubing are positioned to prevent contact with the floor. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	03/20/2024

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	his catheter site could be observed. The area around the catheter was red with dried blood noted. There was no split gauze sponge around the ostomy. On 2/6/24 at 1:30 p.m., the resident was observed in bed. At that time, the catheter bag and tubing were observed on the floor. At 3:30 p.m., the catheter bag was now hanging on the side of the garbage can and the bottom of the bag was touching the floor. On 2/7/24 at 9:06 a.m., the resident was observed in bed. At that time, he lifted up the bed linens, so the suprapubic catheter stoma could be observed. There was no bandage noted around the ostomy, and the area was red with dried blood. The catheter bag was touching the floor. On 2/7/24 at 3:40 p.m., the resident was observed in bed. The catheter bag was not attached to anything, and was laying directly on the floor. The record for Resident B was reviewed on 2/7/24 at 2:05 p.m., Diagnoses included, but were not limited to, quadriplegia, neuromuscular of the bladder, anxiety, alcohol abuse, stroke, major depressive disorder, and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 1/29/24, indicated the resident was cognitively intact and had a suprapubic catheter and an ostomy. The Care Plan, revised on 9/26/23, indicated the resident had an urinary tract infection. The Care Plan, revised on 10/10/23, indicated the resident had a suprapubic catheter.		Catheter care was completed for resident B. The positioning of the urinary drainage bag and tubing for resident B and D were corrected so it did not make contact with the floor. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents who have a catheter have the potential to be affected by the deficient practice. A visual check of all residents with catheters was completed with no further findings of urinary drainage bags or tubing being on the floor. An order was placed in the charts and on the task list on all residents with catheters for catheter care to be completed on each shift. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The facility policies on “Supra Pubic Catheter Care” and “Catheter Care Urinary, Infection Control” were reviewed by the IDT. An in-service was conducted with all facility nursing staff on the policies. A performance improvement tool has been	

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	155246	A. BUILDING 00 B. WING	02/12/2024

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	Physician's Orders, dated 9/21/23, indicated cleanse suprapubic catheter site with soap and water and apply a split sponge dressing every night shift for infection control and hygiene. A Physician's Order, dated 12/19/23, indicated Sulfamethoxazole-Trimethoprim (an antibiotic) tablet 800-160 milligrams (mg), give 1 tablet by mouth two times a day for an urinary tract infection for 10 days. The Medication and Treatment Administration Records (MARS/TARS) for the months of 10/2023, 11/2023, 12/2023, 1/2024 and 2/2024, indicated there was no documentation the foley catheter care was being done daily and a sponge dressing was being applied. During an interview on 2/7/24 at 3:45 p.m., the Director of Nursing indicated she was unaware there was no place on the MAR or TAR to sign out the foley catheter care to ensure it was being completed as ordered. The foley catheter bag and tubing was not to be on the floor. The revised and current 10/2010 "Suprapubic Catheter Care" policy, provided by the Administrator on 2/9/24 at 3:25 p.m., indicated nursing staff were to wash around the catheter site with soap and water. If the resident had a drainage sponge around the stoma site, remove the sponge before washing with soap and water. Document in the resident's medical record the date and time the procedure was performed. 2. On 2/6/24 at 10:30 a.m., Resident D was observed in bed with an indwelling foley catheter. At that time, the bed was low to the floor, and the bag and catheter tubing were observed on the floor. On 2/7/24 at 10:10 a.m., the resident was observed		developed to assure catheter care has been completed and documented each shift on each resident with a catheter and the urinary drainage bag and tubing are positioned off the floor. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A Quality Assurance tool has been developed and implemented that audits all residents with catheters to ensure catheter care has been completed and the urinary drainage bag and tubing are not in contact with the floor. This tool will be completed by the Director of Nursing and/or designee weekly times three, then monthly times three, and then quarterly times three. In the event any further concerns are identified, the issue will be immediately corrected, and additional training will be initiated. The outcomes will be reviewed through the facility Quality Assurance Program at least quarterly. By what date the systemic changes for the deficiency will be completed: March 20, 2024	

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in bed, and the catheter bag was touching the floor.

On 02/09/24 at 9:40 a.m., the resident was observed in bed. At that time, the catheter bag was hanging on the bed rail, and the tubing was laying on the floor next to the resident's bed.

The record for Resident D was reviewed on 2/6/24 at 9:13 a.m. Diagnoses included, but were not limited to, stroke, hemiplegia, muscle weakness, and aphasia.

The State Optional Minimum Data Set (MDS) assessment, dated 1/17/24, indicated the resident was severely impaired for cognitive decision making.

A Care Plan indicated the resident was incontinent of bowel and bladder.

A Physician's Order indicated foley catheter care was to be administered to the resident every shift and as needed.

During an interview, on 2/9/24 at 10:45 a.m., the Director of Nursing (DON) indicated the resident's catheter bag or tubing should not be on the floor.

A facility policy titled, "Catheter Care Urinary, Infection Control", provided as current by the Administrator on 2/9/24 at 2:39 p.m., indicated "... Be sure the catheter tubing and drainage bag are kept off of the floor..."

This citation relates to Complaint IN00423048.

3.1-41(a)(2)

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F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, record review, and interview, the facility failed to care for a PICC line (peripherally inserted central catheter, intravenous catheter placed into the peripheral veins of the upper arm) in accordance with professional standards of practice, related to not flushing the PICC line with the correct amount of saline, and a lack of documentation the saline and heparin flushes were administered as ordered, for 1 of 1 residents observed with a PICC line during medication pass. (Resident 62) Finding includes: On 2/9/24 at 11:55 a.m., RN 1 was observed passing medication to Resident 62. He prepared the intravenous (IV) medication of Ceftriaxone 2 grams (gm) and primed a new IV tubing. The RN cleaned the left upper arm access lumen with an alcohol swab, flushed the PICC line with 4 milliliters (ml) of normal saline, attached the tubing containing the Ceftriaxone, and started the IV infusion. At 1:08 p.m., RN 1 was observed disconnecting the IV tubing after the medication had completed infusing. He flushed the PICC line with 4 ml of normal saline, followed with 5 ml of Heparin (an anticoagulant), and applied a new cap to the lumen.	F 0694	F 694 Parenteral/IV fluids It is the practice of this facility to ensure PICC lines are cared for in accordance with professional standards of practice. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The physicians' order for PICC line flush was corrected for resident 62. The resident no longer has a PICC line in use. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Any resident admitted to the facility with a PICC line has the potential to be affected by the deficient practice. Currently there are no residents in the facility with a PICC line in use. What measures will be put into place and what systemic changes	03/20/2024

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	Interview with RN 1 on 2/9/24 at 12:05 p.m., indicated he did not know how much of the saline flush to administer prior to connecting the IV. Resident 62's record was reviewed on 2/6/24 at 1:00 p.m. Diagnoses included, but were not limited to, infection following a procedure, disruption of wound, fracture of the left lower leg, open wound, and skin infection. A Physician's Order, dated 1/6/24, indicated IV Ceftriaxone 2 gm one time a day for 40 days. A Physician's Order, dated 1/5/24, indicated flush IV with 10 ml of normal saline followed by 5 ml of Heparin at 10 units/ml every 12 hours. The Medication Administration Record (MAR), dated 2/2024, indicated there was no documentation the saline or Heparin flushes had been administered through the PICC line before and after the IV antibiotic. During an interview, on 2/12/24 at 11:40 a.m., the Director of Nursing (DON) indicated the nurse should have followed the Physician's Order related to the amount of saline used to flush the PICC line, and the saline and Heparin flushes were not on MAR for the nurse to sign they had been administered before and after the IV antibiotic. 3.1-47(a)(2)		will be made to ensure that the deficient practice does not recur: The facility policy “Peripherally Inserted Catheter Flush Protocol” was reviewed by the IDT. An in-service was conducted with all facility licensed nursing staff on the policy. A performance improvement tool has been developed to assure any resident with a PICC line has accurate flush orders and the procedure is completed correctly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A Quality Assurance tool has been developed and implemented that audits all residents with a PICC line to ensure flush orders are accurate and the procedure is completed correctly. This tool will be completed by the Director of Nursing and/or designee weekly times three, then monthly times three, and then quarterly times three. In the event any further concerns are identified, the issue will be immediately corrected, and additional training will be initiated. The outcomes will be reviewed through the facility Quality Assurance Program at least quarterly. By what date the systemic changes for the deficiency will be	

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			completed: March 20, 2024	
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, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure oxygen was administered as ordered, and set at the correct flow rate, for 1 of 1 residents reviewed for respiratory care. (Resident 54) Finding includes: On 2/6/24 at 10:40 a.m., Resident 54 was observed in bed and not wearing oxygen. The oxygen concentrator was set at 3 liters. The resident indicated she only wore oxygen at night. On 2/7/24 at 9:08 a.m., the resident was observed in bed not wearing oxygen. The oxygen was set at 4 liters. On 2/8/24 at 9:54 a.m., the resident was observed in bed taking a nap, and was not wearing oxygen. The oxygen concentrator was turned off.	F 0695	F 695 Respiratory/Tracheostomy Care and Suctioning It is the practice of this facility to ensure that residents receive oxygen in accordance with physicians' orders. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Oxygen was applied to resident 54 at the correct liter flow while napping and at night. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:	03/20/2024

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	On 2/9/24 at 7:37 a.m., the resident was sitting up in bed preparing for breakfast. She was wearing oxygen via nasal cannula and the concentrator was set at 3.5 liters. The record for Resident 54 was reviewed on 2/8/24 at 11:00 a.m. Diagnoses included, but were not limited to, hypertension (high blood pressure), heart failure, cancer, respiratory failure, stroke and chronic obstructive pulmonary disease. The Quarterly Minimum Data Set (MDS) assessment, dated 1/22/24, indicated the resident was cognitively intact for daily decision making. The Care Plan, dated 1/22/24, indicated the resident required oxygen therapy due to chronic obstructive pulmonary disease. The interventions were to provide oxygen therapy at 2 liters continuously per nasal cannula and administer medication as ordered. A Physician's Order, dated 9/13/23, indicated to administer oxygen via nasal cannula at 4 liters every night and with naps. A Nursing Progress Note, dated 9/13/23, indicated the resident's oxygen order was increased from 2 liters to 4 liters, and included wearing oxygen when taking naps. The Medication Administration Record (MAR), indicated the order for oxygen to be administered at 4 liter at night and during naps was signed out daily for the month of February 2024. A Policy titled "Oxygen Administration", dated 10/2010, indicated ..."Review the Physician's orders or facility protocol for oxygen administration"...		All residents who require oxygen have the potential to be affected by the deficient practice. An audit was done of all residents with physician orders to receive oxygen with no findings of lack of administration or incorrect liter flows. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The facility policy “Oxygen Administration” was reviewed by the IDT. An in-service was conducted with all facility licensed nursing staff on the policy. A performance improvement tool has been developed to assure that physicians orders are being followed regarding administration and liter flow for all residents that require oxygen. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A Quality Assurance tool has been developed and implemented that audits all residents with a physician’s order for oxygen for correct administration and liter flow. This tool will be completed by the Director of Nursing and/or designee weekly times three, then monthly times three, and then	

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	During an interview on 2/9/24 at 10:27 a.m., the Administrator indicated the resident should have been wearing oxygen as ordered. 3.1-47(a)(6)		quarterly times three. In the event any further concerns are identified, the issue will be immediately corrected, and additional training will be initiated. The outcomes will be reviewed through the facility Quality Assurance Program at least quarterly. By what date the systemic changes for the deficiency will be completed: March 20, 2024	
F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on record review and interview, the facility failed to ensure a Registered Nurse (RN) worked 8 consecutive hours in the facility on any given day. This had the potential to affect 67 of 67 residents who resided in the facility.	F 0727	F 727 RN 8 Hrs/7 days/Wk, Full Time DON It is the practice of this facility to schedule an RN at least 8 consecutive hours a day/7 days a	03/20/2024

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	Finding includes: The staffing schedules for 9/1-9/20/23 and 1/1-1/31/24 were reviewed on 2/7/24 at 8:40 a.m. There were currently 2 RN's who worked in the facility as a floor nurse. The other RN's who were employed at the facility, were the Director of Nursing (DON) and the MDS Coordinator. Nursing time cards were reviewed on 2/7/24 at 9:25 a.m., and the following was noted: There was no RN coverage for 7/22/23. There was no RN coverage for 9/2/23. There was no RN coverage for 9/3/23. There was no RN coverage for 9/16/23. There was no RN coverage for 9/17/23. There was no RN coverage on 1/6/24. During an interview on 2/7/24 at 12:10 p.m., the Administrator indicated that they did not have an RN working on the dates above. 3.1-17(b)(3)		week. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: There were no residents identified in the 2567 that were affected by the deficient practice. Registered Nurse coverage for the dates listed is unable to be corrected. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents that reside in the facility have the potential to be affected by the alleged deficient practice. The facility is hosting a job fair on March 6, 2024 with an emphasis on hiring RN's. Local nursing schools will be contacted regarding the job fair. The facility continues to post ads for facility hiring of Registered Nurses. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The Nursing Scheduler and Nurse Managers on weekend call will be in-serviced on the requirement for RN Coverage 8 Consecutive Hours/7 Days a Week. Weekend	

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			Nurse Managers will monitor RN coverage on the weekends and notify the DON/ED of any RN call offs during this time. A performance improvement tool has been developed to monitor that a Registered Nurse is scheduled for coverage for 8 consecutive hours daily. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A performance improvement tool has been initiated that audits (7) days weekly to ensure Registered Nurse coverage is scheduled as required. This Quality Assurance Audit Tool will be completed by the Administrator/Designee 7 times weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified, the issue will be immediately corrected, and additional training will be initiated. The outcomes will be reviewed through the facility Quality Assurance Program at least quarterly. By what date the systemic changes for the deficiency will be completed: March 20, 2024	

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F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure medications were properly stored, related to loose pills inside the medication drawers, for 2 of 4 medication carts observed. (Hall 100 and 200). Finding includes: 1. During a medication storage observation, on	F 0761	F 761 Label/Store Drugs and Biologicals It is the practice of this facility to ensure medications are properly stored in the medication carts. What corrective action(s) will be accomplished for those residents found to have been affected by the	03/20/2024

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	2/9/24 at 1:16 p.m., the 100 Hall medication cart was observed with RN 1. At that time, there were 9 loose pills inside the drawer of the medication cart. The pills ranged in size and color. 2. During a medication storage observation, on 2/9/24 at 1:30 p.m., the 200 hall cart was observed with RN 1. There were 15 loose pills inside the drawer of the medication cart. The pills ranged in size and color. During an interview, on 2/9/24 at 1:20 p.m., RN 1 indicated he had just cleaned the carts a few days ago and loose pills should not be inside the medication cart. A facility policy, titled, "Storage of Medication and Biologicals", provided by the Director of Nursing as current, indicated, " ... Medication storage areas are to be kept clean, well lit, free of clutter, and free of extreme temperatures". 3.1-25(j)		deficient practice: The medication carts on 100 hall and 200 halls were cleaned to eliminate loose pills from the drawers. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents who received medications have the potential of being affected by the deficient practice. The medication carts on all halls were checked with no further loose pills found in the medication drawers. Weekly cleaning of the carts will be scheduled to be completed by the nursing staff. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The facility policy “Storage of Medications and Biologicals” was reviewed by the IDT. An in-service was conducted with all facility licensed nursing staff and QMA’s on the policy. A performance improvement tool has been developed to audit all medication carts weekly for loose pills in the drawer.	

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(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
			How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A Quality Assurance tool has been developed and implemented that audits all medication carts to ensure there are no loose pills in the drawer. This tool will be completed by the Director of Nursing and/or designee weekly times three, then monthly times three, and then quarterly times three. In the event any further concerns are identified, the issue will be immediately corrected, and additional training will be initiated. The outcomes will be reviewed through the facility Quality Assurance Program at least quarterly. By what date the systemic changes for the deficiency will be completed: March 20, 2024	
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			

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	155246	A. BUILDING 00 B. WING	02/12/2024

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	itself is permitted to do so. §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-			

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	(i) The period of time required by State law; or (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 record review and interview, the facility failed to maintain clinical records that were complete and accurately documented, related to clarification orders for as needed (PRN) pain medications, and documentation of meal consumption, for 2 of 21 records reviewed. (Residents 13 and 22) Findings include: 1. The record for Resident 13 was reviewed on 2/8/24 at 10:53 a.m. Diagnoses included, but were not limited to, osteoarthritis of the left hip and Alzheimer's disease. The Quarterly Minimum Data Set (MDS) assessment, dated 1/2/24, indicated the resident was moderately impaired for daily decision making. The resident received pain medications and she had occasional pain. Her pain scale was a	F 0842	F 842 Resident Records – Identifiable Information It is the practice of this facility to ensure clinical records contain complete and accurate documentation. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 13 Norco order was changed to be administered as needed. The documentation in resident 22 chart is unable to be corrected. POC assignment status on the clinical dashboard will be reviewed in morning clinical meetings for completion of C.N.A	03/20/2024

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	"4." A Physician's Order, dated 2/1/24, indicated the resident was to receive Norco (a narcotic pain medication) 5-325 milligrams (mg), 1 tablet every 8 hours as needed (PRN) for a pain scale of 7-10. The February 2024 Medication Administration Record (MAR), indicated the resident received the PRN Norco on 2/1 at 9:43 a.m., 2/2 at 10:51 p.m., 2/6 at 9:30 a.m., and 2/8/24 at 8:47 a.m. The resident's pain scale was documented as being a "4" each time the medication was received. A Physician's Order, dated 10/12/23, indicated the resident was to receive Norco (a narcotic pain medication) 5-325 milligrams (mg), 1 tablet every 4 hours as needed (PRN) for a pain scale of 7-10. The January 2024 MAR, indicated the resident received the PRN Norco on 1/6 at 10:15 p.m., 1/11 at 9:34 p.m., 1/19 at 8:30 p.m., 1/23 at 8:15 p.m., and 1/31/24 at 9:44 a.m. and 6:24 p.m. The resident's pain scale was documented as less than 7 each time the medication was received. During an interview on 2/9/24 at 10:42 a.m., the Director of Nursing (DON) indicated the resident requested her Norco on a routine basis and she had received it for years. The DON indicated she would contact the Physician and get the order clarified related to the pain scale of 7-10.2. The record for Resident 22 was reviewed on 2/9/24 at 11:10 a.m. Diagnoses included, but were not limited to, end stage renal disease, type 2 diabetes, dependence on renal dialysis, major depressive disorder, heart failure, and high blood pressure. The 11/25/23 Quarterly Minimum Data Set (MDS)		documentation. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential of being affected by the deficient practice. The orders for PRN narcotic administration were reviewed for all residents with no other residents having orders dependent on the pain level for administration. The clinical dashboard is being reviewed daily to ensure meal consumption is being documented on all residents for meals and corrections made as indicated. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: An in-service was conducted with all facility licensed nursing staff and QMA's on administration of pain medication with parameters and all nursing staff on documentation of meal consumption. A performance improvement tool has been developed to audit administration of pain medication with parameters and meal documentation.	

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	assessment, indicated the resident was cognitively intact and needed set up help for eating. A Care Plan, revised on 8/7/23, indicated the resident was at risk for impaired nutrition. The meal consumption log indicated there were no meals documented on 1/14, 1/21, 2/5, and 2/8/24. The dinner meal was blank on 1/18, 1/20, 1/22, and 1/23/24. During an interview with on 2/9/24 at 1:15 p.m., the Director of Nursing indicated the resident would leave and go out to dinner with his ex-wife, and that was why the meal consumption logs were blank and not completed. 3.1-50(a)(1)		How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A Quality Assurance tool has been developed and implemented that audits administration of pain medication with parameters and documentation of meal consumption. This tool will be completed by the Director of Nursing and/or designee weekly times three, then monthly times three, and then quarterly times three. In the event any further concerns are identified, the issue will be immediately corrected, and additional training will be initiated. The outcomes will be reviewed through the facility Quality Assurance Program at least quarterly. By what date the systemic changes for the deficiency will be completed: March 20, 2024	
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 and interview, the facility failed to keep the resident's environment in good repair, related to marred walls, doors, and door	F 0921	F 921 Safe/Functional/Sanitary/Comfortable Environment	03/20/2024

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	frames, gouged walls, missing baseboards, and non-skid strips peeling off the floor, for 2 of 4 units in the facility. (100 and 200 Hall). Findings include: During the Environmental tour on 2/12/24 at 10:53 a.m., the following was observed: 1. Hall 100 a. Room 102 - The resident room and bathroom doors were marred as well as the frames. The corner by the closet and bathroom door was gouged and missing the baseboard. There was 1 resident who resided in the room and used the bathroom. b. Room 104 - The resident room and bathroom doors were marred, as well as the door frames. The walls in the bathroom and in the room were marred. The floor around the toilet was rusty. Two residents resided in the room and used the bathroom. c. Room 107 - The walls in the room were marred. There was 1 resident who resided in the room. 2. Hall 200 a. Room 207 - The non-skid strips were peeling next to bed 2 and in the bathroom in front of the toilet. There were 2 residents in room and both residents used the bathroom. b. Room 210 -The edge of the wall next to the closet was scratched and marred. The wall was marred underneath the grab bar next to the toilet. There were 2 residents in the room and used the bathroom.		It is the practice of this facility to ensure that all procedures and services are conducted in a manner that is in accordance with safe, functional, sanitary and comfortable environment for residents, staff and the public. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The marred doors and frames in rooms in room 102 were painted and the missing baseboard was replaced. The marred walls in room 104 bathroom and resident room were painted and the rusty area around the toilet was cleaned and rust removed. The marred walls in room 107 were painted. The non-skid strips in the room and bathroom in 207 were replaced. The scratched and marred walls in room 210 were repaired and painted and the marred walls in the bathroom were painted. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents who reside in the facility have the potential of being	

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	During the interview on 2/12/24 at 11:15 a.m., the Maintenance Director indicated he was currently training an assistant, and they were currently going through the building to verify and make repairs. 3.1-19(f)		affected by the deficient practice. Rounds were completed in all resident rooms to identify concerns listed in the 2567 and repairs completed as needed. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: An in-service was conducted with the maintenance director on inspection of environmental needs in resident rooms. A performance improvement tool has been developed to audit resident rooms for needed repairs. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A Quality Assurance tool has been developed and implemented to audit resident rooms for needed repairs. This tool will be completed by the Director of Maintenance and/or designee weekly times three, then monthly times three, and then quarterly times three. In the event any further concerns are identified, the issue will be immediately corrected, and additional training will be initiated. The outcomes will be reviewed through the facility Quality Assurance Program at least quarterly.	

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			By what date the systemic changes for the deficiency will be completed: March 20, 2024	