STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155124	A. BUILDING 00 B. WING	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VERMILLION CONVALESCENT CENTER	1705 S MAIN ST CLINTON, IN 47842

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 16, 17, 18, 19, and 22, 2024 Facility number: 000052 Provider number: 155124 AIM number: 100290340 Census Bed Type: SNF/NF: 76 Total: 76 Census Payor Type: Medicare: 11 Medicaid: 52 Other: 13 Total: 76 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 31, 2024.	F 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Due to the low scope and severity, the facility respectfully requests a desk review in lieu of a revisit.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or			

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

Melissa Gum | RN, HFA/Administrator | 08/12/2024

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	enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview and record review, the facility failed to aid a resident in a manner that maintained or enhanced their dignity for 1 of 1 residents randomly observed for resident rights. (Resident 72). Findings include: On 7/18/24 at 10:00 a.m., observed Student Nurse	F 0550	**F550** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #72 has been assessed for indication of mental anguish or other complications as a result of the alleged deficient practice, with	08/19/2024

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	Aide (4) transporting Resident 72 from the shower room to the resident's room while sitting in an open shower chair (a wheeled chair which provides support and stability to individuals who require assistance with bathing or using the restroom). The resident was wearing a blue long sleeve shirt and covered in the front with a light blanket. The back of the shower chair was uncovered, and the resident's buttocks was exposed. On 7/18/24 at 10:05 a.m., during an interview with Licensed Practical Nurse (LPN) 4 she indicated the resident should be completely covered before transporting in a shower chair. On 7/18/24 at 10:20 a.m., during an interview with Student Nurse Aide 4, she indicated the resident should have been covered prior to transporting the resident in a shower chair. On 7/18/24 at 1:30 p.m., the medical record of Resident 72 was reviewed. The resident was admitted with diagnosis including but not limited to, encephalopathy (damage or disease that affects the brain), altered mental status and cognitive communication deficit (trouble expressing needs using basic words and gestures). A care plan, dated 9/7/21, indicated the resident required assistance of one person for activities of daily living (ADL) care and transportation. An admission Minimum Data Set (MDS) assessment, dated 5/28/24, indicated the resident was not cognitively intact and she required maximum assistance of two persons for care needs.		no concerns. Resident #72 has been observed to be transported via shower chair in a manner that maintains and enhances their dignity. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** No other Residents were affected by the alleged deficient practice; however, all residents have the potential to be affected. Random audits of staff transporting Residents have been completed. Special focus placed on transporting to and from the shower room to ensure that each Resident transported in a manner that maintains and enhances their dignity. Corrective action immediately implemented as warranted. Staff re-education immediately implemented as warranted. **What measures will be put into place and systemic change will be made to ensure the deficient practice does not recur?** The facility's policy and procedure for "Resident Rights and Dignity" has been reviewed and no changes are indicated at this time. All Nursing Staff have been re-educated regarding this policy and procedure. The in-service content focused on transporting the residents to and from the	

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	On 7/18/24 at 2:00 p.m., the Regional Nurse Consultant provided a document, titled, "Resident Rights," dated 11/28/2016, and indicated it was the policy currently being used by the facility. The policy indicated, "...Respect and Dignity. The resident has the right to be treated with respect and dignity ...." 3.1-3(a)		shower room in a manner that maintains and enhances their dignity. A monitoring tool/audit tool has been implemented. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The Director of Nursing or designee will be responsible to complete random audits. The audits will include observation of residents being transported in a manner that maintains their dignity at all times. The audits will be conducted two times a week for four weeks and then weekly for four weeks and then monthly. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices on the basis of compliance until 100% compliance is achieved.	
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-			

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	(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances			

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	specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.			

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	Based on interview and record review, the facility failed to ensure documentation of a resident's transfer included information that the physician and family representative were notified of a resident being transferred to the hospital for 1 of 2 reviewed for hospitalization (Resident 17). Finding includes: During an interview, on 7/16/24 at 11:30 a.m., Resident 17 indicated she had recently been sent out to the hospital for a seizure and stayed overnight. Resident 17's record was reviewed on 7/22/24 at 10:00 a.m. The profile indicated the resident's diagnosis included, but were not limited to, Epilepsy (group of non-communicable neurological disorders characterized by recurrent epileptic seizures [uncontrolled jerking, loss of consciousness, blank stares, or other symptoms caused by abnormal electrical activity in the brain]). A quarterly Minimum Data Set (MDS) assessment, dated 7/10/24, indicated the resident was cognitively intact. Review of the Situation, Background, Assessment, and Recommendation (SBAR) form, dated 6/18/24, indicated Resident 17 was being transported to the Emergency Room. The form was not completed in its entirety and lacked documentation of physician notification and family representative notification. Reivew of a nurse's note, dated 6/18/24 at 11:15 p.m., the note indicated Resident 17 had complained to a certified nurse's assistant (CNA) that she was not feeling well. The CNA reported	F 0622	**F 622** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 17 has since returned to the facility; this Resident was not negatively affected by the alleged deficient practice. Resident #17's family and physician have been contacted to ensure that they are aware of the hospital transfer and return to the facility. No changes in orders were given. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** No other Residents were affected by the alleged deficient practice; however, all residents who are transferred to the hospital for a condition change have the potential to be affected. Audits of all Residents who have been transferred to the hospital for a change of condition in the last 60 days has been completed with focus placed proper notification of physician and family. Corrective action immediately implemented as warranted. **What measures will be put into place and systemic change will be made to ensure the deficient practice does not recur?**	08/19/2024

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	to the nurse the resident was unresponsive to verbal stimulation. The resident did regain consciousness, but her color was pale with flushed face. The resident had nausea and vomiting times 2. Emergency Medical Services (EMS) was called to assist with transport to the hospital. The resident was alert at the time of transport. The nurse's note lacked documentation of a physician or family representative being notified of the transfer to the hospital for Resident 17. During an interview, on 7/22/24 at 10:19 a.m., Licensed Practical Nurse (LPN) 13 indicated the nursing staff should complete a SBAR form when sending out residents to the hospital. The form was then placed in a binder at the nurse's station when completed. During an interview, on 7/22/24 at 11:13 a.m., the Regional Nurse Consultant indicated she was unable to find any documentation of where the physician or family representative was notified of Resident 17's transfer to the hospital. The nurse, who had completed the SBAR, was no longer employed with the facility. On 7/22/24 at 11:00 a.m., the Regional Nurse Consultant provided a document with a revised date of 11/15, titled, "SBAR Communication Form," ...2. The licensed nurse will ensure relevant aspects of pages one through three are completed prior to calling the physician or other Healthcare Professional ...." On 7/22/24 at 11:12 a.m., the Regional Nurse Consultant provided a document with a revised date of 11/16, titled, "Change in Resident Condition/Emergency Transfer to Acute Care		The facility's policy and procedure for "change of resident condition" has been reviewed and no changes are indicated at this time. All licensed Nursing Staff have been re-educated regarding this policy and procedure. The in-service content focused on proper completion of the SBAR communication tool and proper notification of the resident family and physician of change in condition requiring a hospital transfer. A monitoring tool/audit tool has been implemented. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The Director of Nursing or designee will be responsible to complete audits. The audits will include observation of documentation completed after a Resident is transferred to a hospital, to ensure completion of all communication documents and proper notification of physician and family. The audits will be conducted on 100% of the residents transferred to the hospital weekly for four weeks and then every other week for four weeks and then monthly. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be	

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	Hospital," and indicated it was the policy currently being used by the facility. The policy indicated, " ...In the event a resident's condition changes warranting medical attention, the licensed nurse shall complete the SBAR communication form and contact the physician ...The family/resident representative shall be notified of the change in condition and corresponding physician orders ...." 3.1-12(a)(5)(A) 3.1-12(a)(6)(A)(ii) 3.1-12(a)(6)(A)(vii) 3.1-12(a)(6)(B)		discussed during the facility's QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices on the basis of compliance until 100% compliance is achieved.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and			

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	(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's indwelling urinary catheter (catheter-a tube which is inserted into the bladder to drain urine) bag and tubing were kept from making contact with the floor for 1 of 1 residents reviewed for urinary catheters (Resident 36). Findings include: During the initial observation, on 7/16/24 at 2:03 p.m., Resident 36 was in his room sitting in a recliner. His catheter was attached to the lower portion of the recliner. The catheter urinary drainage bag (a bag attached to a indwelling urinary catheter to catch the urine) was in contact with the floor. During a random observation, on 7/17/24 at 1:16 p.m., the resident was in his room sitting in his wheelchair. The catheter tubing was observed in contact with the floor. During a random observation, on 7/18/24 at 2:13 p.m., the resident was sitting in his room in the recliner. His catheter was attached to the lower portion of his wheelchair next to the recliner. The	F 0690	**F690** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 36 was not negatively affected by the alleged deficient practice; the catheter tubing and bag were adjusted to ensure that it is kept from making contact with the floor. Resident #36 observed for SXS of UTI or other complications. Resident #36 Physician contacted and updated. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** No other Residents were affected by the alleged deficient practice; however, all residents with indwelling Foley catheters have the potential to be affected. Audits of all Residents who have an indwelling Foley catheter has	08/19/2024

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	catheter bag was observed in contact with the floor. During a random observation with the Assistant Director of Nursing (ADON), on 7/18/24 at 2:31 p.m., the resident was observed sitting in the recliner. The catheter bag was attached to the lower portion of his wheelchair sitting next to the recliner. The catheter bag was observed in contact with the floor. During a random observation, on 7/22/24 at 10:39 a.m., the resident was observed sitting on the side of his bed. The bed was in a very low position. A tub barrier, used to hold the catheter bag while the bed was in a low position, was flipped upside down and the catheter tubing was observed in contact with the floor. Resident 36's record was reviewed on 7/18/24 at 9:58 a.m. The profile indicated the resident's diagnoses included, but were not limited to, obstructive and reflux uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional), unspecified hydronephrosis (a condition where one or both kidneys become stretched and swollen as the result of a build-up of urine inside them), retention of urine, and urinary tract infection (UTI). An admission Minimum Data Set (MDS) assessment, dated 6/21/24, indicated the resident had no cognitive deficit, required extensive assistance of two plus with transfers and toileting, and had an indwelling urinary catheter. A care plan, dated 6/25/24, and revised 7/5/24, indicated the resident had obstructive uropathy and had a catheter. Intervention included, but		been completed with focus placed on proper placement of drainage bag and tubing to ensure that there is no contact with the floor. Corrective action immediately implemented as warranted. **What measures will be put into place and systemic change will be made to ensure the deficient practice does not recur?** The facility's policy and procedure for "Foley catheter drainage system" has been reviewed and no changes are indicated at this time. All Nursing Staff have been re-educated regarding this policy and procedure. The in-service content focused on proper placement of Foley catheter drainage bag and tubing to ensure kept from making contact with the floor. A monitoring tool/audit tool has been implemented. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The Director of Nursing or designee will be responsible to complete audits. The audits will include observation of Foley catheter drainage systems and tubing to ensure that they are stored in a proper manner and are not making contact with the floor. The audits will be conducted on 100% of the residents with Foley	

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	were not limited to, observed for signs and symptoms of infection. A physician's order, dated 7/9/24, with a stop date of 7/12 24, indicated to administer one amoxicillin-potassium clavulanate (a drug used to treat bacterial infections), 875-125 milligrams (mg) tablet, every 12 hours for urinary tract infection (UTI). During an interview, on 7/18/24 at 10:55 a.m., the resident indicated he was aware that he had been taking an antibiotic for a UTI. They had given him a new catheter, a week or so ago, because he had a UTI. He had only taken the antibiotic for 3 days or so and it ended about a week ago. During an interview, on 7/18/24 at 2:31 p.m., the ADON indicated catheter bags and the tubing should never be in contact with the floor. On 7/18/24 at 9:40 a.m., the Regional Nurse Consultant provided a document, with a revision date of 1/2020, titled "Urinary Drainage Bag Maintenance, " and indicated it was the policy currently being used by the facility. The policy indicated, "...Rule: ...Urinary drainage bag should not be allowed to touch the floor. Use the following procedure to secure the drainage bag: ...2. Explain to the resident the following: ...Do not allow the urinary drainage bag or tubing to touch the floor...." 3.1-41(a)(2)		catheters twice weekly for four weeks and then weekly for four weeks and then monthly. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices on the basis of compliance until 100% compliance is achieved.	
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			

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	155124	A. BUILDING 00 B. WING	07/22/2024

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	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 observations and interview, the facility failed to ensure medication were labeled and stored properly for 2 of 2 medication carts and 1 of 2 medication treatment carts reviewed for medication storage (Residents 72, 63 and 5). Findings include: On 7/18/24 at 11:00 a.m., during a medication cart observation. Lantus insulin pen (an injection device that you can use to deliver preloaded insulin into your subcutaneous tissue, the innermost layer of skin in your body) with the name of Resident 72 written on the side of the pen was observed. A pharmacy prescription label was	F 0761	**F 761** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Residents # 72, 63, and 5 were not negatively affected by the alleged deficient practice; All of the medication and treatment carts have been audited to ensure that all medications and treatments are properly labeled, dated open (as per policy) and stored properly. All corrective	08/19/2024

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	not on the pen and there was no indication of when the insulin pen had been opened. Resident 72's Lantus insulin vial (a small glass bottle, used to store medication in the form of liquids) prescription label did not indicate the date it was opened. Resident 63's Lantus insulin pen pharmacy prescription label indicated the dispense date was 5/30/24. The label did not indicate the date it was opened. Resident 5's Novolog insulin pen prescription label indicated the dispense date was 5/1/24. The prescription label did not indicate the date it was opened. Resident 5's Aspart insulin pen prescription label indicated it was dispensed on 2/4/24. The label did not indicate the date it was opened. On 7/18/24 at 11:05 a.m., during an interview with Licensed Practical Nurse (LPN) 4, the nurse indicated every insulin vial and insulin pen should be dated when opened and be discarded after 16 to 30 days. On 7/19/14 at 9:35 a.m., during initial observation of north back hall treatment medication cart. Numerous prescribed ointments and topical medications were loose in the drawer, no medications were bagged, and several medications had no prescription labels. On 7/19/24 at 11:00 a.m., during an interview with the Assistant Director of Nursing, she indicated the treatment medications should be separated in individual bags in the treatment carts.		actions were immediately implemented. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** No other Residents were affected by the alleged deficient practice; however, all residents have the potential to be affected. Audits of all treatment and medication carts have been audited to ensure that all Resident's medications and treatments are labeled and dated as warranted and stored properly. Corrective action immediately implemented as warranted. **What measures will be put into place and systemic change will be made to ensure the deficient practice does not recur?** The facility's policy and procedure for "medication and treatment storage" has been reviewed and no changes are indicated at this time. All Licensed Nursing Staff have been re-educated regarding this policy and procedure. The in-service content focused on proper storage of medication and dating date opened on medication as applicable. A monitoring tool/audit tool has been implemented. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	On 7/18/2024 at 2:20 p.m., the Regional Nurse Consultant provided a document, titled Medication storage, "Storing Drugs," dated 12/2017, and indicated it was the policy currently being used by the facility. The policy indicated, "..Procedures ... 1.Each drug must be kept and stored in the labeled dispensing container ...12. All drug storage areas must be clean, well lit, and free of clutter at all times ...." On 7/18/2024 at 2:00 p.m., the Regional Nurse Consultant provided a document, titled, "Medication Expiration," dated 9/2017, and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure ...1 ... d. Multiple dose injections, such as insulin will expire 28 days after opening unless otherwise noted by manufacturer ...2. Facility staff shall date the label of any multiuse vial when the vial is first accessed ..." 3.1-25(j)		**assurance program will be put into place.** The Director of Nursing or designee will be responsible to complete audits. The audits will include observation of storage of medications and treatments and that medications requiring dates when opened are properly dated. The audits will be conducted on 100% of the medication and treatment carts weekly for four weeks and then every other week for four weeks and then monthly. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices on the basis of compliance until 100% compliance is achieved.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted			

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

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	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 ensure medications administered to a resident had been documented for 1 of 5 residents reviewed for unnecessary medication (Resident 39). Findings include: Resident 39's record was reviewed on 7/17/24 at 2:32 p.m. The profile indicated the resident's diagnoses included, but were not limited to, overactive bladder (causes sudden urges to urinate that may be hard to control), vascular dementia (problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to the brain), anxiety disorder (feelings of fear, dread, and uneasiness that may occur as a reaction to stress), and hyperlipidemia (elevated fats in the blood). A physician's order, dated 11/1/23, indicated to administer 1 tablet of oxybutynin chloride (used to	F 0842	**F 842** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 39 was not negatively affected by the alleged deficient practice. Resident #39 was assessed for potential complications and the Physician was contacted and updated regarding the resident assessment. All corrective actions were immediately implemented. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** No other Residents were affected by the alleged deficient practice;	08/19/2024

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	treat symptoms of overactive bladder) 5 milligrams (mg) twice daily. The July 2024 Medication Administration Record (MAR) lacked documentation of the medication being administered on the evening shift of 7/3/24. A physician's order, dated 12/28/23, indicated to administer 1 tablet of galantamine (used to treat the symptoms of Alzheimer's disease [a type of dementia]), 4 mg two times daily. The July 2024 MAR lacked documentation of the medication being administered on the evening shift of 7/3/24. A physician's order, dated 1/24/24, indicated to administer 1 tablet of lorazepam (used to treat anxiety) 0.5 mg one time daily. The July 2024 MAR lacked documentation of the medication being administered on the evening shift of 7/3/24. A physician order, dated 2/29/24, indicated to administer 1 tablet of atorvastatin (drug to lower the amount of fats in the blood) 20 mg once daily. The July 2024 MAR lacked documentation of the medication being administered on the evening shift of 7/3/24. A physician's order, dated 6/26/24, indicated to administer 1 tablet of memantine (used to treat dementia) 10 mg two times daily. The July 2024 MAR lacked documentation of the medication being administered on the evening shift of 7/3/24. During an interview, on 7/18/24 at 1:45 p.m., the Regional Clinical Nurse indicated the expectation was that nurses would document the administered of a medication when the drug was administered. On 7/18/24 at 2:00 p.m., the Regional Nurse Consultant provided a document, with a revision date of 4/2017, titled, "Medication		however, all residents have the potential to be affected. Audits of medication administration and documentation of medication administration for the last 14 days has been completed to ensure that each medication administered has been properly documented. Corrective action immediately implemented as warranted. **What measures will be put into place and systemic change will be made to ensure the deficient practice does not recur?** The facility's policy and procedure for "medication administration and documentation" has been reviewed and no changes are indicated at this time. All Licensed Nursing Staff have been re-educated regarding this policy and procedure. The in-service content focused on ensuring proper documentation after medication administration. A monitoring tool/audit tool has been implemented. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The Director of Nursing or designee will be responsible to complete audits. The audits will include observation of documentation of medication administration to ensure	

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	Administration," and indicated it was the policy currently being used by the facility. The policy indicated, "...Guidelines for Medication Administration...21. Always record the dose of the medication on the MAR after the resident consumption...." 3.1-48(c)(2)		medications are properly documented. The audits will be conducted on 100% of the residents to ensure that each medication given is properly documented. The rate of the audits will be conducted weekly for four weeks and then every other week for four weeks and then monthly. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices on the basis of compliance until 100% compliance is achieved.	