STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(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. This visit included the Investigation of Complaint IN00390697. Complaint IN00390697-Substantiated. Federal/State deficiencies related to the allegations are cited at F684. Survey dates: November 1, 2, and 3, 2022. Facility number: 000273 Provider number: 15A011 AIM number: 100267870 Census bed type: NF: 127 Total: 127 Census payor type: Medicaid: 126 Other: 1 Total: 127 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on November 9, 2022	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. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.	
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,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dawn Wendel	Administrator	11/22/2022

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

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	including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on interview and record review, the facility failed to ensure staff respect and maintain residents' dignity for 1 of 1 residents reviewed for reportable incidents. (Resident 53)	F 0550	F550 Requires the facility to ensure staff respect and maintain residents' dignity. 1. Resident #53 had mental	11/16/2022

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	Findings include: The clinical record for Resident 53 was reviewed on 11/1/22 at 11:30 a.m. The diagnosis for Resident 53 included, but was not limited to, congenital malformations of brain - cerebral ventriculomegaly. A reportable incident dated 6/22/22 was reported to the Indiana Department of Health. It indicated "...[Certified Nursing Assistant (CNA) Student 2] reports to [License Practical Nurse (LPN) 4] she 'thinks...is pretty sure' she heard CNA [1] slap resident in resident room. [LPN 4] immediately assessed Resident [53]'s forearms, legs, face, to determine if any red marks. Resident was not crying or fussy. Accused staff member was removed from unit and clocked out Administrator notified and employee per policy was walked out of facility pending investigation...Full body assessment was completed...No signs or symptoms of trauma. No red areas. Resident does not exhibit any signs of discomfort. [LPN 4] took statements from the accuser [CNA Student 2] and accused [CNA 1]. [CNA Student 2] states she saw accused enter resident room as resident was pulling on her pulse ox [oximeter] and throwing everything on the floor. It was heard that the accused staff member [CNA 1] stated 'if you're going to act like a three year old, I'm going to treat you like a 3 year old.' There were no witnesses and no one else heard this incident. Accused [CNA 1] via phone states she regrettably did say 'you are acting like a three year old.' Resident was 'upset' and throwing everything on the floor. Resident was in her wheelchair. Accused [CNA 1] denied any physical contact with resident [53]...Resident [53] did not exhibit any changes in demeanor, was not crying or had no areas of		anguish assessment completed with no concerns noted. 2. All residents have the potential to be affected. The staff was immediately inserviced on how to maintain dignity when speaking to residents. Reportables for the last 30 days were reviewed to ensure resident's dignity was maintained. No concerns were noted. See below for corrective measures. 3. The resident rights policy and procedure was reviewed with no changes made. (See attachment A) The staff was inserviced on the above procedure. 4. The DON or her designee will conduct rounds twice a day ensuring dignity is being maintained by the staff towards the residents. The DON or her designee will utilize the nursing monitoring tool daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. 5. The above corrective measures will be completed on or before November 16, 2022.	

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	concern with her full body assessment. Additional inquiries were made to staff members if they have ever observed [CNA 1] abusing residents. They all responded in the negative. Immediate abuse in-servicing was initiated...Follow up: Accused CNA [1] was counseled and very remorseful and understands that her words and actions do matter. The allegation of abuse is unsubstantiated. " The statement written by CNA Student 2 dated 6/22/22 indicated, "At approximately 10:15 p (p.m.) I was standing in the hallway...[Resident 53] was pulling on her pulse/ox [oximeter] and [CNA 1] got mad and went in the room. She yelled [Resident 53's name] and 'No!' then said 'if you are going to act like a 3 year old, I'm going to treat you like a 3 year old.'...All I saw was [CNA 1] acting and speaking in an agitated tone during and after it happened..." The statement written by CNA 1 indicated "...When I was doing my 10 o'clock [10:00 p.m.] bed check, I knew [Resident 53] was upset (she was throwing everything on the floor). I proceeded to gently scold her by saying you are acting like an actual 3 year old. I then took the pulse ox cord out of her hand gently and off her lap and put it back on the table. She pulled it off again and jokingly told [Qualified Medication Aide (QMA) 3] to come get her child. (we joke all the time w/ (with) everyone). I would never, never ever abuse the residents in any sort of way. I look at them like my own kids and family (love them like it too.) I cross my heart, swear, and promise that everything written above is correct. P.S. [written after] I apologize for what I said. I should have never said anything at all. She nor any other resident deserve anything like that. I was not thinking while everything was happening and I should have thought and stood back before I said			

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	or did anything..." A statement by LPN 4 on 6/22/22 indicated "...Patient [Resident 53] had clear assessment. She showed no signs or symptoms of distress. Patient skin was free of any alterations...Continued observation of patient continued. Patient in chair smiling playing with a toy with no signs or symptoms of distress. Patient vital signs within normal limits and skin remains clear of any alteration..." An interview was conducted with CNA Student 2 on 11/2/22 at 5:05 p.m. She indicated she did not visibly observe CNA 1 and Resident 53's interaction. CNA Student 2 had been standing in the hallway across Resident 53's room when she had overheard CNA 1 speaking with an agitated tone to Resident 53 in her room. CNA 1 was heard stating to the resident, "if you are going to act like a 3 year old, I'm going to treat you like a 3 year old." After, CNA Student 2 went in Resident 53's room to check on her and reported the incident. Resident 53 appeared to be okay after the incident. An interview was conducted with CNA 1 on 11/2/22 at 5:11 p.m. She indicated she had went into Resident 53's room, because the resident was crying. The resident then started throwing stuff on the floor. At that time, she stated to Resident 53 'if you are going to act like a three year old, I am going to treat you like a three year old." CNA 1 indicated during that time, she was aggravated, but she had not yelled or slapped the resident. An interview was conducted with QMA 3 on 11/3/22 at 12:09 p.m. She indicated she had been working on the day of the incident between CNA 1 and Resident 53, but she had not observed the			

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	incident. During that time, she was in the bathroom outside of the residents' rooms; bathing another resident. However, she did hear CNA 1 yelling down the hallway for her to get her child while she was in the bathroom. QMA 3 indicated there were occasions, she had observed CNA 1 "agitated" and using a "snappy" tone with the residents. A resident rights policy was provided by the Administrator on 11/3/22 at 1:15 p.m. It indicated "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..." 3.1-3(a)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			

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	Based on interview and record review, the facility failed to thoroughly investigate an allegation of abuse for 1 of 1 residents reviewed for reportable incidents. (Resident 53) Findings include: The clinical record for Resident 53 was reviewed on 11/1/22 at 11:30 a.m. The diagnosis for Resident 53 included, but was not limited to, congential malformations of brain - cerebral ventriculomegaly. A reportable incident dated 6/22/22 was reported to the Indiana Department of Health. It indicated "...[Certified Nursing Assistant (CNA) Student 2] reports to [License Practical Nurse (LPN) 4] she 'thinks...is pretty sure' she heard CNA [1] slap resident in resident room. [LPN 4] immediately assessed Resident [53]'s forearms, legs, face, to determine if any red marks. Resident was not crying or fussy. Accused staff member was removed from unit and clocked out Administrator notified and employee per policy was walked out of facility pending investigation...Full body assessment was completed...No signs or symptoms of trauma. No red areas. Resident does not exhibit any signs of discomfort. [LPN 4] took statements from the accuser [CNA Student 2] and accused [CNA 1]. [CNA Student 2] states she saw accused enter resident room as resident was pulling on her pulse ox [oximeter] and throwing everything on the floor. It was heard that the accused staff member [CNA 1] stated 'if you're going to act like a three year old, I'm going to treat you like a 3 year old.' Statement then says she heard a sound that she that (sic) was a smack. There were no witnesses and no one else heard this incident. Accused [CNA 1] via phone states she regrettably did say 'you are acting like a three	F 0610	F610 Requires the facility to thoroughly investigate an allegation of abuse. 1. Resident #53 has a mental anguish assessment completed with no concerns noted. 2. All residents have the potential to be affected. Reportables for the last 30 days were reviewed to ensure a thorough investigation was completed. No concerns were noted. See below for corrective measures. 3. The Abuse policy and procedure was reviewed with no changes made. (See attachment C) The staff was inserviced on the above procedure. 4. The corporate nurse consultant or her designee will review all reportable incidents to ensure a thorough investigation is completed. The investigation will include interviews from all staff working on the unit that the incident took place on. The DON or her designee will utilize the nursing monitoring tool daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted.	11/16/2022

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	year old.' Resident was 'upset' and throwing everything on the floor. Resident was in her wheelchair. Accused [CNA 1] denied any physical contact with resident [53]...Resident [53] did not exhibit any changes in demeanor, was not crying or had no areas of concern with her full body assessment. Additional inquiries were made to staff members if they have ever observed [CNA 1] abusing residents. They all responded in the negative. Immediate abuse in-servicing was initiated...Follow up: Accused CNA [1] was counseled and very remorseful and understands that her words and actions do matter. The allegation of abuse is unsubstantiated. " The investigation file was provided by the Assistant Administrator on 11/2/22 at 3:55 p.m. It included the following documentation: - incident report that was reported to Indiana Department of Health, - Resident 53's face sheet, - Possible or Potential Mental Anguish Assessment, - documentation titled counseling provided to CNA 1, - statement written by CNA 1, - statement by Respiratory Therapist 5, - Resident 43's skin assessment, - statement by LPN 4, - statement by CNA Student 2, and - statement by Director of Nursing The statement written by CNA 1 indicated "...When I was doing my 10 o'clock [10:00 p.m.] bedcheck, I knew [Resident 53] was upset (she was throwing everything on the floor). I proceeded to gently scold her by saying you are acting like an actual 3 year old. I then took the pulse ox cord out of her hand gently and off her		5. The above corrective measures will be completed on or before November 16, 2022.	

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	lap and put it back on the table. She pulled it off again and jokingly told [Qualified Medication Aide (QMA) 3] to come get her child. (we joke all the time w/ (with) everyone). I would never, never ever abuse the residents in any sort of way. I look at them like my own kids and family (love them like it too.) I cross my heart, swear, and promise that everything written above is correct. P.S. [written after] I apologize for what I said. I should have never said anything at all. She nor any other resident deserve anything like that. I was not thinking while everything was happening and I should have thought and stood back before I said or did anything..." The investigation file did not include a statement from QMA 3. An interview was conducted with the Administrator and the Assistant Administrator on 11/3/22 at 11:49 a.m. The Administrator indicated if the file did not include QMA 3's statement; it must not have been conducted. An interview was conducted with QMA 3 on 11/3/22 at 12:09 p.m. QMA 3 indicated she had not been interviewed about the incident between CNA 1 and Resident 53. She had not observed the incident. During that time, she was in the bathroom outside of the residents' rooms; bathing another resident. However, she did hear CNA 1 yelling down the hallway for her to get her child while she was in the bathroom. An abuse policy was provided by the Assistant Administrator on 11/1/22 at 3:19 p.m. It indicated "...Investigation, Protection and Reporting...If Resident Abuse, or suspicion of abuse is reported:...12. Statements shall be taken including, but not limited to, facts and observations by			

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	witnessing employees,... facts and observations by any others who might have pertinent information,...15. The Administrator is responsible to coordinate the investigation, assure an accurate and complete written record of the incident and investigation..." 3.1-28(d)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to timely assess a resident after sustaining a head injury involving a Hoyer lift and to timely notify the physician of vomiting for 1 of 3 residents reviewed for skin conditions and 1 of 4 residents reviewed for hospitalization. (Residents B and 112) Findings include: 1. The clinical record for Resident B was reviewed on 11/1/22 at 1:45 p.m. The diagnoses included, but were not limited to, traumatic brain injury and spastic quadriparesis. The 8/28/22 hospital emergency department report indicated he had a remote history of a gunshot wound to the head, status post craniotomy (operation in which a small hole is made in the	F 0684	F684 Requires the facility to timely assess a resident after sustaining a head injury involving a Hoyer lift and to timely notify the physician of vomiting. 1. Resident B was assessed at the hospital and no injuries were indentified per head CT scan. Resident #112 had no further issues with vomiting. 2. All residents have the potential to be affected. Nurse's Notes were reviewed to ensure resident's were assessed and the physician was notified with the change in their condition. No concerns were noted. See below for corrective measures. 3. The Change in Resident's	11/16/2022

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	skull or a piece of bone from the skull is removed to show part of the brain,) VP shunt (small plastic tube that helps drain extra cerebrospinal fluid from the brain,) quadriparesis, and was nonverbal at baseline. An observation of Resident B was made on 11/1/22 at 1:51 p.m. The upper left side of his forehead appeared swollen. The 8/28/22, 10:00 a.m. nurse's note, written by LPN 15, read, "QMA informed writer bump on res [resident] head, writer assessed, noted 3 x 3 cm knot to left temple, skin assessment done, neuro checks initiated. Notified [name of Physician 12] [symbol for "no"] N.O.'s [new orders,] notified [name of Family Member 14.]" An interview was conducted with Family Member 14 on 11/1/22 at 2:09 p.m. She indicated Resident B required a Hoyer lift for transfers. When he was being transferred one Friday night, he was hit in the head with the lift. LPN (Licensed Practical Nurse) 15 called her on Sunday to inform her he had a knot on his head and apologized that she wasn't notified sooner. The area of his head where the knot was "is already poofy because that's where his surgery was." She went to the facility immediately and requested he be sent to the hospital for evaluation. His scans were fine, and he was released. She understood that accidents happened, but was concerned that he was hit in the head and went to sleep afterwards. Resident B had a VP shunt on the upper left side of his head, where the knot was, so she was upset that the CNAs (Certified Nursing Assistants) who transferred him "were too comfortable covering up something that could have been detrimental to [name of Resident B.]"		Condition policy and procedure was reviewed with no changes made. (See attachment D) The staff was inserviced on the above procedure. 4. The DON or her designee will review nurse's notes daily and ensure a change in condition of a resident is reported to their physician in a timely manner. The DON or her designee will utilize the nursing monitoring tool daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. 5. The above corrective measures will be completed on or before Nov 16, 2022.	

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	An interview was conducted with LPN 15 on 11/1/22 at 2:44 p.m. He indicated he was the nurse on duty when one of the QMAs (Qualified Medication Aides) found the knot on Resident B's head. He just filled out the incident report and gave it to the DON (Director of Nursing.) He stated, "It was a couple days that went by before we found out about it." He supposed that when the CNA transferred him with the Hoyer lift, the bar from the Hoyer lift hit him in the head. An interview was conducted with the NC (Nurse Consultant) on 11/2/22 at 9:50 a.m. She indicated Resident B received a shower at 3:00 a.m. on 8/28/22 when the incident happened. The CNAs verbally informed the nurse of the incident "in passing," but the nurse, LPN 16, didn't recall hearing it. It was 6 or 7 hours later that one of the aides noticed a bump on his head and informed LPN 15. LPN 15 began neuro (neurological) checks and notification. Family Member 14 wanted him sent to the hospital. A CT scan was done at the hospital and it came back fine, so he returned to the facility and neuro checks were discontinued. The 8/28/22 emergency department report read, "Chief complaint: Head Injury....I spoke with staff member from [name of facility] (by phone), who notified that patient was struck in the head by a part from a Hoyer lift 2 days ago while being transferred. He did not have LOC [loss of consciousness.] They have been doing neurologic checks, which have not shown any change in his neurologic status. He has not had any vomiting. No seizures. His parents visited him today. They learned of the head injury today, requested that he be evaluated....CT [Computerized tomography] head shows no acute findings...Discharge Plan Discharge Clinical			

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	15A011	A. BUILDING 00 B. WING	11/03/2022

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	Impression: Minor head injury." On 11/2/22 at 2:08 p.m., an interview was conducted with CNA 17, who assisted with Resident B's Hoyer lift transfer. She indicated she and CNA 18 assisted Resident B with a bath. When lifting him out of the tub with the Hoyer lift, she was controlling the lift and CNA 18 was guiding Resident B into his chair. When she pulled the lift out above the floor, CNA 18 "yanked on it too hard and too fast to where it hit him on the head," in the forehead area. CNA 17 informed CNA 18 they needed to tell the nurse. She'd never been in that situation before, and CNA 18 worked at the facility longer. When they were assisting Resident B back to his room after his bath, CNA 18 informed LPN 16 of the lift hitting Resident B in the head, but she never saw LPN 16 go into Resident B's room to assess him afterwards. The following Sunday, the DON called and asked her about the incident. There was an incident report that was supposed to be filled out at the time of the incident, but neither she nor CNA 18 completed one. It was 2:00 in the morning and she was tired. LPN 16 and CNA 18 were unavailable for interview. The Accident and Incident Reporting policy was provided by the DON on 11/3/22 at 10:01 a.m. It read, "An Accident/Incident Report form is to be completed for all incidents involving residents, employees and visitors. A written description of circumstances surrounding the incident is to be completed and submitted to the nursing supervisor as soon as possible during the tour of duty in which the incident occurred. The report form should be initiated as soon as possible following the incident, after appropriate			

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	assessment and necessary emergency intervention is completed. The report is an internal facility document and is not part of the resident's clinical record. PROCEDURE: 1. Resident: Complete assessment and provide necessary emergency care. Notify physician, family, and nursing supervisor....In all Cases: Generate Accident/Incident Report Form." A blank Accident and Incident Report and Investigation form was provided by the DON on 11/3/22 at 10:01 a.m. It included fields for the date, time, and location of incident, physician notification date and time, representative notification date and time, thorough description of incident, type of injury, vital signs, whether neurochecks were initiated, whether it was known or suspected that the resident hit their head or face, changes in cognition, signs of pain, etc. 2. The clinical record for Resident 112 was reviewed on 11/1/22 at 12:21 p.m. The diagnoses included, but were not limited to, quadriplegia and chronic respiratory failure. She was admitted to the facility on 7/19/22 with a NG tube (nasogastric tube inserted through the nose, down the throat and esophagus, and into the stomach used to give medication, liquids, or liquid food.) The NG tube care plan indicated she required an NG tube for nutrition/hydration. Interventions were to monitor for complications and report any findings to the nurse for further evaluation and possible physician and resident representative notification. The 9/1/22, 6:40 a.m. note, written by QMA (Qualified Medication Aide) 19, indicated, "...lg [large] amount emesis @ 8p [8:00 p.m.], nurse checked placement, [symbol for "no"] distress,			

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	[symbol for 'no'] further emesis." The note did not reference physician notification of the emesis. The 9/1/22, 7:00 p.m. nurse's note read, "...emisis [sic] x [times] 1..." The note did not reference physician notification of the emesis. The 9/1/22, 9:30 p.m. nurses note, written as a late entry by LPN (Licensed Practical Nurse) 20, read, "Late entry. Res [Resident] lg emesis [symbol for 'with'] NG tube out. Replaced NGT [tube] [symbol for 'right] nare. Tol [Tolerated] well [symbol for 'and'] in place. The note did not reference physician notification of the emesis. The 9/2/22, 2:00 a.m. nurse's note, written as a late entry by LPN 20, read, "Late entry res tol feeding NGT in place [symbol for 'and'] patent." The note did not reference physician notification of the previous episodes of emesis. The 9/2/22, 6:20 a.m. nurse's note, written by LPN 20, read, "[Symbol for 'increased'] Resp [respirations] noted resp [respiratory] distress per RT [respiratory therapy.] PRN [As needed] ALB 0.83% [albuteral inhalation] given per order..." The 9/2/22, 6:25 a.m. nurse's note, written by LPN 20, read, "911 called. [Name of Physician 12] paged [symbol for 'and'] returned call directly informed res condition [symbol for 'change'.]" The 9/2/22 to 9/9/22 hospital notes read, "...presented to the PICU [pediatric intensive care unit] from OSH (and name of facility) on 9/2 with acute on chronic respiratory failure 2/2 [secondary to] suspected aspiration PNA [pneumonia.] ...Admitted on 9/2 with increased respiratory support needs due to pneumonia and UTI [urinary tract infection....]"			

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	An interview was conducted with LPN 20 on 11/3/22 at 4:05 p.m. She indicated she would go by her note from 9/2/22 at 6:25 a.m. as to when she first notified the physician of Resident 112's episodes of emesis. She did not recall earlier notification. An interview was conducted with the DON (Director of Nursing) on 11/2/22 at 1:50 p.m. She reviewed Resident B's nursing notes and indicated she would look into whether the physician was notified of the episodes of emesis sooner than 9/2/22 at 6:25 a.m. when she was in respiratory distress. The physician should have been notified of the episodes of emesis. An interview was conducted with the DON on 11/3/22 at 9:49 a.m. She indicated she was unable to locate any verification the physician was notified of Resident 112's episodes of emesis prior to 9/2/22 at 6:25 a.m. The Tube Feedings policy was provided by the DON on 11/3/22 at 10:01 a.m. It read, "A resident who is fed by a naso-gastric or gastrostomy tube will receive the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcer....Observations: Caregivers must be alert to signs and symptoms of aspiration....When a resident is receiving a tube feeding, the following must be reported to the nurse immediately if observed: nausea..." This Federal tag relates to complaint IN00390697. 3.1-37(a)			

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F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, interview, and record review, the facility failed to provide appropriate care and services to a resident who received tube feeding by not labeling the tube feeding bag correctly and re-using a tube feeding bag in excess of 24 hours. (Resident 69) Findings include: The clinical record for Resident 69 was reviewed on 11/3/22 at 11:46 a.m. Resident 69's diagnoses included, but not limited to, Duchenne or Becker muscular dystrophy, dysphagia (difficulty with swallowing), gastrostomy, and dependence on ventilator.	F 0693	F693 Requires the facility to provide appropriate care and services to a resident who receives tube feeding by labeling the tube feeding bag correctly and using the bag for 24 hours only. 1. Resident #69 tube feed bag was changed and labeled with the correct date. 2. All residents have the potential to be affected. An audit of all tube feeding bags was completed to ensure that the correct date was labeled on the bag and only hung for 24 hours.	11/16/2022

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	An observation of Resident 69 was made on 11/01/22 at 11:07 a.m. At the time, Resident 69 had a feeding bag hanging. It was labeled as "H2O" with a date of "10/30/22" which was handwritten in black marker on the bag and the contents of the bag was being infused via a pump to his G-tube (gastrostomy tube). The feeding bag contained a light tan liquid and the cap at the top of the feeding bag was left off and the contents of the bag was exposed to air. A physician's order dated 10/26/22 indicated, to give Resident 69 a 250 ml (milliliter) bolus of Fibersource HN (sic, high-nitrogen, type of tube feeding) via his G-tube daily at 8 a.m. for nutrition. An interview with LPN (licensed practical nurse) 10 conducted on 11/01/22 at 11:26 a.m. indicated, she had poured the tube feeding into the same bag that was previously used for an infusion of water. She further indicated, she had not noticed the date on the bag was from 2 days prior nor had she realized the cap was left off of the bag. An interview with DON (Director of Nursing) was conducted on 11/03/22 at 11:22 a.m. DON indicated, the contents of the feeding bag should be labeled in accordance with their policy, feeding bag use should not exceed 24 hours and if the feeding was ordered as a bolus, then it should not have been in a hanging bag. Resident 69's tube feeding care plan dated, 9/15/22 indicated, to administer tube feeding as ordered. Resident 69's nutrition care plan dated 9/18/22 indicated, at administer tube feedings and flushes per physician's orders. A Tube Feedings policy and procedure was		No concerns were noted. See below for corrective measures. 3. The Tube Feeding policy and procedure was reviewed with no changes made. (See attachment E) The staff was inserviced on the above procedure. 4. The DON or her designee will conduct daily rounds to ensure that tube feeding bags are dated correctly and hung for 24 hours. The DON or her designee will utilize the nursing monitoring tool daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. 5. The above corrective measures will be completed on or before Nov 16, 2022.	

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	received on 11/3/22 at 10:51 a.m. from DON. The policy and procedure indicated, "Physician orders...1. Formula and flow rate, Include 'continuous' or time frame of installation. If bolus, include the amount to administer with specific time to administer...Labeling/Care of the Feeding Set: Label feeding bag or container with resident's name, date, and time opened. Dispose of the bag or container every 24 hours or as indicated, observant of specific hang time recommendation by the manufacturer to prevent excessive microbial growth." 3.1-44(a)(2)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a			

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	minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on interview and record review, the facility failed to follow through with a pharmacy recommendation for 1 of 5 residents reviewed for unnecessary medications. (Resident 89) Findings include: The clinical record for Resident 89 was reviewed on 11/3/22 at 9:43 a.m. The diagnoses included, but were not limited to, insomnia. The insomnia care plan indicated an intervention was to administer medications as ordered. The monthly physician's orders indicated for one 3 mg tablet of melatonin to be administered at bedtime, effective 7/28/22, for sleep disturbance. The 9/6/22 pharmacy Note To Attending Physician/Prescriber read, "Gradual Dose	F 0756	F756 Requires the facility to follow through with pharmacy recommendations. 1. Resident #89's Melatonin was decreased per the recommendation of the pharmacist by the physician. 2. All residents have the potential to be affected. Pharmacy reports for the last 30 days were reviewed to ensure recommendations were addressed with the physican and implemented. No concerns were noted. See below for corrective measures. 3. The Pharmacy Recommendations/Medication Regimen Review policy and procedure was reviewed with no	11/16/2022

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	Reduction Review Med [Medication] Order for review: Melatonin 3 mg QHS [every night at bedtime] DX [Diagnosis:] sleep disturbance. If appropriate for GDR [gradual dose reduction] please consider: Melatonin 1 mg QHS DX: sleep disturbance." The Physician/Prescriber Response section was signed on 9/16/22 to accept the recommendation. The 9/16/22 hand written telephone physician's order indicated to discontinue the 3 mg of melatonin order and to start 1 mg of melatonin. The 10/4/22 pharmacy Note To Attending Physician/Prescriber read, "There is a signed GDR request from [name of Physician 12] dated 9/16/2022 to decrease the Melatonin order. The new order reads Melatonin 3 mg QHS DX: sleep disturbance, however, Pharmacy did not receive the telephone order. Please discontinue the old Melatonin order & send a new order for Melatonin 1 mg QHS DX: sleep disturbance in [name of electronic health record.]" The September, October, and November, 2022 MARs (medication administration records) indicated Resident 89 continued to received the 3mg of melatonin at bedtime through November 2, 2022. An interview was conducted with the NC (Nurse Consultant) on 11/3/22 at 11:00 a.m. She reviewed Resident 89's September and October, 2022 pharmacy reviews and MARS and indicated she saw the problem and would take care of it. The Pharmacy Recommendations/Medication Regimen Review was provided by the NC on 11/3/22 at 11:19 a.m. It read, "..."The pharmacist shall report any irregularities to the attending		changes made. (See attachment F) The staff was inserviced on the above procedure. 4. The DON or her designee will review all pharmacy recommendations to ensure that the recommendations are reviewed by the physician and implemented. The DON or her designee will utilize the nursing monitoring tool daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. 5. The above corrective measures will be completed on or before Nov 16, 2022.	

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	physician, the facility's Medical Director and Director of Nursing, and these reports shall be acted upon." 3.1-25(i)			