STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155720	A. BUILDING 00 B. WING	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CATHEDRAL HEALTH CARE CENTER	520 W 9TH ST JASPER, IN 47546

(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: September 9, 10, 11, 12, 13, 2024 Facility number: 000315 Provider number: 155720 AIM number: 100289030 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 0 Medicaid: 61 Other: 3 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 26, 2024.	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 request that the plan of correction be considered our allegation of compliance effective October 12th, 2024 to the survey completed on September 13th, 2024. We respectfully request a paper review and will provide any additional information requested.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on interview and record review, the facility failed to ensure the physician and resident representative were notified of a change in condition for 1 of 4 residents reviewed for falls. The physician and resident representative were not notified of a resident's fall or x-ray results, and the resident representative was not notified of an	F 0580	F580 D Based on observation, interview, and record review, the facility failed to ensure the physician and resident representative were notified of a change in condition for 1 of 4 residents reviewed for falls.	10/12/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Allision Betz	HFA	10/03/2024

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	injury. (Resident 8) Findings include: On 9/9/24 at 10:29 A.M., Resident 8's representative indicated she had not been contacted in several months about any falls, injuries, or x-rays. To her knowledge, Resident 8 had not fallen or had any injuries recently. At that time, the representative indicated she would be the one to notify of any changes in Resident 8's condition. On 9/10/24 at 10:26 A.M., Resident 8's clinical record was reviewed. Diagnosis included, but were not limited to, other abnormalities of gait and mobility, diabetes, and Down's Syndrome. The most recent Quarterly and State Optional MDS (Minimum Data Set) Assessment, dated 6/11/24, indicated a severe cognitive impairment, and a requirement of setup with supervision for bed mobility and transfers. Physician orders included, but were not limited to: x-ray right middle finger for finger pain, dated 8/19/24. Progress notes indicated Resident 8 experienced a fall on 8/25/24 with no apparent injury. The clinical record lacked a notification to the physician or representative at the time of the fall. A nurse's note, dated 8/18/24, indicated Resident 8's right middle finger was swollen and crooked. The resident indicated to the nurse the finger had been injured on the bed enabler while getting up. The resident's representative and Nurse Practitioner (NP) were notified of the resident's condition and the note indicated the NP would		(Resident 8) **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** Immediate action was completed with nursing staff to ensure understanding of notification of change in condition to physicians and resident representatives. **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** All residents who have the potential to be affected by the alleged deficiency. An audit was conducted. **What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur:** Nurses have been educated on notification of change policy.	

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	visit the resident the following day. X-Ray report in the record for Resident 8 had an x-ray of the right middle finger on 8/19/24 related to the finger being swollen and crooked. The clinical record lacked notification to the resident's representative that the x-ray had been ordered. The x-ray result, dated 8/19/24, indicated no fractures. The result and clinical record lacked notification to the provider or resident representative of the results. On 9/12/24 at 1:15 P.M., the Director of Nursing (DON) indicated the nurse on duty when a resident falls should notify the DON, physician, and the family. She indicated on 8/25/24, no one had been notified of Resident 8's fall. She indicated a risk management note may have been entered (not part of the clinical record) and would include notification to the physician and family, but a progress note of the notification should have been put in as well. At that time, she indicated staff was expected to notify the physician and family of injuries and x-rays, and should have been done for Resident 8 for the finger pain and x-ray. On 9/13/24 at 11:00 A.M., the Administrator indicated although it was not in the facility policy to notify the physician after every fall (only those resulting in injury), it was best practice for staff to notify family and the physician following every fall. At that time, she indicated staff should be notifying family and the physician of any test results, including x-rays. On 9/13/24 at 12:00 P.M., a current Notification policy, dated 11/28/16, was provided and indicated "Our facility shall promptly notify the		**How the corrective actions will be monitored to ensure the deficient practices will not occur:** A performance improvement tool has been initiated that randomly audits five (5) residents to ensure that notification of change's is completed to physician and resident representative. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools. **By what date the systemic changes will be made:** 10/12/24	

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	Resident, his or her Physician/Physician Assistant/Nurse Practitioner, and Resident Representative/interested family member of changes in the Resident's medical/mental condition and/or status ... The Nurse will notify the Resident's Physician Assistant/Nurse Practitioner when there has been (including, but not limited to) ... An accident or incident involving the resident ... A discovery of injuries of an unknown source" 3.1-5(a)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on interview and record review, the facility failed to ensure accuracy of MDS (Minimum Data Set) Assessments for 1 of 1 resident assessments reviewed and 2 of 5 unnecessary medications reviewed. A resident's traumatic brain injury, a resident's injections, and a resident's insulin use were not marked on the MDS Assessments. A resident's bed rail was marked incorrectly as a restraint on the MDS. (Resident 8, Resident 5, Resident 27) Findings included: 1. On 9/11/24 at 8:42 A.M., Resident 5's clinical record was reviewed. Diagnoses included, but were not limited to, hemiplegia on right dominant side, dementia, epilepsy, and TBI (Traumatic Brain Injury). The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 8/6/24, indicated Resident 5's cognition was moderately impaired, an extensive assist of 2 staff for bed mobility, transfers, toileting, and the active diagnosis of	F 0641	F641 D Based on observation, interview, and record review, the facility failed to ensure MDS (Minimum Data Set) Assessments were accurate for 2 of 5 residents reviewed for unnecessary medications, and 1 of 1 resident assessment reviewed (Resident 8, Resident 5, Resident 27) **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** Resident 8's MDS assessment was revised to reflect insulin injections. Resident 5's MDS was revised to traumatic brain injury. Resident 27's MDS assessment	10/12/2024

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	TBI was marked no. 2. On 9/10/24 at 10:39 A.M., Resident 27's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's and Rhabdomyolysis (breakdown of muscle tissue that releases a damaging protein into the blood and can damage kidneys). The most recent Quarterly MDS Assessment, dated 6/28/24, indicated Resident 27's cognition was severely impaired, an extensive assist of 2 staff for bed mobility, transfers, toileting, and used a bed rail as a restraint daily. During an interview on 9/12/24 at 9:09 A.M., the MDS Coordinator indicated Resident 5 did have a TBI and the question was answered incorrectly. It should have been marked yes. Resident 27 does not use the mobility bar as a restraint. The question was answered incorrectly and should have been marked no restraints were used. 3. On 9/13/24 at 12:15 P.M., Resident 8's clinical record was reviewed. Diagnosis included, but were not limited to, type 2 diabetes mellitus. The most recent State Optional and Quarterly MDS (Minimum Data Set) Assessment, dated 6/11/24, indicated Resident 8 had a severe cognitive impairment and did not receive insulin or injections during the assessment period. Physicians Orders during the assessment period included, but was not limited to: Humalog mix 75/25 (Insulin Lispro Protamine and Lispro) subcutaneous suspension 100 Unit/ML (milliliter). Inject 15 units once a day subcutaneously related to type 2 diabetes mellitus, dated 4/20/24.		was revised to reflect no restraints. **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** All residents who have the potential to be affected by the alleged deficiency. An audit was conducted. **What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur:** MDS coordinator was educated on accuracy of MDS assessment. **How the corrective actions will be monitored to ensure the deficient practices will not occur:** A performance improvement tool has been initiated that randomly audits five (5) residents to ensure that patient's MDS Assessment is accurately completed related to insulin injections, traumatic brain	

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	Humalog mix 75/25 (Insulin Lispro Protamine and Lispro) subcutaneous suspension 100 Unit/ML (milliliter). Inject 40 units once a day subcutaneously related to type 2 diabetes mellitus, dated 4/20/24. Resident 8's MAR (Medication Administration Review) for June 2024 indicated Humalog was administered during the assessment period for the 6/11/24 MDS. During an interview on 9/13/24 at 12:20 P.M., the MDS Coordinator indicated the 6/11/24 should have indicated Resident 8 received insulin and injections, and it was coded in error. On 9/12/24 at 9:09 A.M., the MDS Coordinator indicated they did not have a policy for filling out an MDS Assessment, but they would use the RAI (Resident Assessment Instrument) manual.		injuries, restraints. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools. **By what date the systemic changes will be made:** 10/12/24	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure comprehensive assessments were completed for 1 of 12 residents reviewed with diabetes. A follow up assessment was not completed after a low blood sugar reading as indicated. (Resident 8) Finding includes:	F 0684	F684 D Based on observation, interview, and record review, the facility failed to ensure comprehensive assessments were completed for 1 of 12 residents reviewed with diabetes. (Resident 8)	10/12/2024

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	On 9/10/24 at 10:26 A.M., Resident 8's clinical record was reviewed. Diagnosis included, but were not limited to, diabetes. The most recent Quarterly and State Optional MDS (Minimum Data Set) Assessment, dated 6/11/24, indicated a severe cognitive impairment, and a requirement of setup with supervision for bed mobility and transfers. Physician orders included, but were not limited to: Accu check four times a day for diabetes, dated 2/17/24. Blood sugar 70 or below and able to swallow - Give 4 ounces orange juice or 6 ounces soda and repeat blood sugar after 15 minutes. Repeat if necessary and follow up with cheese crackers, milk and fruit or sandwich as needed for hypoglycemia, dated 12/18/24. A current diabetes mellitus care plan included, but was not limited to, the following interventions: Obtain and monitor lab and /or diagnostic work as ordered. Repeat results to physician and follow up as indicated, dated 1/14/19. A nurse's note, dated 8/16/24 at 5:00 A.M. indicated Resident 8's fasting blood sugar was 48. The Registered Nurse (RN) gave the resident a chocolate ensure and an oatmeal cream pie, and would recheck the blood sugar in 15 minutes per physician's order. Resident was alert and eating the snack. A nurse's note, dated 8/16/24 at 5:22 A.M. indicated Resident 8's blood sugar was rechecked and was 68. The resident woke for the accu check and went back to sleep. Resident indicated he		**What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** Immediate action was completed with nursing staff to ensure understanding of assessment and follow up assessment of low blood sugar. **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** All residents who have the potential to be affected by the alleged deficiency. An audit was conducted. **What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur:** Nurses have been educated on low blood sugar assessments and follow up assessments. **How the corrective actions will**	

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	was feeling ok. Resident 8's Medication Administration Record (MAR) for August 2024 indicated the following blood sugar readings on 8/26/24: 5:30 A.M. 48 12:00 P.M. not recorded (leave of absence) 4:00 P.M. 155 8:00 P.M. 175 Resident 8's August 2024 MAR lacked documentation that an as needed blood sugar was checked for a blood sugar below 70. On 9/12/24 at 1:15 P.M., the Director of Nursing (DON) indicated she had been the nurse on duty on 8/16/24 when Resident 8's blood sugar had read below 70 twice. She indicated she had not rechecked it after it read 68 although the physician's order should have been followed. On 9/12/24 at 2:20 P.M., the Administrator provided a current, non-dated, Staff Nurse job description. She indicated at that time that the information would serve as a facility policy. The form indicated "Documents accurately in resident chart any significant changes in care ... Responsible for interpretation and execution of physician's orders and call physician as indicated ... Is responsible for accurate observation, evaluation, and reporting of residents" 3.1-37(a)		**be monitored to ensure the deficient practices will not occur:** A performance improvement tool has been initiated that randomly audits five (5) residents to ensure low blood sugar assessments are completed and follow up is completed. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools. **By what date the systemic changes will be made:** 10/12/24	
F 0689 SS=D	483.25(d)(1)(2) Free of Accident			

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Bldg. 00	Hazards/Supervision/Devices Based on observation, interview and record review, the facility failed to ensure comprehensive assessments were completed appropriately for 2 of 5 residents reviewed for accidents. Fall risk assessments were not thorough and complete, and 72 hour follow up for a fall was not initiated immediately after the fall. (Resident 20, Resident 8) Findings include: 1. On 9/12/24 at 9:01 A.M., Resident 20 was propelling self down the hall in a wheelchair when she stood up and pushed wheelchair to room. LPN 6 was walking down the hall, came up beside Resident 20 and reminded her she had a walker to use if she didn't want to use the wheelchair. On 9/10/24 at 11:27 A.M., Resident 20's clinical records were reviewed. Diagnosis included, but were not limited to schizoaffective disorder, bipolar type, type II diabetes mellitus, repeated falls, extrapyramidal and movement disorder, anxiety disorder, and borderline personality disorder. The most current Quarterly MDS (Minimum Data Set) assessment, dated 8/2/24, indicated Resident 20 was severely cognitively impaired, required supervision with bed mobility and eating, limited assistance of one for transfers and extensive assistance of one for toilet use, had one fall with no injury and one fall with injury. Nursing Note 5/23/2024 10:00 Note Text: Resident fell in her room. She was found lying on her side. Resident was able to move all extremities. She was assisted to get up. Resident went to the bathroom. Resident was moaning and complaining about her roommate's	F 0689	F689 D Based on observation, interview, and record review, the facility failed to ensure comprehensive assessments were completed appropriately for 2 of 5 residents reviewed for accidents. (Resident 20, Resident 8) **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** Immediate action was completed with nursing staff to ensure fall risk assessments were completed and 72hr follow up are initiated. **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** All residents who have the potential to be affected by the alleged deficiency. An audit was conducted. **What measures will be put in place and what systemic changes will be made to**	10/12/2024

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	chair. Resident walked without difficulties. No bruised or injury noted. Resident in on neurological checks. Family, DON (Director of Nursing), and NP (Nurse Practitioner) notified. After a fall in Resident 20's room on 5/23/24, the care plan failed to be updated. After a fall on 7/5/24, the fall risk assessment indicated Resident 20 did not have any falls in the previous three months when the resident had a fall on 5/23/24. During an interview on 9/12/24 at 2:45 P.M., Administrator indicated the fall risk assessment completed on 7/5/24 should have been marked 1-2 falls in the last 3 months. During an interview on 9/13/24 at 8:21 A.M., Administrator indicated fall risk assessments were done per regulation and included in the quarterly nurse evaluations. During an interview on 9/13/24 at 8:28 A.M., Administrator indicated care plans were updated after every fall. During an interview on 9/13/24 at 9:31 A.M., Social Services indicated the care plan should be updated after each fall. She indicated she could not find an updated care plan for the 5/23/24 fall. 2. On 9/10/24 at 10:26 A.M., Resident 8's clinical record was reviewed. Diagnosis included, but were not limited to, other abnormalities of gait and mobility, unsteadiness on feet, other lack of coordination, and unspecified lack of coordination.		**ensure that deficient practice does not recur:** Nurses have been educated on fall risk assessments and 72hr follow up. **How the corrective actions will be monitored to ensure the deficient practices will not occur:** A performance improvement tool has been initiated that randomly audits five (5) residents to ensure that fall risk assessments are completed and thorough and that 72hr follow up is initiated. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools.	

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	The most recent Quarterly and State Optional MDS (Minimum Data Set) Assessment, dated 6/11/24, indicated a severe cognitive impairment, and a requirement of setup with supervision for bed mobility and transfers. A current falls care plan indicated cognitive impairment, lack of coordination, unsteadiness on feet, weakness, and abnormal gait, initiated 1/15/19 and revised 8/22/24. Resident 8 experienced four falls from December 2023 through September 2024 on 12/4/23, 12/5/23, 2/4/24 and 8/25/24. A fall risk evaluation, dated 2/4/24, indicated no falls in the past 3 months and no noted drop in blood pressure between lying and standing. Resident 8's fall score was 6 (a score of 10 or more indicated high risk for falls). A fall risk evaluation, dated 8/25/24, indicated no falls in the past 3 months and no noted drop in blood pressure between lying and standing. Resident 8's fall score was 8. On 8/29/24, an order was placed for a 72 hour follow up charting every shift for the fall on 8/25/24 to document in progress notes for 3 days. An Interdisciplinary (IDT) note, dated 9/3/24, indicated Resident 8 had fallen and the care plan had been updated. On 9/10/24 at 3:03 P.M., the leave of absence binder was reviewed and lacked documentation that Resident 8 had been LOA on 8/16/24. On 9/12/24 at 1:15 P.M., the Director of Nursing (DON) indicated falls were typically reviewed from		**By what date the systemic changes will be made:** 10/12/24	

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	the previous day at the morning meetings. If a fall occurred over the weekend, it was reviewed on Monday morning. She indicated she learned Resident 8 may have had a fall on 8/29/24, and at that time reached out to the nurse to see if anything had been initiated and apparently had not. It was then when the 72 hour post fall follow up had been put in, although it had already been 72 hours post fall. She indicated when filling out fall risk evaluations, the fall that occurred that same day should be counted in the history of falls, and that staff would need to be inserviced on that. She further indicated the nurses that filled out the fall risk evaluations on 2/4/24 and 8/25/24 and marked no drop in blood pressure from lying to standing did not actually check the blood pressure at the time the forms were filled out. She indicated normally for the resident's lying to standing blood pressure to be checked, there needed to be a physician's order and they didn't get many of those. On 9/12/24 at 2:20 P.M., the Administrator provided a current Fall Risk Assessment policy, dated 3/2018, that indicated "The attending physician and nursing staff will evaluate the resident's vital signs, assess the resident for medical conditions ... that may predispose to falls" On 9/12/24 at 2:20 P.M., the Administrator provided a current Falls policy, dated 3/2018, that indicated "For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall" On 9/12/24 at 2:20 P.M., the Administrator provided a current, non-dated, Staff Nurse job description. She indicated at that time that the information would serve as a facility policy. The form indicated "Documents accurately in resident			

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	155720	A. BUILDING 00 B. WING	09/13/2024

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	chart any significant changes in care ... Responsible for interpretation and execution of physician's orders and call physician as indicated ... Is responsible for accurate observation, evaluation, and reporting of residents" 3.1-45(a)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on record review and interview, the facility failed to monitor for side-effects related to antipsychotic drug use for 1 of 1 resident reviewed for psychotropic drug use. (Resident 63) Findings included: Resident 63's clinical record was reviewed on 9/13/24 at 1:02 P.M. An annual MDS (Minimum Data Set) Assessment, dated 6/20/24 indicated Resident had some cognitive impairment, no behaviors noted, required anywhere from supervision to extensive assist with mobility and transfers. Diagnoses in Resident 63's chart included but were not limited to paranoid schizophrenia. Physician orders in Resident 63's chart included but were not limited to, clozapine 100 mg (milligrams) 3 tablets a day, dated 5/11/23. Another order for clozapine 100 mg 1.5 tablets daily was found, dated 4/2/234. The Resident was being given a total of 450 mg a day of clozapine. Clozapine is an antipsychotic medication used for treatment resistant schizophrenia. An order was also placed on 3/15/23 to monitor for side effects of antipsychotic medications, listing many side effects for nursing staff to monitor every shift, if	F 0758	F758 D Based on observation, interview, and record review, the facility failed to monitor for side effects related to antipsychotic drug use for 1 of 1 resident reviewed for psychotropic drug use. (Resident 63) **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** Immediate action was completed with nursing staff on monitor the side effects of psychotropic drug use. **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:**	10/12/2024

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	side effects present, document in progress notes. When reviewing Resident 63's clinical record on 9/13/24 at 2:00 P.M., it was found that in the treatment administration record there were many dates where nursing staff indicated "y" (yes), that Resident had side effects but failed to put in a progress note to follow with information on what side effects the resident was experiencing. The following dates are dates with "y" indicated on record but no progress note: May 2, 6, 7, 9, 13, 14, 16, 17, 20, 21, 28, 30 of 2024. June 5, 6, 10, 11, 13, 17, 18, 20, 27 of 2024. July 1, 2, 9, 15, 18, 22, 25, 27, 29, 30 of 2024. August 1, 6, 8 of 2024. On 9/13/24 at 9:46 A.M., the DON (Director of Nursing) indicated that sometimes the orders to monitor side effects will have a key for staff to use to show what side effect was present instead of staff giving a yes or no answer, that she would have to look into it. LPN (Licensed Practical Nurse) 6, on 9/13/24 at 10:05 A.M., indicated that when charting in the treatment administration record for side effects, when it is marked "yes" it means the resident was monitored for side effects. LPN also indicated if she were to observe side effects during her shift that she puts in a progress note regarding them. On 9/13/24 at 10:50 A.M., the DON indicated that she called the nursing staff who had been marking "y" in the treatment administration record for side effects. This nursing staff indicated that she was under the impression that she should have been marking "y", meaning yes she was monitoring the resident for side effects. On 9/12/24 at 2:20 P.M., the Administrator		All residents who have the potential to be affected by the alleged deficiency. An audit was conducted. **What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur:** Nurses have been educated on monitoring on psychotropic drug use side effect monitoring. **How the corrective actions will be monitored to ensure the deficient practices will not occur:** A performance improvement tool has been initiated that randomly audits five (5) residents to ensure that residents receiving psychotropic medications have side effect monitoring completed. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue	

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	provided a current, non-dated, Staff Nurse job description. She indicated at that time that the information would serve as a facility policy. The form indicated "Documents accurately in resident chart any significant changes in care ... Responsible for interpretation and execution of physician's orders and call physician as indicated ... Is responsible for accurate observation, evaluation, and reporting of residents" 3.1-48(a)(3)		as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools. **By what date the systemic changes will be made:** 10/12/24	
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors Based on interview and record review, the facility failed to ensure residents were free from any significant medication errors for 1 of 1 residents reviewed for notification of change. A resident received a dose of the wrong insulin. (Resident 8) Finding includes: On 9/10/24 at 10:26 A.M., Resident 8's clinical record was reviewed. Diagnosis included, but were not limited to, diabetes. The most recent Quarterly and State Optional MDS (Minimum Data Set) Assessment, dated 6/11/24, indicated a severe cognitive impairment, and a requirement of setup with supervision for bed mobility and transfers. Current physician orders included, but were not	F 0760	F760 D Based on observation, interview, and record review, the facility failed to ensure residents were free from any significant medication errors for 1 of 1 resident reviewed for notification of change. (Resident 8) **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** Immediate action was completed with nursing staff to ensure the importance of following the five rights of medication	10/12/2024

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	limited to: NovoLOG Mix 70/30 FlexPen (a mixture of insulin aspart protamine, an intermediate-acting human insulin, and insulin aspart, a rapid-acting insulin) subcutaneous suspension pen-injector (70/30) 100 unit/ml (milliliter), inject 20 units one time a day, dated 7/24/24. NovoLOG Mix 70/30 FlexPen subcutaneous suspension pen-injector (70/30) 100 unit/ml (milliliter), inject 50 units one time a day, dated 7/24/24. Resident 8 did not have a physician's order for Novolin R (insulin regular - a short-acting insulin) or Novolin N (insulin isophane - an intermediate-acting insulin). A current diabetes mellitus with history of longterm use of insulin care plan indicated, but was not limited to, the following intervention: Administer my medications as ordered, dated 1/14/19. A nurse's note on 9/8/24 at 8:15 A.M. indicated "Resident rec'd [received] incorrect insulin for AM dose. MD notified et [and] stated to monitor resident." A nurse's note on 9/9/24 at 11:00 A.M. indicated the physician rounded with the resident. Resident 8 had received Novolin R instead of Novolin. One was short acting and one was intermediate acting. No new orders were given. On 9/10/24 at 1:02 P.M., the Director of Nursing (DON) indicated the Unit Manager had called her over the weekend to tell her that an agency nurse had given Resident 8 Novolin R instead of Novolin N, but did not have specific information		administration. **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** All residents who have the potential to be affected by the alleged deficiency. An audit was conducted. **What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur:** Nurses have been educated on the five rights of medication administration. **How the corrective actions will be monitored to ensure the deficient practices will not occur:** A performance improvement tool has been initiated that randomly audits five (5) residents to ensure that residents receive correct medication per MD order. This Quality Assurance Audit Tool will	

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	as to how much he was administered, whose insulin had been given, but assumed the same units ordered had been given. She indicated the only difference between what the resident was ordered (Novolog FlexPen) and what had been given (Novolin R) is that one was fast acting, and one was intermediate acting. She indicated at that time that Novolog and Novolin were the same thing. On 9/12/24 at 2:20 P.M., the Administrator provided a current Administering Medications policy, dated 12/2012, that indicated "Medications must be administered in accordance with the orders, including any required time frame ... The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication ... Insulin pens will be clearly labeled with the resident's name or other identifying information. Prior to administering insulin with an insulin pen, the Nurse will verify that the correct pen is used for that resident" 3.1-48(c)(2)		be completed by the Director of Nursing/Designee weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools. **By what date the systemic changes will be made:** 10/12/24	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to ensure a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection for 2 of 5 residents observed for care, and 2 of 10 residents reviewed for medication administration. Staff did not wash hands with at least a 20 second lather, did not change gloves and perform hand sanitization from	F 0880	F880 D Based on observation and interview, the facility failed to ensure a safe, sanitary, and comfortable environment to help prevent development and transmission of disease and infection for 2 of 5 residents observed for care, and 2 of 10 residents reviewed for medication	10/12/2024

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	dirty to clean tasks, did not wear gloves when administering an injection, and touched resident pills with bare hands. (Resident 34, Resident 37, Resident 20, Resident 9) Findings included: 1. On 9/9/24 at 7:27 A.M., RN (Registered Nurse) 15 was observed during a medication administration to Resident 20. RN 15 came out of the pantry room upstairs with a drink for the resident. She proceeded to prepare her medications without performing hand hygiene. She opened the medication cart, opened the narcotic box, popped out the resident's clonazepam (anxiety medication) tablet into her bare hand, and then placed it into the medication cup. After preparing all of the medications, RN 15 administered them to Resident 20. 2. On 9/10/24 at 10:57 A.M., RN 23 was observed using a glucometer to check Resident 37's blood sugar. After she was done, she took the used supplies out of the room to the medication cart. RN 23 took off her gloves, washed her hands with a 6 second lather of soap, went to computer to look up the insulin dose, and indicated he needed 10 units of Humalog (insulin). She grabbed the syringe and insulin vial from the medication cart, wiped the top of insulin vial with an alcohol wipe, drew back air then pushed it into the vial. She drew up 10 units of insulin, wiped Resident 37's left lower abdomen with an alcohol swab, and administered 10 units of Humalog to his left lower abdomen without putting on gloves. During an interview on 9/13/24 at 11:42 A.M., the DON (Director of Nursing) indicated medications should not be touched with a bare hand and administered. Staff should be popping the		administration. (Resident 34, Resident 37, Resident 20, Resident 9) **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** RN 15, RN 23, LPN 14, and CNA 7 have received training on proper hand hygiene. Nurses/qmas received training on infection control related to medication administration. See below for measures implemented to prevent reoccurrence. **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** All residents have the potential to be affected by the alleged deficient practice. All residents are receiving services in a manner that are within acceptable parameters of infection control. **What measures will be put in place and what systemic changes will be made to**	

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	medication directly into the medication cup. Staff should wear gloves while administering insulin and staff should wash hands, lathering with soap at least 20 seconds, or using hand sanitizer between tasks. 3. During an observation of care on 9/13/24 at 11:10 A.M., LPN (Licensed Practical Nurse) 14 washed her hands with an 8 second hand lather and donned gloves to clean a wound on Resident 9's neck. LPN 14 cleaned the wound with soap and water on a washrag, removed gloves, and washed hands with an 8 second lather. At that time, she donned new gloves and placed the bandage on Resident 9's neck, then removed an empty trashbag from the trash can and placed the soiled linens in the bag and removed her gloves, and an 11 second hand lather was performed. 4. On 9/13/24 at 11:34 A.M., Certified Nurse Aide (CNA) 7 was observed to transfer Resident 34 from the bed into a wheelchair. CNA 7 placed a gait belt on the resident, assisted out of bed to a standing position, then assisted the resident to pivot and sit in the wheelchair. CNA 7 washed their hands in the resident's sink. Hands were lathered for five seconds with soap then rinsed. On 9/13/24 at 11:42 A.M., the Director of Nursing indicated staff should be washing their hands with a lather of at least 20 seconds. On 9/9/24 at 10:00 A.M., a current Handwashing/Hand Hygiene Policy, dated January 2019, was provided by the Administrator and indicated "This facility considers hand hygiene the primary means to prevent the spread of infections ... All personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors ... Single-use disposable gloves should be used: ... when		**ensure that deficient practice does not recur:** All staff will be educated by DON and/or IP nurse regarding hand hygiene with return demonstration. Nurses/QMAs educated on infection control related to medication administration **How the corrective actions will be monitored to ensure the deficient practices will not occur:** A performance improvement tool has been initiated that will observe staff during the medication administration to ensure within acceptable parameters of infections control. The DON or designee will randomly review 5 staff members during the provision of care to ensure proper handwashing is in accordance with facility policy. **By what date the systemic changes will be made:** 10/12/24	

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	anticipating contact with blood or body fluids ... vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) ... " 3.1-18(l) 3.1-18(b)			