STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155166	A. BUILDING 00 B. WING	05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALPARAISO CARE & REHABILITATION	606 WALL STREET VALPARAISO, IN 46383

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 17, 18, 19, 20 and 21, 2021. Facility number: 000083 Provider number: 155166 AIM number: 100289670 Census Bed Type: SNF/NF: 118 Total: 118 Census Payor Type: Medicare: 7 Medicaid: 101 Other: 10 Total: 118 These deficiencies reflec State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/25/21.	F 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.** **Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after June 17, 2021.**	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to anticoagulant and antipsychotic medication use for 2 of 27 MDS assessments reviewed. (Residents 101 and 77)	F 0641	**F641 – Accuracy of Assessments** It is the practice of this provider that each resident's assessment accurately reflects each resident's status. **What corrective action(s) will be accomplished for those**	06/17/2021

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

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	Findings include: 1. The record for Resident 101 was reviewed on 5/19/21 at 1:15 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's dementia, dysphasia and syncope. A Significant Change MDS assessment, dated 4/8/21, indicated the resident was on an anticoagulant medication daily during the 7 day assessment period. There was not a Physician's Order for an anticoagulant medication, current or discontinued. Interview with MDS Nurse 2 on 5/21/21 at 10: 35 a.m., indicated the resident was never on an anticoagulant and it was an error. 2. Resident 77's record was reviewed on 5/19/21 at 3:10 p.m. Diagnoses included, but were not limited to general anxiety disorder, hypertension, and dementia with behavioral disturbance. A Physician's Order, dated 1/30/21, indicated the resident received Ativan (lorazepam, an anti-anxiety medication) 0.25 mg (milligrams) at 9 a.m. daily and 0.5 mg at 1 p.m. and 5 p.m. daily. The Medication Administration Record (MAR), dated 4/2021, indicated the resident had received the Ativan medication as ordered. The Quarterly Minimum Data Set (MDS) assessment, dated 4/15/21, lacked documentation the resident had received an anti-anxiety medication. Interview with MDS Nurse 1 on 5/20/21 at 2:22 p.m., indicated she had reviewed her worksheet and she should have marked the anti-anxiety medication on the assessment.		**residents found to have been affected by the deficient practice:** Resident # 101 – MDS has been modified to accurately reflect the resident's anticoagulant medication use. This resident experienced no negative outcome related to this finding. Resident #77 – MDS was modified to accurately reflect the resident's anti-anxiety medication use. This resident experienced no negative outcome related to this finding. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. A facility audit will be completed by MDS Coordinator/Designee for all MDS assessments completed in the past 30 days to ensure accuracy of each resident assessment including any received anticoagulant medications and/or receipt of psychotropic medications. Any identified inaccurate MDS assessments will be modified as indicated. MDS Coordinator will be in-serviced by the DNS/Designee regarding accuracy of MDS assessment completion. **What measures will be put into place and what systemic changes will be made to ensure that the deficient**	

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	3.1-31(c)(13) 3.1-31(d)(3)		**practice does not recur:** A nursing in-service will be completed on the facility policy related to accuracy in completion of MDS/Resident Assessments by DNS/Designee. This in-service will also include review of the facility policy and procedure related to proper coding of each resident's medication usage on the MDS/Resident Assessment. MDS Coordinator will be in-serviced by the DNS/Designee regarding accuracy of MDS assessment completion. Any new resident medication and treatment orders and/or changes will be reviewed by the IDT to ensure the accuracy of the MDS. **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:** To ensure ongoing compliance with this corrective action, the DNS/designee will be responsible for completion of the QAPI Audit Tool weekly x4 weeks and monthly thereafter related to MDS Accuracy. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up.	

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F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems.			

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	Based on observation, record review, and interview, the facility failed to ensure the necessary care and services were provided to a resident who required assistance with activities of daily living (ADLs) related to long untrimmed fingernails for 1 of 5 residents reviewed for activities of daily living. (Resident 77) Finding includes: On 5/17/21 at 10:24 a.m. Resident 77 was observed with long untrimmed fingernails. On 5/19/21 at 1:41 p.m. the resident was lying in bed in his room. He was observed with long untrimmed fingernails. The resident indicated his fingernails were "long and ragged" and he would like them cut because he did not like to keep them so long. He indicated no one had offered to cut his nails "in a long time, probably because they were so busy." Resident 77's record was reviewed on 5/19/21 at 3:10 p.m. Diagnoses included, but were not limited to general anxiety disorder, hypertension, and dementia with behavioral disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 4/15/21, indicated the resident was cognitively impaired. The resident required a limited 1 person assist with bed mobility, a limited 2 person assist with transfers, and an extensive 1 person assist with toilet use and personal hygiene. The resident was totally dependent on staff for bathing assistance. A Care Plan indicated the resident required assistance with ADLs. Interventions included staff assistance as needed with bathing and assist with dressing, grooming, and hygiene as needed.	F 0676	**F676 – Activities Daily Living (ADLs)/Mntn Abilities** It is the practice of this facility that all residents are provided the necessary care and services to maintain or improve his or her ability to carry out the activities of daily living including hygiene, bathing, dressing, grooming and oral care. **What corrective action(s) will be accomplished for those residents found to have been affected by** the deficient practice: Resident #77 fingernails have been cleaned and trimmed. This resident has been receiving assistance with grooming, hygiene and nail care needs as identified in the plan of care. This resident experienced no negative outcome as a result of this finding. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Any resident requiring assistance with grooming, personal hygiene and nail care has the potential to be affected by this finding. A facility wide assessment of all resident fingernails was conducted by the Nurse Management Team. The care plans and Resident Profiles were reviewed for all residents requiring assistance with ADL care such as grooming, hygiene and nail care to ensure each resident specific need was	06/17/2021

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	The ADL documentation indicated the resident received a shower on 5/16/21 and 5/19/21. NA 1 had documented he assisted the resident with the shower on 5/19/21. Interview with NA 1 on 5/19/21 at 1:55 p.m. indicated he had not given the resident a shower this morning but had assisted him with morning care. He had not noticed the resident's nails were long, but indicated the resident hadn't mentioned anything to him about wanting his nails cut. During bathing, he would assist the residents with nail care if they asked. He would pass it along to the oncoming shift that the resident would like his nails cut. 3.1-38(a)(3)(E)		accurately addressed. Resident needs specific to grooming, hygiene and nail care were updated as identified and communicated to all direct care staff. Changes in residents requiring ADL assistance such as grooming, hygiene and nail care are reviewed quarterly during the care plan review process and/or with any noted change in resident condition. Nursing Rounds will be conducted on each shift to ensure residents are receiving ADL assistance as identified in their individual plan of care by licensed nurses/designee. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Nursing in-service will be conducted by the DNS/Designee and will include review of the facility policy related to grooming, hygiene and nail care. Changes in residents requiring ADL assistance such as grooming, hygiene and nail care are reviewed quarterly during the care plan review process and/or with any noted change in resident condition. Nursing Rounds will be conducted on each shift to ensure residents are receiving ADL assistance as identified in their individual plan of care by licensed nurses/designee.	

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			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: This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS/Designee will be responsible for completing the QAPI Audit tool related to Hygiene and Grooming daily for 4 weeks and weekly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up.	
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-			

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	(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review, and interview, the facility failed to ensure a resident with a urinary catheter received the necessary treatment and services related to not assessing and notifying the Physician with a change in condition of the resident's urine for 1 of 2 residents reviewed for urinary catheters. (Resident 311) Finding includes: On 5/17/21 at 2:32 p.m., Resident 311 was lying in bed. A urinary catheter bag was attached to the side of the bed. The bag was observed to have dark brown colored urine in the bag. There was sediment (particles in the urine) observed in the catheter tubing.	F 0690	**F690 – Bowel/Bladder Incontinence, Catheter, UTI** It is the practice of this facility that any resident with an indwelling catheter receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #311 has been receiving necessary assessment, care and services related to use of the	06/17/2021

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	On 5/19/21 at 1:20 p.m., Resident 311 was lying in bed. The urinary catheter bag was attached to the side of the bed. The bag was observed with dark red/brown urine in the bag. There was sediment observed in the catheter tubing. On 5/21/21 at 11:50 a.m., Resident 311 was lying in bed. The urinary catheter bag was attached to the side of the bed. The bag was observed to have red tinged urine in the bag. There was sediment observed in the catheter tubing. Record review for Resident 311 was completed on 5/20/21 at 3:12 p.m. Diagnoses included, but were not limited to, respiratory failure with hypoxia, neurogenic bladder, sepsis, and quadriplegia. A Significant Change Minimum Data Set (MDS) assessment, dated 3/24/21, indicated the resident was cognitively impaired. The resident had an indwelling catheter. A Care Plan indicated the resident required an indwelling urinary catheter related to functional quadriplegia and neurogenic bladder. Interventions included to report signs of a UTI (urinary tract infection). Those signs included blood in urine. A Progress Note, dated 4/28/21 at 9:24 a.m., indicated the resident was noted to have hematuria (presence of blood in urine) in his catheter bag. The Physician was notified and ordered to hold the resident's Eliquis (blood thinning medication) for 2 days and to complete blood work. The staff was also to notify the Physician in the morning if the hematuria persisted.		indwelling catheter. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents with indwelling catheters have the potential to be affected by this finding. All residents utilizing an indwelling catheter were assessed by a licensed nurse for any changes in appearance and consistency of urinary output and to ensure proper function and drainage of the catheter. Care plans for residents utilizing indwelling catheters were also reviewed and updated as necessary. Nursing Rounds will be conducted on each shift to ensure resident's indwelling catheters are free from changes in appearance and changes in consistency of urinary drainage by licensed nurses/designee. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Nursing in-service will be conducted by the DNS/designee and will include review of the facility policy related to care and treatment of residents with indwelling catheters including assessment of appearance and consistency of urinary drainage. All nursing staff will receive skills validations by	

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	The resident was discharged out to the hospital on 5/1/21 and returned to the facility on 5/13/21. The resident was admitted to the hospital with sepsis. The Admission Observation, dated 5/13/21, indicated the resident's urine was clear, yellow, and no sediment was present. The record lacked any documentation the resident's change in color of his urine had been assessed and the Physician had been notified. Interview with the West Wing Unit Manager on 5/21/21 at 1:39 p.m., indicated she and the resident's nurse was unaware of the resident's darkened urine. Staff should have assessed the resident's urine and notified the Physician. 3.1-41(a)(2)		DNS/designee related to care and treatment for residents with indwelling catheters. Nursing Rounds will be conducted on all shifts to ensure resident's indwelling catheters are free from changes in appearance and consistency of urinary output by licensed nurses/designee. The DNS/Nurse Management Team will be responsible for ensuring that any resident utilizing an indwelling catheter has MD orders verified to ensure proper care and treatment is being provided per physician order. **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:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS/designee will be responsible for completing the QAPI Audit Tools related to Catheters daily for 4 weeks and then weekly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up.	

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F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (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)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and interview, the facility failed to ensure a dependent resident had fluids accessible to maintain proper hydration for 1 of 4 residents reviewed for hydration. (Resident 40) Finding includes: On 5/17/21 at 10:30 a.m., Resident 40 was observed lying in bed. A Styrofoam cup was observed across the room on a bedside table. The resident indicated she was thirsty. No fluids were observed in the resident's reach. On 5/19/21 at 9:18 a.m., Resident 40 was observed lying in bed with her eyes open. The cup was	F 0692	**F692 – Nutrition/Hydration Status Maintenance** It is the practice of this provider that each resident maintains acceptable parameters of nutritional status and is offered sufficient fluid intake to maintain proper hydration and health. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #40 has been receiving care and treatment to maintain proper hydration and nutrition and	06/17/2021

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	observed on the bedside table across the room. No fluids were observed in the resident's reach. On 5/20/21 at 11:04 a.m., Resident 40 was observed lying in bed with her eyes open. There were no fluids observed in the resident's reach. Record review for Resident 40 was completed on 5/19/21 at 1:46 p.m. Diagnoses included, but were not limited to, traumatic brain dysfunction, hypertension, hemiplegia (paralysis on one side of the body), repeated falls, and dysphagia (difficulty swallowing foods or liquids). The Quarterly Minimum Data Set (MDS) assessment, dated 3/11/21, indicated the resident was cognitively impaired. The resident required an extensive 2 + person assist for bed mobility, an extensive 1 person assist for transfers, and a limited 1 person assist for eating. The resident had an impairment on one side of her upper and lower extremities for a limitation in functional range of motion. The Physician's Order Summary (POS), dated May 2021, indicated an order for nectar thick liquids. Interview with the West Wing Unit Manager on 5/20/21 at 11:08 a.m., indicated the resident was on thickened liquids. The resident was able to hold a cup and drink fluids on her own. The resident should have thickened liquids available and within reach for her at all times. 3.1-46(b)		fluids have been accessible per the individualized plan of care. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Any resident requiring assistance with fluid consumption has the potential to be affected by this finding. The care plans and Resident Profiles were reviewed by the IDT to ensure each resident specific need was accurately addressed. Resident needs specific to hydration and fluid consumption were updated as identified and communicated to all direct care staff. Changes in residents needs related to hydration and fluid consumption are reviewed quarterly during the care plan review process and/or with any noted change in resident condition. Nursing Rounds will be conducted each shift by licensed nurses/designee to ensure resident's hydration needs are being met and that fluids are available and accessible to residents in their personal rooms as identified in their individual plan of care. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The DNS/Designee will be conducting an in-service that will	

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VALPARAISO CARE & REHABILITATION	606 WALL STREET VALPARAISO, IN 46383

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			include review of the policy related to proper maintenance of hydration for all residents based on identified individualized need. Nursing Rounds will be conducted by licensed nurses/designee on each shift to ensure resident's hydration needs are being met and that fluids are available and accessible to residents in their personal rooms as identified in their individual plan of care. **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:** To ensure ongoing compliance with these corrective actions, the DNS/designee will complete the QAPI Audit Tool related to Hydration Management daily for 3 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance Performance Improvement Committee for review and follow up.	
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-			

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	§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 ensure residents' tube feedings were replaced as needed and set on accurate flow rates for 2 of 5 residents reviewed for tube feedings. (Residents 48 and 64) Findings include: 1. On 5/17/21 at 12:01 p.m., Resident 48 was observed in her room. Her bottle of tube feeding was hanging next to her bed, partially full and dated 5/15/21. On 5/18/21 at 9:48 a.m., the resident's tube feeding was hanging next to her bed, partially full and dated 5/15/21. On 5/19/21 at 8:27 a.m., the tube feeding bottle was hanging next to her bed, empty and dated 5/15/21. The resident's record was reviewed on 5/19/21 at 9:00 a.m. The resident's diagnoses included, but	F 0693	**F693 – Tube Feeding Mgmt/Restore Eating Skills** It is the practice of this provider to ensure that any resident who is fed by enteral means receives the appropriate treatment and services to maintain nutrition, hydration and prevent complications. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #48 is receiving appropriate treatment and services as well as proper administration of her enteral feedings per physician's order. Resident # 64 is receiving appropriate treatment and services as well as proper administration of her enteral feedings per physician's order. **How other residents having the**	06/17/2021

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	were not limited to, Parkinson's disease and infectious gastroenteritis. A Physician's Order, dated 3/4/21, indicated Jevity 1.5 (a type of tube feeding) 80 milliliters an hour for 12 hours a day, on at 6 p.m. and off at 6 a.m. The manufacture's website was reviewed on 5/21/21 at 10:21 a.m. The website indicated, "...hang product for up to 48 hours after initial connection when clean technique and only one new set are used. Otherwise hang no more than 24 hours...." Interview with the Director of Nursing on 5/19/21 at 8:40 a.m., she indicated Jevity should be used within 24 hours of opening. She was not aware the resident's Jevity was expired and indicated she would take care of it. 2. On 5/17/21 at 10:23 a.m., Resident 64 was observed in her room in bed. The resident's tube feeding was set at the flow rate of 70 ml (milliliters) per hour. On 5/18/21 at 10:30 a.m., Resident's 64 was observed in her room in bed. The resident's tube feeding was set at the flow rate of 70 ml per hour. Resident 64's record was reviewed on 5/19/21 at 9:36 a.m. Diagnoses included, but were not limited to, chronic respiratory failure, quadriplegic, seizures and dysphagia (difficulty in swallowing). The current Physician's Order Summary, indicated enteral feeding with Jevity 1.5 at 75 ml per hour for 18 hours a day. The Readmission Minimum Data Set assessment, completed on 4/6/21, indicated the resident is rarely understood, has a tube feeding for nutrition		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents with orders for enteral tubes and enteral tube feeding administration have the potential to be affected by this finding. An audit will be completed by the DNS/designee to identify all residents with orders for enteral tube feeding administration. Physician orders will be reviewed and verified to ensure all enteral feeding administration via enteral tube are being followed per physician's order and facility policy. In addition, the DNS/CEN and/or designee will be responsible for completing skills validations related to enteral tube feeding administration via enteral tube with all licensed nurses. In addition, Nursing Rounds will be conducted by licensed nurses/designee on each shift to ensure resident's enteral tube feedings are being administered per physician's order including the proper rate of flow. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** A Nursing In-service will be conducted by DNS/Designee to include review of the policy related to enteral tube feeding administration. Each licensed	

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	and is totally dependent on staff for all activities of daily living. A Care Plan for the resident's nutritional status, dated 3/30/21, indicated she is at risk for aspiration and deemed unsafe to consume oral diet leading to nothing by mouth status and percutaneous endoscopic gastrostomy (feeding tube placed through the abdominal wall and into the stomach) tube placement. Interventions included, but were not limited to, provide tube feeding per the physician's orders of Jevity 1.5 calories with the flow rate of 75 ml per hour for 18 hours a day. Interview with LPN 3 on 5/20/21 at 11:03 a.m., indicated the Registered Dietician completed spot checks and the Nurses should be monitoring the flow rate on the tube feeding pumps. Interview with the Registered Dietician, on 5/20/21 at 11:05 a.m., indicated she completed checks on all tubing feeding once a week. The Nurse should also be checking the pumps as well for correct feeding and flow rates. 3.1 - 44(a)(2)		nurse will be validated related to enteral feeding administration via enteral tube. In addition, Nursing Rounds will be conducted by licensed nurses/designee on each shift to ensure resident's enteral tube feedings are being administered per physician's order including the proper rate of flow. **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:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS/designee will be responsible for completing the QAPI Audit tool related to Enteral Nutrition weekly for 4 weeks and monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning,			

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	is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review and interview, the facility failed to ensure respiratory care was completed as ordered related to incorrect oxygen flow rate and no humidification for oxygen for 2 of 5 residents reviewed for respiratory care. (Residents 48 and 102) Findings include: 1. On 5/17/21 at 12:01 p.m., Resident 48 was observed in her room. Her oxygen concentrator did not have a water bottle for humidification attached. On 5/18/21 at 9:48 a.m., there was no water bottle on the oxygen concentrator. On 5/19/21 at 8:27 a.m., there was no water bottle on the oxygen concentrator. The resident's record was reviewed on 5/19/21 at 9:00 a.m. The resident's diagnoses included, but were not limited to, Parkinson's disease and chronic obstructive pulmonary disease. A Physician's Order, dated 4/23/21, indicated to change the oxygen tubing and humidity (water bottle) one a week on Sunday. Interview with the Director of Nursing on 4/19/21 at 8:40 a.m., indicated she was not aware there was no humidity on the oxygen concentrator and she would take care of it. 2. On 5/19/21 at 8:18 a.m., Resident 102 was	F 0695	**F695 – Respiratory/Tracheostomy Care and Sunctioning** It is the practice of this provider that any resident who needs respiratory care, including tracheostomy care and tracheal suctioning is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #48 is receiving humidified oxygen therapy per physician's order. Resident #102 has been discharged from the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Any resident receiving oxygen therapy has the potential to be affected by this finding. DNS/designee will conduct an audit to determine all residents with physician orders for oxygen therapy. Each resident with	06/17/2021

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	observed in bed. He had his oxygen on and the flow rate was set at 5 liters. On 5/20/21 at 8:40 a.m., the resident was in bed with oxygen on and set at 5 liters. The resident's record was reviewed on 5/20/21 at 8:30 a.m. The resident's diagnoses included, but were not limited to, chronic kidney disease with heart failure and chronic obstructive pulmonary disease. A Physician's Order, dated 4/21/21, indicated the resident was to have continuous oxygen at 3 liters. Interview with the West Unit Manager on 5/20/21 at 8:40 a.m., she indicated the oxygen was set on 5 liters. She checked the Physician Order and indicated it should be set on 3 liters. 3.1-47(a)(6)		physician orders for oxygen therapy will be assessed and reviewed to determine if the presence of water bottles is appropriate on the oxygen concentrator and that each resident is being administered the proper rate of oxygen flow per physician order. Nursing Rounds will be conducted on each shift by licensed nurses/designee to ensure oxygen therapy for all residents is being administered per physician's order including the proper rate of flow. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** DNS/Designee will conduct an in-service to include review of the policy related to oxygen administration, use of humidification therapy and strict adherence to physician orders related to oxygen flow rates. Nursing Rounds will be conducted by licensed on each shift to ensure oxygen therapy for all residents is being administered per physician's order including the proper rate of flow. **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:** Compliance with this corrective	

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			action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS/designee will be responsible for completing the QAPI Audit tool related to Oxygen Therapy daily for 4 weeks and weekly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up.	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, record review and interview, the facility failed to ensure a resident's pain was adequately managed and reported to the Physician for 1 of 2 residents reviewed for pain. (Resident 102) Finding includes. On 5/19/21 at 8:18 a.m., Resident 102 was observed lying in bed. He indicated his back and feet were hurting. The resident's record was reviewed on 5/20/21 at 8:30 a.m. The resident's diagnoses included, but were not limed to, lumbar disc degeneration, diabetes, chronic migraine and chronic kidney	F 0697	**F697 – Pain Management** It is the practice of this provider that pain management is provided to any resident who requires such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #102 has been	06/17/2021

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	disease with heart failure. A Physician's Order, dated 5/13/21, indicated Norco (an opioid pain medication) 10/325 milligrams (mg) every four hours for severe pain. This had been increased from the previous order dated 4/22/21 for Norco 7.5/325 mg every four hour for severe pain. A Physician's Order, dated 4/28/21, indicated to monitor effectiveness of pain medication every shift and notify the Physician if not effective. A Pain Care Plan, updated 5/17/21, included the approach to notify the doctor if pain is unrelieved and/or worsening A Nursing Note, dated 5/21/21 at 7:16 a.m., indicated the resident was refusing to go to dialysis that morning stating, "the pain is to unbearable, and I'm ready to die". The writer contacted the family and social services and explained the consequences of not going to dialysis to the resident. A Nursing Note, dated 5/21/21 at 12:33 p.m., indicated the writer had spoke at length with the resident and he indicated he was having a hard time in life now. He indicated, "...I'm in so much pain that I don't want to do anything..." The writer indicated she repositioned for comfort and notified social services. The Medication Administration Record for the day shift on 5/21/21, asked the question if the scheduled pain medication was effective, and if not, the Physician should be notified. It was marked, Yes, as effective. The Physician had not been notified the resident		discharged from the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. A Pain Assessment/Interview will be completed by the Nurse Management Team/designee for each resident. The Pain Assessment/Interview will assist in determining that any resident experiencing issues with pain is being adequately managed and reported to the physician as necessary. Pain Assessments/Interviews are completed at the time of admission, re-admission, quarterly, annually, weekly with the Weekly Nursing Assessments and with any change of condition and/or new onset of pain. The Nurse Management Team/Designee will be responsible for daily review of Nursing Progress Notes, Medication Administration Reports including evaluation and assessment of effectiveness of scheduled and PRN pain medication administration, completed Weekly Summaries and review of Pain Assessments/Interviews to ensure each resident's pain is being adequately managed and addressed. Physician will be notified as necessary with any	

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	was having severe pain. Interview with the West Unit Manager, on 5/21/21 at 2:00 p.m., indicated the resident was more comfortable lying flat, and his pain medication had been increased a couple days ago, (It was 12 days prior) but she indicated she understood the concern. 3.1-37(a)		ongoing pain issues. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** A Nursing In-service will be conducted by the DNS/designee and will include review of the facility policy related to Pain Interviews/Pain Assessments, Pain Medication Administration including evaluation and assessment of effectiveness of schedule and PRN pain medication administration. The Nurse Management Team will be responsible for daily review of Nursing Progress Notes, Medication Administration Reports including evaluation and assessment of effectiveness of scheduled and PRN pain medication administration, completed Weekly Summaries and review of Pain Assessments/Interviews to ensure each resident's pain is being adequately managed and addressed. **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:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance	

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			Improvement Program. The DNS/designee will be responsible for completing the QAPI Audit tool related to Pain Management weekly for 4 weeks and monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which			

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	the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure medications were properly stored safely for 3 of 4 medication carts observed. (Cottage Medication Cart, West Front Hall Medication Cart, and South Hall Medication Cart) Findings include: 1. On 5/21/21 at 1:25 p.m., with QMA 1, the Cottage medication cart was observed. There were approximately 30 pills of different sizes and colors that were loose and out of packages throughout the bottoms of the drawers in the cart. The QMA indicated she was unaware of the loose pills in the cart. Interview with the East Wing Unit Manager on 5/21/21 at 1:33 p.m., indicated there should be no loose pills in the medication carts and the staff should have disposed of them. The nursing staff was responsible for making sure the medication carts were cleaned out. 2. On 5/21/21 at 2:14 p.m., with LPN 1, the West Front Hall medication cart was observed. There was 1 loose pill observed on the bottom of one of the drawers in the cart. The LPN indicated she was unaware of the loose pill and would dispose of it. 3. On 5/21/21 at 2:20 p.m., with LPN 2, the South Hall medication cart was observed. There were multiple loose pills observed on the bottom of the drawers in the cart. There were also loose pills observed between the bottom drawer and bottom of the medication cart. The LPN indicated she was unaware of the loose pills in the medication cart.	F 0761	**F761 – Label/Store Drugs and Biologicals** It is the practice of this facility that all drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All facility Medication and Treatment Carts including the Cottage Medication Cart, West Front Hall Medication Cart and South Hall Medication Cart were inspected, cleaned and organized. Any loose pills/medications and treatments were discarded/destroyed and any new medication or treatment was obtained and properly stored. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents receiving medications have the potential to be affected by this finding. The DNS/designee will complete an inspection of all Medication Carts and Treatment Carts to ensure that they are free	06/17/2021

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	Interview with the West Wing Unit Manager on 5/21/21 at 2:26 p.m., indicated the nursing staff was responsible for cleaning out the medication carts. There should not be loose pills in the medication carts and should would make sure they were cleaned out. 3.1-25(j) 3.1-25(o)		of loose pills and that all medications have been properly stored per facility policy. Any expired or loose medications will be destroyed and/or discarded immediately. In addition, the DNS/designee will be responsible for facility wide weekly Medication Cart and Treatment Cart inspections. This will ensure that all medications and treatments are being safely and properly stored per facility policy. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** A Nursing in-service will be conducted by the DNS/designee and will review the facility policy related to Storage of Medication and Treatments. In addition, the DNS/designee will be responsible for facility wide weekly Medication Cart and Treatment Cart inspections. This will ensure that all medications and treatments are being safely and properly stored per facility policy. **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:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Improvement Program. The DNS/designee will be responsible for completing the QAPI Audit tool related to Medication and Treatment Storage daily for 4 weeks and weekly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;			

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	155166	A. BUILDING 00 B. WING	05/21/2021

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	§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread			

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	of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure infection control guidelines were in place and implemented, including those specific to properly prevent and/or contain COVID-19, related to staff unaware of TBP (transmission based precautions) procedures to follow with residents who received nebulizer (aerosol) breathing treatments for a random observation for infection control on the Ventilator Unit. (Room 221) Finding Includes: On 5/19/21 at 9:26 a.m., Respiratory Therapist (RT) 1 was observed at a medication cart outside of Room 221. There was a PPE (personal protective equipment) bin observed outside of the door. The room door was open and a TBP sign was observed on the door. The therapist indicated the resident had just received a nebulizer treatments 5 minutes prior. She then removed the sign off of the resident's door and placed the sign on the PPE bin. She indicated since the resident was fully vaccinated, the room door could remain open and staff did not need to wear any PPE going into the room after the procedure. The therapist indicated she was unaware that regardless of the vaccination status of the resident, since the county positivity rate was greater than 5%, the resident's room door must be closed for an hour after the treatment and staff should wear full PPE when entering the room for 1 hour after the treatment was finished.	F 0880	**F880 – Infection Prevention & Control** It is the practice of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Resident residing in Room 221 continues to receive nebulizer/aerosol breathing treatments per physician order and all necessary transmission-based precaution procedures are being strictly followed per facility, ISDH and CDC Guidelines. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Any resident receiving nebulizer/aerosol breathing treatments has the potential to be affected by this finding. Any	06/17/2021

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	Interview with the Director of Nursing on 5/21/21, indicated there were 5 residents in the facility who received nebulizer treatments who were to be placed on TBPs during and 1 hour after the treatment. Review of the CDC county positivity rate indicated the facilities county positivity rate was greater than 5%. The rate was 6.48%. The Indiana State Department of Health, "Long-term Care Facilities Guidelines in Response to COVID -19 Vaccination", last updated 5/13/21, indicated, "...AGPs (aerosol-generating procedures) in Green zones:.." "...For unvaccinated residents or AGP on anyone during moderate or high community positivity; >5% or if facility is in outbreak testing: CDC guidance for aerosol-generating procedures should be followed for infection control measures for the duration of the contact and droplet precautions for the duration of the procedure and 1 hour post procedure. This includes N-95 mask, eye protection, gown and gloves and keeping the door closed throughout the procedure and one hour after, and disinfecting all surfaces following the procedure...." 3.1-18(b)(2)		resident receiving nebulizer/aerosol breathing treatments will be identified and specific Infection Control, transmission-based precautions and use of PPE will be clearly communicated to direct care staff including Respiratory Therapists. Changes in facility, ISDH and CDC guidelines and recommendations regarding Aerosol Generating Procedures will be communicated as needed to the direct care staff and Respiratory Therapy Department. ED/DNS/Designee will conduct rounds each shift to ensure proper Aerosol Generating Procedures and Practices are in place, PPE is properly being utilized and strict adherence to transmission-based precaution procedures is being followed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** A Nursing In-service will be conducted by the DNS/designee and will include review of the policy related to Aerosol Generating Procedures, use of personal protective equipment and adherence to transmission-based precaution procedures per ISDH and CDC Guidelines based on county positivity rates. ED/DNS/Designee will conduct rounds each shift to ensure proper	

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			Aerosol Generating Procedures and Practices are in place, PPE is properly being utilized and strict adherence to transmission-based precaution procedures is being followed. **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:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS/designee will be responsible for completing the QAPI Audit tool related to Transmission Based Precautions procedures for residents receiving nebulizer/aerosol breathing treatments daily for 4 weeks and weekly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up.	