STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LINCOLN HILLS OF NEW ALBANY	326 COUNTRY CLUB DRIVE NEW ALBANY, IN 47150

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 23, 24, 25, 28 and 29, 2023. Facility number: 000321 Provider number: 155614 AIM number: 100286130 Census Bed Type: SNF: 7 SNF/NF: 118 Total: 125 Census Payor Type: Medicare: 21 Medicaid: 72 Other: 32 Total: 125 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 1, 2023.	F 0000	September 15, 2023 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance **Survey Event ID VM4711** Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the Complaint Survey conducted on August 29, 2023. This letter is to inform you that the plan of correction attached is to serve as Lincoln Hills of New Albany credible allegation of compliance. We allege substantial compliance on September 13,2023. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-512-4655. Sincerely, Kim Povinelli, HFA	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kimberly Povinelli	Administrator	09/21/2023

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

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			Lincoln Hills of New Albany Submission of this plan of correction in no way constitutes an admission by Lincoln Hills of New Albany or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for			

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	requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to			

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	room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to ensure the physician was notified when a resident's blood sugar readings fell outside the physician ordered parameters for 1 of 3 residents reviewed for notification of change. (Resident 104) Findings include: The record for Resident 104 was reviewed on 8/25/23 at 11:29 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with hyperglycemia and hypoglycemia, type 1 diabetes without complications, nutritional anemia, and dependence on renal dialysis. A care plan, dated 6/4/23, indicated the resident had the potential for hypoglycemia or hyperglycemia and diabetic complications related to diabetes mellitus. The goal was for the resident to be free of unrecognized hypoperglycemia or hyperglycemia. The approaches included, but were not limited to, administer accu checks (blood sugar checks) and any insulin coverage per physician's order; and to report any signs of hypoglycemia or hyperglycemia. The Quarterly Minimum Data Set (MDS) assessment, dated 6/27/23, indicated the resident was cognitively intact; had frequent appetite issues; and received insulin daily. The resident was admitted to the facility from the hospital on 4/5/23 with the following order: finger stick blood sugar AC (before meals) and HS (at bedtime). Notify the physician if the blood sugar was less than 60 mg/dL (milligrams per deciliter) or greater than 400 mg/dL.	F 0580	**F 580 Notify of Changes** **The facility failed to ensure the physician was notified when a resident's blood sugar readings fell outside the physician ordered parameters for 1 of 3 residents reviewed for notification of change.** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Resident's (104) physician was notified of out of range blood sugars with interventions put in place. Resident suffered no ill effects from this alleged deficient practice. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents residing at Lincoln Hills have the potential to be affected by this alleged deficient practice. Resident's blood sugar readings have been audited to ensure physicians have been notified of any readings out of range. **III. The facility will put into**	09/13/2023

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	On 4/7/23, a new physician's order was received, in addition to the 4/5/23 order, for Insulin lispro insulin pen 100 unit per mL (milliliter); amt (amount): Per Sliding Scale: - If Blood Sugar was less than 60 mg/dL, call physician. If Blood Sugar was greater than 499 mg/dL, call physician. Give subcutaneous four times a day. Indicate (Y=yes or N=no) if physician required notification. Four Times A Day and PRN (as needed) symptoms. The April 2023 Medication Administration Record (MAR), indicated the resident had the following blood sugar reading. - dated 4/30, upon rising the resident's blood sugar reading was "high". The June 2023 MAR, indicated the resident had the following blood sugar readings: - dated 6/7, before lunch the resident's blood sugar reading was 422 mg/dL - dated 6/13, before bedtime the resident's blood sugar reading was 413 mg/dL The August 2023 MAR, indicated the resident had the following blood sugar readings: - dated 8/4, before lunch the resident's blood sugar reading was 416 mg/dL - dated 8/9, upon rising the resident's blood sugar reading was 479 mg/dL - dated 8/9, afternoon the resident's blood sugar reading was 450 mg/dL - dated 8/9, before bedtime the resident's blood sugar reading was 479 mg/dL - dated 8/12, before lunch the resident's blood		**place the following systematic changes to ensure that the deficient practice does not recur.** Licensed nurses, IDT team, and nurse managers were re-educated on notifying physicians of any resident changes, including out or range blood sugars. **IV The facility will monitor the corrective action by implementing the following measures.** DON/Designee will audit 5 random residents records at least five (5) times per week for four (4) weeks, then weekly for four (4) weeks, then biweekly for (4) weeks, then monthly for an additional 3 months to ensure physicians are notified of any blood sugars out of range. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve a 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **V. Plan of Correction completion date. September 13, 2023** This statement of deficiencies and	

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	sugar reading was 425 mg/dL Documentation was lacking in the clinical record of the physician having been notified of the blood sugar readings above 400 mg/dL. During an interview with the Director of Nursing (DON) on 8/29/23 at 8:10 a.m., she indicated the facility did not have a diabetic blood sugar monitoring policy. During an interview with LPN (Licensed Practical Nurse) 1 on 8/29/23 at 8:50 a.m., she indicated that she would follow both physician and hospital physician orders. She would give the resident the required amount of sliding scale insulin and then would notify the physician of the high blood sugar reading. During an interview with the Infection Preventionist on 8/29/23 at 9:10 a.m., she indicated the nurses should follow both physician orders until they could get the orders clarified as to which high blood sugar reading the physician wanted to be notified about. During an interview with the ADON (Assistant Director of Nursing) on 8/29/23 at 12:50 p.m., she indicated the days the physician was not notified of the high blood sugars was because the staff were following the sliding scale orders and forgot to discontinue the first order. The resident had one set of orders and then after only a couple of days, nursing realized his blood sugars were not regulated, so new sliding scale orders were obtained. The new orders indicated the physician was to be notified if the resident's blood sugar was above 499 mg/dL. The most current Change in a Resident's		plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	

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	Condition or Status policy included, but was not limited to, "Our facility shall promptly notify the resident, his or her Attending Physician and representative of changes in the resident's medical/mental condition and/or status...Policy Interpretation: 1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or the On-Call Physician when there has been:...e. A need to alter the resident's medical treatment significantly;...h. Instructions to notify the physician of changes in the resident's condition...6. The Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status..." 3.1-5(a)(2) 3.1-5(a)(3)			
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure interventions were implemented for falls and to ensure safe transfer procedures were implemented for a resident that required maximum assistance which resulted in multifocal acute intracranial hemorrhage, right convexity subdural hematoma, small acute subarachnoid hemorrhage in the right sylvian fissure and interhemispheric fissure and small volume acute	F 0689	**F-689** **Free of Accident Hazards/Supervision/Devices** **The facility failed to ensure interventions were implemented for falls and to ensure safe transfer procedures**	09/20/2023

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	intraventricular hemorrhage in the right lateral ventricle for 1 of 6 residents reviewed for accidents. (Resident 57) Findings include: 1.a The record for Resident 57 was reviewed on 8/24/23 at 9:30 a.m. The resident's diagnoses included, but were not limited to, traumatic subdural hemorrhage without loss of consciousness, the need for assistance with personal care, reduced mobility, unsteadiness on feet, and contracture of the left hand. The Annual MDS (Minimum Data Set) assessment, dated 5/9/23, indicated the resident was severely cognitively impaired. She required extensive assistance with 2 staff members physical assistance with transfers, personal hygiene, and toileting. The resident had impairment to the upper and lower extremities. The care plan, dated 11/10/19 and last revised on 8/7/23, indicated the resident was at risk for falling and fall related injuries related to impaired cognition, decreased mobility, generalized muscle weakness and some decreased bilateral knee ROM (Range of Motion). The interventions included, but were not limited to, the resident would be in a supervised area while up in her wheelchair, with a start date of 7/10/23; assistance of 2 staff members while providing incontinent care, with a start date of 6/19/23; and a bolster mattress on the resident's bed, with a start date of 6/21/21. The nurse's note, dated 6/17/23 at 4:16 a.m., by LPN 7 (Licensed Practical Nurse) indicated around 3:48 a.m., a staff member came and got her and stated that a resident just rolled out of the bed and hit her head. The CNA (Certified Nursing		**were implemented for a resident requiring maximum assistance.** **I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident (57) has been reviewed by the IDT team with fall interventions and level of assistance required for hygiene and toileting updated in her care plan and on care sheets. Interventions are in place and staff have been educated on interventions and updated level of assistance requirement during toileting and hygiene requiring 2 person assist. **II 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:** Current residents have the potential to be affected. Current residents have been reviewed to ensure that the appropriate level of assistance required for hygiene and toileting is in place and being utilized. **III What measures will be put into place and what systemic**	

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	Aide) indicated she tried to catch her but did not get to the resident in time. The resident was on the side of her bed on her right side and the resident was incontinent of urine. She was able to move all 4 extremities without any groaning or grimacing. The resident had a baseball sized mass on the right size of her head. At 3:51 a.m., the physician was called, and he stated just to do neurological checks. When the residents POA (Power of Attorney) was called at 3:52 a.m., he stated to send her to the hospital to be checked out. The nurse's note, dated 6/17/23 at 2:26 p.m., indicated the resident was admitted to the hospital ICU (Intensive Care Unit) with a diagnosis of subdural hematoma. The Incident Report, dated 6/18/23, indicated the resident rolled out of bed and hit her head. The CNA tried to catch the resident but did not get to the resident in time. The resident was sent to the hospital for evaluation. A written document by CNA 8, dated 6/18/23, indicated the CNA stated she was providing incontinent care for the resident when the incident happened. The hospital discharge summary, dated 6/20/23, indicated the resident was on chronic anticoagulation with Eliquis for atrial fibrillation. The CT (Computerized Tomography) scan indicated on admission the resident had a multifocal acute and cranial hemorrhage, right convexity subdural hematoma measuring 1.1 cm (centimeters) as well as small other intracranial hemorrhages. The nurse's note, dated 6/24/23 at 4:21 p.m.,		**changes will be made to ensure that the deficient practice does not recur:** IDT will communicate with the MDS and clinical team at Morning Meeting to review any residents that have a change in level of assistance required for hygiene and toileting. Care Plan and care sheets will be updated, and staff educated on the change in level of assistance required and proper positioning. Nurses and CNA's have been re-educated regarding safe positioning when a resident is rolled to their side with impairments to upper and lower extremities and regarding utilizing the appropriate level of assistance during care. **IV How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The DON or Designee will do 5 random observations weekly to determine if appropriate assistance level and proper positioning is being implemented weekly for 4 weeks, then bi-weekly for 8 weeks, then monthly for 9 months. Any identified residents will be reviewed with the IDT. The results of the audits will be	

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	indicated the resident's right eye had a bruised hematoma. She was able to open her right eye a little bit with some redness observed to the sclera. When speaking to the resident she was not able to speak back. She would open her eyes to verbal stimuli. During an interview on 8/28/23 at 9:20 a.m., LPN 5 indicated the CNA was assisting the resident with incontinence care. The CNA pulled the resident towards her, and the resident's legs came out of the bed, and she slid out. 1.b. The nurse's note, dated 7/7/23 at 6:08 a.m., indicated the resident fell during care that morning. Staff was transferring the resident to a chair when she leaned forward and went down. The resident often pushed the opposite way during care making it harder and harder to control her body weight. The resident could benefit from a mechanical full body lift where she would have 2 staff available for all transfers. The resident was sent to the hospital for evaluation and treatment. The nurse's note, dated 7/8/23 at 9:40 p.m., indicated the resident had a large bump to her right forehead with steri strips in place. A small amount of bloody drainage was observed. During an interview on 8/28/23 at 10:30 a.m., RN 6 indicated she was the nurse on duty when the resident fell out of her chair. One CNA came to get her indicating the resident had fallen out of her chair. The CNA indicated the resident was transferred to the chair and she leaned forward and went down. The Fall Prevention Policy, dated 5/2016, provided on 8/29/23 at 8:24 a.m. included, but were not limited to, "...The components of this fall program		reviewed at the monthly quality assurance meetings with a 100% threshold. Changes may be made to the auditing process when the 100% compliance criteria has been reached and maintained for a minimum of 3 months. **V. Plan of Correction completion date. September 20, 2023** This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	

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	include: 1. Fall risk assessment; 2. Fall event assessment; 3. Strategies of prevention; 4. Strategies of intervention; 5. Interdisciplinary guidance; 6. Care planning; and 7. Staff education. As such, the Community must take reasonable steps to ensure it implements, best practices and evidence-based approaches to prevent falls and protect residents who are at risk for falling. Due to the risk associated with falls for older adults living in long-term care facilities, compliance with this policy is essential..." 3.1-45(a)(1)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder			

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	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 follow appropriate infection control guidelines related to perineal care for 3 of 6 residents with a history of urinary track infections reviewed for bowel and bladder. (Residents 76, 42, and 35) Findings include: 1. During an observation of perineal care for Resident 76 on 8/29/23 at 9:39 a.m., CNA (Certified Nurse Aide) 9 performed hand hygiene and applied gloves from her pocket. A wet soapy washcloth was obtained and with 4 swipes of the same area of the washcloth the labial area was cleaned. She obtained a wet washcloth and with 3 swipes of the same area of the washcloth she rinsed the creases. She obtained a wet washcloth and with 2 swipes of the same area of the washcloth she rinsed the labial area. The resident was rolled onto her left side and a wet soapy washcloth was obtained. With 11 swipes of the same area of the washcloth she cleaned the buttocks and anal area with a back-and-forth motion. Stool was observed on the washcloth. She obtained a wet soapy washcloth with 5 swipes of the same area of the washcloth she cleaned the buttocks and anal area using a back-and-forth motion. A wet soapy washcloth	F 0690	**F 690** **Bowel/Bladder Incontinence, Catheter, UTI** **The facility failed to follow appropriate infection control guidelines related to perineal care for 3 of 6 residents audited.** **I The corrective actions to be accomplished for those residents found to have been affected by the practice.** Residents 76, 42, and 35 have had proper perineal care completed and suffered no ill effects from this alleged deficient practice. **II The facility will identify other residents that may potentially be affected by this practice.** Current residents have the potential to be affected by this alleged deficient practice. Residents have been audited	09/13/2023

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	was obtained and with 4 swipes of the same area of the washcloth she cleaned the anal area using a back-and-forth motion. She obtained a wet washcloth and with 8 swipes of the same area of the washcloth she rinsed the buttocks and anal area using a back-and-forth motion. A clean brief was placed and fastened. The record for Resident 76 was reviewed on 8/24/23 at 1:53 p.m. The resident's diagnoses included, but were not limited to, a personal history of UTI (urinary tract infections), sepsis, muscle weakness, and unsteadiness on her feet. The care plan, dated 11/4/22 and last revised on 8/9/23, indicated the resident was unable to independently perform late loss ADLs (Activities of Daily Living) related to a recent history of sepsis and a UTI with a decline in selfcare, and required assistance and encouragement for toileting. The interventions, dated 11/4/22, indicated staff were to provide incontinence care with toileting as needed. The UA (urinalysis) report, dated 11/23/22, indicated the resident's urine had three plus large leukocytes and one plus blood. The urine was positive for macrolide resistance markers. The nurse's note, dated 2/10/23 at 10:52 a.m., indicated the resident complained of flank pain, foul odor of urine, and confusion. The physician was notified, and a new order was received for a UA with culture and sensitivity as indicated. The UA report, dated 2/13/23, indicated the urine was enterococcus faecalis positive and morganella morganii positive. The urine was positive for ESBL (extended spectrum beta lactamase) and macrolide resistance markers.		during perineal care to ensure proper perineal care has been provided efficiently. **III The facility will put into place the following systemic changes to ensure that the practice does not recur.** Nursing staff and CNA's have been re-educated on proper perineal care and were required to pass skills check off. The Annual Skills Fair scheduled for September will also require a skills check off related to perineal care. **IV The facility will monitor the corrective action by implementing the following measure.** DON/Designee will complete perineal care competencies on 3 random nursing staff members per week for four (4) weeks, then weekly for four (4) weeks, then biweekly for (4) weeks, then monthly 3 additional months to ensure proper perineal care is completed correctly. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits.	

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	The Quarterly MDS (Minimum Data Set) assessment, dated 2/15/23, indicated the resident was moderately cognitively impaired. She required extensive assistance of one staff for toileting. The physician's order, dated 2/17/23, indicated the resident was to receive Macrobid 100 mg (milligrams) twice daily until 8/24/23. The physician's order, dated 2/25/23, indicated the resident was to receive nitrofurantoin microcrystal capsule 50 mg at bedtime. The medication was discontinued on 5/24/23. 2. During an observation of perineal care for Resident 42 on 8/28/23 at 9:58 a.m., CNA 10 performed hand hygiene and applied gloves. She filled the two basins with water and let the resident test it. She brought the basin back into the room after getting the temperature to the resident's liking. The CNA obtained a wet washcloth and applied soap. Using 3 swipes with the same area of the cloth the resident's creases were cleaned in a front to back motion. She obtained another wet washcloth and applied soap. Using 2 swipes with the same area of the cloth she cleaned the labia in a front to back motion. She folded the washcloth and with 2 swipes of the same area of the cloth she cleaned the labia again. She obtained a wet washcloth and with 2 swipes of the same area of the washcloth she rinsed the labia and creases. She folded the washcloth and with 2 swipes of the same area of the washcloth she rinsed the labia and creases. She patted the resident dry. The resident was rolled onto her left side and the CNA obtained a wet washcloth. With 5 swipes of the same area of the washcloth the resident's buttocks and anal area were cleaned. The resident had a slight bowel movement. She		Plan to be updated as indicated. **V. Plan of Correction completion date. September 13, 2023** This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	

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	rinsed the resident and patted the anal area dry. The clean brief was placed under the resident. During an interview on 8/28/23 at 10:23 a.m., CNA 10 indicated during perineal care she would perform hand hygiene, explain the procedure to the resident, test the water in the basin, and lay the resident back. Wiping from front to back, she would clean the labial area, rinse, and dry them. The same process would be conducted on the resident's anal area. She would clean the resident from front to back and using only one wipe of the washcloth, and then change to another washcloth. The record for Resident 42 was reviewed on 8/25/23 at 8:27 a.m. The resident's diagnoses included, but were not limited to, hemiplegia and hemiparesis following a cerebral infarction affecting the left side, urinary tract infection, weakness, and anemia. The care plan, dated 11/29/22 and last revised on 7/8/23, indicated the resident had specific needs related to care. The interventions, dated 11/29/22, indicated the resident was incontinent of bladder and bowel. The Quarterly MDS assessment, dated 1/24/23, indicated the resident was severely cognitively impaired. The resident required extensive assistance of 2 staff for toileting. The UA results, dated 6/7/23, indicated the resident's urine had three plus large leukocytes, positive nitrates, two plus protein, and three plus blood in the urine. The nurse practitioner's note, dated 6/19/23 at 2:29 p.m., indicated the resident was being seen that			

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	day in follow-up for dysuria and urinary urgency. The resident began to experience the symptoms on 6/18/23. Staff were unable to get a urine sample for 3 attempts due to sediment. An order was received for Macrobid 100 mg twice daily for 5 days. The Events indicated, on 8/19/23 at 4:48 p.m., the resident was having a burning feeling during urination. The nurse's note, dated 8/20/23 at 4:25 p.m., indicated a sterile in and out procedure was performed. The urine was placed in sterile UA tubes. The specimen was collected around 4:00 p.m. The UA results, dated 8/20/23, indicated the resident's urine had three plus large leukocytes, one plus protein, and trace blood in the urine. 3. During an observation of perineal care for Resident 35 on 8/29/23 at 10:10 a.m., CNA 9 performed hand hygiene and applied gloves. She swiped the labial area 4 times with the same area of the washcloth to rinse. The brief was soaked through and onto the chuck under the resident. The resident was rolled onto her left side and with 10 swipes of the same area of the washcloth the buttocks and anal area were cleaned with a back-and-forth motion. She folded the washcloth and with 2 swipes of the same area of the washcloth she cleaned the buttocks and anal area again from the vagina to the coccyx. She obtained a clean washcloth and with 6 swipes of the same area of the washcloth she rinsed the buttocks and anal area. She folded the washcloth and with 3 swipes of the same area of the washcloth she rinsed the buttocks and anal area.			

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	The record for Resident 35 was reviewed on 8/29/23 at 11:07 a.m. The diagnoses included, but were not limited to, urinary tract infection, elevated white blood cell count, muscle weakness, and overactive bladder. The Quarterly MDS assessment, dated 2/13/23, indicated the resident was cognitively intact. The resident required extensive assistance of one staff for toileting. The care plan, dated 8/25/23 and last revised on 8/28/23, indicated the resident had signs and symptoms of a urinary tract infection. The interventions, dated 8/28/23, indicated staff were to administer antibiotics as ordered, assist with incontinence care, encourage fluid per plan of care, report adverse side effects of antibiotic, and report continued or worsening symptoms of a UTI. The nurse's note, dated 8/24/23 at 10:22 a.m., indicated new orders were received from the physician for a UA with culture and sensitivity, a chest x-ray, and 1 gram of Rocephin intramuscularly now. The nurse's note, dated 8/25/23 at 8:21 a.m., indicated a doctor's order to continue intramuscular Rocephin 1 gram daily until the UA results were available. The UA results, dated 8/24/23, indicated the resident's urine had one plus small leukocytes in the urine. The nurse's note, dated 8/29/23 at 7:27 a.m., indicated a new order was received to discontinue the rocephin and to start Ciprofloxacin 250 mg twice daily for 7 days for a diagnosis of a UTI			

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	through 9/4/23. The current Incontinence Care Skills Validations included, but was not limited to, " ... 9. For Females:-Using a warm moistened cloth apply 4 in 1 and; Separate labia. Wash urethral area first. Wash between and outside labia in downward strokes, alternating from side to side and moving outward to thighs. Use different part of washcloth for each stroke ..." 3.1-41(a)(2)			
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 record review and interview, the facility failed to ensure appropriate pain management interventions were implemented for 1 of 2 residents reviewed for pain. (Resident 102) Findings include: The record for Resident 102 was reviewed on 8/24/23 at 10:00 a.m. The diagnoses included, but were not limited to, unspecified pain (present on admission on 5/26/23), low back pain (added on 7/14/23), and intercostal pain (added on 7/18/23). The physician's order, dated 5/29/23, indicated staff were to administer the resident's hydrocodone-acetaminophen 5/325 mg (milligram) every 4 hours as needed for pain.	F 0697	F 697 **Pain Management** **The facility failed to ensure appropriate pain management interventions were were implemented for 1 of 2 residents reviewed for pain.** **I The corrective actions to be accomplished for those residents found to have been affected by the practice.** Resident's (102) pain management interventions have	09/13/2023

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	The physician's note, dated 5/26/23 at 10:31 p.m., indicated the physician was contacted for a controlled substance refill, a bridge supply was ordered until the primary team evaluated the resident. The physician indicated they discussed non-pharmacological pain management options, however, did not indicate what they were. The Admission MDS (Minimum Data Set) Assessment, dated 6/2/23, indicated the resident was cognitively intact and in the last five days prior to the assessment, the resident had received as needed pain medication but had not received non-medicated interventions for pain. A pain assessment was conducted, and the resident indicated she had pain frequently. The Quarterly MDS Assessment, dated 6/3/23, indicated the resident was cognitively intact and in the last five days prior to the assessment, the resident had received as needed pain medication but had not received non-medicated interventions for pain. A pain assessment was conducted, and the resident indicated she had pain frequently. The Controlled Drug Record sheet indicated in June the resident received 7 doses of hydrocodone-acetaminophen without any documentation of the administration on the MAR (Medication Administration Record), a pain assessment, or nonpharmacological interventions on the following dates: June 6, 11, 13, 16, 20, 23, and 25, 2023. The physician's note, dated 7/18/23 at 1:48 p.m., indicated the resident was seen due to a recent change in her medication regimen. The resident had a fall since her blood pressure medication had been increased and had left sided rib pain. She took hydrocodone for chronic pain control and		been reviewed and updated to reflect non-pharmacological interventions and to ensure documentation of effectiveness. Resident has suffered no ill-effects from this alleged deficient practice. **II The facility will identify other residents that may potentially be affected by this practice.** All residents have the potential to be affected by this practice. Current residents on pain medication have been reviewed and updated to ensure appropriate non-pharmacological interventions are in place. **III The facility will put into place the following systemic changes to ensure that the practice does not recur.** Licensed nurses have been re-educated on administering appropriate non-pharmacological interventions and documenting effectiveness. **IV The facility will monitor the corrective action by implementing the following measure.** Director of nursing or designee will audit current residents pain management interventions at least	

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	could use ice packs. The physician's order, dated 7/19/23, indicated staff were to apply ice packs to the resident's left rib as needed once a morning. The physician's note, dated 7/19/23 at 1:50 p.m., indicated the resident had no fractures on the x-ray and the resident was to have ice packs applied several times daily for 20 minutes, as well as Bio-freeze twice daily for three days and to reassess if no improvement. The Controlled Drug Record sheet indicated in July the resident received 7 doses of hydrocodone-acetaminophen without any documentation of the administration on the MAR (Medication Administration Record), a pain assessment, or nonpharmacological interventions on the following dates: July 3, 5, 6, 13, 14, and twice on July 15, 2023. The Controlled Drug Record sheet indicated in August the resident received 2 doses of hydrocodone-acetaminophen without any documentation of the administration on the MAR (Medication Administration Record), a pain assessment, or nonpharmacological interventions on the following dates: August 2 and 20, 2023. The record lacked documentation of a care plan for pain, including nonpharmacological interventions and an assessment of pain. The MAR lacked documentation of any administrations of ice packs to the resident's ribs in July or August. During an interview on 8/23/23 at 2:08 p.m., Resident 102 indicated she had recently asked the		5 times a week for four weeks, then bi-weekly times four weeks, then weekly times four weeks, then monthly times 7 months. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **V. Plan of Correction completion date. September 13, 2023** This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	

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	nurse for a pain pill and the nurse would not give it to her. She believed it was on 8/22/23, the day prior. She couldn't recall who it was, but her head was hurting and she had to lay down because it got so bad. It didn't get any better after laying down. During an interview on 8/28/23 at 1:46 p.m., LPN (Licensed Practical Nurse) 1 reviewed the Controlled Drug Record sheet and indicated she had only administered pain medication to the resident one time on 8/1/23. When they administered pain medication, they would document then what the pain level was. She only did pain assessments if the system asked her to. If it popped up to be done, then she would. During an interview on 8/29/23 at 12:40 p.m., MDS Coordinator 3 indicated they developed the long-term care plans for residents. They looked at diagnoses, medications, and got an overall picture. Most of the time everyone got a care plan for pain even if they didn't trigger, because everyone was at risk for pain. The resident should have had a care plan for pain implemented. During an interview on 8/29/23 at 12:54 p.m., MDS Coordinator 4 indicated it was a fluke that Resident 102 did not have a care plan. When her Quarterly MDS assessment triggered, she should have had a care plan for pain initiated. During an interview on 8/29/23 at 12:56 p.m., LPN 2 indicated when administering as needed pain medication to a resident, she would ask their pain rating and ask about their pain, including where it was and what level of pain it was. She would sign it out on both the Controlled Drug Record sheet and the MAR. Documentation on the MAR included what the pain level was, where it was, a			

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	description of pain, and if it was effective. She would not sign the medication out on the Controlled Drug Record sheet without signing it also on the MAR. Some of the MAR's did not include nonpharmacological interventions, they were supposed to document those. She did not know why they did not include nonpharmacological interventions. During an interview on 8/29/23 at 1:59 p.m., Resident 102 indicated she had pain at different times. She had chest pain from where she'd had open heart surgery in the past and it still hurt at times. She had been hit by a car when she was younger and had two broken vertebrae. She fell once and broke her hip and had to have surgery on that. Her knees ached all winter and summer from a prior surgery she'd experienced. Staff did not come in and ask her if she was having any pain. She was lucky if she got her pain medicine. The most current Pain Policy included, but was not limited to, "... Pain is whatever the person says it is, existing whenever he/she says it does... Pain cannot be managed with analgesics alone, the underlying cause of the pain must be addressed whenever possible. Alternative treatments should be sought such as: lower doses, alternative medications to prevent the risk of adverse consequences... Nursing considerations... Acute pain is assessed by the licensed nurse routinely and reviewed by the clinical team to determine if a pain assessment needs to be performed... It is recommended that residents using PRN [as needed] analgesics routinely be assessed by the physician or practitioner and the clinical team perform a root cause analysis to discover the etiology of the pain..."			

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	3.1-37(a)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure the physician was notified when a dialysis resident's weight was above the physician-ordered set parameters for 1 of 7 dialysis residents currently residing in the facility. (Resident 104) Findings include: The record for Resident 104 was reviewed on 8/25/23 at 11:29 a.m. The diagnoses included, but were not limited to, metabolic syndrome, diabetes mellitus with hyperglycemia and hypoglycemia without coma, nutritional anemia, and end stage renal disease with dependence on renal dialysis. A care plan, dated 6/4/23 with a last review date of 8/28/23, indicated the resident was at nutritional risk related to the carbohydrate controlled diet, fluid restricted diet and an altered BMI (body mass index).The goal was for the resident to tolerate the carbohydrate controlled/fluid restricted diet. The approaches included, but were not limited to, monitor/record weight routinely and notify the physician and Registered Dietitian of significant weight changes. A care plan, dated 6/4/23 with a last review date of 8/28/23, indicated the resident received	F 0698	**F 698 Dialysis** **The facility failed to ensure the physician was notified when a dialysis resident's weight was above the physician- ordered set of parameters for 1 of 7 residents reviewed.** **I The corrective actions to be accomplished for those residents found to have been affected by the practice.** Resident's (104) weights that were out of range have been reported to the physician. Resident has suffered no ill effects from this alleged deficient practice. **II The facility will identify other residents that may potentially be affected by this practice.** All residents have the potential to be affected by this practice.	09/13/2023

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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
	hemodialysis due to end stage renal disease and was at risk for complications. The goal was for the resident to have effective fluid management and be hemodynamically stable, without complications. The approaches included, but were not limited to, monitor vital signs as indicated; provide diet as ordered and encourage compliance; and report fluid excess (wt. gain). The Quarterly Minimum Date Set (MDS) assessment, dated 6/27/23, indicated the resident was cognitively intact; had frequent appetite issues; and received dialysis three times a week. On 4/21/23, a physician's order indicated the resident was to be weighed three times weekly on (Monday, Wednesday, and Friday); and staff were to notify the physician if the resident had a weight gain of 3 pounds daily or 5 pounds in a week. The April 2023 Medication Administration Record (MAR) indicated the resident had the following weights which required physician notification: - On 4/10, the resident's weight was 298.4 pounds. On 4/12, the resident's weight was 302.4 pounds. the Resident had a weight gain of 4 pounds. - On 4/26, the resident's weight was 287.8 pounds. On 4/28, the resident's weight was 297.4 pounds. The resident had a gain of 9.6 pounds. The May 2023 MAR indicated the resident had the following weight which required physician notification: - On 5/3, the resident's weight was 289.6 pounds. On 5/5, the resident's weight was 302.8 pounds. The resident had a weight gain of 13.2 pounds.		Current residents that are on dialysis have been audited to ensure pre and post assessments are completed, dialysis documents are accessible for staff, and that changes in weight that are outside the physician ordered set of parameters are reported to the physician. **III The facility will put into place the following systemic changes to ensure that the practice does not recur.** Licensed nurses have been re-educated on completing the pre and post dialysis assessment, ensuring dialysis documents are accessible, and that changes in weight that are outside the physician ordered set of parameters are reported to the physician. **IV The facility will monitor the corrective action by implementing the following measure.** Director of nursing or designee will audit current residents that receive dialysis at least 5 times a week for four weeks, then bi-weekly times four weeks, then weekly times four weeks, then monthly times 7 months. The results of these audits will be presented to the monthly Quality Assurance/Performance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155614	A. BUILDING 00 B. WING	08/29/2023

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	The June 2023 MAR indicated the resident had the following weight which required physician notification: - On 6/26, the resident's weight was 296 pounds. On 6/28, the resident's weight was 308.4 pounds. The resident had a weight gain of 8.4 pounds. The July 2023 MAR indicated the resident had the following weights which required physician notification: - On 7/3, the resident's weight was 295 pounds. On 7/5, the resident's weight was 305.8 pounds. The resident had a weight gain of 10.8 pounds. - On 7/19, the resident's weight was 280.7 pounds. On 7/21, the resident's weight was 288 pounds. The resident had a weight gain of 7.3 pounds. - On 7/24, the weight was 264.4 pounds. On 7/26, the weight was 290.4 pounds which was a gain of 16 pounds. The August 2023 MAR indicated the resident had the following weights which required physician notification: - On 8/4, the resident's weight was 277.2 pounds. On 8/7, the resident's weight was 282.9 pounds. The resident had a weight gain of 5.7 pounds. - On 8/16, the resident's weight was 276.1 pounds. On 8/18, the resident's weight was 279.8 pounds. The resident had a weight gain of 3.7 pounds. Documentation was lacking in the clinical record of the physician having been notified of the resident's weight gains per his order.		Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **V. Plan of Correction completion date. September 13, 2023** This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	

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A nurse's note, dated 6/9/23 at 3:53 a.m., indicated the resident was requesting fluids to drink. He was advised of being on a 1500 ml (milliliter) fluid restriction. The resident stated he would call his family to share with them regarding fluid restrictions.

A nurse's note, dated 6/26/23 at 10:29 a.m., indicated the resident left dialysis earlier than his scheduled time. The nurse contacted the resident's POA (Power of Attorney) to let her know the resident was continuously cutting his treatments short. The Dialysis nurse informed the nurse that the resident was retaining fluid and was educated that he could end up back in the hospital. The resident indicated he was aware. The Nurse Practitioner was also notified.

During an interview with the Director of Nursing (DON) on 8/28/23 at 11:14 a.m., she indicated that usually with dialysis residents, the dialysis nurse would let the nephrologist know if the weight fluctuated as they were the ones monitoring pre and post weights. She also indicated the dialysis nurse would let the nurses know through the SBAR (Situation, Background, Assessment, Recommendation) dialysis note.

The most current Change in a Resident's Condition or Status included, but was not limited to, "Our facility shall promptly notify the resident, his or her Attending Physician and representative of changes in the resident's medical/mental condition and/or status...Policy Interpretation: 1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or the On-Call Physician when there has been:...e. A need to alter the resident's medical treatment significantly;...h. Instructions to notify the physician of changes in

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	the resident's condition...6. The Nurse Supervisor/Chargé Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status..." 3.1-37(a)			