| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155160 | A. BUILDING 00<br>B. WING | 01/24/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| STONEBROOKE REHABILITATION CENTER | 990 N 16TH ST<br>NEW CASTLE, IN 47362 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00383507 and IN00399789.<br><br>Complaint IN00383507 - Substantiated. No deficiencies related to the allegations were cited.<br><br>Complaint IN00399789 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684.<br><br>Survey dates: January 18, 19, 20, 23, and 24, 2023.<br><br>Facility number: 000080<br>Provider number: 155160<br>AIM number: 100289330<br><br>Census Bed Type:<br>SNF/NF: 65<br>SNF: 13<br>Total: 78<br><br>Census Payor Type:<br>Medicare: 4<br>Medicaid: 54<br>Other: 20<br>Total: 78<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on January 27, 2023 | F 0000 | Stonebrooke Rehabilitation Center respectfully requests to be considered for Paper Compliance. | |
| F 0584<br>SS=E<br>Bldg. 00 | 483.10(i)(1)-(7)<br>Safe/Clean/Comfortable/Homelike Environment | | | |

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

Eileen Thomas HFA | Executive Director | 02/10/2023

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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| | §483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of | | | |

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| | comfortable sound levels.<br><br>Based on observation, interview, and record review, the facility failed to maintain clean tables in the activity/dining room on the locked unit. This affected all 19 residents who used the activity/dining room.<br><br>Findings include:<br><br>On 1/20/23 at 2:03 p.m., the six square tables in the activity/dining area were observed to have a build up of a brown, gummy substance around all the edges. There were six square tables and one rectangle table. The rectangle table is wooden and the wooden legs were scuffed and marred.<br><br>On 1/23/23 at 3:14 p.m., the dining room/activity room was observed to have six square tables and one rectangle table. The square tables have a metal stand in the center of the table to the floor with 4 supports that come out from the metal pole. The square tables have a laminated wood grain top with an off white band around the table edges. The band has streaks of a brown substance in the crease of the edge of the table, and scattered brown/tan smudges along the band. The rectangle table has scuffed and marred table legs on all 4 of the legs. The edge of the table has faded brown around the edges revealing an off white surface underneath. During the day, residents have been observed seated at the four square tables lined up together, and at the rectangle table. Two square tables sat along the wall between the double outside doors and a window and sometimes had no residents seated at them. The residents have been observed eating their meals at the tables, and have activities throughout the day at the tables. | F 0584 | · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.<br>**Tables on the secured Memory Care unit will be cleaned, repaired, or replaced.**<br>· 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.<br>**All residents have the potential to be affected. An audit will be conducted to identify any other dining or activity tables in use that require cleaning, repairs, or replacement.**<br>· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.<br>**All staff will be inserviced regarding proper cleaning of Dining or Activity tables.**<br>**Dining or Activity tables will be inspected daily for cleanliness by housekeeping supervisor, Issues identified will be immediately addressed by a member of housekeeping staff or the Maintenance Director.**<br>· 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. | 03/01/2023 |

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| | On 1/23/23 at 3:57 p.m., the Memory Care Specialist used a sanitizing bucket and washed the edge of one of the tables. The brown substance washed off onto the cloth, and when she rubbed in the groove on the edge, with her gloved fingernail, the brown substance came out of the groove. She indicated "it comes out when you use your fingernail."<br><br>On 1/24/23 at 3:20 p.m., the Administrator indicated the brown substance is like a varnish, and it keeps rubbing off the more they clean it. She said they used a brush and it didn't clean more off.<br><br>A policy for "Cleaning Practices" was provided by the Administrator on 1/24/23 at 10:07 a.m. The policy included, but was not limited to, "1. Cleaning always precedes disinfection...4. Cleaning and disinfection shall be done in a manner that begins at the least soiled area moving to the most soiled area, using a one directional cleaning method...."<br><br>3.1-(f)(5) | | **The Housekeeping Supervisor or designee will utilize POC Audit Tool weekly x 4 weeks, monthly x 3 months, and quarterly until the QAPI committee determines that substantial compliance has been accomplished. If 95% compliance is not achieved an action plan will be implemented.** | |
| F 0641 SS=E Bldg. 00 | 483.20(g)<br>Accuracy of Assessments<br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br><br>Based on observation, interview, and record review the facility failed to ensure accuracy of the MDS (Minimum Data Set) assessment regarding 2 residents' dental status (Resident 61 and Resident 47), indicate the use of BiPap/CPAP device for Resident 39, and indicate dialysis for Resident 43 for 4 of 29 residents reviewed for MDS accuracy. | F 0641 | · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **The MDS for Residents 61, 47, 39 and 43 have been modified to reflect an accurate assessment of each resident.** | 03/01/2023 |

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| | Findings include:<br><br>1. The clinical record for Resident 47 was reviewed on 1/23/23 at 10:43 a.m. The diagnoses included, but were not limited to, congestive heart failure, diabetes mellitus, vascular dementia, weakness, dysphagia, and malnutrition.<br><br>A care plan for dental care, dated 2/8/22, indicated Resident 47 had caries or missing teeth.<br><br>An admission MDS assessment, dated 2/17/22, indicated Resident 47 had "none of the above" in regard to dental concerns.<br><br>A significant change MDS assessment, dated 3/22/22, indicated Resident 47 had "none of the above" in regard to dental concerns.<br><br>Another significant change MDS assessment, dated 4/17/22, indicated Resident 47 had "none of the above" in regard to dental concerns.<br><br>Another significant change MDS assessment, dated 7/3/22, indicated "none of the above" in regard to dental concerns.<br><br>An observation conducted of Resident 47, on 1/18/23 at 3:33 p.m., with missing front teeth.<br><br>An interview conducted with the Assistant Director of Nursing (ADON), on 1/20/23 at 2:30 p.m., indicated Resident 47's partial was broken and he was on the list to be seen by the dentist.<br><br>An interview conducted with the RAI (Resident Assessment Instrument) Specialist, on 1/23/23 at 3:57 p.m., indicated she would go back and modify the MDS assessments that noted no concerns in | | · 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.<br>**All residents have the potential to be affected. An audit will be conducted by the RAI Specialist to determine if any other residents MDS was inaccurate in dental status, use of BiPap/CPap or dialysis.**<br>· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.<br>**MDS and MDS support nurses will be in-serviced on the importance of accuracy of assessments for dental status, use of BiPap/CPap or dialysis. DNS or designee will review all assessments transmitted to ensure accuracy of MDS assessments in regards to coding of dental status, BiPap/CPap use and dialysis.**<br>· 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.<br>**The DNS or designee will utilize POC Audit Tool weekly x 4 weeks, monthly x 3 months, and quarterly until the QAPI committee determines that substantial compliance has** | |

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| | regard to Resident 47's dental status.<br><br>2. The clinical record for Resident 61 was reviewed on 1/23/23 at 3:00 p.m. The diagnoses included, but were not limited to, dementia, malnutrition, and muscle weakness.<br><br>An interview conducted with Resident 61, on 1/19/23 at 1:10 p.m., indicated she wore upper and lower dentures. She didn't have any natural teeth.<br><br>A dental care plan, dated 12/31/20, indicated she was edentulous (lacking teeth) and had a full set of dentures.<br><br>An admission MDS assessment, dated 1/5/21, marked Resident 61 as edentulous.<br><br>An annual MDS assessment, dated 12/22/21, marked Resident 61 as edentulous.<br><br>A significant change MDS assessment, dated 4/19/22, marked "none of the above" in regard to dental status.<br><br>A significant change MDS assessment, dated 6/13/22, marked "none of the above" in regard to dental status.<br><br>A document titled "Oral Status and Swallowing Disorder Screening", dated 12/20/22, indicated Resident 61 was edentulous.<br><br>An interview conducted with RAI specialist, on 1/23/23 at 3:57 p.m., indicated she would go back and modify the MDS assessments that noted no concerns in regard to Resident 61's dental status.<br>3. The clinical record for Resident 39 was reviewed on 1/20/2023 at 11:27 a.m. The medical diagnoses included obstructive sleep apnea and chronic | | **been accomplished. If 95% compliance is not achieved an action plan will be implemented.** | |

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| | obstructive pulmonary disease.<br><br>A Significant Change of Condition Minimum Data Set Assessment, dated 1/9/2023, indicated that Resident 39 was cognitively intact and did not indicate the use of Bi/CPap.<br><br>A physician order, dated 12/7/2022, indicated for Resident 39 to have BiPap at home settings twice a day.<br><br>An interview with RAI Specialist (Resident Assessment Instrument Specialist) on 1/23/2023 at 1:25 p.m. indicated that Resident 39's 1/9/2023 assessment should have reflected the use of a Bi/CPap, and she would open a modification of this assessment.<br><br>4. The clinical record for Resident 43 was reviewed on 1/20/2023 at 11:40 a.m. The medical diagnoses included end stage renal disease and diabetes mellitus type two.<br><br>A Significant Change of Condition Minimum Data Set Assessment, dated 11/2/2022, indicated that Resident 43 was cognitively impaired and did not receive dialysis service.<br><br>A physician order, dated 10/27/2022, indicated that Resident 43 received dialysis at an outside dialysis center on Mondays, Wednesdays, and Fridays.<br><br>A nursing progress note, dated 10/28/2022, indicated dialysis reported complications during treatment.<br><br>An interview with RAI Specialist on 1/23/2023 at 1:25 p.m. indicated that Resident 43's 11/2/2022 assessment should have reflected the specialized | | | |

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| | services of dialysis and she would open a modification of this record.<br><br>An interview with the RAI Specialist on 1/23/2023 at 2:35 p.m. indicated that there is no specific policy for accuracy of Minimum Data Set Assessment, but that they code to the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual published by the Center for Medicare and Medicaid Services. | | | |
| F 0656 SS=E Bldg. 00 | 483.21(b)(1)(3)<br>Develop/Implement Comprehensive Care Plan<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with | | | |

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| | the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br><br>Based on interview and record review, the facility failed to develop and implement care plans for a resident with high blood pressure medications and low thyroid hormone medication (Resident 36), a resident with a catheter (Resident 74), a resident with a BiPap (bilevel positive airway pressure)/CPAP (continuous positive airway pressure) for Resident 39, and low air loss mattress for Resident 50. This affected 4 of 29 reviewed for care plans.<br><br>Findings include:<br><br>1. Resident 36's record was reviewed, on 1/20/23 at 1:53 p.m., and indicated diagnoses that included, but were not limited to, dementia, psychotic disorder with delusions, other sleep disorders, depression, anxiety, high blood | F 0656 | · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.<br>**The Care Plans for Residents 36,74,39 and 50 have been updated and implemented for each resident affected.**<br>· 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.<br>**All residents receiving medication for hypertension or hypothyroidism, with indwelling catheter, using BiPap/CPap, or LAL mattresses have the potential to be** | 03/01/2023 |

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| | pressure, cognitive communication deficit, and hypothyroidism (low thyroid hormone).<br><br>An Admission Minimum Data Set assessment, dated 12/11/22, indicated Resident 36 was severely impaired in cognitive skills for daily decision making, had behaviors directed toward others, wandering, had non-Alzheimer's dementia, anxiety and depression.<br><br>Current medications included hydrochlorothiazide (removes excess water in the body to decrease blood pressure) 25 milligrams every day, started 12/8/22 for high blood pressure, losartan 50 milligrams by mouth every day, started 12/8/22 for high blood pressure, and levothyroxine 125 micrograms by mouth every day, started 12/8/22 for hypothyroidism.<br><br>There were no care plans in the clinical record that addressed the use of the high blood pressure medications nor the hypothyroidism medication.<br><br>On 1/24/23 at 12:12 p.m., the Memory Care Specialist indicated several staff update and implement the care plans and she could not locate a care plan for the use of the levothyroxine or for the blood pressure medications.<br>2. The clinical record for Resident 74 was reviewed on 1/20/2023 at 11:13 a.m. The medical diagnoses included severe protein malnutrition and urinary retention.<br><br>A Significant Change of Condition Minimum Data Set Assessment, dated 12/6/2022, indicated that Resident 74 was cognitively impaired and utilized an indwelling urinary catheter.<br><br>A physician order, dated 12/15/2022, indicated for Resident 74 to have a foley catheter (a type of | | **affected. An audit will be conducted of residents receiving medications for hypertension, hypothyroidism, residents who have an indwelling catheter, utilize a BiPap/CPap or LAL mattress to ensure they had care plans in place.**<br>· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.<br>**All nurses will be inserviced regarding comprehensive care planning. The IDT will review all new orders during Clinical meeting to ensure that comprehensive care plans are in place for residents receiving medication administration services; residents with catheters, residents utilizing a BiPap/CPap or LAL mattress.**<br>· 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.<br>**The DNS or designee will utilize the POC Audit Tool weekly x 4 weeks, monthly x 3 months, and quarterly until the QAPI committee determines that substantial compliance has been accomplished. If 95% compliance is not achieved an action plan will be** | |

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| | indwelling urinary catheter) anchored.<br><br>No active urinary catheter care plan was indicated on the record.<br><br>An interview with RAI Specialist (Resident Assessment Instrument Specialist) on 1/23/2023 at 1:25 p.m. indicated that Resident 74 had a urinary catheter care plan, but it had been discontinued in December when he was trialing a discontinuation of his catheter. He failed this trial, and an indwelling urinary catheter was replaced, and the care plan was not re-initiated.,<br><br>3. The clinical record for Resident 39 was reviewed on 1/20/2023 at 11:27 a.m. The medical diagnoses included obstructive sleep apnea and chronic obstructive pulmonary disease.<br><br>A Significant Change of Condition Minimum Data Set Assessment, dated 1/9/2023, indicated that Resident 39 was cognitively intact.<br><br>A physician order, dated 12/7/2022, indicated for Resident 39 to have BiPap at home settings twice a day.<br><br>No active BiPap care plan was indicated on the record.<br><br>An interview RAI Specialist on 1/23/2023 at 1:25 p.m. indicated that Resident 39 did not have his BiPap/CPap listed on his care plan, but she would update the care plans to reflect this device.<br><br>4. The clinical record for Resident 50 was reviewed on 1/23/2023 at 9:45 a.m. The medical diagnoses included weakness and protein-calorie malnutrition. | | **implemented.** | |

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| | An Admission MDS, dated 12/22/2022, indicated that Resident 50 was cognitively intact, was at risk for new/worsened pressure areas, and had current pressure areas.<br><br>A physician order, dated 12/21/2022, indicated for Resident 50 to have a low air loss mattress. A low air loss mattress is a specialty mattress utilize to aid in the prevention and healing of pressure areas.<br><br>No active care plan was indicated on the record to the low air loss mattress.<br><br>An interview with RAI Specialist on 1/23/2023 at 1:25 p.m. indicated that the intervention of the low air loss mattress was discontinued with the wound care plans when they resolved, she would update the skin impairment care plan to include the intervention of a low air loss mattress.<br><br>A policy entitled, "IDT [Intradisciplinary Team] Comprehensive Care Plan Policy", was provided by the Executive Director on 1/24/2023 at 10:00 a.m. The policy indicated, "...The care plan will include measurable foals and resident specific interventions based on the residents needs and preference to promote the resident's highest level of functioning including medical, nursing, mental and psychosocial needs..."<br><br>3.1-35(a)<br>3.1-35(b)(1) | | | |
| F 0677<br>SS=D<br>Bldg. 00 | 483.24(a)(2)<br>ADL Care Provided for Dependent Residents<br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral | | | |

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| | hygiene;<br><br>Based on observation, interview, and record review, the facility failed to ensure showers were provided as preferred (Resident 31) and a resident was toileted timely that resulted in incontinence (Resident 46) for 2 of 3 residents reviewed for activities of daily living (ADLs).<br><br>Findings include:<br><br>1. The clinical record for Resident 31 was reviewed on 1/20/23 at 2:18 p.m. The diagnoses included, but were not limited to, muscle weakness, anxiety disorder, and repeated falls.<br><br>A quarterly minimum data set (MDS) assessment, dated 12/26/22, indicated Resident 31 was cognitively intact and assistance of 1 staff person for personal hygiene and bathing.<br><br>An interview conducted with Resident 31, on 1/19/23 at 10:28 a.m., indicated she had not received a shower for 2 weeks and within the past week she had received a "sponge shower". She prefers to have a shower.<br><br>A care plan for ADLs, dated 4/7/22, indicated Resident 31 required assistance with ADLs and the approach to assist with bathing as needed per resident preference. Offer showers two times per week with a partial bath in between.<br><br>A document titled "Preferences for Customary Routine and Activities", dated 1/17/23, indicated Resident 31 preferred showers.<br><br>A document titled "ADL Category Report", dated for December of 2022 and January of 2023, indicated the following date(s) where Resident 31 | F 0677 | · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.<br>**The ADL preferences for Residents 31 and 46 have been updated and implemented for each resident affected.**<br>· 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.<br>**All residents receiving ADL assistance have the potential to be affected. An audit will be conducted of residents receiving ADL assistance for showers and/or toileting to ensure their preferences and needs were in their plans of care and would be accomplished.**<br>· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.<br>**All nursing staff will be inserviced regarding ADL preferences and needs. The IDT will review ADL preferences and needs with resident or their representative during on-going quarterly care plan meetings to ensure that residents preferences and needs are being met. The facility internal grievance** | 03/01/2023 |

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| | received a shower:<br><br>11/30/22,<br>1/4/23,<br>1/11/23, &<br>1/21/23.<br><br>Shower Report sheets were reviewed and noted the following:<br><br>12/3/22- complete bed bath,<br>12/7/22- partial bed bath,<br>12/14/22- no documentation of complete bed bath or shower given,<br>12/17/22- refused shower,<br>12/21/22- no documentation of complete bed bath or shower given,<br>12/28/22- no documentation of complete bed bath or shower given,<br>12/31/22- complete bed bath,<br>1/7/23- complete bed bath,<br>1/11/23- complete bed bath,<br>1/14/23- complete bed bath, &<br>1/18/23- no documentation of complete bed bath or shower given.<br><br>An interview conducted with the Director of Nursing (DON), on 1/24/23 at 1:58 p.m., indicated Resident 31 had treatments to her bilateral lower extremities that are to be changed weekly. The staff were trying to coordinate when her showers were given based on the dressing change. She was unsure if the nursing staff made attempts to wrap or have an option to keep the dressings dry while providing a shower to Resident 31.<br><br>2. An observation conducted of Resident 46, on 1/23/23 at 12:08 p.m., of resident sitting up in wheelchair. There was a puddle underneath Resident 46's wheelchair and he indicated that he | | **policy will be followed for any concerns identified during the quarterly care plan meeting or at any other time. All staff will be inserviced on the internal grievance policy.**<br>· 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.<br>**The DNS or designee will utilize the POC Audit Tool weekly x 4 weeks, monthly x 3 months, and quarterly until the QAPI committee determines that substantial compliance has been accomplished. If 95% compliance is not achieved an action plan will be implemented.** | |

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| | had been waiting for approximately 15 to 20 minutes for staff assistance. He came to his room, and he notified the staff that he needed to utilize the bathroom "bad". He ended up having an incontinent episode of urine and feces while waiting for staff assistance. Resident 46 indicated he was "embarrassed" because "that's not right". Resident 46's call light was not on during the observation.<br><br>The nursing staff still proceeded to pass lunch trays on 1/23/23 at 12:14 p.m.<br><br>A staff member proceeded to enter Resident 46's room on 1/23/23 at 12:15 p.m. to offer assistance.<br><br>On 1/23/23 at 12:21 p.m., the staff went into Resident 46's room to pass the last lunch tray to him.<br><br>An interview conducted with Certified Nursing Assistant (CNA) 8, on 1/23/23 at 12:38 p.m., indicated she was told to wait until the meal trays were passed before conducting resident care. She told Resident 46 that the staff would assist him when they were done passing meal trays.<br><br>The clinical record for Resident 46 was reviewed on 1/23/23 at 3:39 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, acquired absence of left leg below knee, pain, and muscle weakness.<br><br>An ADL care plan, dated 5/3/21, indicated Resident 46 required staff assistance with ADLs including transfers and toileting.<br><br>A quarterly MDS assessment, dated 11/21/22, indicated extensive assistance with 2 staff for transfers and toilet use. Extensive assistance with | | | |

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| | one staff for dressing and personal hygiene was noted as well as being occasionally incontinent of urine and frequently incontinent of bowel.<br><br>An interview conducted with the DON on 1/24/23 at 2:03 p.m., indicated the expectations are for the nursing staff to prioritize their needs.<br><br>A document titled "Resident Rights", undated, was provided by the Executive Director on 1/24/23 at 10:20 a.m. The document indicated the right to a dignified existence.<br><br>3.1-38(a)(2)(A)<br>3.1-38(a)(2)(C)<br>3.1-38(a)(3)(A)<br>3.1-38(a)(3)(B) | | | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br><br>Based on interview and record review, the facility failed to follow-up with a change in a resident's condition of decreased level of consciousness and decreased appetite that was later hospitalized with sepsis for 1 of 3 residents reviewed for change of condition. (Resident G)<br><br>Findings include: | F 0684 | · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **Resident G no longer resides at the facility.**<br>· how other residents having the potential to be affected by the same deficient practice will be identified and what corrective | 03/01/2023 |

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| | The clinical record for Resident G was reviewed on 1/24/23 at 1:25 p.m. The diagnoses included, but were not limited to, weakness, chronic obstructive pulmonary disease, chronic kidney disease, muscle weakness, congestive heart failure, atrial fibrillation, diabetes mellitus, repeated falls, and mild cognitive impairment.<br><br>A quarterly MDS (Minimum Data Set) assessment, dated 11/4/22, indicated he was cognitively intact and required extensive staff assistance with transfers, dressing, personal hygiene along with supervision for bed mobility and toilet use. He was occasionally incontinent of bladder and always continent of bowel.<br><br>A care plan, dated 10/21/22 and discontinued on 1/17/22, indicated Resident G was at risk for ineffective tissue perfusion related to: systolic and diastolic congestive heart failure, atrial fibrillation, hyperlipidemia, hypertension, and coronary artery disease. The approach was administer medications as ordered, monitor vital signs, observe for and document signs and symptoms: change in mental status, disorientation, increased confusion, anxiety, and notify the physician.<br><br>A progress note, dated 1/2/23 at 12:49 p.m., indicated the following, "...Resident sitting up in w/c [wheelchair] in room. Dressings changed to both legs with no s/s [signs and symptoms] of infection or drainage noted. BLE [bilateral lower extremity] edema noted; ace wraps in place. Resident elevating legs on chair at this time...."<br><br>A progress note, dated 1/6/23 at 8:54 a.m., indicated the following, "...Called to residents room per cna [certified nursing assistant] and found res [resident] with his head bent over and | | action(s) will be taken.<br>**All residents have the potential to be affected, however no other residents were identified to be affected.**<br>· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.<br>**All nursing staff will be inserviced regarding quality of care and services, specifically reporting change of condition for a resident to MD, DNS, ED, and resident's responsible party. DNS or designee will review facility activity report daily to identify any resident's change in condition and ensure MD and responsible party is notified.**<br>· 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.<br>**The DNS or designee will utilize the POC Audit Tool weekly x 4 weeks, monthly x 3 months, and quarterly until the QAPI committee determines that substantial compliance has been accomplished. If 95% compliance is not achieved an action plan will be implemented.** | |

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| | slightly responding to verbal stimuli. VS checked and Bp [blood pressure] 128/72, pulse 74, resp19 sats [oxygen saturation] on room air is 94%, bs [blood sugar] checked and was 94 breakfast being passed at this time. Unable to get him to take his meds. Checked with other staff on unit what was his normal condition and they voiced that sometimes he responds and sometimes he goes into a deep sleep...." The progress note was signed by Registered Nurse (RN) 5.<br><br>A progress note, dated 1/6/23 at 1:30 p.m., indicated the following, "...Resident responded when checked and changed, incon [incontinent] of large amount of urine, res only took a few small bites of his lunch. Still refused to take his meds [medications]...." The progress note was signed by RN 5.<br><br>There was no follow up noted after Resident G continued to refuse his medications and had a decreased appetite.<br><br>A progress note, dated 1/6/23 at 7:09 p.m., indicated the following, "...Resident sent out to ED [emergency department] via ambulance. Resident found in room sitting in wheelchair, resident unable to lift up his head, unable to converse only able to mumble. Residents BS [blood sugar] 89, HR [heart rate] 111, 94% r/a [room air], temp [temperature] 98.6. 107/71 b/p [blood pressure]. Placed 2 sugar packets under residents tongue. Resident has not been responsive today, resident has been in same position as reported to this nurse per staff. Resident unable to lift head...."<br><br>A progress note, dated 1/6/23 at 11:30 p.m., indicated Resident G was admitted to the hospital for sepsis, respiratory failure, CHF (congestive | | | |

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| | heart failure) exacerbation, and pneumonia.<br><br>An interview conducted with RN 5, on 1/23/23 at 3:54 p.m., indicated she was not familiar with the residents on that unit due to her only working up there one other time previously. Certified Nursing Assistant (CNA) 10 was working on that unit on 1/6/23. She asked the staff what Resident G's baseline was, and the staff told her he loves food. So, she took his tray into his room, and she attempted to get Resident G to respond, and he would "moan" when she asked him about taking his medications or that breakfast was here. So, that was Resident G responding. She asked Resident G to grip her hands and he did on command and so she took that as Resident G responding. If Resident G was septic "he would be running a temperature".<br><br>An interview conducted with CNA 10, on 1/24/23 at 9:15 a.m., indicated Resident G was "always sleepy". He didn't consume breakfast the morning on 1/6/23 and there were times in the past that he didn't consume breakfast. Right before lunch, he was still sleepy, and she was concerned because "he's a good eater". She asked RN 5 to check his vital signs and RN 5 commented on how she already took Resident G's vital signs. Resident G was responding when we approached him. At lunch, he was sleepy but responded by saying "yeah" when asked by CNA 10. When Resident G was still sleepy at lunch time I was concerned. He was usually more alert at lunch then compared to breakfast time.<br><br>An interview conducted with the Director of Nursing (DON), on 1/24/23 at 2:11 p.m., indicated she interviewed the Qualified Medication Aide (QMA) to get a timeline. Resident G was up around 6:00 a.m. and the staff obtained his weight, | | | |

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| | and he was able to engage in a conversation. The CNA on day shift commented on how Resident G was alert and oriented per his usual. The only change the staff observed was when he didn't want to eat as much for lunch. RN 5 was new and not familiar with Resident G. The nursing staff say it was normal for Resident G to be tired in the morning and would only mumble sometimes. The DON indicated she conducted coaching and counseling for RN 5 about when she isn't familiar with a situation to obtain a manager. The nurse came in on evening shift, at 6:00 p.m., and noticed enough of a change to send out Resident G to the hospital.<br><br>The vital signs were reviewed in Resident G's clinical record. There were no vital signs documented for the afternoon of 1/6/23 for Resident G besides a heart rate of 78 beats per minute. On 1/6/23, it was documented that Resident G consumed 76-100% of breakfast and 51-75% of lunch. There was documentation that Resident G consumed 76-100% of dinner at 7:54 p.m. but he was sent out to the hospital prior to that time.<br><br>A policy titled "Resident Change of Condition", dated 11/2018, was provided by the Executive Director on 1/23/23 at 10:20 a.m. The policy indicated the following, "...It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place...2. Acute Medical Change...a. Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician...d. All nursing actions/interventions will be documented in the medical record as soon as possible after resident | | | |

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| | needs have been met...."<br><br>This Federal tag relates to Complaint IN00399789.<br><br>3.1-37(a) | | | |
| F 0686<br>SS=D<br>Bldg. 00 | 483.25(b)(1)(i)(ii)<br>Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br><br>Based on interview and record review, the facility failed to ensure a treatment was initiated timely for an identified pressure ulcer after readmission to the facility for 1 of 3 residents reviewed for pressure ulcers. (Resident 47)<br><br>Findings include:<br><br>The clinical record for Resident 47 was reviewed on 1/23/23 at 3:10 p.m. The diagnoses included, but were not limited to, congestive heart failure, vascular dementia, malnutrition, and diabetes mellitus.<br><br>A care plan for skin integrity, dated 12/21/22, | F 0686 | · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **Residents 47 treatment for pressure ulcer was implemented on 1/10/2023.**<br>· 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 newly admitted residents have the potential to be affected. An audit will be conducted Nurses on the IDT to** | 03/01/2023 |

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| | indicated Resident 47 admitted with pressure ulcers to left buttock and right heel. An approach was listed for treatment as ordered.<br><br>An admission observation, dated 1/4/23, indicated Resident 47 had an ulcer to the right buttock and left buttock that was open upon readmission to the facility.<br><br>A document titled "Wound Management Detail Report" for Resident 47 indicated a wound assessment of the right buttock pressure ulcer was noted on 1/5/23 with measurements of 0.4 x 0.5 x 0.1 centimeters. A pressure ulcer was noted to the left buttock with measurements of 1.5 x 1 x 0.2 centimeters.<br><br>A physician order, dated 1/10/23, indicated to cleanse left and right buttocks with wound wash, pat dry, and apply a foam dressing to bilateral buttocks daily.<br><br>There was no physician order for a treatment to Resident 47's buttocks from the readmission date, 1/4/23, until 1/10/23.<br><br>An interview conducted with the Director of Nursing on 1/24/23 at 11:20 a.m., indicated she did not see a treatment to Resident 47's buttocks until 1/11/23.<br><br>A policy titled "SKIN MANAGEMENT PROGRAM", dated 5/2022, was provided by the Executive Director on 1/24/23 at 10:00 a.m. The policy indicated the following, "...1. Alterations in skin integrity will be reported to the MD/NP [Medical Director/Nurse Practitioner], the resident and/or resident representative as well as to the direct care staff...2. Treatment order will be obtained from MD/NP...." | | **ensure all identified skin integrity concerns have been addressed for new admissions/ readmissions with treatment orders, if applicable.**<br>· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.<br>**All nursing staff will be inserviced regarding recognizing and/or implementing orders for skin integrity concerns for new admissions. IDT will review new admissions/readmissions by the following business day to ensure treatment orders are in place, if applicable.**<br>· 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.<br>**The DNS or designee will utilize the POC Audit Tool weekly x 4 weeks, monthly x 3 months, and quarterly until the QAPI committee determines that substantial compliance has been accomplished. If 95% compliance is not achieved an action plan will be implemented.** | |

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| STONEBROOKE REHABILITATION CENTER | 990 N 16TH ST<br>NEW CASTLE, IN 47362 |

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| | 3.1-40(a)(2) | | | |
| F 0689 SS=D Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>Based on observation, record review, and interview, the facility failed to implement fall interventions for a Resident at risk for falls for 1 of 3 residents review for fall management. (Resident 43)<br><br>Findings include:<br><br>The clinical record for Resident 43 was reviewed on 1/20/2023 at 11:40 a.m. The medical diagnoses included end stage renal disease and diabetes mellitus type two.<br><br>A 5-day Minimum Data Set Assessment, dated 12/28/2022, indicated that Resident 43 was cognitively impaired and had one fall since prior assessment without injury.<br><br>A care plan, dated 1/22/2021, indicated that Resident 43 was at risk for falls due to history of falling, incontinence, high risk medication, oxygen acting a tether, impaired cognition, impaired mobility, unsteady gait, multiple comorbidities, weakness, and amputation. A fall intervention, | F 0689 | · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **Residents 43's call light cord has been wrapped with brightly colored tape.**<br>· 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 fall interventions have the potential to be affected. An audit will be conducted of residents with fall interventions to ensure all fall inventions had been implemented.**<br>· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **All staff will be inserviced** | 03/01/2023 |

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| | dated 11/21/2022, indicated to wrap call light with brightly colored tape.<br><br>An observation on 1/19/2023 at 4:44 p.m. indicated Resident 43 was laying in bed at this time with his call light within reach, it was a standard off-white call light with no tape in place.<br><br>An observation on 1/20/2023 at 4:23 p.m. indicated Resident 43 was laying in bed at this time with his call light within reach, it was a standard off-white call light with no tape in place.<br><br>A policy entitled, "Fall Management Policy", was provided by the Infection Preventionist Nurse on 1/24/2023 at 3:30 p.m. The policy indicated, " ...Facilities must implement comprehensive, resident-centered fall preventions plans for each resident as risk for falls or with a history of falls ..."<br><br>3.1-45(b) | | **regarding fall interventions. The IDT will review fall interventions as part of the CARE round initiative to ensure fall interventions are in place, per plan of care.**<br>· 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 DNS or designee will utilize the POC Audit Tool weekly x 4 weeks, monthly x 3 months, and quarterly until the QAPI committee determines that substantial compliance has been accomplished. If 95% compliance is not achieved an action plan will be implemented.** | |
| F 0690 SS=D Bldg. 00 | 483.25(e)(1)-(3)<br>Bowel/Bladder Incontinence, Catheter, UTI<br>§483.25(e) Incontinence.<br>§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.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition | | | |

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| | demonstrates that catheterization was necessary;<br>(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<br>(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.<br><br>§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.<br>Based on interview, observation, and record review, the facility failed to promote Resident 234's dignity by utilizing a dignity bag with a urinary catheter drainage bag and failed to ensure Resident 74's urinary catheter drainage bag was kept free of contact with the floor for 2 of 3 residents reviewed for urinary catheter management.<br><br>Findings include:<br><br>1. The clinical record for Resident 234 was reviewed on 1/19/2023 at 1:14 p.m. The medical diagnoses included muscle weakness and urinary tract infections.<br><br>A 5-day Minimum Data Set Assessment, completed on 1/12/2023, indicated Resident 234 was cognitively intact, utilized an indwelling urinary catheter and needed extensive assistant | F 0690 | · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **Resident 234 no longer resides at the facility. Resident 74's care plan has been updated and staff have been inserviced regarding placement of the urinary drainage bag.**<br>· 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 urinary catheters have the potential to be affected. An audit will be conducted of residents with catheters to ensure their** | 03/01/2023 |

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| | with hygiene activities of daily living.<br><br>A urinary catheter care plan, dated 1/10/2023, indicated the intervention of storing the urinary catheter collection bag inside a protective dignity pouch.<br><br>An observation on 1/18/2023 at 4:30 p.m. indicated Resident 234 laying in bed with a urinary catheter drainage bag hanging from the left side of her bed with a moderate amount of yellow urine visible.<br><br>An observation on 1/19/2022 at 10:17 a.m. indicated Resident 234 sitting in bed with her urinary catheter drainage bag hanging from the lift side of her bed with a moderate among of yellow urine visible.<br><br>2. The clinical record for Resident 74 was reviewed on 1/20/2023 at 11:13 a.m. The medical diagnoses included severe protein malnutrition and urinary retention.<br><br>A Significant Change of Condition Minimum Data Set Assessment, dated 12/6/2022, indicated that Resident 74 was cognitively impaired and utilized an indwelling urinary catheter.<br><br>A physician order, dated 12/15/2022, indicated for Resident 74 to have a foley catheter (a type of indwelling urinary catheter) anchored.<br><br>No active urinary catheter care plan was indicated on the record.<br><br>An observation on 1/19/2023 at 2:14 p.m. indicated Resident 74 laying in a low bed with his urinary catheter drainage bag contacting the floor and partially under his fall mat. | | **drainage bag was covered with a dignity bag and was properly placed.**<br>· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.<br>**All nursing staff will be inserviced regarding urinary catheter drainage bags to ensure dignity bags are in place and drainage bags are properly place. CARE Companions/IDT or designee will round daily to ensure all urinary drainage bags have a dignity cover in place and are properly placed.**<br>· 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.<br>**The DNS or designee will utilize the POC Audit Tool weekly x 4 weeks, monthly x 3 months, and quarterly until the QAPI committee determines that substantial compliance has been accomplished. If 95% compliance is not achieved an action plan will be implemented.** | |

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| | An observation on 1/20/2023 at 2:48 p.m. indicated Resident 74 laying in a low bed with the bottom fourth of his urinary catheter bag contacting the floor.<br><br>An interview with the Director of Nursing on 1/24/2023 at 2:27 p.m. indicated that it is the expectation that urinary catheter drainage bags would be kept in dignity pouches and that urinary catheter tubing and drainage bags would be kept free of contact with the floor.<br><br>3.1-41(a)(2) | | | |
| F 0756 SS=D Bldg. 00 | 483.45(c)(1)(2)(4)(5)<br>Drug Regimen Review, Report Irregular, Act On<br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant | | | |

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| | drug, and the irregularity the pharmacist identified.<br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.<br><br>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.<br><br>Based on record review and interview, the facility failed to ensure a pharmacy recommendation was followed up timely by the physician, for 1 of 5 residents reviewed. (Resident 72)<br><br>Findings include:<br><br>Resident 72's record was reviewed on 1/20/23 at 11:49 a.m. The record indicated Resident 72 had diagnoses that included, but were not limited to, Alzheimer's disease with late onset, dementia, with behavioral disturbance, high blood pressure, cognitive communication deficit, visual hallucinations, depression, delirium, and wandering.<br><br>An Admission Minimum Data Set assessment (MDS), dated 10/17/22, indicated Resident 72 was severely impaired in cognitive skills for daily decision making, understands others and is | F 0756 | · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **The Pharmacy Recommendation for Resident 72 has been addressed.**<br>· 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. An audit will be conducted of pharmacy recommendations to ensure timely follow-up.**<br>· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not | 03/01/2023 |

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| | understood by others, had no behaviors, had Alzheimer's disease, and non-Alzheimer's dementia, received antipsychotic medications for 7 of the 7 assessment days, and antidepressant medications for 6 of the 7 assessment day.<br><br>Current physician's orders included, but were not limited to, fluoxetine (antidepressant) 40 milligrams (mg) at bedtime every day, started on 10/12/22 for depression, and olanzapine (antipsychotic) 2.5 milligrams at bedtime, started 12/13/22 for major, recurrent, moderate depressive disorder.<br><br>A Pharmacy Consultation Report, dated 10/12/22, indicated: "Comment: [Resident 72] has a diagnosis of Alzheimer's disease and receives Olanzapine 5 mg once a day. Recommendations: Please attempt a gradual dose reduction to Olanzapine 2.5 mg once a day, with the end goal of discontinuation...." The pharmacy recommendation was not addressed by the physician until 12/8/22.<br><br>On 1/24/23, at 1:16 p.m., the Director of Nursing indicated they had waited on the family to get back to them about psych services, and the family declined psych services. They forwarded the pharmacy recommendation to the physician and they had a change of physicians right after that time. They have an action plan to give psych services a week to get back with them, then notify the physician, and they notify them every week until they get a response. She indicated it is more streamlined now because they have one physician provider for the building.<br><br>A Policy for "Medication Regimen Reviews and Pharmacy Recommendations" was provided by the Memory Care Specialist on 1/24/23 at 12:10 p.m. The policy indicated, but was not limited to, | | recur.<br>**The IDT will review all pharmacy recommendations during the Clinical meeting to ensure timely follow-up.**<br>**Regional Director of Clinical Services will inservice DNS on the Pharmacy Recommendations policy.**<br>· 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.<br>**The DNS or designee will utilize the POC Audit Tool weekly x 4 weeks, monthly x 3 months, and quarterly until the QAPI committee determines that substantial compliance has been accomplished. If 95% compliance is not achieved an action plan will be implemented.** | |

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| | "Purpose: It is the policy of [American Senior Communities] that the facility maintains the resident's highest practicable level of physical, mental, and psychosocial well-being and prevents or minimizes adverse consequences related to medication therapy to the extent possible by providing oversight by a licensed Pharmacist, Attending Physician Medical Director, and Director of Nursing. Policy: Medication Regimen Review: The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The drug regimen review must include a review of the resident's medical chart...The Consultant Pharmacist recommendations will be reviewed by the Director of Nursing and the Attending Physician will e notified promptly of any recommendations needing immediate attention, Pharmacy recommendations should be reviewed with follow up by the physician within 30 days of the facility receiving...."<br><br>3.1-25(i) | | | |
| F 0758<br>SS=D<br>Bldg. 00 | 483.45(c)(3)(e)(1)-(5)<br>Free from Unnec Psychotropic Meds/PRN Use<br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that--- | | | |

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| | §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br><br>Based on observation, interview and record review, the facility failed to provide education for the risk of using antipsychotic medications (Residents 36 and 72), and failed to identify and monitor target behaviors for a resident receiving | F 0758 | · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.<br>**Education for the use of antipsychotic medication use** | 03/01/2023 |

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| | antipsychotic medications (Resident 42). This affected 3 of 5 residents reviewed for unnecessary medications.<br><br>Findings include:<br><br>1. Resident 36's record was reviewed, on 1/20/23 at 1:53 p.m., and indicated diagnoses that included, but were not limited to, dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, psychotic disorder with delusions, other sleep disorders, depression, anxiety, high blood pressure, cognitive communication deficit, and low thyroid hormone.<br><br>An Admission Minimum Data Set assessment, dated 12/11/22, indicated Resident 36 was severely impaired in cognitive skills for daily decision making, had behaviors directed toward others, wandering, had non-Alzheimer's dementia, anxiety and depression, received antipsychotic medication 7 of the 7 assessment days, and a gradual dose reduction was not attempted.<br><br>Current medications included, but were not limited to, Risperdal (antipsychotic medication) 0.5 milligrams (mg) by mouth twice a day, started on 1/9/23 for psychotic disorder with delusions due to known physiological condition,<br><br>On 1/24/23 at 12:59 p.m., the Administrator indicated she was unable to find anything that had been signed that the family had been educated on the black box warning; no informed consent.<br><br>2. Resident 72's record was reviewed on 1/20/23 at 11:49 a.m. The record indicated Resident 72 had diagnoses that included, but were not limited to, | | **as been provided to Residents 36 and 72 or their responsible party. Behavior monitoring has been implemented for Resident 42**<br>· 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.<br>**All residents receiving antipsychotic medications have the potential to be affected. An audit will be conducted to identify other residents receiving antipsychotic medications to ensure education has been provided to them or their responsible parties. An audit will be conducted to ensure behavior monitoring is in place for a resident receiving antipsychotic medications.**<br>· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.<br>**All residents who admit with or receive new orders for antipsychotic medications will receive education on the use of the medication, if applicable the responsible party will educated. All residents with physician orders for the use of antipsychotic medications will have behavior monitoring reviewed and/or developed** | |

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| STONEBROOKE REHABILITATION CENTER | 990 N 16TH ST<br>NEW CASTLE, IN 47362 |

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| | late onset Alzheimer's disease, dementia, with behavioral disturbance, high blood pressure, cognitive communication deficit, visual hallucinations, major depressive disorder, delirium, and wandering.<br><br>An Admission Minimum Data Set assessment, dated 10/17/22, indicated Resident 72 was severely impaired in cognitive skills for daily decision making, understands others and is understood by others, had no behaviors, had Alzheimer's disease, and non-Alzheimer's dementia, and received antipsychotic medications for 7 of the 7 assessment days.<br><br>Current physician's orders included, but were not limited to, olanzapine (antipsychotic) 2.5 milligrams at bedtime, started 12/13/22 for major, recurrent, moderate depressive disorder.<br><br>A Pharmacy Consultation Report, dated 10/12/22 indicated: "Comment: [Resident 72] has a diagnosis of Alzheimer's disease and receives Olanzapine 5 mg once a day. Recommendations: Please attempt a gradual dose reduction to Olanzapine 2.5 mg once a day, with the end goal of discontinuation...."<br><br>On 1/24/23 at 12:59 p.m., the Administrator indicated she was unable to find anything that had been signed that the family had been educated on the black box warning; no informed consent.<br><br>A Policy for "Medication Regimen Reviews and Pharmacy Recommendations" was provided by the Memory Care Specialist on 1/24/23 at 12:10 p.m. The policy indicated, but was not limited to, "Purpose: It is the policy of [American Senior Communities] that the facility maintains the | | **and implemented. All Nursing staff will be inserviced regarding the education for risk of use of antipsychotic medications. All staff will be inserviced regarding behavior monitoring for residents.**<br>· 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.<br>**The DNS or designee will utilize the POC Audit Tool weekly x 4 weeks, monthly x 3 months, and quarterly until the QAPI committee determines that substantial compliance has been accomplished. If 95% compliance is not achieved an action plan will be implemented.** | |

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| | resident's highest practicable level of physical, mental, and psychosocial well-being and prevents or minimizes adverse consequences related to medication therapy to the extent possible by providing oversight by a licensed Pharmacist, Attending Physician Medical Director, and Director of Nursing. Policy: Medication Regimen Review: The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The drug regimen review must include a review of the resident's medical chart...The Consultant Pharmacist recommendations will be reviewed by the Director of Nursing and the Attending Physician will e notified promptly of any recommendations needing immediate attention, Pharmacy recommendations should be reviewed with follow up by the physician within 30 days of the facility receiving...."<br>3. The clinical record for Resident 42 was reviewed on 1/23/2023 at 10:15 a.m. The medical diagnoses included metabolic encephalopathy and dementia with mood disturbances.<br><br>An Admission Minimum Data Set Assessment, dated 12/5/2022, indicated that Resident 42 was cognitively impaired and did not exhibit behaviors of wander, physical or verbal behaviors, rejection of care, or other behavioral symptoms.<br><br>A physician order for Resident 42, dated 11/29/2022, indicated fluoxetine (an antidepressant) 20 milligrams (mg) daily for the use of major depressive disorder.<br><br>A physician order for Resident 42, dated 11/29/2022, indicated quetiapine (an antipsychotic) 25 mg at bedtime for other specified aftercare.<br><br>No specialized care plan for indication of use, | | | |

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| | nonpharmacological interventions for, nor behaviors to monitor for the use of antipsychotic medication was noted on the record.<br><br>A Behavior Health Monthly Review for Resident 42, dated 1/4/2023, indicated the use of fluoxetine but did not indicate the use of quetiapine, had no behavioral expressions exhibited, and it was not applicable for staff educated as to interventions.<br><br>A policy entitled, "Psychotropic Management", was provided by the Executive Director on 1/24/2023 at 10:00 a.m. The policy indicated, " ...These medications are managed in collaboration with professional services and facility staff to include non-pharmacological interventions ...Symptoms and therapeutic goals must be clearly documented ..."<br><br>A policy entitled, "Behavior Management", was provided by the Executive Director on 1/24/2023 at 10:00 a.m. The policy indicated, " ...Care plans should be initiated when a resident is receiving a psychotropic mediation used to treat either mood or behavior. The care plan should clearly identify the specific mood, thought process, or behavioral expression which the prescriber has identified as the indicate of use of the psychotropic medication ..."<br><br>3.1-3(n)(2)<br>3.1-48(b)(2) | | | |
| F 0812<br>SS=F<br>Bldg. 00 | 483.60(i)(1)(2)<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources | | | |

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| | approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>Based on observation, interview, and record review, the facility failed to ensure temperature logs were completed and the sanitizing solution was tested for a chemical dishwasher that resulted in lack of sanitizing solution being distributed for an unknown period of time. This had the potential to affect all 78 residents that receive food from the kitchen.<br><br>Findings include:<br><br>An observation of the kitchen was conducted on 1/18/23 at 10:30 a.m. Culinary Assistant (CA) 11 was proceeding to run dirty dishes through the dishwasher. CA 11 indicated the machine was a chemical dishwasher. The dial registered the temperature to be 138 degrees. She took a testing strip for the sanitizing solution and the strip did not change color to indicate the presence of a chemical sanitizing solution. CA 11 proceeded to press a button the prime the line to see if | F 0812 | · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.<br>**The dish machine concern was immediately addressed/corrected by the Maintenance Director and Culinary Manager.**<br><br>· 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.<br>**All residents have the potential to be affected. All culinary staff have been inserviced regarding the proper use of and documentation for the dish machine.** | 03/01/2023 |

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| | sanitizing solution was coming out and there wasn't any exiting the line. There was a bin located underneath the dishwasher to which CA 11 indicated was the sanitizing solution and it was "low". This will occur when the sanitizing solution bin is low. CA 11 indicated she hadn't checked the test strip to check for the concentration of sanitizing solution that morning. There was a temperature log located on the wall by the dishwasher. The log showed temperature and sanitizing solution checks not being conducted since 1/17/23 in the morning, breakfast time. The facility was expected to receive a shipment of sanitizing solution 1/17/23 but it was delayed and should be in on 1/18/23.<br><br>A follow up observation of the kitchen was conducted with the Culinary Manager (CM) on 1/18/23 at 11:10 a.m. Maintenance staff came to look at the dishwasher and they were able to advance the tubing to the sanitizing solution to allow for more solution to come out. A test strip was utilized and registered at 50 PPM (parts per million) per the guide. CM indicated she checked the dishwasher the evening on 1/17/23 but "if it wasn't written, it wasn't done".<br><br>A document titled "Low Temp [Temperature] Dishmachine Temperature/Sanitizer Log", dated January of 2023, was provided by the Executive Director (ED) on 1/18/23 at 11:14 a.m. The log indicated the dishwasher temperature and sanitation was not documented as checked on 1/17/23, lunch and dinner, and 1/18/23, breakfast.<br><br>A document titled "Cleaning Dishes and Dish Machine", dated 10/17, was provided by the ED on 1/24/23 at 10:20 a.m. The policy stated to ensure detergent and sanitizer dispensers are properly loaded. | | · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.<br>**All culinary staff have been in-serviced regarding the proper use of and documentation for the dish machine. The Culinary Manager or designee will ensure proper operation of and documentation for the dish machine daily.**<br><br>· 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.<br>**The Culinary Manager or designee will utilize the POC Audit Tool weekly x 4 weeks, monthly x 3 months, and quarterly until the QAPI committee determines that substantial compliance has been accomplished. If 95% compliance is not achieved an action plan will be implemented.** | |

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| | 3.1-21(i)(2)<br>3.1-21(i)(3) | | | |
| F 0825<br>SS=D<br>Bldg. 00 | 483.65(a)(1)(2)<br>Provide/Obtain Specialized Rehab Services<br>§483.65 Specialized rehabilitative services.<br>§483.65(a) Provision of services.<br>If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must-<br><br>§483.65(a)(1) Provide the required services; or<br><br>§483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act.<br><br>Based on interview and record review, the facility failed to ensure therapy recommendations were followed through and therapy referrals were followed up with timely for 1 of 2 residents reviewed for therapy services. (Resident 62)<br><br>Findings include:<br><br>The clinical record for Resident 62 was reviewed on 1/19/23 at 1:46 p.m. The diagnoses included, but was not limited to, dysphagia, adult failure to | F 0825 | what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.<br>**Resident 62 has been referred to Therapy for evaluation.**<br>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.<br>**All residents who require** | 03/01/2023 |

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| | thrive, and cognitive communication deficit. Resident 62 was admitted to the facility on 1/1/2021.<br><br>An admission (MDS) Minimum Data Set assessment, dated 1/7/21, indicated no impairment in Resident 62's range of motion (ROM) to the upper and lower extremities.<br><br>An Occupational Therapy (OT) discharge summary, dated 1/21/21, indicated the following, "...Discharge Plans & Instructions...Patient discharge to same SNF [skilled nursing facility] with 24 hour assistance as needed due to payor change. Recommendations for continuation of skilled therapy services under new payor in order to facilitate increased engagement and independence in transfers and self care tasks...."<br><br>A Physical Therapy (PT) discharge summary, dated 1/21/21, indicated the following, "...Discharge Plans and Instructions...Patient discharged to SNF with recommendations including wellness program...."<br><br>A quarterly MDS assessment, dated 5/10/21, indicated no impairment in ROM to the upper extremities but impairment on one side of the lower extremities.<br><br>A significant change MDS assessment, dated 6/23/21, indicated impairment in ROM in both upper extremities and lower extremities.<br><br>There was no indication in Resident 62's clinical record that therapy services continued and/or were offered after 1/21/21.<br><br>There were no care plans that indicated Resident 62 was in a restorative program in regard to her | | **specialized rehabilitation services have potential to be affected. An audit will be conducted to determine if all residents with a decline in function have received their required specialized rehabilitation services.**<br>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.<br>**Therapy referrals will be reviewed daily during the Clinical meeting, any follow up concerns will be added to the on-going CQI process.**<br>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.<br>**The Director of Therapy or designee will utilize the POC Audit Tool weekly x 4 weeks, monthly x 3 months, and quarterly until the QAPI committee determines that substantial compliance has been accomplished. If 95% compliance is not achieved an action plan will be implemented.** | |

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| | limited ROM or had received a device for any impairment in her ROM.<br><br>A document titled "Nursing to Therapy Referral", dated 12/29/21, indicated a therapy referral was requested due to wheelchair positioning.<br><br>A document titled "Therapies and Wellness Therapy Screen", dated 2/14/22, indicated the following, "...Resident requires therapy screen for wheelchair positioning due to poor posture...."<br><br>A document titled "Nursing to Therapy Referral", dated 3/23/22, indicated a therapy referral was requested, again, due to wheelchair positioning and transfers.<br><br>A document titled "Therapies and Wellness Therapy Screen", dated 3/25/22, indicated Resident 62 was screened by therapy staff in regard to transfer difficulty and "taught staff proper way of transfer".<br><br>A MDS assessment, dated 5/27/22, indicated impairment in ROM to upper and lower extremities.<br><br>There were no therapy documents to indicated Resident 62 was receiving therapy services and/or a restorative program due to the decline in her ROM.<br><br>A document titled "Therapies and Wellness Therapy Screen", dated 9/30/22, indicated Resident 62 was screened for the use of a mechanical lift. The comments stated "Patient requiring use of dependent mechanical lift in order to improve safety and comfort of patient. Per Nursing, patient with decline in physical functional and no longer able to assist staff with transfers". | | | |

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An interview conducted with the Assistant Director of Nursing (ADON), on 1/20/23 at 2:30 p.m., indicated Resident 62's lower extremities are stiff and she didn't believe Resident 62 had concerns with her upper extremities.

An interview conducted with Registered Nurse (RN) 9, on 1/20/23 at 2:50 p.m., indicated Resident 62's legs are more stiff but she doesn't believe they are contracted. RN 9 has worked at the facility since September of 2022 and Resident 62 had been wheelchair bound with her condition remaining the same since then.

An interview conducted with Certified Nursing Assistant (CNA) 8, on 1/23/23 at 12:03 p.m., indicated Resident 62 was able to move her legs but they appear still with limited ability to bend them. When Resident 62 first admitted to the facility she was more talkative and had more mobility.

An interview conducted with Resident Assessment Instrument (RAI) Specialist, on 1/23/23 at 3:57 p.m., indicated she reviewed therapy notes from after she initially admitted to the facility. There was no indication of limitations in her ROM. Therapy was working with her in regard to walking and transfers. Resident 62 was not in a restorative program. Her legs are "stiff" now.

Another interview with RAI Specialist, on 1/23/23 at 4:45 p.m., indicated she went to assess Resident 62 and believes the MDS is coded correctly. Resident 62's upper and lower extremities are still, and she wasn't able to bend either extremity.

An interview conducted with the Director of

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| | Nursing (DON), on 1/24/23 at 11:20 a.m., indicated she didn't see a care plan for therapy for Resident 62 and she was not on a restorative program.<br><br>Another interview conducted with the DON, on 1/24/23 at 1:20 p.m., indicated there was a referral for therapy in December of 2021. She was told that the payer source had changed, and she was then private pay. The family didn't want to pay for therapy services privately and wanted to wait for her to start on Medicaid. Resident 62 went on Medicaid in November of 2021. She thought Resident 62 was on a restorative program, but it was paper charting. They were unable to locate such charting.<br><br>An interview conducted with the Therapy Director, on 1/24/23 at 1:27 p.m., indicated due to Resident 62's cognition she wasn't able to follow commands. It wasn't indicative that she needed to be picked up for therapy. There was a list of dates provided of what the Therapy Director called "screenings". The dates were from the year 2022.<br><br>A policy titled "Restorative Nursing Program", dated 11/2018, was provided by the Executive Director on 1/24/23 at 10:20 a.m. The policy indicated the following, "...Purpose...To provide a nursing program for residents who no longer need skilled therapy, but still have functional goals to be met or maintained through practice and repetition. The resident can also be placed on a program to maintain the ability to function at his or her optimal level within the given environment. These programs facilitate the use of skills that are present but not utilized unless compensations or adaptations are provided and designed to foster maximum independence in functional activities...Program initiation...Appropriateness of current programs or the need for a new program | | | |

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| | will be determined by routine assessment of the resident via the RAI process...Programs may also be initiated following cessation of skilled therapy...Programs may also be initiated when IDT [interdisciplinary team] determines there is a potential for decline in resident function...."<br><br>3.1-23(a)(1)<br>3.1-23(a)(2) | | | |