| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155758 | A. BUILDING 00<br>B. WING | 06/14/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| ASBURY TOWERS HEALTH CARE CENTER | 102 W POPLAR ST<br>GREENCASTLE, IN 46135 |

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| F 0000<br><br>Bldg. 00 | | F 0000 | | |

This visit was for a Recertification and State Licensure Survey. This visit resulted in an Extended Survey-Immediate Jeopardy.

This visit included a State Residential Licensure Survey.

Survey dates: June 6, 7, and 8, 2021

Extended Survey dates: June 9, 10, and 11, 2021

Residential Survey date: June 14, 2021

Facility Number: 001120
Provider Number: 155758
AIM Number: 200525120

Census Bed Type:
SNF/NF: 30
Residential: 41
Total: 71

Census Payor Type:
Medicare: 8
Medicaid: 10
Other: 12
Total: 30

These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.

Quality review completed on June 21, 2021.

| | | | | |
|---|---|---|---|---|
| F 0550<br>SS=D | 483.10(a)(1)(2)(b)(1)(2)<br>Resident Rights/Exercise of Rights | | | |

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

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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| Bldg. 00 | §483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as | | | |

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| | required under this subpart.<br>Based on observation, record review, and interview, the facility failed to ensure a resident's Foley catheter (a flexible tube passed through the urethra into the bladder to drain urine) urine drainage bag was covered (Resident 3), privacy was provided during repositioning, and clothing labels were not clearly visible (Resident 20) for 2 of 2 residents reviewed for dignity.<br><br>Findings include:<br><br>1. On 6/6/21 at 10:51 a.m., Resident 3 was observed sitting up in her recliner, with the Foley catheter drainage bag hanging on the side of the recliner. There was urine in the drainage bag, and the bag was clearly visible from the doorway in the hallway.<br><br>On 6/6/21 at 2:28 p.m., Resident 3 was observed in her recliner, with the Foley catheter drainage bag hanging on the side of the recliner. There was urine in the drainage bag, and the bag was clearly visible from the doorway in the hallway.<br><br>On 6/7/21 at 11:48 a.m., Resident 3 was observed sitting in her wheelchair, in her room, with a visitor. The Foley catheter drainage bag was underneath the wheelchair, with urine in the bag. The Foley catheter drainage bag was clearly visible from the doorway in the hallway.<br><br>Resident 3's record was reviewed on 6/7/21 at 11:41 a.m. An admission Minimum Data Set (MDS) assessment, dated 3/2/21, indicated the resident had a moderate cognitive impairment.<br><br>A care plan, last revised 3/4/21, indicated the resident required an indwelling catheter related to urinary retention. Interventions included, but were | F 0550 | Policy: "Catheter Care" has been updated to state the following: a. Privacy bag will be available and catheter drainage bags will be covered at all times unless a resident refuses. b. If a resident refuses a privacy bag, it will be documented in the resident's plan of care as a care preference.<br><br>Nursing staff will be educated on policy "Catheter Care"<br><br>All residents with a catheter will be identified and checked for catheter cover bags (completed 07/01/2021)<br><br>Audits will be completed by designee based on the following schedule to ensure catheter bags are covered: daily x 6 weeks; weekly x 2 months; monthly x 2 months<br><br>Audits will continue monthly thereafter and reviewed at QAPI until 95% compliance is reached.<br><br>Nursing staff will be educated on policy "Promoting/Maintaining Resident Dignity During Mealtimes"<br><br>Environmental Services Director or designee will complete an audit of laundry for all residents to identify which clothing needs re-labeled. | 07/14/2021 |

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| | not limited to, position catheter bag and tubing away from entrance room door.<br><br>During an interview, on 6/8/21 at 1:13 p.m., Certified Nursing Assistant (CNA) 21 indicated catheter bags should have been covered by a dignity bag. The urine drainage bag should not have been visible from the doorway.<br><br>During an interview, on 6/8/21 at 2:13 p.m., the Assistant Director of Nursing (ADON) indicated she thought Foley catheter bags should have been covered with a dignity bag.<br><br>On 6/8.21 at 3:00 p.m., the Director of Nursing (DON) provided a document titled, "Catheter Care," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. Policy Explanation: ...2. Privacy bags will be available and catheter drainage bags will be covered at while residents are out of their room (unless resident request otherwise) ...."<br><br>2. During a lunch observation, on 6/6/21 at 11:44 a.m., Resident 20 was observed to have slid down in her wheelchair. Qualified Medication Aide (QMA) 7 stood behind the resident, placed her arms underneath the resident's arms, and pulled her back in the wheelchair. The resident was not offered privacy, and there were five other residents in the dining. The resident's socks were labeled with her first initial and last name, and this was clearly visible when looking at the resident.<br><br>On 6/6/21 at 2:27 p.m., Resident 20 was observed sitting in her wheelchair, near the nurse's station, | | Environmental Services Director will ensure all articles of clothing are labeled on the inside in order to protect resident dignity.<br><br>Audits will be conducted monthly and reviewed at QAPI until 95% compliance is reached. | |

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| | wearing socks with a clearly visible label, printed with her first initial and last name.<br><br>On 6/7/21 at 1:17 p.m., Resident 20 was observed sitting in her wheelchair, near the nurse's station, wearing socks with a clearly visible label, printed with her first initial and last name.<br><br>On 6/9/21 at 3:00 p.m., Resident 20 was observed in the dining room, during an activity, wearing socks with a clearly visible label, printed with her first initial and last name.<br><br>Resident 20's record was reviewed on 6/10/21 at 11:45 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 4/28/21, indicated the resident had a moderate cognitive impairment.<br><br>Diagnosis on the resident's profile included, but was not limited to, dementia (a group of thinking and social symptoms that interferes with daily functioning in other diseases classified elsewhere) with behavioral disturbance.<br><br>A care plan, last revised on 5/25/21, indicated the resident had impaired cognitive function related to a diagnosis of dementia.<br><br>During an interview, on 6/10/21 at 11:35 a.m., the Director of Nursing (DON) indicated she was not sure if residents should have been repositioned in the dining room or if privacy should have been provided. Clothing should have probably been labeled in an area where the label was not clearly visible.<br><br>On 6/10/21 at 12:45 p.m., the DON provided a document titled, "Resident Rights," and indicated it was the policy currently being used by the facility. The policy indicated, "...Resident rights. | | | |

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| | The resident has a right to a dignified existence...."<br><br>3.1-3(a) | | | |
| F 0561<br>SS=D<br>Bldg. 00 | 483.10(f)(1)-(3)(8)<br>Self-Determination<br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.<br><br>Based on interview and record review, the facility failed to ensure a resident was provided showers | F 0561 | An audit of documented showers for the month of July will be completed on all skilled residents | 07/14/2021 |

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| | as preferred for 1 of 3 residents reviewed for choices (Resident 30).<br><br>Finding includes:<br><br>During an interview, on 6/6/21 at 11:53 a.m., Resident 30 indicated she had requested and was supposed to be on the shower schedule for three showers a week, but that never happened. She did not usually get two showers a week and one time went three weeks without a shower.<br><br>Resident 30's record was reviewed on 6/8/21 at 10:42 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 5/19/21, indicated the resident was cognitively intact, required assistance of one person for bathing, but had not received a bath nor a shower during the seven day look back period of the assessment.<br><br>A care plan, initiated on 10/4/19, indicated the resident had impaired ability to perform independent activities of daily living (ADL's) and required extensive assistance of one staff for bathing/showering.<br><br>A preference for customary routines and activities questionnaire, dated 12/9/20, indicated the resident wanted three showers a week in the evening on Mondays, Wednesdays, and Fridays. The resident's preferred time to retire in the evening was around 10 p.m. or 11 p.m.<br><br>Shower reports for May 2021 and June 2021, indicated the resident had received showers on Wednesday, May 5 at 7:33 p.m.; Friday, May 7 at 2:30 a.m.; Tuesday, May 11 at 3:51 a.m.; Friday, May 14 at 12:30 a.m.; Monday, May 17 at 7:04 p.m.; Thursday, May 20 at 9:04 p.m.; Friday, May 21 at 2:36 p.m.; Monday, May 24 at 9:49 p.m.; | | to identify if other residents are affected by this deficiency.<br><br>The Life Enrichment Director or designee will complete an updated shower preference sheet for each skilled resident and will ensure they are updated quarterly moving forward. The DON or designee will ensure that the shower preferences/schedules are entered into the EHR correctly.<br><br>Nursing staff will be educated on policy "Skin Audits by Nursing Assistants".<br><br>Audits of the showers and shower sheets will be completed by designee as follows: daily x 6 weeks; weekly x 2 months; monthly x 2 months<br><br>Ongoing monthly audits will be completed and reviewed at QAPI until 95% compliance is reached. | |

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| | Tuesday, May 25; Tuesday, June 1 at 2:56 a.m.; Friday, June 4 at 3:55 a.m.; and Sunday, June 6 at 7:56 p.m. The record lacked documentation the resident had been showered in the evenings three times a week or had refused showers.<br><br>On 06/9/21 at 10:50 a.m., the Life Enrichment Coordinator indicated Resident 30 had requested three evening showers a week, on Mondays, Wednesdays, and Fridays, when the resident's preferences form was completed on 12/9/20.<br><br>On 6/9/21 at 3:15 p.m., the Director of Nursing provided and identified a document as a current facility policy, titled "Resident Self Determination and Participation (Schedules)," dated 5/1/21. The policy indicated, "...Policy: It is the policy of this facility to promote and facilitate a resident's right to self-determination through support of resident choice...According to federal regulations, the resident has the right to: ...Choose activities, schedules, and providers of health care services consistent with his or her interests, assessments, and plans of care...Make choices about aspects of his or her life in the facility that are significant to the resident...The social service designee and/or other designee should assist the resident to engage in meaningful activity during the day, including activities of daily living, according to preference...."<br><br>On 6/11/21 at 2:37 p.m., the Administrator (ADM) indicated the Certified Nursing Assistant shower aides had to be pulled to perform resident care, therefore the showers became limited due to short staffing.<br><br>3.1-3(u)(3) | | | |

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| F 0577<br>SS=B<br>Bldg. 00 | 483.10(g)(10)(11)<br>Right to Survey Results/Advocate Agency Info<br>§483.10(g)(10) The resident has the right to-<br>(i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and<br>(ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.<br><br>§483.10(g)(11) The facility must--<br>(i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.<br>(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and<br>(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.<br>(iv) The facility shall not make available identifying information about complainants or residents.<br>Based on interview, observation, and record review, the facility failed to ensure state survey results were readily accessible for residents who resided on the first floor of the building.<br><br>Findings include:<br><br>During a resident council meeting, on 6/9/21 at 1:42 p.m., Residents 29, 18, and 30 were not aware of how to access state survey results. | F 0577 | No residents were harmed by failure to have survey binders in place.<br><br>Survey Result binders have been placed in the main lobby and both skilled floors and the Oasis. They are now clearly marked and readily available and accessible for all residents in the building. | 06/30/2021 |

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| | On 6/9/21 at 1:57 p.m., the Life Enrichment Coordinator observed the first floor hallway and indicated the state survey results were not available in that area. She thought they were located on the ground floor and in the main lobby area of the building. The residents who resided on the first floor required a key fob to proceed past the secured doors to access the ground floor and the lobby areas. Not all residents had a key fob and would have to ask for access if they did not.<br><br>On 6/9/21 at 2:16 p.m., the Social Services Director (SSD) observed the main lobby area of the building and indicated there were no state survey results located in that area. The state survey results were located on the ground floor, and she was not sure how residents who resided on the first floor would access it.<br><br>During an interview, on 6/9/21 at 2:18 p.m., the Director of Nursing (DON) indicated the state survey results were located in a binder on the ground floor. The residents on the first floor would need to request to see it, and the state survey results would have been provided. She was not aware the state survey results needed to be readily available without the residents needing to ask.<br><br>On 6/9/21 at 3:17 p.m., the DON provided a document titled, "Availability of Survey Results," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: The purpose of this policy is to uphold a resident's right to examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility. Definitions: 'Place readily accessible' is a place (such as a lobby or other area frequented by most | | | |

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| | residents, visitors or other individuals) where individuals wishing to examine survey results do not have to ask to see them...Policy Explanation and Compliance Guidelines: 1. A readable copy of our company's most recent federal and/or state survey report and plan of correction for any identified deficiencies is maintained in a 3-ring loose-leaf binder titled 'Results of Most Recent Survey.' ...6. Signs identifying the availability and location of our 'survey binder' and availability of previous survey results are posted throughout the building and public bulletin boards...."<br><br>3.1-3(b)(1) | | | |
| F 0636<br>SS=A<br>Bldg. 00 | 483.20(b)(1)(2)(i)(iii)<br>Comprehensive Assessments & Timing<br>§483.20 Resident Assessment<br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>§483.20(b) Comprehensive Assessments<br>§483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:<br>(i) Identification and demographic information<br>(ii) Customary routine.<br>(iii) Cognitive patterns.<br>(iv) Communication.<br>(v) Vision.<br>(vi) Mood and behavior patterns.<br>(vii) Psychological well-being.<br>(viii) Physical functioning and structural | | | |

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| | problems.<br>(ix) Continence.<br>(x) Disease diagnosis and health conditions.<br>(xi) Dental and nutritional status.<br>(xii) Skin Conditions.<br>(xiii) Activity pursuit.<br>(xiv) Medications.<br>(xv) Special treatments and procedures.<br>(xvi) Discharge planning.<br>(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).<br>(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.<br><br>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.<br>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)<br>(iii)Not less than once every 12 months.<br><br>Based on record review and interview, the facility | F 0636 | No residents were harmed by the lack of a MDS nurse. | 07/14/2021 |

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| | failed to ensure a newly admitted resident's admission Minimum Data Set (MDS) assessment was completed timely (Resident 232).<br><br>Findings include:<br><br>Resident 232's record was reviewed on 6/8/21 at 1:27 p.m. A facility census indicated the resident had been admitted to the facility on 5/15/21, for admitting diagnosis which included, but was not limited to, unspecified intracapsular fracture of the right femur (a fracture which involves the head and neck of the femur).<br><br>A nursing admission assessment was observed to have been completed on 5/16/21.<br><br>An admission MDS assessment, dated 5/22/21, was documented as in progress and 12 days overdue. The Assessment Reference Date (ARD-the date that signifies the end of the look back period) for the admission assessment was 5/28/21.<br><br>During an interview, on 6/9/21 at 10:27 a.m., the Social Services Director (SSD) indicated the facility had no current MDS Coordinator. They had been using a contracted-services consultant company to complete all MDS assessments. The company had been coming to the facility weekly to work on the completion of the assessments.<br><br>On 6/9/21 at 1:00 p.m., the Assistant Director of Nursing (ADON) provided a document, dated 6/9/21, titled, "MDS Submission Policy," and indicated it was the policy currently being used by the facility. The policy indicated, "Asbury Towers will follow the MDS 3.0 Resident Assessment Instrument (RAI) User's Manual for submission guidelines. Policy Explanation and | | Ongoing recruitment efforts are being made to hire an MDS nurse.<br><br>Outside consultant will continue completing MDS assessments until a permanent nurse is hired. | |

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| | Compliance Guidelines: 1. In accordance with the requirements...long-term care facilities in the Medicare and Medicaid programs must meet the following conditions: ...b. For the Admission assessment, the MDS Completion Date...must be no later than 13 days after the Entry Date...."<br><br>3.1-31(d)(1) | | | |
| F 0641 SS=B 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 record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were accurate for 5 of 13 residents reviewed for MDS assessment accuracy (Residents 19, 3, 20, 7, and 24).<br><br>Findings include:<br><br>1. A record review was completed for Resident 19 on 6/7/21 at 11:45 a.m. A facility census indicated the resident admitted to the facility on 4/19/21. An admission assessment, dated 4/19/21, indicated the resident had two pressure ulcers to the coccyx. The assessment lacked documentation of measurements and staging.<br><br>A skin observation assessment, dated 4/20/21, indicated the resident had a stage II pressure ulcer to the left buttock that measured in centimeters (cm) 1.3 length (l) by (x) 1.5 width (w) x 0.1 depth (d) and a stage II pressure ulcer to the right buttock that measured in cm 1.0 l x 1.3 w x 0.1 d.<br><br>A review of an admission Minimum Data Set (MDS) assessment for Resident 19, dated 4/26/21, | F 0641 | SSD and LED are attending MDS training on 06/30/2021<br><br>Ongoing efforts are being made to hire a permanent MDS nurse<br><br>A copy of the RAI 3.0 manual will be available to each department as a reference via the internal drive<br><br>All persons completing the MDS assessments will review their assigned sections of the RAI manual on a quarterly bases during QAPI.<br><br>All admission assessments will be audited for accuracy of completion by DON or designee within 48 hours of admission (excluding holidays or weekends) | 07/14/2021 |

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| | indicated the resident was cognitively intact and an extensive assist of two for bed mobility, transfer, dressing, toilet use, and personal hygiene. The assessment also indicated the resident had one stage II pressure ulcer on admission. The assessment lacked documentation the resident had two stage II pressure ulcers.<br><br>During an interview on 6/9/21 at 10:40 a.m. the Director of Nursing (DON) indicated the facility did not currently have an MDS Coordinator and a contracted-services consultant company would come at least weekly to complete the assessments. She was unsure why Resident 19's admission assessment had not included she had two stage II pressure ulcers.<br><br>A copy of Section M of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, was provided by the MDS Assessment Support on 6/11/21 at 11:25 a.m. The manual indicated, "...M0300B: Stage 2 Pressure Ulcers...5. Identify the number of these pressure ulcers that were present on admission/entry or reentry...Coding Instructions for M0300B: M0300B1: Enter the number of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 2...."2. Resident 3's record was reviewed on 6/7/21 at 11:41 a.m. An admission Minimum Data Set (MDS) assessment, dated 3/2/21, indicated the brief interview for mental status (BIMS) (an assessment of cognitive status) was not assessed. The staff assessment of cognition indicated the resident had a moderate cognitive impairment.<br><br>A social services note, dated 2/26/21, indicated the resident's speech was understandable, but sounded slurred at times. | | | |

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| | During an interview, on 6/9/21 at 11:23 a.m., the Social Services Director (SSD) indicated she had not completed the BIMS for the MDS assessment, dated 3/2/21, because the resident refused to talk to her. She was not sure how the assessment should have been coded.<br><br>3. Resident 20's record was reviewed on 6/10/21 at 11:45 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 4/28/21, indicated the brief interview for mental status (BIMS) (an assessment of cognitive status) was not assessed. The staff assessment of cognition indicated the resident had a moderate cognitive impairment.<br><br>A care plan, last revised 5/25/21, indicated the resident had impaired cognitive function and disorganized speech.<br><br>During an interview, on 6/11/21 at 10:15 a.m., the Social Services Director (SSD) indicated the quarterly MDS assessment BIMS should have indicated the assessment was not completed related to the resident was rarely or never understood. It was coded incorrectly.<br><br>A copy of Section C of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, was provided by the SSD on 6/9/21 at 11:19 a.m. The manual indicated, "...SECTION C: COGNITIVE PATTERNS: ...Steps for Assessment: ...Coding Instructions: Code 0, no: if the interview should not be conducted because the resident is rarely/never understood, cannot respond verbally, in writing, or using another method; or an interpreter is needed but not available. Skip to C0700 Staff Assessment of Mental Status...." | | | |

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| | 4. Resident 7's record was reviewed on 6/10/21 at 9:50 a.m. An admission Minimum Data Set (MDS) assessment, dated 3/30/21, lacked documentation the resident had no natural teeth or tooth fragments (edentulous).<br><br>A nursing admission assessment, dated 3/23/21, lacked documentation the resident was edentulous.<br><br>On 6/10/21 at 11:32 a.m., Resident 7 was observed to be edentulous. At the same time, the resident indicated she did not have any teeth.<br><br>During an interview on 6/10/21 at 11:35 a.m., the Director of Nursing (DON) indicated if the resident was edentulous it should have been indicated on the nursing admission assessment. The MDS information would have been gathered from the nursing admission assessment. The admission MDS assessment should have been coded as the resident being edentulous.<br>5. Resident 24's record was reviewed on 6/9/21 at 12:49 p.m. A facility census indicated the resident had been admitted on 4/27/21, with admitting diagnosis which included, but was not limited to, multiple sclerosis (a chronic, typically progressive disease that involves damage to the sheaths of nerve cells in the brain and spinal cord).<br><br>An admission nursing assessment, dated 4/27/21, indicated the resident had 4 natural teeth and no dentures.<br><br>A nursing progress note, dated 4/27/21 at 4:32 p.m., indicated the resident had arrived at the facility via facility transportation, at 12:40 p.m. The note further indicated the resident had 4 natural teeth and no dentures. | | | |

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| | An admission Minimum Data Set (MDS), dated 5/4/21, indicated the resident had no cognitive deficit and had no documented dental conditions.<br><br>Review of the resident's care plans, indicated no observed dental care plan had been developed.<br><br>During an interview, on 6/9/21 at 10:27 a.m., the Social Services Director (SSD) indicated the facility had no current MDS Coordinator. They had been using a contracted-services consultant company to complete all MDS assessments. The company had been coming to the facility weekly to work on the completion of the assessments.<br><br>A copy of Section L of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, was provided by the Director of Nursing (DON) on 6/10/21 at 12:45 p.m. The manual indicated, "Section L: Oral/Dental Status...Intent: This item is intended to record any dental problems present in the 7-day look-back period...Coding Instructions...Check L0200C, no natural teeth or tooth fragment(s) (edentulous): if the resident is edentulous/lacks all natural teeth or parts of teeth...."<br><br>3.1-31(a)<br>3.1-31(c)(1)<br>3.1-31(c)(2)<br>3.1-31(c)(3)<br>3.1-31(c)(9) | | | |
| F 0657<br>SS=D<br>Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion | | | |

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| | of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br><br>Based on record review and interview, the facility failed to ensure a hospice care plan was reviewed and revised for 1 of 1 resident reviewed for hospice (end of life care) services (Resident 6).<br><br>Findings include:<br><br>Resident 6's record was reviewed on 6/9/21 at 10:09 a.m. Diagnoses included but were not limited to hypertensive (high blood pressure) heart disease with unspecified heart failure and chronic kidney disease. | F 0657 | All care plans were reviewed for current residents on hospice and updated. Those who are responsible for care plans have been educated on this deficiency. (completed by 07/01/2021)<br><br>Social Service Director will monitor Target dates for hospice care plans. These will be monitored weekly times three months , one time a month for three months, 1 time every quarter to be added to QAPI. | 07/14/2021 |

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| | A quarterly Minimum Data Set (MDS) assessment, dated 3/24/21, indicated the resident had a condition or chronic disease that may result in a life expectancy of less than 6 months and received hospice services.<br><br>A hospice care plan, initiated on 12/30/20 with an expired target date of 5/19/21, indicated Resident 6 would be kept comfortable and pain managed throughout the progression of disease with interventions included but not limited to, unit nurse to collaborate with hospice nurse.<br><br>On 6/9/21 at 3:35 p.m., the Director of Nursing (DON) indicated Resident 6 received hospice services and the care plan should have been updated with a revised target date. At that time DON provided and identified a document as a current facility policy, titled "Care planning guidelines," dated 6/9/21, which indicated, "...Care planning is a process that has several steps that may occur at the same time or in sequence...Changes to the care plan should occur as needed in accordance with professional standards of practice and documentation (e.g., signing and dating entries to the care plan)...."<br><br>3.1-35(a)<br>3.1-35(c)(1) | | | |
| F 0660<br>SS=D<br>Bldg. 00 | 483.21(c)(1)(i)-(ix)<br>Discharge Planning Process<br>§483.21(c)(1) Discharge Planning Process<br>The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. | | | |

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| | The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-<br>(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.<br>(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.<br>(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.<br>(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.<br>(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.<br>(vi) Address the resident's goals of care and treatment preferences.<br>(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.<br>(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.<br>(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. | | | |

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| | (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.<br>(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.<br>(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. | | | |
| | Based on record review and interview, the facility failed to ensure a resident's discharge planning care plan was updated when the resident's discharge plans changed for 1 of 1 resident reviewed for discharge to the community (Resident 33).<br><br>Findings include:<br><br>Resident 33's record was reviewed on 6/10/21 at | F 0660 | When a determination is made that a resident will be discharged to another LTC agency or to another level in the community, discharge planning will begin with the IDT. This will include updating the plan of care, making arrangements for services needed after discharge, and initiating the "Discharge Instructions" | 07/14/2021 |

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| | 2:24 p.m. A comprehensive Minimum Data Set (MDS) assessment, dated 3/14/21, indicated the resident was cognitively intact and planned to stay at the facility long term.<br><br>Census information indicated the resident admitted to the facility on 3/8/21.<br><br>A nurse's note, dated 3/8/21, indicated the resident was admitted to the facility with hospice (a type of health care that focuses on the palliation of a terminally ill patient's pain and symptoms) services.<br><br>A social services note, dated 3/15/21, indicated the resident received hospice services and planned to stay at the facility long term.<br><br>A plan of care note, dated 3/23/21, indicated a care plan meeting was held. The resident was to return to assisted living on 3/25/21. The note lacked documentation of the discharge care plan being updated or initiation of discharge planning.<br><br>A physician's order, dated 3/23/21, indicated may discharge to assisted living on 3/25/21.<br><br>A social services note, dated 3/25/21, indicated the resident was returning to assisted living with hospice services. The note lacked documentation the care plan was updated or any discharge planning occurred.<br><br>A care plan, target dated 6/16/21, indicated the resident planned to stay at the facility long term. The care plan lacked documentation it was updated when the resident decided to return to assisted living or any initiation of discharge planning. | | assessment which includes the discharge summary. Within 24 hours of the anticipated discharge, the DON or designee will ensure that the discharge summary is complete and all sections of the "Discharge Instructions" have been completed by each discipline.<br><br>Discharges for July audited to determine how many residents were affected by this deficiency<br><br>All discharges will be audited by the IDT to ensure all steps were properly taken and to identify any concerns or issues with existing procedures.<br><br>This plan will be reviewed by QAPI for 6 months and ongoing until 95% completion is reached. | |

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| ASBURY TOWERS HEALTH CARE CENTER | 102 W POPLAR ST<br>GREENCASTLE, IN 46135 |

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| | During an interview, on 6/11/21 at 9:20 a.m., the Social Services Director (SSD) indicated she only handled making referrals to necessary agencies at discharge. Nursing handled the rest of discharge planning. Discharge planning should have been started at admission.<br><br>During an interview, on 6/11/21 at 10:14 a.m., the SSD indicated the resident's discharge care plan should have been updated when the resident decided to discharge to assisted living on 3/23/21. The care plan was not updated.<br><br>On 6/11/21 at 10:14 a.m., the SSD provided a document titled, "Discharge Planning Process," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: It is the policy...to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. Definitions: 'Discharge planning' is a process that generally begins on admission and involves identifying each resident's discharge goals and needs, developing and implementing interventions to address them, and continuously evaluating them throughout the resident's stay to ensure a successful discharge. Procedure: ...2. The facility will determine the resident's expected goals and outcomes regarding discharge upon admission...and as needed...b. Subsequent assessment information and discharge goals will be included in the resident's comprehensive care plan...5. If discharge to community is a goal, an active discharge care plan will be implemented and will involve interdisciplinary team, including the resident and/or resident representative. The plan | | | |

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| | shall be documented in the progress notes and comprehensive care plan. 6. An active individualized discharge care plan will address, at a minimum: a. Discharge destination, with assurances the destination meets the resident's health/safety needs and preferences. b. Identified needs, such as medical, nursing, equipment, educational, or psychosocial needs...."<br><br>3.1-12(a)(18) | | | |
| F 0661 SS=D Bldg. 00 | 483.21(c)(2)(i)-(iv)<br>Discharge Summary<br>§483.21(c)(2) Discharge Summary<br>When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:<br>(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.<br>(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.<br>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).<br>(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to | | | |

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| | reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.<br>Based on record review and interview, the facility failed to ensure discharge instructions were provided and a recapitulation of the resident's stay was completed for 1 of 1 resident reviewed for discharge to the community (Resident 33).<br><br>Findings include:<br><br>Resident 33's record was reviewed on 6/10/21 at 2:24 p.m. A comprehensive Minimum Data Set (MDS) assessment, dated 3/14/21, indicated the resident was cognitively intact and planned to stay at the facility long term.<br><br>Census information indicated the resident admitted to the facility on 3/8/21.<br><br>A nurse's note, dated 3/8/21, indicated the resident was admitted to the facility with hospice (a type of health care that focuses on the palliation of a terminally ill patient's pain and symptoms) services.<br><br>A social services note, dated 3/15/21, indicated the resident received hospice services and planned to stay at the facility long term.<br><br>A plan of care note, dated 3/23/21, indicated a care plan meeting was held. The resident was to return to assisted living on 3/25/21. The note lacked documentation discharge instructions, or a recapitulation of the resident's stay were initiated.<br><br>A physician's order, dated 3/23/21, indicated may discharge to assisted living on 3/25/21. | F 0661 | When a determination is made that a resident will be discharged to another LTC agency or the community, discharge planning will begin with the IDT. This will include updating the plan of care, making arrangements for services needed after discharge, and initiating the "Discharge Instructions" assessment which includes the discharge summary. Within 24 hours of the anticipated discharge, the DON or designee will ensure that the discharge summary is complete and all sections of the "Discharge Instructions" have been completed by each discipline.<br><br>July discharges audited to determine how many residents were affected by this deficiency<br><br>All discharges will be audited by the IDT to ensure all steps were properly taken and to identify any concerns or issues with existing procedures.<br><br>This plan will be addressed in QAPI for 6 months and ongoing until compliance of 95% is reached. | 07/14/2021 |

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| | A social services note, dated 3/25/21, indicated the resident was returning to assisted living with hospice services. The note lacked documentation discharge instructions, or a recapitulation of the resident's stay were initiated.<br><br>The clinical record lacked documentation the resident was provided with discharge instructions at the time of the discharge, or a recapitulation of the resident's stay was documented.<br><br>A care plan, target dated 6/16/21, indicated the resident planned to stay at the facility long term. The care plan lacked documentation it was updated when the resident decided to return to assisted living or any initiation of discharge planning.<br><br>During an interview, on 6/11/21 at 9:20 a.m., the Social Services Director (SSD) indicated she only handled making referrals to necessary agencies at discharge. Nursing handled the rest of discharge planning. The discharge instructions and recapitulation of the resident's stay should have been completed by nursing.<br><br>On 6/11/21 at 10:14 a.m., the SSD provided a document titled, "Discharge Planning Process," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: It is the policy...to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. Definitions: 'Discharge planning' is a process that generally begins on admission and involves identifying each resident's discharge goals and needs, | | | |

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| | developing and implementing interventions to address them, and continuously evaluating them throughout the resident's stay to ensure a successful discharge. Procedure: ...2. The facility will determine the resident's expected goals and outcomes regarding discharge upon admission...and as needed...b. Subsequent assessment information and discharge goals will be included in the resident's comprehensive care plan...5. If discharge to community is a goal, an active discharge care plan will be implemented and will involve interdisciplinary team, including the resident and/or resident representative. The plan shall be documented in the progress notes and comprehensive care plan. 6. An active individualized discharge care plan will address, at a minimum: a. Discharge destination, with assurances the destination meets the resident's health/safety needs and preferences. b. Identified needs, such as medical, nursing, equipment, educational, or psychosocial needs...12. The results of the evaluation and the final discharge plan will be discussed with the resident or resident's representative. All relevant information will be provided in a discharge summary to avoid unnecessary delays in the resident's discharge or transfer, and to assist the resident in adjustment to his or her new living environment. 13. Education needs, as identified in the discharge plan, will be provided to the resident and/or family member prior to discharge...."<br><br>3.1-12(a)(18) | | | |
| F 0685<br>SS=D<br>Bldg. 00 | 483.25(a)(1)(2)<br>Treatment/Devices to Maintain Hearing/Vision<br>§483.25(a) Vision and hearing<br>To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, | | | |

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| | if necessary, assist the resident-<br><br>§483.25(a)(1) In making appointments, and<br><br>§483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.<br>Based on interview and record review, the facility failed to ensure a resident was able to see an audiologist when desired for 1 of 13 residents reviewed for ancillary services (Resident 7).<br><br>Findings include:<br><br>During an interview, on 6/6/21 at 11:43 a.m., Resident 7 indicated she was very hard of hearing. She wanted to see the audiologist and get hearing aids, but this had not been offered to her.<br><br>Resident 7's record was reviewed on 6/10/21 at 9:50 a.m. An admission Minimum Data Set (MDS) assessment, dated 3/30/21, indicated the resident was cognitively intact.<br><br>Census information indicated the resident was admitted to the facility on 3/23/21.<br><br>A nursing admission assessment, dated 3/23/21, indicated the resident was very hard of hearing. The assessment lacked documentation the resident was offered to see the audiologist.<br><br>A social services note, dated 3/31/21, indicated the resident's hearing was impaired, and a quiet environment was needed to hear. She used to have hearing aids a long time ago, but she was not sure what happened to them. The note lacked | F 0685 | All admission packets will include information about ancillary services and residents/caregivers will indicate which service they chose to utilize (completed).<br><br>Ancillary service preferences will be reviewed at each plan of care meeting and changes will be made as needed.<br><br>An audit will be completed on every resident to determine if other residents are affected by this deficiency and to update each individual ancillary preference<br><br>An audit will be completed on 10% of the skilled residents by SSD based on the following schedule: weekly x 2 months; monthly ongoing for not less than 6 months | 07/14/2021 |

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| | documentation the resident was offered to see the audiologist.<br><br>A care plan note, dated 3/30/21, indicated a baseline care plan meeting was held with the resident, staff, and the resident's sister and son. The resident indicated reported an earache at times. The note lacked documentation the resident was offered to see the audiologist.<br><br>A care plan, initiated 3/31/21, indicated the resident was hard of hearing at times if not in a quiet environment. The care plan lacked documentation the resident was offered to see the audiologist.<br><br>During an interview, on 6/10/21 at 9:10 a.m., the Social Services Director (SSD) indicated she was unable to locate any documentation the resident was offered to see the audiologist since her admission to the facility. They had just started putting the forms for the residents to indicate which ancillary services they desired in the admissions packets on 5/21/21. She was unsure how ancillary services were offered to residents prior to that date. The resident had not visited or been offered a visit with an audiologist.<br><br>On 6/10/21 at 9:59 a.m., the SSD provided a document titled, "Ancillary Services," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: It is the policy...to ensure that residents have access to and receive proper treatment regarding...hearing...Policy Explanation and Compliance Guidelines: ...2. Employees should refer any identified need for ancillary services/appliances to the social service designee...The social service designee will alert the supplies clerk...of the change or addition in | | | |

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| | services. The supplies clerk will fax the information...3. The social service designee and supplies clerk will collaborate with family and residents in signing up for additional in house services. If outside services are warranted, the Life Enrichment Director will set up the appointment and transportation for the resident. 4. Upon admission, ancillary services will be explained and offered in the admission packet...."<br><br>3.1-39(a)(1) | | | |
| F 0686 SS=J 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>A. Based on observation, interview, and record review, the facility failed to prevent pressure ulcers from worsening, complete follow-up assessments, track wound progression, follow interventions, and notify the physician with worsening of wounds up to and including, infections for 1 of 2 residents reviewed for pressure ulcers resulting in Resident 19's stage II (partial thickness loss of dermis) pressure ulcer progressing to a stage III (full thickness tissue | F 0686 | A BRADEN assessment was completed on all residents on 06/09/2021<br><br>BRADEN assessments are to be completed upon admission, quarterly, when a new wound is found, and as needed.<br>Assessment audits will be completed daily x 6 weeks; | 07/14/2021 |

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| | loss where subcutaneous fat may be visible) pressure ulcer and developing osteomyelitis (bone infection) requiring hospitalization and surgical debridement resulting in a stage IV (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer.<br><br>B. Based on observation, interview, and record review, the facility failed to prevent pressure ulcers, complete follow-up assessments, follow interventions, and notify the physician resulting in the potential for harm that is not immediate jeopardy to 1 of 2 residents reviewed for pressure ulcers (Residents 3).<br><br>The immediate jeopardy began on 4/19/21 when staff failed to complete assessments, wound treatments, and notify the physician of a pressure ulcer with symptoms of infection which resulted in the pressure ulcer being a stage II when assessed and worsening to a stage III with osteomyelitis which required hospitalization and surgical debridement The Executive Director (ED), Director of Nursing (DON), and Assistant Director of Nursing (ADON) were notified of the immediate jeopardy at 4:10 p.m. on 6/9/21. The immediate jeopardy was removed on 6/11/21 at 4:59 p.m., but noncompliance remained at a lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy.<br><br>Findings include:<br><br>A. During an observation, on 6/7/21 at 11:52 a.m., Resident 19 was observed lying on her back in bed on a low air loss mattress.<br><br>A record review was completed for Resident 19 on 6/7/21 at 11:45 a.m. A facility census indicated the resident admitted to the facility on 4/19/21. An | | weekly x 6 weeks; then monthly ongoing.<br><br>Skin assessments were completed on all skilled residents on 06/10/2021<br><br>Skin assessments will occur on admission, weekly, and as needed for all skilled residents. Audits of skin assessments will be completed daily x 6 months; weekly x 6 month; monthly ongoing. Nurse management will also conduct random skin audits no less than bi-weekly.<br><br>Newly identified wounds are to be reported to the wound nurse no less that 24 hours (72 on weekends/holidays) after identification via an incident report.<br><br>All staff education on skin integrity, pressure ulcer care, treatments, and notification of physician will be completed by DON or designee (target completion date of 06/17/2021 was extended to 07/02/2021 for PRN staff).<br><br>Weekly wound assessments will be completed by designated wound nurse or designee and documented. Wounds will also be addressed every week in IDT risk and wound meeting. | |

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| | admission assessment, dated 4/19/21, indicated the resident had two pressure ulcers to the coccyx. The assessment lacked documentation of measurements and staging.<br><br>A hospital discharge summary, dated 4/19/21, indicated the resident had a stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red, pink wound bed, without slough) sacral coccyx wound.<br><br>Diagnoses included, but were not limited to, type II diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), chronic kidney disease (longstanding disease of the kidneys leading to renal failure), and congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should).<br><br>A skin observation assessment, dated 4/20/21, indicated the resident had a stage II pressure ulcer to the left buttock that measured in centimeters (cm) 1.3 length (l) by (x) 1.5 width (w) x 0.1 depth (d) and a stage II pressure ulcer to the right buttock that measured in cm 1.0 l x 1.3 w x 0.1.<br><br>The record lacked documentation of treatment order or treatment from 4/20/21 to 4/23/21.<br><br>A review of an admission Minimum Data Set (MDS) assessment for Resident 19, dated 4/26/21, indicated the resident was cognitively intact and an extensive assist of two for bed mobility, transfer, dressing, toilet use, and personal hygiene. The assessment also indicated the resident had one stage II pressure ulcer on admission.<br><br>A Treatment Administration Record (TAR), start | | Wound assessment audits will be completed by the DON or designee weekly x 6 weeks then monthly ongoing.<br><br>Treatment records and dressings will be audited for accuracy and completion by DON or designee every day x 6 weeks; every week x 6 week; then monthly ongoing | |

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| | dated 4/23/21 and discontinued on 4/27/21, indicated to cleanse wounds on coccyx with normal saline and pat dry. Apply allevyn dressing (absorbent foam dressing) and change every seven days and as needed for displacement or soilage. The TAR lacked documentation this had been completed from 4/23/21 through 4/27/21.<br><br>A care plan, initiated 4/23/21 and target dated 5/6/21, indicated the resident had a pressure ulcer to the sacrum related to weakness, assistance with activities of daily living, type II diabetes mellitus, atrial fibrillation, coronary artery disease, hypertension, and renal insufficiency. The goal indicated the resident's pressure ulcer would show signs of healing and remain free from infection. Interventions included, but were not limited to, administer treatments as ordered and monitor for effectiveness. Assess, record, and monitor wound healing weekly. Measure length, width, and depth, where possible. Assess and document status of wound perimeter, wound bed, and healing progress. Report improvements and declines to the physician. Encourage resident to offload wound by laying on her sides during healing process. Follow facility policies and protocols for the prevention and treatment of skin breakdown.<br><br>A skin observation assessment, dated 4/28/21, indicated the resident had a stage II pressure ulcer to the left buttock that measured in cm 1.6 l x 1.5 w x 0.1 depth and a stage II pressure ulcer to the right buttock that measured in cm 1.2 l x 1.3 w x 0.1 d. Dressing removed and wound assessed. There was a small amount of blood noted on the bandage when removed with no odor noted. The wound was cleansed with normal saline, patted dry, and border foam gauze was applied to the area. | | | |

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| | A TAR, start dated 4/27/21 and discontinued on 5/1/21, indicated to cleanse wound on coccyx with normal saline and pat dry. Apply border foam dressing and change every other day and as needed for displacement or soilage. The TAR lacked documentation this had been completed.<br><br>A TAR, start dated 4/28/21 and discontinued on 5/1/21, indicated to cleanse wound on coccyx with normal saline and pat dry. Apply border foam dressing and change every other day and as needed for displacement and soilage every shift for wound care. The TAR lacked documentation this had been completed on 4/30/21.<br><br>The record lacked documentation a skin observation assessment had been completed from 4/29/21 through 5/11/21.<br><br>A TAR, dated May 2021, indicated to cleanse wounds to coccyx with normal saline and pat dry. Apply hydrogel to wound bed, cover with non-bordered foam dressing, and secure dressing with transparent film. Change dressing every other day and as needed one time a day every other day for wound. The TAR lacked documentation dressing was completed on 5/1/21, 5/3/21, 5/7/21 and 5/11/21.<br><br>A skin observation assessment, dated 5/12/21, indicated the resident had a stage III (full thickness tissue loss where subcutaneous fat may be visible, slough or eschar may be present on some parts of wound bed, and often undermining and tunneling) pressure ulcer to the coccyx that measured in cm 5.5 l x 3.5 w x 1.5 depth.<br><br>A wound progress note, dated 5/13/21, indicated the coccyx pressure ulcer had a moderate amount | | | |

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| | of serosanguinous fluid, no odor, and no undermining or tunneling was noted. The wound was 80% granulation with 20% slough. The resident continued to be non-compliant with position changes and was incontinent of bowel frequently with a foley catheter in place. The nurses had reinforced with resident the importance of frequent position changes to help aide in wound healing and resident verbalized understanding. A dressing change was completed at this time. A new order was received to cleanse wound with anasept skin and wound cleanser mix, apply collagen powder to wound bed and cover with foam and secure with transparent film. Resident was started on zinc, vitamin c and pro mod to promote wound healing.<br><br>A TAR, start dated 5/14/21 and discontinued on 5/18/21, indicated to cleanse wound with anasept skin and wound cleanser, mix and apply collagen powder to wound bed, cover with foam and secure with transparent film as needed for soilage or displacement. The TAR lacked documentation this had been completed from 5/14 through 5/16/21.<br><br>A skin observation assessment, dated 5/12/21, indicated the resident had a stage III pressure ulcer to the coccyx that measured in cm 6.1 x 4.5 w x 1.8 d.<br><br>A wound progress note dated 5/18/21 at 2:13 p.m., indicated the wound had a moderate amount of serosanguinous fluid, with no odor, and no undermining or tunneling noted. The wound was 70% granulation with 10% slough. The resident continued to be non-compliant with position changes and was incontinent of bowel frequently with a foley catheter in place. The nurses had reinforced with resident the importance of | | | |

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| | frequent position changes to help aide in wound healing and resident verbalized understanding. A dressing change was completed at this time. The resident continued zinc, vitamin c and pro mod to promote wound healing.<br><br>A wound culture report, collected on 5/21/21 and results noted on 5/24/21, indicated a final report for a wound culture of coccyx pressure injury. The result indicated there was a moderate growth of gram positive cocci and included enterococcus faecalis (gram positive bacteria), isolate 3- vancomycin resistant enterococcus (VRE) has been determined by vancomycin resistance and reported to infection control and heavy growth of gram negative rods and included Klebsiella pneumoniae (a gram negative bacteria), Proteus mirabilis (a gram negative bacteria), and enterococcus faecalis (gram positive bacteria), isolate 3- vancomycin resistant enterococcus has been determined by vancomycin resistance and reported to infection control.<br><br>A nurse's progress noted, dated 5/25/21 at 2:28 p.m., indicated the resident continued contact isolation for VRE in wound to coccyx.<br><br>A nurse's progress note, dated 5/25/21 at 5:18 p.m., indicated the nurse had called the hospital to inquire if an x-ray had been ordered the prior week and was told one had not been completed. A new order for x-ray of lumbar and sacral spine was obtained and would be completed that night. The physician was notified, lab results reported, and informed the pharmacy was unable to get streptomycin (antibiotic) and that was the only medication her VRE was susceptible to. A new order was received to refer resident to infection disease physician. | | | |

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| | A nurse's note, dated 5/26/21 at 8:55 a.m., indicated the x-ray had not been completed the night before and resident had not started the antibiotic due to not being available. New order received to transport resident to the hospital for treatment.<br><br>A hospital operative report, dated 5/27/21, indicated the resident's preoperative diagnosis was necrotic sacral wound. The dead necrotic tissue was sharply debrided away with a scalpel. The wound was then packed with moistened betadine gauze and mepilex dressing was than applied. The postoperative plan indicated the dressing would change once per shift twice daily, or when soiled. The resident needed offloading on her side or stomach to allow for the wound to heal. The best course of action would be the resident being ambulatory but that seemed doubtful.<br><br>A facility census document indicated the resident readmitted to the facility on 5/30/21.<br><br>A hospital discharge instruction, dated 5/30/21, indicated the resident had a decubitus with osteomyelitis and had received cubicin (antibiotic) and Rocephin (antibiotic).<br><br>The medical record lacked documentation the wound had been assessed on 5/30/21 when the resident readmitted from the hospital.<br><br>A nurse's note, dated 5/30/21 at 6:35 p.m., indicated the resident was readmitted to the facility with a diagnosis of osteomyelitis to the sacrum. Resident was on two intravenous antibiotics until 6/24/21.<br><br>A MAR, dated May 2021, indicated a start date of | | | |

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| | 5/30/21, ceftriaxone sodium solution reconstituted to 1 gram intravenously one time a day for osteomyelitis until 8/24/21. The TAR indicated the ceftriaxone was not administered on 5/30/21 and to see progress notes.<br><br>A nurse's note, dated 5/30/21 at 11:47 p.m., indicated awaiting delivery from pharmacy and writer was unable to give estimated time of delivery.<br><br>A MAR, dated May 2021, indicated a start date of 5/30/21, daptomycin solution reconstituted use 500 mg intravenously one time a day for osteomyelitis until 8/24/21. The TAR indicated the medication was not administered on 5/30/21 and to see progress notes.<br><br>A nurse's note, dated 5/30/21 at 11:48 p.m., indicated awaiting delivery from pharmacy and writer was unable to give estimated time of delivery.<br><br>A TAR, start dated 5/30/21 and discontinued on 6/1/21, indicated to cleanse coccyx wound with normal saline, pat dry with gauze, apply betadine-soaked gauze, and apply dry gauze. The TAR indicated the resident refused on 5/30/21 during night shift. And to see progress notes for day and night shift on 5/31/21.<br><br>A progress note, dated 5/31/21 at 5:57 p.m., indicated supplies were not available.<br><br>A progress note, dated 5/31/21 at 7:29 p.m., indicated medication not available and pharmacy was notified.<br><br>A progress note, dated 5/31/21 at 10:23 p.m., indicated treatment supplies were not available. | | | |

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| | A wound progress note, dated 6/2/21 at 2:37 p.m., indicated the resident had a stage IV (full thickness tissue loss with exposed bone, tendon, or muscle with possible slough or eschar on some parts of the wound bed, and often includes undermining and tunneling) pressure ulcer with a large amount of serosanguinous fluid with no odor. The pressure ulcer measured at 6.5 w x 6.5 l x 3.0 d with tunneling noted at 11 o'clock of 3.5 cm x 3 cm at 6 o'clock 80% slough 20% granulation was noted. The resident continued to be noncompliant with position changes. The resident was educated of importance of frequent position changes to help to aide in wound healing. Physician orders indicated to cleanse wound with normal saline, pat dry, and mix anasept with collagen powder to a paste form and apply to wound bed, apply silver alginate to wound and cover daily. The resident received Cubicin and Rocephin IV for VRE.<br><br>A TAR, dated June 2021, indicated cleanse wound with normal saline and pat dry. Mix anasept with collagen powder to a paste form and apply to wound bed, apply silver alginate to wound and cover daily every shift for wound care. The TAR lacked documentation this had been completed on 6/3/21 and 6/5/21.<br><br>A MAR, dated June 2021, indicated ceftriaxone sodium solution reconstituted to 1 gram intravenously one time a day for osteomyelitis until 8/24/21. The TAR indicated the medication was not administered on 6/2/21 and 6/3/21 due to the resident sleeping.<br><br>A MAR, dated June 2021, indicated daptomycin solution reconstituted use 500 mg intravenously one time a day for osteomyelitis until 8/24/21. The TAR indicated the medication was not | | | |

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| | administered on 6/2/21 and 6/3/21 due to the resident sleeping.<br><br>During an interview, on 6/8/21 at 2:04 p.m., the Assistant Director of Nursing (ADON) indicated she was the wound nurse. The resident admitted to the facility with two stage II pressure ulcers. The pressure ulcer had merged to one stage III pressure ulcer and had developed an infection of three different bacteria. The physician ordered the resident to be sent to the hospital on 5/26/21 due to being unable to obtain a susceptible antibiotic from the facility pharmacy. The resident readmitted back to the facility on 5/30/21 and had been diagnosed with osteomyelitis. The pressure ulcer had not been documented as assessed upon readmission and the first assessment documented was on 6/2/21 and at that time was documented to be a stage IV pressure ulcer. The resident's treatments should have been completed as ordered and the resident's diabetes should have been managed appropriately to aide in wound healing. She was unsure why the treatments had not been administered as ordered.<br><br>On 6/8/21 at 9:05 a.m., the Director of Nursing (DON) provided a document, revised on 5/20/21, and titled, "Wound Treatment Management," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Policy Explanation and Compliance Guidelines: 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change ...7. Treatments will be documented on the Treatment Administration | | | |

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| | Record. 8. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include: a. Lack of progression towards healing. b. Changes in the characteristics of the wound ...."<br><br>On 6/8/21 at 9:05 a.m., the Director of Nursing (DON) provided a document, revised on 5/20/21, and titled, "Pressure Injury Prevention and Management," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: Asbury Towers is committed to the prevention of avoidable pressure injuries and the promotion of healing of existing pressure injuries ...Policy Explanation and Compliance Guidelines: ...c. Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. d. Assessments of pressure injuries will be performed by a licensed nurse, and documented in Point Click Care... The staging of pressure injuries will be clearly identified to ensure correct coding of MDS ...5. Monitoring: ...b. The attending physician will be notified of: ...ii. The progression towards healing, or lack of healing, of any pressure injuries weekly. iii. Any complications (such as infection, development of a sinus tract, etc.) as needed ...."<br><br>The immediate jeopardy that began on 4/19/21 was removed on 6/11/21 when the facility assessed all residents for risk of pressure ulcer development, and if at risk, interventions were implemented. Residents with current pressure ulcers were reviewed for appropriate care and treatment, and care plans updated. Physician and families were notified of wounds as needed. Nursing staff were in-serviced on pressure ulcer | | | |

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| | care. The noncompliance remained at the lower scope and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need for continued monitoring.B. On 6/6/21 at 10:51 a.m., Resident 3 was observed sitting in the recliner with her heels resting on the footrest. No pressure relief devices were in place.<br><br>On 6/6/21 at 2:28 p.m., Resident 3 was observed sitting in the recliner with her heels resting on the footrest. No pressure relief devices were in place.<br><br>On 6/8/21 at 1:18 p.m., Resident 3 was observed sitting in her wheelchair, wearing house slippers. There were no dressings observed on the resident's heels.<br><br>On 6/9/21 at 9:37 a.m., Resident 3 was observed sitting up in the recliner with her feet in house slippers and resting on the floor. There were no dressings observed on the resident's heels.<br><br>Resident 3's record was reviewed on 6/7/21 at 11:41 a.m. Diagnoses on the resident's profile included, but were not limited to, pressure ulcer to left heel, pressure ulcer to right heel, and type 2 diabetes mellitus (an impairment in the way the body regulates and uses sugar for fuel) without complications.<br><br>Census information indicated the resident was admitted on 2/15/21.<br><br>A nursing admission assessment, dated 2/15/21, indicated the resident did not have any open areas on the skin.<br><br>Census information indicated the resident was hospitalized from 2/17/21 to 2/23/21. | | | |

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A re-admission nursing assessment, dated 2/23/21, indicated the resident's heels were soft and the coccyx (tailbone) was red. The assessment lacked documentation the physician or family were notified of the skin impairments or a treatment was initiated.

A nurse's note, dated 2/23/21, indicated the resident returned from the hospital, and her son was at the bedside. The resident's coccyx was red and non-blanchable (does not turn white when pressed; stage 1 pressure areas included redness which does not turn white when pressed). The note lacked documentation the physician was notified of the skin impairment or a treatment was ordered.

A Treatment Administration Record (TAR), dated February 2021, lacked documentation the resident received any treatments to skin impairments, including preventative treatments.

Census information indicated the resident was hospitalized from 2/27/21 to 3/1/21.

A re-admission nursing assessment, dated 3/2/21, was opened, but not completed. The assessment lacked documentation of a skin assessment.

An admission Minimum Data Set (MDS) assessment, dated 3/2/21, indicated the resident had a moderate cognitive impairment, required extensive assistance of two staff members for bed mobility and transfers, and was at risk for developing pressure ulcers (injury to skin and underlying tissue resulting from prolonged pressure on the skin).

A skin assessment, dated 3/8/21, indicated the

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| | resident's coccyx was denuded (loss of the top layer of skin, caused by prolonged moisture and friction). The assessment lacked documentation the physician or family were notified, or a treatment was initiated.<br><br>A skin assessment, dated 3/16/21, indicated the resident had a stage two (a sore extending into deeper layers of the skin which could look like a blister or crater) pressure ulcer, measured 3 centimeters (cm) in length, 2.5 cm in width, and 0 cm in depth. The assessment lacked documentation a treatment was initiated.<br><br>A nurse's note, dated 3/16/21, indicated the physician and family were notified of the pressure ulcer to the left buttock. The note lacked documentation a treatment was initiated to the area.<br><br>A skin assessment, dated 3/29/21, indicated the resident had a stage two area to the left buttock, measured 3.5 cm in length, 2 cm in width, and less than 0.1 cm in depth.<br><br>A nurse's note, dated 3/29/21, indicated the resident had a pressure ulcer to the left buttock and a treatment was started, wound cleansed with normal saline, apply skin prep (a treatment that forms a barrier to protect intact skin) to the area around the wound, and a thin hydrocolloid (a breathable dressing which provides a moist, insulated environment for healing) dressing.<br><br>A TAR, dated March 2021, indicated an undated physician's order, discontinued on 4/3/21, cleanse wound to left buttock with normal saline, apply skin prep to area round the wound, and cover wound bed with hydrocolloid thin, change every three days and as needed if soiled or dislodged. | | | |

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| | The TAR lacked documentation the treatment was offered, refused, or completed during the month, any other treatments were ordered or completed, and any preventative treatments.<br><br>A skin assessment, dated 4/7/21, indicated the resident had a pressure ulcer, suspected deep tissue injury (purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure) to the left heel and a pressure ulcer, suspected deep tissue injury to the right heel. The note indicated bilateral (both) heels were discolored, intact, and mushy. The unit nurse was notified and would obtain orders for skin prep. The previous open area to the coccyx was healed. The assessment lacked documentation the physician or family were notified and measurements of the areas.<br><br>A skin assessment, dated 4/12/21, indicated the resident had a suspected deep tissue injury to the left heel measured 3 cm in length, 3 cm in width, and 0 cm in depth, a stage two pressure ulcer to the left heel measured 4 cm in length, 4 cm in width, and 0.1 cm in depth, and a suspected deep tissue injury to the right heel measured 3 cm in length, 4 cm in width, and 0 cm in depth. The note indicated a new order was obtained to clean the stage two area with normal saline and pat dry, apply prisma (prevents infection and promotes wound healing) or an equivalent to wound, and apply Unna boot (a special gauze dressing used to treat venous ulcers) dressings on Tuesdays and Fridays.<br><br>A skin assessment, dated 4/27/21, indicated the resident had a stage two pressure ulcer to the right inner ankle, measured 7 cm in length, 2.5 cm in width, and 0.1 cm in depth, a stage two pressure | | | |

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| | ulcer to the left heel, measured 3.5 cm in length, 3.2 cm in width, and 0.1 cm in depth, a suspected deep tissue injury to the left heel, measured 3 cm in length, 2.5 cm in width, and 0 cm in depth, and a suspected deep tissue injury to the right heel, measured 2 cm in length, 2 cm in width, and 0 cm in depth. The area to the right inner foot was a weeping blister with moderate drainage. The assessment lacked documentation the physician or family were notified of the areas, or treatments were initiated.<br><br>A TAR, dated April 2021, indicated an undated physician's order to cleanse stage two to left heel with normal saline and pat dry with gauze, cover wound with Prisma to fit or equivalent, apply Unna boot dressing to bilateral lower extremities from base of toes to knees every Tuesday and Friday and as needed if soiled or dislodged. The TAR indicated the treatment was completed on 4/14/21, 4/16/21, and 4/20/21, but lacked documentation the treatment was offered, refused, or completed any other days. The TAR indicated an undated physician's order to cleanse the left buttock with normal saline, apply skin prep to the area around the wound, cover wound bed with hydrocolloid thin dressing, change every three days and as needed if soiled or dislodged related to a stage two pressure ulcer. The treatment was completed on 4/3/21 and 4/6/21. The TAR lacked documentation the treatment was offered, refused, or completed any other days during the month. The TAR indicated an undated physician's order to cleanse wounds to bilateral heels with normal saline and pat dry with gauze, apply Maxorb (an absorbent dressing which prevents infection) to weeping areas to bilateral heels, cover both with a nonstick pad and secure the dressing with tape every Tuesday and Friday. The TAR indicated the treatment was completed on 4/27/21, but lacked | | | |

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| | 155758 | A. BUILDING 00<br>B. WING | 06/14/2021 |

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| | documentation the treatment had been offered, refused, or completed any other days. The TAR indicated a preventative treatment to bilateral heels was ordered from 4/7/21 to 4/13/21, skin prep twice a day.<br><br>A skin assessment, dated 5/12/21, indicated a stage three (a worsening sore extending into the area beneath the skin forming a small crater, fat may show) pressure ulcer to the left heel, measured 2 cm in length, 2 cm in width, depth not measured, and a stage three pressure ulcer to the right heel, measured 3.5 cm in length, 3 cm in width, and 1.2 cm in depth. Notes indicated new orders for dressing changed and heel boots to continue while in bed.<br><br>A TAR, dated May 2021, indicated a preventative treatment for skin prep was ordered to the inner portion of the heels prior to applying the dressings from 5/13/21 to 5/18/21. The TAR lacked documentation the skin prep was offered, refused, or completed on 5/14/21 and 5/16/21. The TAR indicated a physician's order, initiated 5/4/21 and discontinued on 5/15/21, indicated cleanse wounds to bilateral heels with normal saline and pat dry with gauze, apply Maxorb dressing to weeping areas, and cover with a nonstick pad and secure with tape every Tuesday and Friday. The TAR lacked documentation the treatment was offered, refused, or completed on 5/7/21 and 5/14/21. The TAR indicated a physician's order, initiated 5/13/21 and discontinued 5/18/21, to cleanse wounds to bilateral heels with normal saline and pat dry with gauze, apply Maxorb dressing, cover with a nonstick pad, and secure with tape daily. The TAR lacked documentation the treatment was offered, refused, or completed on 5/14/21 and 5/16/21. The TAR indicated skin prep to bilateral heels and float heels when in | | | |

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| | recliner or bed every shift, was initiated on 5/18/21.<br><br>A weekly wound assessment note, dated 6/4/21, indicated a stage two pressure ulcer to the left buttock, measured 2 cm in length, 2 cm in width, and 0.1 cm in depth, and a stage two pressure ulcer to the right buttock, measured 2 cm in length, 2.3 cm in width, and 0.1 cm in depth. The physician ordered hydrogel (a treatment to keep the wound moist) to the open areas.<br><br>The resident's lab testing lacked documentation vascular studies (testing to check blood flow) were obtained prior to compression dressings (treatments used for venous ulcers and contradicted in arterial ulcers) being applied.<br><br>A care plan, target dated 7/22/21, indicated the resident had potential for pressure ulcer development related to required assistance with bed mobility, and weakness. The resident was admitted with red areas to the buttocks, coccyx, and bilateral heels. Interventions included, but were not limited to, administer treatments as ordered and monitor for effectiveness, follow facility policies and protocols for the prevention and treatment of skin breakdown, and obtain and monitor lab and diagnostic work as ordered.<br><br>A care plan, target dated 7/22/21, indicated the resident had a stage two pressure ulcer to the left buttock and a suspected deep tissue injury to the bilateral heels. Interventions included, but were not limited to, administer treatments as ordered and monitor for effectiveness, assess, monitor, and record wound healing weekly including measurements of length width, and depth where possible, assess and document status of wound perimeter, wound bed and healing progress and | | | |

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| | report improvements and declines to the physician, follow facility policies and protocols for the prevention and treatment of skin breakdown, monitor, document, and report as needed any changes in skin status, and weekly wound documentation to include measurements of each area of skin breakdown's width, length, depth, type of tissue and exudate.<br><br>During an interview, on 6/7/21 at 2:18 p.m., the Director of Nursing (DON) indicated she was aware the weekly wound assessments had not been consistently completed.<br><br>During an interview, on 6/8/21 at 11:07 a.m., the Assistant Director of Nursing (ADON) indicated she was the facility's wound nurse. If a resident was re-admitted to the facility with mushy heels and non-blanchable areas, the wound nurse should have been notified and a preventative treatment and care plan initiated. A skin assessment should have been completed with each admission and re-admission to the facility. Treatment orders should have been obtained when each new skin impairment was noted. The March 2021 TAR was reviewed, and indicated she was unable to find any documentation a treatment was provided to the left buttock pressure ulcer. There should have been a treatment provided. All wounds should have been measured weekly, including suspected deep tissue injuries. She was initially not aware she needed to measure suspected deep tissue injuries, so the measurements were missed. The resident was not able to walk, so Unna boots most likely were not an effective treatment. Vascular studies were not obtained, and should have been, prior to Unna boots or any compression dressings being applied. The April 2021 TAR was reviewed, and treatments were not consistently documented. | | | |

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| | She thought the fluid filled blister to the right inner ankle healed around 5/13/21, but this was not documented. When wounds healed, this should have been documented. She was not aware the pressure ulcers were ever staged at stage three, however upon further review, indicated she was the nurse who documented the bilateral heels as having stage three pressure ulcers. There should have been physician's orders for preventative measures prior to 5/18/21. She was not aware of what was put in place to prevent the pressure ulcers to the buttocks from developing again after they initially healed. She was not sure if the resident wore the pressure relief boots in her recliner. The resident very rarely got into the bed, and normally slept in her recliner.<br><br>During an interview, on 6/8/21 at 1:13 p .m., Certified Nursing Assistant (CNA) 21 indicated when the resident was in the recliner her feet usually hung over the edge. The resident wore the pressure relief boots in bed; however, she did not normally lay down in her bed. The resident was non ambulatory. On 6/8/21 at 9:05 a.m., the DON provided a document titled, "Pressure Injury Prevention and Management," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy...is committed to the prevention of avoidable pressure injuries and the healing of existing pressure ulcers.<br>Definitions...'Avoidable' means that the resident developed a pressure ulcer/injury that the facility did not do one or more of the following: evaluate the resident's clinical | | | |

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| | condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of interventions; or revise the interventions as appropriate. Policy Explanation and Compliance Guidelines...2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of interventions; and modifying the interventions as appropriate. 3. Assessment of Pressure Injury Risk: ...c. Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record...4. Interventions for Prevention and to Promote Healing...c. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine interventions could included, but are not limited to: i. Redistribute pressure (...offloading heels)...d. Evidence-based treatments in accordance with current standards of practice will be provided for all residents who have a pressure injury present...5. | | | |

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| | Monitoring: a. The floor nurse will complete skin assessments and report any new pressure injuries or risks to the wound nurse, and document a summary of findings in the medical record. b. The attending physician will be notified of: i. The presence of a new pressure injury upon identification...6 Modifications of Interventions: ...Interventions on a resident's plan of care will be modified as needed. Considerations for modifications include: ...ii. New onset or recurrent pressure ulcer development...."On 6/8/21 at 9:05 a.m., the DON provided a document titled, "Wound Treatment Management," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Policy Explanation and Compliance Guidelines: 1. Wound treatments will be provided in accordance with physician orders...2. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders...4. Dressings will be applied in accordance with manufacturer recommendations. 5. Treatment decisions will be based on: a. Etiology of the wound...b. Characteristics of the wound (to | | | |

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| | be documented weekly along with treatment): i. Pressure injury stage...ii. Size...iii. Volume and characteristics of exudate, iv. Presence of pain. v. Presence of infection or need to address bacterial bioburden. vi. Presence of non-viable tissue. vii. Condition of peri-wound skin...7. Treatments will be documented on the Treatment Administration Record...."On 6/8/21 at 1:31 p.m., the DON provided a document titled, "Unna Boot/Unna Boot with Calamine," and indicated it was the manufacturer's guidance currently being used by the facility. The guidance indicated, "Unna Boot: Gauze bandage that has been evenly impregnated with a non-hardening paste of zinc oxide to provide venous ulcer compression therapy...Indications: Provides venous ulcer compression therapy in actively ambulatory patients...Contraindications: ...Unna boots are not intended to provide compression therapy in non-ambulatory patients...."3.1-40(a)(1)3.1-40(a)(2)3.1-40(a)(3) | | | |
| 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 | | | |

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| | adequate supervision and assistance devices to prevent accidents.<br><br>Based on observation, interview, and record review, the facility failed to implement fall interventions and follow post fall procedures resulting in a resident sustaining a fractured hip after a fall for 1 of 1 resident reviewed for falls (Resident 26).<br><br>Findings include:<br><br>A record review was completed for Resident 26 on 6/9/21 at 10:34 a.m. A review of a quarterly Minimum Data Set (MDS) assessment, dated 5/5/21, indicated the resident was cognitively intact.<br><br>A fall incident report, date of incident 2/27/21 at 9:30 a.m., lacked the resident's vital signs, neurological checks, range of motion, and if the resident had footwear in place.<br><br>A nursing progress note, dated 2/27/21 at 11:25 a.m., indicated the resident was found on the floor in her room face down bleeding from her head. The resident indicated she had picked something up from her floor and her wheelchair was not locked and rolled out from under her and she went headfirst.<br><br>A nursing progress note, dated 2/27/21 at 11:23 a.m., indicated the Director of Nursing (DON), family, and physician were notified of the fall. A new order was received to send the resident to the emergency room to evaluate and treat.<br><br>A nursing progress note, dated 2/27/21 at 7:00 p.m., indicated late entry: resident returned to the facility from hospital. The resident had a | F 0689 | All nursing staff will be re-educated on fall prevention and follow up<br><br>This deficiency effects all residents as they are all considered a fall risk<br><br>Nursing staff will document immediate interventions when completing the incident report<br><br>IDT will review all falls for accuracy of documentation within 24 hours (72 for holiday or weekend) and update the plan of care<br><br>If a fall results in an ER visit or hospitalization, updated interventions will be put into place and care planned based on the resident's status upon return<br><br>Falls with major injury will be reported to the ISDH gateway within 24 hours<br><br>Falls will be reviewed in QAPI as a PIP (minimum of 6 months) until the facility fall rate is below 5% | 07/14/2021 |

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| | laceration to the left brow with six sutures and covered with a dressing. A sling to the right arm/shoulder post non-displaced fracture of scapula. Call light placed within reach and bed in low position.<br><br>A review of care plans lacked documentation an intervention had been initiated after the resident's fall with major injury on 2/27/21.<br><br>A nursing progress note, dated 4/11/21 at 2:44 p.m., indicated the resident was up out of chair and transferred self to bathroom without assistance and fell. The roommate called for help. Resident was legally blind and could not see. Resident indicated her buttocks hurt on both sides and in the middle. Physician notified and a new order was received to send to the emergency for evaluation and treatment.<br><br>A fall incident report, date of incident 4/11/21 at 2:50 p.m., lacked the resident's vital signs, neurological checks, range of motion, and if the resident had footwear in place.<br><br>A nursing progress note, dated 4/11/21 at 6:37 p.m., indicated the resident returned from the hospital at 5:10 p.m. with no fractures or new orders noted. Resident was barely able to stand when getting in the bed, pain medication was administered and documented effective.<br><br>A nursing progress note, dated 4/12/21 at 7:04 a.m., indicated the resident continued to have back and buttock pain and as needed pain medication was not effective. The physician was notified.<br><br>A nursing progress note, dated 4/15/21 at 10:49 a.m., indicated an x-ray was completed today at | | | |

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| | 10:50 a.m. and was pending results.<br><br>A nursing progress note, dated 4/15/21 at 2:47 p.m., indicated a new order was received for x-ray of resident's right hip.<br><br>A nursing progress note, dated 4/16/21 at 6:41 p.m., indicated radiology stated they may not get resident's x-ray done until Monday April 19th and if the last 2 x-rays were read it would be seen the pelvic area and right hip are intact and was not in any imminent danger. The progress note lacked documentation the resident's physician was notified of this delay.<br><br>A nursing progress note, dated 4/18/21 at 6:16 p.m., indicated received results from resident's right hip x-ray showed a nondisplaced fracture of the right superior pubic ramus. Physician was notified and physician responded nothing would done with this type of fracture. The physician was called back to request stronger pain medication and left message. There was no return call back yet.<br><br>A care plan, revised 4/23/21, indicated the resident was at risk for falls related to assistance needed for transfers. Interventions dated 2/12/21 included, but were not limited to, be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed, the resident needed prompt response to all requests for assistance, and ensure the resident was wearing appropriate footwear when ambulating or mobilizing in wheelchair.<br><br>During an interview, on 6/11/21 at 10:04 a.m., the DON indicated the resident had fallen on 2/27/21 and was sent to the hospital where she was diagnosed with a fractured scapula and had a | | | |

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| | laceration to the face. She was unable to find that an intervention had been put into place after the fall and one should have been. A post fall incident report was initiated but lacked being fully completed. The resident also fell on 4/11/21 and was sent to the hospital. It was not determined until 4/18/21 the resident had fractured her right superior pubic ramus, and intervention was put into place on 4/15/21 to encourage the resident to ask for assistance to the bathroom.<br><br>On 6/10/21 at 3:30. m., the DON provided a document, revised on 3/11/21, and titled, "Fall Prevention Program," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls...7. Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed. 8. a. Assess the resident. b. complete and document post fall assessment note. c. completes an incident report on PCC...e. Review the resident's care plan and update as indicated. f. document at all assessments and actions. g. obtains witness statements in the care of injury and document on incident report."<br><br>3.1-45(1)<br>3.1-45(2) | | | |
| F 0692<br>SS=D<br>Bldg. 00 | 483.25(g)(1)-(3)<br>Nutrition/Hydration Status Maintenance<br>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic | | | |

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| | gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>Based on record review and interview, the facility failed to ensure interventions were put in place when a resident lost weight, and the physician and resident representative were notified of the weight loss for 1 of 2 residents reviewed for nutrition (Resident 3).<br><br>Findings include:<br><br>Resident 3's record was reviewed on 6/7/21 at 11:41 a.m. An admission Minimum Data Set (MDS) assessment, dated 3/2/21, indicated the resident had a moderate cognitive impairment.<br><br>Census information indicated the resident admitted to the facility on 2/15/21, and was hospitalized from 2/17/21 to 2/23/21, and from 2/27/21 to 3/1/21.<br><br>A behavior note, dated 2/16/21, indicated the resident refused nutritional shakes. | F 0692 | The policy "Weight Monitoring" has been updated to include contacting the physician when a weight is not obtained.<br><br>All skilled charts reviewed to determine how many had a significant weight loss in the past 3 months and interventions put into place.<br><br>All nursing staff will be educated on the updated policy<br><br>DON or designee will supply nursing staff a list of weights to be obtained daily<br><br>During weekly Risk and Wound meeting, the Dietary Manager or designee will communicate the | 07/14/2021 |

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| | 155758 | A. BUILDING 00<br>B. WING | 06/14/2021 |

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| | A dietary note, dated 2/17/21, indicated the resident received Ensure twice daily.<br><br>A physician's order, dated 2/23/21, indicated daily weight via Hoyer (a mechanical lift) while on isolation, then per wheelchair related to localized edema (swelling).<br><br>A weight, dated 2/23/21, indicated 172 pounds.<br><br>A Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated February 2021, lacked documentation a weight was obtained on 2/24/21, 2/25/21, and 2/26/21. The MAR and TAR lacked documentation the physician was notified of the missed daily weights and any nutritional shakes or supplements, including Ensure, were ordered.<br><br>A weight, dated 3/4/21, indicated 170 pounds.<br><br>A nurse's note, dated 3/4/21, indicated the resident refused meals at times, but sometimes took Glucerna.<br><br>A weight, dated 3/9/21, indicated 163 pounds.<br><br>A nutrition progress note, dated 3/11/21, indicated the resident's weight was 163 pounds, a nine pound weight loss. The resident received Ensure twice daily. The note lacked documentation the physician or resident representative were notified of the weight loss or a physician's order was obtained for the Ensure supplement.<br><br>A second nutrition note, dated 3/11/21, indicated the Registered Dietitian (RD) met with the resident's son to discuss food preferences. They decided to change the supplement to Glucerna | | needed weights to the nursing department and will be added to the list of weights to be obtained<br><br>DON or designee will audit the weights daily x 6 weeks; weekly x 2 months; then monthly ongoing | |

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| | twice daily. The note lacked documentation the physician was notified, or a physician's order was obtained for the Glucerna supplement.<br><br>A weight, dated 3/13/21, indicated 154.4 pounds.<br><br>A weight, dated 3/14/21, indicated 157.4 pounds.<br><br>A weight, dated 3/15/21, indicated 158 pounds.<br><br>A weight, dated 3/16/21, indicated 156 pounds.<br><br>A nutrition note, dated 3/17/21, indicated the resident's current weight was 156 pounds, stable since 3/13/21. The resident received Ensure twice daily. The RD recommended the resident be monitored weekly for one week. The note lacked documentation a physician's order was obtained for the Ensure or Glucerna supplement.<br><br>An interdisciplinary team (IDT) note, dated 3/18/21, indicated all agreed to monitor the resident's weight weekly for one week. The note lacked acknowledgement of the physician's order for daily weights, or a physician's order was obtained for the Ensure or Glucerna supplement.<br><br>A weight, dated 3/22/21, indicated 168.4 pounds.<br><br>A weight, dated 3/23/21, indicated 168.4 pounds.<br><br>A weight, dated 3/24/21, indicated 160.8 pounds.<br><br>A weight, dated 3/25/21, indicated 159.5 pounds.<br><br>A nutrition note, dated 3/25/21, indicated the resident's current weight was 160.8 pounds, a four pound change since the last review. The resident received Ensure twice daily. The note lacked documentation the team was aware the resident | | | |

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| | required daily weights per the physician's order, the physician was notified of the weight fluctuations, or a physician's order was obtained for the Ensure supplement.<br><br>A weight, dated 3/26/21, indicated 159.6 pounds.<br><br>A weight, dated 3/27/21, indicated 159.6 pounds.<br><br>A weight, dated 3/29/21, indicated 162.4 pounds.<br><br>A MAR and TAR, dated March 2021, lacked documentation a weight was obtained on 3/1/21, 3/2/21, 3/3/21, 3/6/21, 3/7/21, 3/8/21, 3/10/21, 3/11/21, 3/12/21, 3/17/21, 3/18/21, 3/19/21, 3/20/21, 3/21/21, 3/28/21, 3/30/21, and 3/31/21. The MAR and TAR lacked documentation the physician was notified of the missed daily weights or the weight fluctuations, and any nutritional shakes or supplements were ordered.<br><br>A weight, dated 4/1/21, indicated 160 pounds.<br><br>A nutrition note, dated 4/1/21, indicated the resident's current weight was 162.4 pounds, a slight gain since the last review. The resident received Ensure twice daily, and the RD recommended to discontinue the Ensure related to weight stability. The note lacked documentation the team was aware the resident required daily weights and ordered by the physician and a physician's order was obtained to give the Ensure or discontinue it.<br><br>A weight, dated 4/2/21, indicated 160 pounds.<br><br>A weight, dated 4/3/21, indicated 168.8 pounds.<br><br>A weight, dated 4/5/21, indicated 167.9 pounds. | | | |

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| | A weight, dated 4/6/21, indicated 168 pounds.<br><br>A nutrition note, dated 4/7/21, indicated the resident's current weight was 168 pounds, a gain since last review. Ensure was discontinued, however, the note lacked documentation physician's orders were ever obtained to administer or discontinue Ensure. The team recommended to discontinue weekly weights and monitor monthly. The note lacked documentation the team was aware the resident required daily weights as ordered by the physician.<br><br>A weight, dated 4/8/21, indicated 167.6 pounds.<br><br>A weight, dated 4/9/21, indicated 168 pounds.<br><br>A weight, dated 4/10/21, indicated 151.2 pounds.<br><br>A weight, dated 4/12/21, indicated 163.4 pounds.<br><br>A weight, dated 4/15/21, indicated 159.4 pounds.<br><br>A weight, dated 4/16/21, indicated 157 pounds.<br><br>A weight, dated 4/17/21, indicated 157 pounds.<br><br>A weight, dated 4/20/21, indicated 155.2 pounds.<br><br>A weight, dated 4/24/21, indicated 156.6 pounds.<br><br>A weight, dated 4/25/21, indicated 156.6 pounds.<br><br>A weight, dated 4/27/21, indicated 157 pounds.<br><br>A weight, dated 4/28/21, indicated 158.2 pounds.<br><br>A weight, dated 4/29/21, indicated 158.2 pounds.<br><br>A MAR and TAR, dated April 2021, lacked | | | |

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| | documentation a weight was obtained on 4/4/21, 4/7/21, 4/11/21, 4/13/21, 4/14/21, 4/18/21, 4/19/21, 4/21/21, 4/22/21, 4/23/21, 4/26/21, and 4/30/21. The MAR and TAR lacked documentation the physician was notified of the missed daily weights or the weight fluctuations, and any nutritional shakes or supplements were ordered.<br><br>A weight, dated 5/1/21, indicated 160.6 pounds.<br><br>A weight, dated 5/2/21, indicated 160.7 pounds.<br><br>A physician's order, dated 5/3/21, indicated no concentrated sweets diet, regular consistency. The order lacked documentation the resident required any supplements with meals.<br><br>A weight, dated 5/6/21, indicated 161 pounds.<br><br>A weight, dated 5/7/21, indicated 156.4 pounds.<br><br>A weight, dated 5/8/21, indicated 156 pounds.<br><br>A weight, dated 5/9/21, indicated 156 pounds.<br><br>A weight, dated 5/11/21, indicated 154.8 pounds.<br><br>A weight, dated 5/12/21, indicated 154.8 pounds.<br><br>A weight, dated 5/13/21, indicated 155.6 pounds.<br><br>A nutrition note, dated 5/13/21, indicated the resident's current weight was 154.8 pounds, a 5.3 percent loss in 30 days. The note lacked documentation the physician or resident representative were notified of the weight loss. The resident would be monitored weekly. The note lacked documentation the team was aware the resident required daily weights as ordered by the physician. | | | |

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A weight, dated 5/15/21, indicated 154.6 pounds.

A weight, dated 5/18/21, indicated 153.4 pounds.

A nutrition note, dated 5/20/21, indicated the resident's current weight was 153.4 pounds, no significant change. The resident would be monitored weekly. The note lacked documentation the team was aware the resident required daily weights as ordered by the physician.

A weight, dated 5/22/21, indicated 155 pounds.

A weight, dated 5/23/21, indicated 154.1 pounds.

A weight, dated 5/24/21, indicated 152.5 pounds.

A weight, dated 5/25/21, indicated 151.7 pounds.

A weight, dated 5/26/21, indicated 145.4 pounds.

A nutrition note, dated 5/26/21, indicated the resident's current weight was 151.7 pounds, a 5.5 percent weight loss from 5/1/21. The note lacked documentation the physician or resident representative were notified of the weight loss. The resident would continue to be monitored weekly for one week or until the weight stabilized. The note lacked documentation the team was aware the resident required daily weights as ordered by the physician.

An RD note, dated 5/26/21, indicated the resident's current weight was 145.5 pounds, a 26.6 pound loss, 15 percent, weight loss in 90 days, since the admission weight of 172 pounds in February 2021. The resident received supplements to aid in wound healing but did not to supplement caloric intake. The note lacked documentation of

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| | any recommendations to prevent further weight loss, the physician or resident representative were notified of the weight loss. The resident would continue to be monitored.<br><br>An IDT note, dated 5/27/21, indicated the resident had a 5.5 percent weight loss in an unspecified amount of time. The resident would be monitored weekly for one week or until stable. The note lacked documentation the physician or resident representative were notified of the weight loss, any recommendations were made to prevent further weight loss, or the team was aware the resident required daily weights as ordered by the physician.<br><br>An RD note, dated 5/27/21, indicated the RD and DON discussed the resident's weight loss and recommended adding Glucerna. DON was to follow up with the physician to get an order for the supplement.<br><br>A weight, dated 5/28/21, indicated 155.1 pounds.<br><br>A weight, dated 5/29/21, indicated 156.3 pounds.<br><br>A MAR and TAR, dated May 2021, lacked documentation a weight was obtained on 5/3/21, 5/4/21, 5/5/21, 5/10/21, 5/14/21, 5/16/21, 5/17/21, 5/19/21, 5/20/21, 5/21/21, 5/27/21, 5/30/21, and 5/31/21. The MAR and TAR lacked documentation the physician was notified of the missed daily weights or the weight fluctuations, and any nutritional shakes or supplements were ordered.<br><br>A weight, dated 6/1/21, indicated 155.4 pounds.<br><br>A weight, dated 6/2/21, indicated 156.8 pounds. | | | |

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| | A nutrition note, dated 6/2/21, indicated the resident's current weight was 155.4 pounds, a 6.9 percent gain from 5/26/21. The resident would be monitored weekly for one week or until the weight stabilized. The note lacked documentation the team was aware the resident required daily weights as ordered by the physician.<br><br>A weight, dated 6/7/21, indicated 153.6 pounds.<br><br>A MAR and TAR, dated June 2021, lacked documentation a weight was obtained on 6/3/21, 6/4/21, 6/5/21, and 6/6/21. The MAR and TAR lacked documentation the physician was notified of the missed daily weights or the weight fluctuations, and any nutritional shakes or supplements were ordered.<br><br>Current physician's orders lacked documentation of any supplements the resident required for increased caloric intake.<br><br>A care plan, target dated 7/22/21, indicated the resident was at risk for weight loss related to therapeutic diet restrictions and poor appetite. Interventions included, but were not limited to, monitor, record, and report to the physician as needed any significant weight loss of three pounds in one week, greater than five percent in one month, greater than 7.5 percent in 90 days, and greater than ten percent in six months, provide and serve supplements as ordered. Care plans lacked documentation the resident required daily weights or had actual weight loss.<br><br>During an interview, on 6/8/21 at 1:55 p.m., the DON indicated the physician, and the resident representative should have been notified of any significant weight changes, five percent in 30 days and 10 percent in 180 days. Daily weights | | | |

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| | should have been completed each day as ordered.<br><br>During an interview, on 6/8/21 at 2:13 p.m., the Assistant Director of Nursing (ADON) indicated she thought if a resident received a supplement there should have been a physician's order. This would have included supplements such as Ensure and Glucerna. The nurses were made aware to administer the supplement because of the order on the MAR.<br><br>During an interview, on 6/8/21 at 2:19 p.m., the Dietary Services Director indicated he was not sure what the process was for the RD's recommendations. Supplements such as Ensure or Glucerna were ordered by the nursing department and required a physician's order for the staff to know who to distribute them to.<br><br>During an interview, on 6/10/21 at 2:27 p.m., the RD indicated she recently assessed the resident and spoke with the DON. They decided Glucerna would be a good option for the resident as she was still losing weight. Once a recommendation was made, a physician's order should have been obtained.<br><br>On 6/8/21 at 3:00 p.m., the DON provided a document titled, "Nutritional Management," and indicated it was the policy currently being used by the facility. The policy indicated, "...Compliance Guidelines...5. Monitoring/revision: a. Monitoring of the resident's condition and care plan interventions will occur on an ongoing basis. Examples of monitoring include: ...v. Evaluating the care plan to determine if current interventions are being implemented and are effective...d. The physician will be notified of: i. Significant changes in weight, intake, or nutritional status...." | | | |

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| | On 6/8/21 at 3:00 p.m., the DON provided a document titled, "Weight Monitoring," and indicated it was the policy currently being used by the facility. The policy indicated, "...Compliance Guidelines: ...5. A weight monitoring schedule will be developed upon admission for all residents: ...d. If clinically indicated-monitor weight daily...6. Weight analysis: The newly recorded resident weight should be compared to the previous recorded weight. A significant change in weight is defined as: a. 5% change in 1 month (30 days). b. 7.5% change in weight in 3 months (90 days). c. 10% change in weight in 6 months (180 days)...7. Documentation: a. The physician should be informed of a significant change in weight and may order nutritional intervention...."<br><br>3.1-46(a)(1) | | | |
| F 0698 SS=D Bldg. 00 | 483.25(l)<br>Dialysis<br>§483.25(l) Dialysis.<br>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.<br>Based on observation, record review, and interview, the facility failed to ensure a resident's dialysis perma-cath (a catheter used for dialysis) was assessed, daily weights were obtained as ordered, and assessment forms from the dialysis appointments were maintained for 1 of 1 resident reviewed for dialysis (Resident 13).<br><br>Findings include:<br><br>On 6/6/21 at 10:28 a.m., Resident 13 was observed | F 0698 | Orders for daily assessment of dialysis central venous catheter, fistula, and/or graft will be entered for all dialysis residents upon admission or initiation of dialysis treatment<br><br>See F0692 for daily weight POC<br><br>Policy "Hemodialysis" has been updated to include notifying the | 07/14/2021 |

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| | with a perma-cath site to the right side of his chest.<br><br>Resident 13's record was reviewed on 6/9/21 at 10:09 a.m. An admission Minimum Data Set (MDS) assessment, dated 4/9/21, indicated the resident was cognitively intact and received dialysis.<br><br>Diagnosis on the resident's profile included, but were not limited to, chronic kidney disease stage four (advanced kidney disease).<br><br>Census information indicated the resident admitted to the facility on 4/2/21.<br><br>A physician's order, dated 4/3/21, indicated daily weight.<br><br>A physician's order, dated 4/3/21, indicated dialysis three times a week on Mondays, Wednesdays, and Fridays.<br><br>A physician's order, dated 4/3/21, indicated the resident had a perma-cath in the right upper chest wall, and the dialysis center provided care to the site.<br><br>A care plan, initiated 4/8/21, indicated the resident required dialysis due to chronic kidney disease stage four. Interventions included, but were not limited to, check, and change dressing daily at access site and document.<br><br>A nurse's notes, dated 4/14/21, 4/28/21, 5/5/21, 5/17/21, 5/18/21, 5/19/21, 5/21/21, and 5/23/21 indicated the resident had a perma-cath in the left upper chest for dialysis access.<br><br>The clinical record lacked documentation a daily weight was obtained on 4/4/21, 4/13/21, 4/18/21, | | physician if a treatment is missed<br><br>This deficiency has effected the one dialysis resident currently in the skilled facility.<br><br>All nursing staff will be educated on the "Hemodialysis" policy<br><br>Weekly audits will be completed by DON or designee on a weekly basis to ensure proper communication documentation is completed between this facility and the dialysis facility<br><br>This plan will be reviewed in QAPI for a minimum of 6 months | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| ASBURY TOWERS HEALTH CARE CENTER | 102 W POPLAR ST<br>GREENCASTLE, IN 46135 |

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| | 4/21/21, 4/22/21, 4/23/21, 4/25/21, 4/26/21, 4/27/21, 4/30/21, 5/4/21, 5/5/21, 5/11/21, 5/15/21, 5/16/21, 5/19/21, 5/20/21, 5/21/21, 5/23/21, and 5/27/21. The record lacked documentation the physician was notified of the missed daily weights.<br><br>On 6/10/21 at 9:56 a.m., the Director of Nursing (DON) provided the resident's dialysis binder and indicated all communication from the dialysis provider was in the binder. The binder included dialysis communication forms from 4/7/21, 4/14/21, 4/19/21, 4/21/21, 4/23/21, 5/3/21, 5/7/21, 5/10/21, 5/25/21, 6/2/21, 6/4/21, 6/7/21, and 6/9/21. The binder lacked documentation of dialysis communication forms for 4/9/21, 4/12/21, 4/16/21, 4/26/21, 4/28/21, 4/30/21, 5/5/21, 5/12/21, 5/14/21, 5/17/21, 5/19/21, 5/21/21, 5/24/21, 5/26/21, 5/28/21, and 5/31/21.<br><br>During an interview, on 6/9/21 at 2:18 p.m., the DON indicated the perma-cath should have been assessed daily and documented accurately. Daily weights should have been obtained as ordered by the physician.<br><br>During an interview, on 6/10/21 at 9:41 a.m., the DON indicated if the dialysis center had not sent the dialysis communication form back to the facility with the resident, the staff nurse should have called the dialysis center and requested the form.<br><br>On 6/8/21 at 3:00 p.m., the DON provided a document titled, "Weight Monitoring," and indicated it was the policy currently being used by the facility. The policy indicated, "...Compliance Guidelines: ...5. A weight monitoring schedule will be developed upon admission for all residents: ...d. If clinically indicated-monitor weight daily...." | | | |

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| | On 6/9/21 at 3:17 p.m., the DON provided a document titled, "Hemodialysis," and indicated it was the policy currently being used by the facility. The policy indicated, "...Purpose: ...2 Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services...Compliance Guidelines: ...2. The facility will coordinate and collaborate with the dialysis facility to assure that: ...d. There is ongoing communication and collaboration for the development and implementation of the dialysis care plan by nursing home and dialysis staff...4. The licensed nurse will communicate to the dialysis facility via telephonic communication or written format, such as dialysis communication form or other form...7. The nurse will observe and document the status of the resident's access site(s) daily and document any complications...."<br><br>3.1-37(a) | | | |
| F 0725 SS=E Bldg. 00 | 483.35(a)(1)(2)<br>Sufficient Nursing Staff<br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the | | | |

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| | following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br><br>Based on observation, interview, and record review, the facility failed to ensure sufficient staffing to accommodate safe transfer when using a lift (Resident 24) for 1 of 1 resident reviewed for lift safety, to ensure timely dining service to 2 residents observed during 1 of 1 dining observation (Residents 10 and 232), to accommodate a resident's preference related to showers for 1of 3 residents reviewed for choices (Resident 30), and to complete Minimum Data Set (MDS) assessments timely and accurately for 6 of 13 residents reviewed for MDS assessment accuracy (Residents 19, 3, 20, 7, and 24).<br><br>Findings include:<br><br>During an interview, on 6/11/21 at 2:37 p.m., the Administrator (ADM) indicated the staffing was horrible, and it was hard to hire staff. They had had to use agency staff since COVID-19 started. They had to pull Certified Nursing Aides (CNA) shower aides to perform resident care, therefore the showers became limited due to the short staffing.<br><br>1. During an interview, on 6/6/21 at 12:03 p.m., Resident 24 indicated she required a sit-to-stand | F 0725 | No Residents were harmed by failure to have sufficient amount of nursing staff to operate the sit to stand or have the initial MDS assessment completed.<br><br>Ongoing efforts are being made to increase the amount of nursing staff providing care. We have hired nine nursing staff members in the last two weeks.<br><br>Human resources is working to develop a recruitment and retention plan including pay increases, bonuses, and longevity incentives. Agency staff will be utilized in the interim.<br><br>All new admissions are screened by the DON or designee to determine if the facility is currently able to meet the needs.<br><br>While there is no permanent MDS nurse, an outside agency will be utilized for MDS completion | 07/14/2021 |

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| | lift (lifts specifically designed to secure patients during transfers from a seated position to a standing position) for transfers, which required the assistance of 2 staff to use. She would usually wake up at 3:00 a.m., and wish to get out of bed, be taken to the restroom, and get into her recliner. It was not uncommon, once she put on her call light, to have to wait a long time for the staff on her floor to get staff from another floor to assist with the lift. She had often wet herself due to waiting so long for a staff to come upstairs to assist. There had been instances where she had waited several hours for enough staff to be available to safely operate the lift.<br><br>Resident 24's record was reviewed on 6/9/21 at 12:49 p.m. The profile indicated the resident's diagnoses included, but were not limited to, multiple sclerosis (a chronic, typically progressive disease that involves damage to the sheaths of nerve cells in the brain and spinal cord) and cellulitis (inflammation of subcutaneous connective tissue) of her lower extremities.<br><br>A care plans, dated 4/29/21, indicated the resident had Activities of Daily Living (ADL) self-care performance deficit related to her diagnoses of multiple sclerosis and impaired balance. Interventions included, but were not limited to, the resident required extensive assistance by staff to move between surfaces.<br><br>An admission Minimum Data Set (MDS) assessment, dated 5/4/21, indicated the resident had no cognitive deficit, was an extensive assistance of 2 or more with transfers, was only able to steady with staff assist with transitions, and was frequently incontinent of urine.<br><br>During an interview, on 6/9/21 at 11:14 a.m., | | The Administrator and Human Resource Director are monitoring the hiring process to make sure the hiring process is being completed rapidly and the new staff can work the floor.<br>Every week for two months the Human Resource Director and Administrator will review staff hired and resigned the previous week to ensure we have staff sufficient to meet the needs of our residents. Then it will be monitored twice a month for two months and then once a month ongoing to ensure we have adequate staffing. | |

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| | Certified Nursing Assistant (CNA) 7 indicated she worked the day shift on the lower (health center) floor. Her floor almost always had 2 CNAs, but the 100 hall (upstairs) only had 1 CNA. It required 2 persons to assist Resident 24 with her sit-to-stand lift. She had been called upstairs to assist many times, due to the 100 hall not having enough available staff to safely complete the task.<br><br>During an interview, on 6/9/21 at 11:25 a.m., CNA 8 indicated she worked the day shift on the 100 hall. Resident 24 required 2 persons in order to safely transfer with the sit-to-stand lift. When the resident requested to transfer, she would have to get the nurse to assist her. If the nurse was not available, she would have to call someone from another hall to assist her.<br><br>During an interview, on 6/9/21 at 1:08 p.m., Agency Licensed Practical Nurse (LPN) 9, indicated she had worked at the facility on the 100 hall, 3 shifts in the past 3 weeks. Each time there had been just her and a CNA on the hall.<br><br>2. During a dining observation, on 6/10/21 at 12:28 p.m., on the first floor (100 hall) dining room, Resident 10 indicated she had been sitting in the dining room since 11:20 a.m. and had not yet received her meal tray. At the same time, Resident 232, indicated the wait happened almost every day. She believed it was due to the lack of available staff to serve the trays on the floor.<br><br>During an interview, on 6/10/21 at 12:30 p.m., Cook 14, indicated he was not allowed to begin serving the meal trays until a staff person was present in the dining room to monitor the meal. The staff, on the hall, had to pass the room trays, prior to assisting in the dining room. | | | |

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| | During an interview, on 6/10/21 at 12:33 p.m., Agency CNA 15 indicated she had to serve the room trays, before she was able to go into the dining room to serve. A staff was required to be in the dining room when meals were being consumed.<br><br>Trays were observed to be served to the residents in the dining room at 12:35 p.m.<br>3. The facility failed to ensure a resident was provided showers as preferred for 1 of 3 residents reviewed for choices (Resident 30).<br><br>During an interview, on 06/06/21 at 11:53 a.m., Resident 30 indicated she had requested and was supposed to be on the shower schedule for three showers a week, but that never happened. She did not usually get two showers a week and one time went three weeks without a shower.<br><br>During an interview, on 6/11/21 at 2:37 p.m., the Administrator (ADM) indicated the Certified Nursing Assistant shower aides had to be pulled to perform resident care, therefore the showers became limited due to short staffing.<br><br>Cross Reference F561.<br><br>4. The facility failed to ensure a newly admitted resident's admission Minimum Data Set (MDS) assessment was completed timely (Resident 232) and failed to ensure Minimum Data Set (MDS) assessments were accurate for 6 of 13 residents reviewed for MDS assessment accuracy (Residents 19, 3, 20, 7, and 24).<br><br>During an interview, on 6/9/21 at 10:27 a.m., the Social Services Director (SSD) indicated the facility had no current MDS Coordinator. They had been using a contracted-services consultant | | | |

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| | company to complete all MDS assessments. The company had been coming to the facility weekly to work on the completion of the assessments.<br><br>Cross Reference F636 and F641.<br><br>On 6/11/21 at 1:49 p.m., the Director of Nursing provided and identified a document as a current facility policy, titled "Skilled Staffing," dated 6/11/21, which indicated, "...Policy: It is the policy of this facility to establish staffing ratios based on the facility assessment and ongoing needs of the residents...Direct care staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental and psychosocial well-being...."<br><br>3.1-17(a) | | | |
| F 0732 SS=B Bldg. 00 | 483.35(g)(1)-(4)<br>Posted Nurse Staffing Information<br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:<br>(i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>(A) Registered nurses.<br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>(C) Certified nurse aides.<br>(iv) Resident census. | | | |

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| | §483.35(g)(2) Posting requirements.<br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br>(ii) Data must be posted as follows:<br>(A) Clear and readable format.<br>(B) In a prominent place readily accessible to residents and visitors.<br><br>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br><br>Based on observation, interview, and record review, the facility failed to ensure nurse staffing data was posted daily for 6 of 6 observations of staff postings.<br><br>Findings include:<br><br>On 6/6/21 at 11:00 a.m., observation of the staffing information posted at the ground floor nurses' station was dated 6/4/21. The staffing information was not posted on the first-floor healthcare unit.<br><br>On 6/7/21 at 9:25 a.m., observation of the staffing information posted at the ground floor nurses' station was dated 6/4/21. The staffing information was not posted on the first-floor healthcare unit.<br><br>On 6/8/21 at 10:09 a.m., observation of the staffing | F 0732 | Posted nurse staffing information will be updated daily by the nursing scheduler or designee<br><br>Posted nursing staffing information will be available at each of the skilled nurses' stations in the main lobby<br><br>Audits to ensure daily posting is accurate will be completed daily by designee | 07/14/2021 |

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| | information posted at the ground floor nurses' station was dated 6/4/21. The staffing information was not posted on the first-floor healthcare unit.<br><br>On 6/9/21 at 1:12 p.m., observation of the staffing information posted at the ground floor nurses' station was dated 6/9/21. The staffing information was not posted on the first-floor healthcare unit.<br><br>On 6/10/21 at 11:03 a.m., observation of the staffing information posted at the ground floor nurses' station was dated 6/10/21. The staffing information was not posted on the first-floor healthcare unit.<br><br>On 6/11/21 at 10:02 a.m., observation of the staffing information posted at the ground floor nurses' station was dated 6/11/21. The staffing information was not posted on the first-floor healthcare unit.<br><br>During an interview, on 6/11/21 at 1:45 p.m., the Director of Nursing (DON) indicated the staffing information was posted at the ground floor nurses' station and should have been updated daily. The residents on the first floor would need to request to see it. She was not aware the staffing information needed to be readily available without the residents needing to ask.<br><br>On 6/11/21 at 1:49 p.m., the DON provided and identified a document as a current facility policy, titled "Nurse Staffing Posting Information," dated 11/11/20, which indicated, "...Policy: It is the policy of this facility to make staffing information readily available in a readable format to residents and visitors at any given time...The Daily Staffing Sheet will be posted on a daily basis and will contain the following information: ...Facility name...The current date...Facility's current resident | | | |

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| | census...The facility will post the Daily Staffing Sheet each day...The information posted will be...In a prominent place readily accessible to residents and visitors...."<br><br>3.1-13(i)(4) | | | |
| 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 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 | | | |

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| | 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>Based on record review and interview, the facility failed to ensure a physician documented response when a pharmacy recommendation was made for 3 of 5 residents reviewed for unnecessary medications (Residents 19, 26, and 30).<br><br>Findings include:<br><br>1. A record review was completed for Resident 19 on 6/7/21 at 11:45 a.m. Diagnosis included but were not limited to gastroesophageal reflux disease (Gerd) and clostridium difficile infection (cdi).<br><br>A pharmacy consultation report, dated 4/21/21, indicated the resident received pantoprazole (proton pump inhibitor [ppi]) 40 milligrams (mg) daily and had recently been diagnosed with cdi. A recommendation indicated to evaluate the risk verses the benefit of continued ppi use. The use of ppi may be associated with an increased risk of cdi recurrence. The report lacked documentation of a physician's response.<br><br>A care plan, initiated 4/23/21, indicated the resident was on antibiotic therapy related to cdi.<br><br>A care plan, initiated 4/23/21, indicated the | F 0756 | All pharmacy recommendations will be emailed to the DON or designee who will audit weekly to ensure the recommendations are addressed by the physician and implemented in a timely manner.<br><br>Audits for the month of June will be completed to determine if any other residents have been affected by this deficiency.<br><br>This plan will be reviewed at QAPI for no less than 6 months and until 100% compliance is reached. | 07/14/2021 |

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| | resident had Gerd. Interventions included but were not limited to administer medications as ordered and monitor/document the side effects and effectiveness.<br><br>2. A record review was completed for Resident 26 on 6/9/21 at 10:34 a.m. A diagnosis included but was not limited to hypertension (high blood pressure).<br><br>A pharmacy consultation report, dated 3/10/21, indicated the resident had an order for an as needed (prn) diuretic, Lasix 20 milligrams (mg) every day in the afternoon related to edema. The recommendation indicated to please contact the prescriber and clarify the order to include a specific, measurable, set of instructions for administration (e.g., as needed for weight gain of 2 pounds in 2 days, repeat as needed every 2 days, report to prescriber if ineffective). The report lacked documentation of a physician's response.<br><br>A current physician order indicated Lasix 20 mg every day in the afternoon related to edema.<br><br>A review of physician orders, dated 3/10/21 to 6/9/21, lacked documentation of a resident specific set of criteria for administration of the prn diuretic.<br><br>A care plan, revised 3/18/21, indicated the resident had hypertension. Interventions included, but were not limited to, administer medications as ordered, monitor for and document any edema.<br><br>During an interview, on 6/11/21 at 10:04 a.m., the Director of Nursing (DON) indicated the physician should document a response if he agreed or disagreed with the recommendation and a rationale of why if he disagreed. 3. Resident 30's record was reviewed, on 6/8/21 at 10:42 a.m., | | | |

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| | diagnoses included but were not limited to urinary tract infection (UTI) recurrence, anxiety, and osteoporosis (medical condition in which the bones become brittle and fragile from loss of tissue, typically as a result of hormonal changes, or deficiency of calcium or vitamin D).<br><br>A pharmacy consultation report, dated 9/8/20, indicated, "... [Resident 30's name] received cranberry concentrate 500 mg (milligrams) BID (twice a day) for prevention of urinary tract infection (UTI) recurrence ...Recommendation: Please consider discontinuing cranberry supplement ...Rationale for Recommendation: Cranberry supplements have not been shown to be helpful in decreasing UTI recurrence in older adults ...." The report lacked documentation of a physician's response to the recommendation.<br><br>A physician's order, dated 2/1/21, indicated a medication order of cranberry concentrate capsule 500 mg to give 1 capsule by mouth two times a day related to personal history of urinary (tract) infections.<br><br>A pharmacy consultation report, dated 9/8/20, indicated, " ...[Resident 30's name] received venlafaxine ER (extended release) 150 mg QD (every day) since 9/27/19 for anxiety ...Recommendation: Resident's venlafaxine is due for review for the initial attempt at a gradual dose reduction (GDR)...Rationale for Recommendation: A GDR should be attempted in 2 separate quarters, with at least 1 month between attempts, within the first year in which an individual is admitted on a psychotropic medication or after the facility has initiated such medication, and then annually unless clinically contraindicated ...." The report lacked documentation of a physician's response to the recommendation. | | | |

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| | A physician's order, dated 3/15/21, indicated a medication order of Venlafaxine HCL (hydrochloride) ER (extended release 24 hour) 75 mg to give 1 capsule by mouth at bedtime for major depressive disorder.<br><br>A pharmacy consultation report, dated 2/11/21, indicated, "... [Resident 30's name] received 2 or more active osteoporosis treatments, Calcitonin nasal spray and Prolia, concomitantly ...Recommendation: Please consider discontinuing calcitonin nasal spray while continuing Prolia ...." The report lacked documentation of a physician's response to the recommendation.<br><br>A physician's order, dated 2/8/21, indicated a medication of Prolia solution prefilled syringe 60 mg/ml to injection 1 milliliter subcutaneously in the afternoon every 6 months starting on the 8th for 1 day related to age-related osteoporosis without current pathological fracture.<br><br>A physician's order, dated 2/2/21, indicated a medication of Calcitonin (Salmon) solution 200 unit/act to give 1 spray alternating nostrils one time a day related to age- related osteoporosis without current pathological fracture.<br><br>On 6/8/21 at 9:03 a.m., the Director of Nursing (DON) indicated if a pharmacy consultation report does not have a physician's response on it, the physician had not addressed the pharmacy recommendation.<br><br>On 6/8/21 at 1:31 p.m., DON indicated the pharmacy emailed her the monthly recommendations. She printed out the pharmacy medication recommendations and gave them to the physician. The facility had identified there was | | | |

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| | an issue with the pharmacy recommendations being completed by the physician.<br><br>The DON, on 6/8/21 at 1:50 p.m., provided and identified a document as a current facility policy, titled "Medication Regimen Review," dated 5/20/21, which indicated, "...Policy: The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart...Policy explanation and compliance guidelines: ...Medication Regimen Review (MRR), or Drug Regimen Review, is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication...Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities...."<br><br>3.1-25(j) | | | |
| F 0757 SS=D Bldg. 00 | 483.45(d)(1)-(6)<br>Drug Regimen is Free from Unnecessary Drugs<br>§483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications | | | |

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| | for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br>Based on record review and interview, the facility failed to ensure medications were administered and daily weights were obtained as ordered by the physician and the physician had been notified for 2 of 5 residents reviewed for unnecessary medications (Residents 19 and 26).<br><br>Findings include:<br><br>1. A record review was completed for Resident 19 on 6/7/21 at 11:45 a.m. Diagnoses included, but were not limited to type II diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), chronic kidney disease (longstanding disease of the kidneys leading to renal failure), and congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should).<br><br>A Treatment Administration Record (TAR), start dated 4/23/21 and discontinued on 5/28/21, indicated a daily weight for congestive heart failure. The TAR lacked documentation this had been completed on 4/23/21, 4/25/21, 4/26/21, 4/29/21, and 4/30/21. The record lacked documentation the physician had been notified.<br><br>A Medication Administration Record (MAR), dated May 2021, indicated Lantus Solostar solution pen (insulin) 100 unit/milliliter (ml). Inject 10 units subcutaneously at bedtime for diabetes | F 0757 | See F0692 for daily weight POC<br><br>The policy "Medication Administration" has been updated to include contacting the physician if a medication is not given and to document their response.<br><br>An audit for the month of July will be completed to determine if other residents are affected by this deficiency<br><br>All nursing staff will be educated on the updated policy<br><br>Audits on the medication administration record will be completed daily x 6 weeks; weekly x 2 months; and monthly ongoing<br><br>This plan will be reviewed during QAPI for no less than 6 months and until at least 95% compliance is reached | 07/14/2021 |

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| | mellitus. The MAR lacked documentation the insulin had been administered on 5/2/21, 5/6/21, 5/12/21, 5/19/21, 5/20/21 due to the resident sleeping and was blank on 5/11/21. The record lacked documentation the physician had been notified.<br><br>A MAR, dated May 2021, indicated accu-checks (blood sugar monitoring) before meals and at bedtime.<br>Blood sugar (bs) readings indicated at 7:00 a.m. on 5/3/21 bs was 188, on 5/13/21 bs was 218, on 5/20/21 bs was 193, and 5/21/21 bs was 175. At bedtime on 5/2/21 bs was 250, on 5/12/21 bs was 266, on 5/19/21 bs was 211, and 5/20/21 bs was 236.<br><br>A TAR, dated May 2021 and discontinued on 5/28/21, indicated a daily weight for congestive heart failure. The TAR lacked documentation this had been completed on 5/3/21, 5/9/21, 5/11/21, 5/14/21 through 5/16/21, and 5/19/21 through 5/21/21. The record lacked documentation the physician had been notified.<br><br>A MAR, dated June 2021, indicated Lantus Solostar solution pen 100 unit/ml. Inject 10 units subcutaneously at bedtime for diabetes mellitus. The MAR indicated the insulin not administered on 6/2/21 and 6/3/21 due to the resident sleeping.<br><br>A care plan, initiated 4/23/21, indicated the resident had diabetes mellitus. Interventions included, but were not limited to, administer medication as ordered by physician and monitor and document side effects and effectiveness.<br><br>A care plan, initiated 4/23/21, indicated the resident had renal insufficiency/chronic kidney disease. Interventions included, but were not | | | |

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| | limited to, monitor/document/report as needed edema or weight gain of over 2 pounds (lbs.) a day.<br><br>2. During an interview, on 6/6/21 at 10:33 a.m., Resident 26 indicated there were two times during evening shift where she had not received her medication. She was unable to remember the exact dates but felt that should not have happened.<br><br>A record review was completed for Resident 26 on 6/9/21 at 10:34 a.m. A review of a quarterly Minimum Data Set (MDS) assessment, dated 5/5/21, indicated the resident was cognitively intact.<br><br>Diagnoses included but were not limited to atrial fibrillation (a fib [an irregular, often rapid heart rate that commonly causes poor blood flow]) and type II diabetes mellitus (a chronic condition that affects the way the body processes blood sugar).<br><br>A Medication Administration Record (MAR), dated April 2021, indicated Novolog Flex Pen Solution Pen-injector inject as per sliding scale: if 0 to 79 give 0 units; 80 to 199 give 4 units; 200 to 299 give 6 units; 300 to 999 give 8 units, subcutaneously before meals for type 2 diabetes mellitus. The MAR lacked documentation this had been completed at 11:00 a.m. on 4/25/21, and 4:00 p.m. on 4/23/21 and 4/25/21. The record lacked documentation the physician had been notified.<br><br>A MAR, dated April 2021, indicated Coumadin (anticoagulant) give 5 milligrams (mg) by mouth in the evening for a fib. The TAR lacked documentation this had been administered on 4/23/21 and 4/25/21. The record lacked documentation the physician had been notified. | | | |

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| | A care plan, initiated 2/12/21, indicated the resident had diabetes mellitus. Interventions included, but were not limited to, administer medication as ordered by physician and monitor and document side effects and effectiveness.<br><br>A care plan, initiated 2/12/21, indicated the resident received anticoagulant therapy related to a fib. Interventions included, but were not limited to, administer medication as ordered by physician and monitor and document side effects and effectiveness.<br><br>On 6/8/21 at 9:05 a.m., the Director of Nursing (DON) provided a document, implemented on 6/11/21, and titled, "Medication Orders," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: This facility shall use uniform guidelines for the ordering of medication. Policy Explanation and Compliance Guidelines: 1. medications should be administered only upon the signed order of a person lawfully authorized to prescribe...4. Documentation of Medication Orders: ...d. If using electronic medication records, input the medication order according to the electronic health record (EHR) instructions...."<br><br>On 6/9/21 at 3:17 p.m., the DON provided a document, implemented on 5/20/21, and titled, "Medication Administration," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines: ...4. Cleanse hands prior to administering medication | | | |

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| | per facility protocol and product...10. Review MAR to identify medication to be administered...19. Report and document any adverse side effects or refusals...."<br><br>3.1-48(a)(3) | | | |
| F 0758 SS=D 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---<br><br>§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 | | | |

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| | 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 record review and interview, the facility failed to ensure pharmacy recommendations were addressed and an Abnormal Involuntary Movement Scale (AIMS) test was completed timely for a resident who received a psychotropic medication for 1 of 5 residents reviewed for unnecessary medications (Resident 22).<br><br>Findings include:<br><br>Resident 22's medical record was reviewed on 6/7/21 at 1:25 p.m. Diagnoses included but were not limited to, psychotic disorder and hallucinations.<br><br>A quarterly Minimum Data Set (MDS) assessment, dated 4/28/21, indicated the resident had no cognitive impairment and received antipsychotic medication routinely.<br><br>A current physician's order, dated 2/5/21, indicated olanzapine tablet (antipsychotic | F 0758 | When psychotropic medications are ordered, an abnormal involuntary movement scale (AIMS) assessment will be completed upon ordering (upon admission of a new resident) and quarterly thereafter<br><br>DON completed a medication review of all skilled residents to determine if other residents were affected by this deficiency<br><br>DON or designee will ensure that an AIMS assessment is scheduled quarterly for residents currently taking a psychotropic medication<br><br>This plan will be reviewed in QAPI for no less than 6 months and until 95% compliance is reached | 07/14/2021 |

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| | medication) give 5 milligrams by mouth two times a day for hallucinations.<br><br>A pharmacy consultation report, dated 2/11/21, indicated, "...[Resident 22's name] receives OLANZAPINE which may cause involuntary movements including tardive dyskinesia (TD) (involuntary neurological movement disorder), but an Abnormal Involuntary Movement Scale (AIMS) or Dyskinesia Identification System: Condensed User Scale (DISCUS) assessment was not documented in the medical record within the previous 6 months...Recommendation: Please monitor for involuntary movements now and at least every 6 months or per facility protocol...Rationale for recommendation: Early detection of involuntary movements can prevent potentially irreversible TD...." Resident 22's record lacked documentation the pharmacy recommendation was addressed, or an AIMS assessment was completed.<br><br>A pharmacy consultation report, dated 3/10/21, indicated, "...REPEATED RECOMMENDATION from 2/11/21: Please respond promptly to assure facility compliance with Federal regulations... [Resident 22's name] receives OLANZAPINE which may cause involuntary movements including tardive dyskinesia (TD) (involuntary neurological movement disorder), but an Abnormal Involuntary Movement Scale (AIMS) or Dyskinesia Identification System: Condensed User Scale (DISCUS) assessment was not documented in the medical record within the previous 6 months...Recommendation: Please monitor for involuntary movements now and at least every 6 months or per facility protocol...Rationale for recommendation: Early detection of involuntary movements can prevent potentially irreversible TD...." Resident 22's record | | | |

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| | lacked documentation the pharmacy recommendation was addressed, or an AIMS assessment was completed.<br><br>A pharmacy consultation report, dated 4/12/21, indicated, "...REPEATED RECOMMENDATION from 2/11/21 and 3/10/21: Please respond promptly to assure facility compliance with Federal regulations...[Resident 22's name] receives OLANZAPINE which may cause involuntary movements including tardive dyskinesia (TD) (involuntary neurological movement disorder), but an Abnormal Involuntary Movement Scale (AIMS) or Dyskinesia Identification System: Condensed User Scale (DISCUS) assessment was not documented in the medical record within the previous 6 months...Recommendation: Please monitor for involuntary movements now and at least every 6 months or per facility protocol...Rationale for recommendation: Early detection of involuntary movements can prevent potentially irreversible TD...." Resident 22's record lacked documentation the pharmacy recommendation was addressed, or an AIMS assessment was completed.<br><br>An AIMS assessment was completed for Resident 22 on 5/18/2021 with a physician's order to complete an AIMS assessment every six months.<br><br>During an interview, on 6/8/21 at 1:35 p.m., the Director of Nursing (DON) indicated the pharmacy recommendations should have been addressed and the resident should have had an AIMS assessment completed quarterly, according to the facility policy. At that time, the DON provided a document and identified it as a current facility policy, titled "Use of Psychotropic Drugs," dated 5/21/21, which indicated, "...Policy: Residents are not given psychotropic drugs unless the | | | |

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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 |
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| | medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s)...Residents who receive an antipsychotic medication will have an Abnormal Involuntary Movement Scale (AIMS) test performed on admission, quarterly, with a significant change in condition, change in antipsychotic medication, PRN (as needed) or as per facility policy...."<br><br>On 6/8/21 at 1:50 p.m., the DON provided and identified a document as a current facility policy, titled "Medication Regimen Review," dated 5/20/21, which indicated, "...Policy: The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart...Policy explanation and compliance guidelines: ...Medication Regimen Review (MRR), or Drug Regimen Review, is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication...Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities...."<br><br>3.1-48(b)(1)<br>3.1-48(b)(2) | | | |
| F 0760<br>SS=D<br>Bldg. 00 | 483.45(f)(2)<br>Residents are Free of Significant Med Errors<br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>Based on record review and interview, the facility | F 0760 | An audit will be completed on all | 07/14/2021 |

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| | 155758 | A. BUILDING 00<br>B. WING | 06/14/2021 |

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| | failed to ensure medications were administered as ordered by the physician for 1 of 5 residents reviewed for significant medication errors (Residents 26).<br><br>Findings include:<br><br>A record review was completed for Resident 26 on 6/9/21 at 10:34 a.m. A diagnosis included but was not limited to hypertension (high blood pressure).<br><br>A review of a quarterly Minimum Data Set (MDS) assessment, dated 5/5/21, indicated the resident was cognitively intact.<br><br>A Medication Administration Record (MAR), dated April 2021, indicated diltiazem (antihypertensive) extended release (er) 240 milligrams (mg), give 1 capsule at bedtime for hypertension hold if systolic blood pressure was less than (<) 85. The MAR indicated the medication was administered on 4/12/21 with a blood pressure (b/p) reading of 81/40. The medication was also administered on the following dates in conjunction with diltiazem 180 mg: 4/22/21, 4/25/21, 4/26/21, 4/27/21, 4/29/21, and 4/30/31.<br><br>A physician progress note, dated 4/19/21 at 7:45 a.m., indicated the resident had hypertension and b/p had been low and to decrease diltiazem to 180 mg per day.<br><br>A MAR, dated April 2021, indicated diltiazem er 180 mg, give 1 capsule by mouth at bedtime. The MAR indicated the medication was administered on the following dates in conjunction with diltiazem 240 mg: 4/22/21, 4/25/21, 4/26/21, 4/27/21, 4/29/21, and 4/30/31. | | orders for the month of July to determine what other residents may have been affected by this deficiency.<br><br>DON or designee will audit all medication orders daily (or during next normal business if a weekend or holiday) to ensure correct entry. During non-normal business hours, the DON will designate another licensed staff members to perform this audit.<br><br>This plan will be reviewed in QAPI for no less than 6 months and until at least 95% compliance is reached | |

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| | A MAR, dated May 2021 and discontinued 5/8/21, indicated diltiazem er 240 mg, give 1 capsule at bedtime for hypertension hold if systolic blood pressure was < 85. The MAR indicated the medication was administered on 5/7/21 with a b/p reading of 84/64. The medication was also administered on the following dates in conjunction with diltiazem 180 mg: 5/1/21 and 5/3/21.<br><br>A MAR, dated April 2021, indicated diltiazem er 180 mg, give 1 capsule by mouth at bedtime. The MAR indicated the medication was administered on the following dates in conjunction with diltiazem 240 mg: 5/1/21 and 5/3/21.<br><br>The record lacked documentation the physician had been notified the antihypertensive medication was not reduced as ordered and the resident received two different doses of the medication at bedtime.<br><br>A care plan, revised 3/18/21, indicated the resident had hypertension. Interventions included, but were not limited to, administer medications as ordered. Monitor for side effects such as orthostatic hypotension and increased heart rate.<br><br>During an interview, on 6/11/21 at 10:04 a.m., the Director of Nursing indicated the antihypertensive medication should have been reduced on 4/19/21 per the physician's progress note. She was unsure what had happened.<br><br>On 6/8/21 at 9:05 a.m., the Director of Nursing (DON) provided a document, implemented on 6/11/21, and titled, "Medication Orders," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: This facility shall use uniform guidelines for the | | | |

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| | ordering of medication. Policy Explanation and Compliance Guidelines: 1. medications should be administered only upon the signed order of a person lawfully authorized to prescribe...4. Documentation of Medication Orders: ...d. If using electronic medication records, input the medication order according to the electronic health record (EHR) instructions...."<br><br>3.1-4(c)(2) | | | |
| F 0761 SS=D Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. | | | |

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| | Based on observation, interview and record review, the facility failed to ensure medication storage refrigerator temperatures were taken and documented for 2 of 2 medication refrigerators observed, a resident's liquid medication was labeled (Resident 19), and an opened vial of Tuberculin (TB) (a solution of a combination of proteins that are used in the diagnosis of tuberculosis, administered as an intradermal [under the skin] test) had an opened date during 2 of 2 medication rooms observations.<br><br>Findings include:<br><br>1. During an observation of first floor medication storage refrigerator, on 6/11/21 at 9:46 a.m., the daily temperature log, dated June 2021, indicated the temperature had been taken on 6/2/21, 6/3/21, 6/7/21, and 6/10/21. The logs lacked documentation of the other dates for the month. At the same time, Registered Nurse (RN) 22 indicated the refrigerator temperature should be obtained and documented daily.<br><br>2. During an observation of the health center medication storage refrigerator on 6/11/21 at 10:34 a.m., the following were observed:<br><br>a. The daily temperature log, dated June 2021, indicated the temperature had been taken on 6/3/21, 6/4/21, 6/7/21, and 6/11/21. The logs lacked documentation of the other dates for the month. At the same time, Licensed Practical Nurse (LPN) 23 indicated the requirement was for the temperature to be monitored daily and documented on the temperature log.<br><br>b. An unlabeled bottle of Vancomycin | F 0761 | Nursing staff will be re-educated on the policy "Storage of Medication Requiring Refrigeration"<br><br>All skilled refrigerators will be audited to determine what other residents may be affected by this deficiency.<br><br>Audits on refrigerated medication and temperature logs will be conducted daily x 6 weeks; weekly x 2 week; then monthly ongoing<br><br>This plan will be reviewed in QAPI for no less than 6 months and until 95% compliance is reached. | 07/14/2021 |

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| | Hydrochloride solution (antibiotic used in the prophylaxis [prevention] and treatment of infections caused by Gram-positive bacteria), 250 milligram (mg) per 5 milliliters (ml). The bottle lacked documentation of the name of the resident it had been prescribed to and an opened date. The bottle appeared to be empty. At the same time, LPN 23 indicated she had no resident who on this medication, at this time. She believed that the medication may have belonged to Resident 19, as the resident was currently prescribed the same medication in pill form.<br><br>Resident 19's record was reviewed on 6/11/21 at 11:04 a.m. The physician's orders indicated the resident had been prescribed the Vancomycin Hydrochloride solution and the order had been discontinued on 5/11/21.<br><br>c. An opened vial of Tuberculin solution was observed. The vial lacked documentation of a date the vial had been opened.<br><br>On 6/11/21 at 1:49 p.m., the Director of Nursing (DON) provided a document, dated 6/11/21, titled, "Storage of Medication Requiring Refrigeration," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy Explanation and Compliance Guidelines: ...2. The facility will ensure that all drugs and biologicals used will be labeled in accordance with professional standards...4. Refrigerators used for the storage of medications and biologicals: ...f. Temperature to be monitored daily to ensure proper temperature control and documented on the temperature log with date, time, and signature of person performing the check clearly written...6. Mechanisms to minimize loss/diversion: ...d. Date label of any multi-use vial in first accessed (needle puncture), the vial should be dated and discarded | | | |

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| | within 28 days...7, Accurate labeling of precautions and safe administration...d. Resident name, e. Route of administration, f. Appropriate instructions/precautions...."<br><br>3.1-25 (j)<br>3.1-25(k)(1)<br>3.1-25(k)(2)<br>3.1-25(m) | | | |
| F 0790 SS=D Bldg. 00 | 483.55(a)(1)-(5)<br>Routine/Emergency Dental Srvcs in SNFs<br>§483.55 Dental services.<br>The facility must assist residents in obtaining routine and 24-hour emergency dental care.<br><br>§483.55(a) Skilled Nursing Facilities<br>A facility-<br><br>§483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident;<br><br>§483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services;<br><br>§483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility;<br><br>§483.55(a)(4) Must if necessary or if requested, assist the resident;<br>(i) In making appointments; and | | | |

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| | (ii) By arranging for transportation to and from the dental services location; and<br><br>§483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.<br><br>Based on interview and record review, the facility failed to offer ancillary services and provide dental services to 2 of 13 residents reviewed for dental services (Residents 24 and 7).<br><br>Findings include:<br><br>1. During an interview, on 6/6/21 at 12:07 p.m., Resident 24 indicated the facility had not yet offered her an opportunity to see a dentist. She only had 5 teeth on her upper jaw and wore a lower denture. She wanted to see a dentist to get her upper teeth removed and see if she could get a denture for her upper jaw.<br><br>Resident 24's record was reviewed on 6/9/21 at 12:49 p.m. A facility census indicated the resident had been admitted on 4/27/21, with admitting diagnosis which included, but was not limited to, multiple sclerosis (a chronic, typically progressive disease that involves damage to the sheaths of nerve cells in the brain and spinal cord).<br><br>An admission nursing assessment, dated 4/27/21, indicated the resident had 4 natural teeth and no dentures. | F 0790 | All admission packets will include information about ancillary services and residents/caregivers will indicate which service they chose to utilize (completed).<br><br>Ancillary service preferences will be reviewed at each plan of care meeting and changes will be made as needed.<br><br>An audit will be completed to update each individual ancillary preference<br><br>An audit will be completed on 10% of the skilled residents by SSD based on the following schedule: weekly x 2 months; monthly x 2 months; quarterly thereafter. | 07/14/2021 |

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| | A nursing progress note, dated 4/27/21 at 4:32 p.m., indicated the resident had arrived at the facility via facility transportation, at 12:40 p.m. The note further indicated the resident had 4 natural teeth and no dentures.<br><br>An admission Minimum Data Set (MDS), dated 5/4/21, indicated the resident had no cognitive deficit and had no documented dental conditions.<br><br>Review of the resident's care plans, indicated no dental care plan had been developed.<br><br>During an interview, on 6/10/21 at 9:10 a.m., the Social Services Director (SSD) indicated she was unable to locate any documentation which indicated ancillary services were offered to Resident 24 at her admission, and the resident had not yet been seen by a dentist. The facility had just started including the ancillary services, "Request for Service," documents into their admissions packet on 5/21/21. She was unsure how ancillary services were offered to the residents prior to the form being placed in the admission packet.<br><br>On 6/10/21 at 10:00 a.m., the SSD provided a document, dated 6/10/21, titled, "Request for Service." The document indicated Resident 24 had requested to be seen by Eye care and Podiatry services. The resident had declined Audiology services. The document was signed by the resident on 6/10/21.<br><br>On 6/10/21 at 10:00 a.m., the SSD provided a document, dated 6/10/21, titled, "Application For Limited Benefit In Facility Dental Policy," and indicated the document demonstrated the resident had elected to receive dental services. The document had been signed by the resident on | | | |

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| | 6/10/21.<br>2. During an interview, on 6/6/21 at 11:42 a.m., Resident 7 indicated did not have any teeth or dentures. She wanted to get dentures but had not been offered to see the dentist.<br><br>Resident 7's record was reviewed on 6/10/21 at 9:50 a.m. An admission Minimum Data Set (MDS) assessment, dated 3/30/21, indicated the resident was cognitively intact. The assessment lacked documentation the resident was edentulous (no natural teeth or tooth fragments).<br><br>Census information indicated the resident admitted to the facility on 3/23/21.<br><br>A nursing admission assessment, dated 3/23/21, lacked documentation the resident was edentulous, did not have dentures, or had been offered to see the dentist.<br><br>A social services note, dated 3/31/21, lacked documentation the resident was edentulous, did not have dentures, or had been offered to see the dentist.<br><br>Current care plans lacked documentation the resident was edentulous.<br><br>During an interview, on 6/10/21 at 9:10 a.m., the Social Services Director (SSD) indicated she was unable to locate any documentation the resident was offered to see the dentist since her admission to the facility. They had just started putting the forms for the residents to indicate which ancillary services they desired in the admissions packets on 5/21/21. She was unsure how ancillary services were offered to residents prior to that date. The resident had not visited or been offered a visit with a dentist. | | | |

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| | During an interview on 6/10/21 at 11:35 a.m., the Director of Nursing (DON) indicated if a resident was edentulous it should have been documented on the nursing admission assessment. She was not sure if there should have been a dental status care plan.<br><br>On 6/10/21 at 9:59 a.m., the SSD provided a document titled, "Ancillary Services," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: It is the policy...to ensure that residents have access to and receive proper treatment regarding...hearing...Policy Explanation and Compliance Guidelines: ...2. Employees should refer any identified need for ancillary services/appliances to the social service designee...The social service designee will alert the supplies clerk...of the change or addition in services. The supplies clerk will fax the information...3. The social service designee and supplies clerk will collaborate with family and residents in signing up for additional in house services. If outside services are warranted, the Life Enrichment Director will set up the appointment and transportation for the resident. 4. Upon admission, ancillary services will be explained and offered in the admission packet...."<br><br>3.1-24(a)(1) | | | |
| F 0867<br>SS=G<br>Bldg. 00 | 483.75(g)(2)(ii)<br>QAPI/QAA Improvement Activities<br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee must:<br>(ii) Develop and implement appropriate plans | | | |

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| | of action to correct identified quality deficiencies;<br><br>Based on observation, record review, and interview, the facility failed to ensure issues were identified in which quality assessment and assurance activities were necessary as evidenced by the severity and number of deficiencies cited and to ensure active quality assessment and performance improvement (QAPI) plans were implemented to prevent deficiencies from re-occurring. This had the potential to affect 30 residents residing in the facility.<br><br>Findings include:<br><br>On 6/6/21 at 3:00 p.m., the Director of Nursing (DON) provided and identified a document as the current facility policy, titled "Facility QAPI (Quality Assessment and Assurance/Performance Improvement) Plan," dated 2014. The policy indicated, " ...Our vision is to create a safe and secure person centered care environment where people are valued for their contributions, past and present, nurturing individuality and independence ...The purpose of QAPI in our facility is to focus on our vision and mission by including all residents, staff members, and family members in the performance improvement process to support a safe and secure care environment that nurtures meaningful relationships ...Our care practices are guided by a structured Quality Assurance and Performance Improvement process ...We focus on systems and processes and encourage our staff to identify potential errors and system breakdowns ...We set goals to improve performance, measure our progress towards the goal, and revise the goal when necessary ...."<br><br>During this recertification survey, 6/6/21 to | F 0867 | A Braden assessment was completed on all residents on 06/09/21. Skin assessments were completed on all skilled residents on 06/10/21. Wound assessments will be addressed monthly at the QAPI meeting for six months and ongoing.<br><br>The nursing staff will be re-educated on fall prevention and follow up. This deficiency effects all residents as they are all considered a fall risk. Falls will be reviewed in QAPI as a PIP (minimum of 6 months) until the facility fall rate is below 5%.<br><br>The Human Resource Director and Administrator will review weekly the staff hired and resignations to ensure we have adequate coverage to meet the needs of the residents. This will be monitored weekly for two months, twice a month for two months and monthly thereafter. This will be added to our monthly QAPI meeting.<br><br>Audits were completed in June and July to determine if any other residents were affected by not following our pharmacy recommendation policy and by the failure to include contacting the physician if a medication is not given and to document their response. This plan will be | 07/14/2021 |

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| | 155758 | A. BUILDING 00<br>B. WING | 06/14/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| ASBURY TOWERS HEALTH CARE CENTER | 102 W POPLAR ST<br>GREENCASTLE, IN 46135 |

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| | 6/11/21, one deficiency was cited at immediate jeopardy harm level- F686 J. The facility also received twenty-three additional deficiencies cited at potential for harm F550, F561, F577, F636, F641, F657, F660, F661, F685, F689, F692, F698, F725, F732, F756, F757, F758, F760, F761, F790, and F880. The facility was cited F686 at harm and F761 at potential for harm on the previous recertification survey and F880 at potential for harm was cited on the two previous recertification surveys.<br><br>The facility's Quality Assurance Committee did not identify, develop, and implement appropriate measures to prevent deficiencies as follows:<br><br>1. Pressure ulcers:<br><br>The facility failed to prevent pressure ulcers from worsening, complete follow-up assessments, track wound progression, follow interventions, and notify the physician with worsening of wounds up to and including, infections for 1 of 2 residents reviewed for pressure ulcers resulting in Resident 19's stage II (partial thickness loss of dermis) pressure ulcer progressing to a stage III (full thickness tissue loss where subcutaneous fat may be visible) pressure ulcer and developing osteomyelitis (bone infection) requiring hospitalization and surgical debridement resulting in a stage IV (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer.<br><br>The facility failed to prevent pressure ulcers, complete follow-up assessments, follow interventions, and notify the physician resulting in the potential for harm that was not immediate jeopardy to 1 of 2 residents reviewed for pressure ulcers (Residents 3).<br><br>There was no evidence the facility had identified, | | reviewd at QAPI no less than 6 months and until 95% compliance is reached.<br><br>All skilled charts reviewed to determine how many had a significant weight loss in the past 3 months and interventions put into place. This information will be brought before the QAPI meeting held monthly. It will be monitored ongoing by the QAPI team.<br><br>QAPI assessment tool completed 06/29/2021 to identify areas of improvement<br><br>QAPI policy and procedures will be reviewed and updated based on QAPI assessment tool during July QAPI meeting and monthly at the QAPI meetings to be continued ongoing.<br><br>QAPI performance improvement plan will be developed based on QAPI assessment tool and updated policy and procedures<br><br>Administrator or designee will oversee QAPI performance improvement plan and continue to audit QAPI process to ensure all requirements are being met. | |

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| | developed, or implemented an action plan with measures to prevent the occurrence and worsening of pressure ulcers<br><br>Cross reference F686.<br><br>2. Accidents:<br>The facility failed to implement fall interventions and follow post fall procedures resulting in a resident sustaining a fractured hip after a fall for 1 of 1 resident reviewed for falls (Resident 26).<br><br>There was no evidence the facility had identified, developed, or implemented an action plan to ensure fall interventions and post fall procedures were followed.<br><br>Cross reference F689.<br><br>3. Sufficient Nursing Staff:<br>The facility failed to ensure sufficient staffing to accommodate safe transfer when using a lift (Resident 24) for 1 of 1 resident reviewed for lift safety, to ensure timely dining service to 2 residents observed during 1 of 1 dining observation (Residents 10 and 232), to accommodate a resident's preference related to showers for 1of 3 residents reviewed for choices (Resident 30), and to complete Minimum Data Set (MDS) assessments timely and accurately for 6 of 13 residents reviewed for MDS assessment accuracy (Residents 19, 3, 20, 7, and 24).<br><br>There was no evidence the facility had identified, developed, or implemented an action plan to ensure sufficient nursing staff for a resident's accommodations of safe and timely lift transfers, timely dining service for residents, and residents received scheduled showers. | | | |

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| | Cross reference F725.<br><br>4. Drug regimen is free from unnecessary drugs:<br>One resident's medication was not administered and was without physician notification, daily weights were not obtained for another resident, and pharmacy recommendations were not addressed for a resident who received an antipsychotic medication for 3 of 5 residents reviewed for unnecessary medications.<br><br>There was no evidence the facility had identified, developed, or implemented an action plan to ensure medications were administered according to the physician's orders, the physician was notified of a missed dose of medication, daily weights were monitored, and pharmacy recommendations were addressed by the facility.<br><br>Cross reference F757 and F758.<br><br>5. Nutrition:<br>The facility failed to ensure interventions were put in place when a resident lost weight, and the physician and resident representative were notified of the weight loss for 1 of 2 residents reviewed for nutrition (Resident 3).<br><br>Cross reference F692.<br><br>During an interview, on 6/11/21 at 2:37 p.m., the Administrator (ADM) indicated the QAPI team met monthly, and team members brought concerns to the meetings to be addressed, so that they could find resolutions to the problems. The DON was fairly new to the facility. She had been at the facility for less than a year. The former DON brought pressure ulcers to QAPI, but after the new DON started, the issue of pressure ulcers was dropped. The pharmacy reviews of the physician | | | |

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| | not addressing the recommendations was overlooked due to COVID-19. The staffing was horrible, and it was hard to hire staff. The facility had had to use agency staff since COVID-19 started. They had to pull Certified Nursing Aides (CNA) shower aides to perform resident care, therefore the showers became limited due to the short staffing.<br><br>3.1-52(b)(2) | | | |
| F 0880 SS=D Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must | | | |

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

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| | The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>Based on observation, interview, and record review, the facility failed to ensure infection control practices for were implemented for a newly admitted resident with a clostridium difficile infection (cdi) on transmission based precautions (tbp) for 1 of 1 residents reviewed for tbp (Resident 19) and failed to ensure proper infection control practices were used for a resident during 1 of 3 medication administration observations (Resident 10).<br><br>Findings include:<br><br>1. During an observation, on 6/7/21 at 11:52 a.m., a sign on Resident 19's door indicated the resident was on transmission-based precautions. A Certified Nursing Assistant (CNA) 4 was observed to enter Resident 19's room with no gown or gloves in place. At this time, CNA 4 indicated she should have had the required personal protective equipment (ppe) on due to the resident was on tbp for cdi and COVID-19 precautions.<br><br>A record review was completed for Resident 19 on 6/7/21 at 11:45 a.m. A facility census indicated the resident re-admitted to the facility on 5/30/21. A diagnosis on the resident's profiled included, but was not limited to, cdi.<br><br>A physician's order, dated 5/30/21, indicated to place resident on transmission-based precautions due to re-admission every shift for 14 days.<br><br>A physician's order, dated 5/30/21, indicated Vancomycin (antibiotic) capsule, administer 125 milligrams (mg) by mouth four times daily for cdi | F 0880 | Facility is working with Teresa Hostettler from QSource on directed plan of correction.<br><br>Perform a root cause analysis (RCA) and develop/implement needed solutions/system changes to address findings within the RCA (completed June 30, 2021)<br><br>In-services<br>- Medication Administration (07/07/2021)<br>- Proper procedure for medication pass<br>- Ensuring adherence to infection control practices during medication administration<br>- Infection control overview - in-service along with PowerPoint and Pre/Post test will be provided by QIO/IP consultant - 07/07/2021<br>- Donning and Doffing PPE<br>- Proper usage when entering isolation rooms - mask, gown, gloves, eye protection<br>- Hand Hygiene<br>- COVID Zones (Red, Green, and Yellow)<br>- Focus Survey Review<br><br>Bi-Annual infection control education/in-services will be preformed for all staff including a general overview as well as, specific infection control guidelines for each department | 07/14/2021 |

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| | times 10 days.<br><br>The CDC Guidance, updated 3/29/21, and titled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes," included but was not limited to, "Personal Protective Equipment (PPE): -Employers should select appropriate PPE and provide it to HCP in accordance with Occupational Safety and Health Administration (OSHA) PPE standards. Facilities should have supplies of facemasks, N95 or higher-level respirators, gowns, gloves, and eye protection (i.e., face shield or goggles). Source control refers to use of well-fitting cloth masks, facemasks, or respirators to cover a person' s mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. New Admissions and Residents who Leave the Facility. Create a Plan for Managing New Admissions and Readmissions Residents with confirmed SARS-CoV-2 infection who have not met criteria for discontinuation of Transmission-Based Precautions should be placed in the designated COVID-19 care unit. In general, all other new admissions and readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission. -Exceptions include residents within 3 months of a SARS-CoV-2 infection and fully vaccinated residents as described in CDC' s Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination. Facilities located in areas with minimal to no community transmission might elect to use a risk-based approach for determining which residents require quarantine upon admission. Decisions should be based on whether the resident had close contact with someone with SARS-CoV-2 infection while outside the facility | | within the facility<br><br>Orientation - in addition to the required infection control practices are being followed<br>- Appropriate Infection Control r/t proper PPE usage for all staff and medication administration for licensed staff<br>- Daily x 6 weeks for Plan of Correction<br>- Weekly x 2 months<br>- monthly x 2 months<br>- Audits will be reviewed by QAPI committee and the QIO/IP consultant for no less than 6 months to identify trending opportunities and will adjust POC as warranted<br>- Quarterly monitoring will be random and will cover all shifts<br><br>Return Demonstration of donning and doffing PPE will be conducted with staff immediately and will be conducted ongoing throughout project timeline until all staff have completed competency checkoff then on an annual basis or as needed if deficiencies are present as a result of quarterly monitoring - July 2021<br><br>Resources from QIO on an ongoing basis throughout the project time period. Initial resources will include (but not limited to): PPE Sequencing guide, infection control in-service along with powerpoint and pre/post | |

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| | and if there was consistent adherence to IPC practices in healthcare settings, during transportation, or in the community prior to admission ...."<br><br>2. During a medication administration observation, on 6/7/21 at 8:40 a.m., Registered Nurse (RN) 22 was observed to prepare 18 pills from medication cards for Resident 10. RN 22 placed each medication into her bare hand prior to placing them into the medication cup. At this time, she indicated that was her standard of practice when she prepped pills for her medication administration pass and it was not an infection control concern because she used hand sanitizer at the very beginning of the preparation for Resident 10.<br><br>During an interview, on 6/11/21 at 10:04 a.m., the Director of Nursing (DON) indicated the nursing staff should not touch medication tablets or capsules with bare hands during a medication administration. The staff should pop the medication from the medication card straight into a medication cup.<br><br>On 6/9/21 at 3:17 p.m., the DON provided a document, implemented on 5/20/21, and titled, "Medication Administration," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines: ...4. Cleanse hands prior to administering medication per facility protocol and product...10. Review MAR to identify medication to be | | test, resident screening process when reporting s/s consistent with COVID-19, data collection tool, ppe competency tool, ppe monitoring tool | |

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| | administered...19. Report and document any adverse side effects or refusals...."<br><br>On 6/11/21 at 11:27 a.m., the DON provided a document, revised on 9/8/20, and titled, " Infection Prevention and Control Program," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections. Policy Explanation and Compliance Guidelines: ...4. Standard Precautions: ...b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. c. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE...5. Isolation Protocol (Transmission-Based Precautions): a. A resident with an infection or communicable disease shall be placed on isolation precautions as recommended by current CDC guidelines...All staff shall demonstrate competence in relevant infection control practices...."<br><br>3.1-18(b)(1)<br>3.1-18(b)(2) | | | |
| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey.<br><br>Survey date: June 14, 2021 | R 0000 | | |

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| | Facility number: 001120<br><br>Residential Census: 41<br><br>Asbury Towers Health Care Center was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.<br><br>Quality review completed on June 21, 2021. | | | |