STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155719	A. BUILDING 00 B. WING	01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GEORGE ADE MEMORIAL HEALTH CARE CENTER	3623 EAST STATE RD 16 BROOK, IN 47922

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 8, 9, 10, 11, and 12, 2024. Facility number: 000559 Provider number: 155719 AIM number: 100267170 Census Bed Type: SNF/NF: 55 SNF: 1 Total: 56 Census Payor Type: Medicare: 3 Medicaid: 42 Other: 11 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/17/24.	F 0000	February 1, 2024 Brenda Baroker, Director Division of Long Term Care Indiana State Department of Health 2 North Meridian Section 4-B Indianapolis, IN 46204-3006 Re: POC for the annual survey, EVENT ID Y9JC11, of George Ade Memorial Health Care Center, Brook, IN. Survey Cycle Date: January 12, 2024 Dear: Brenda This letter is in regard to the survey conducted on January 12, 2024, here at George Ade Memorial Health Care Center, Brook, IN. The following plan of correction is being submitted as our allegation of substantial compliance. We further submit that this facility is in substantial compliance as of February 1, 2024. At this time, we are requesting the Indiana State Department of Health conduct a desktop review to clear the survey findings and stop any and all proposed or implemented remedies that have been present	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Scott James	HFA	02/01/2024

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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			to date. If you have questions or need further information, please call 219-275-2531 or fax 219-275-7472, and we would be happy to assist you in any way possible. I can also be reached via email at admin@georgeade.org. Thank you, Scott James, HFA cc: survey file The preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of the federal and state law. This provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render	

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			adequate resident care. Furthermore, the operation and licensor of the long-term care facilities, and this plan of correction in its entirety, constitutes this providers allegation of compliance. Completion dates are provided for the procedural preceding purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in with requirements of participation or that the corrective action was necessary.	
F 0636 SS=A Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §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: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns.			

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	(iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (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. §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. (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			

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	hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. Based on record review and interview, the facility failed to complete the comprehensive Minimum Data Set (MDS) assessment timely for 2 of 19 residents whose MDS assessments were reviewed. (Residents 40 and 43) Findings include: 1. The Resident Assessment Task MDS tracking data indicated Resident 40's last MDS assessment was over 120 days old. Record review for Resident 40 was completed on 1/10/24 at 9:12 a.m. A Quarterly Minimum Data Set (MDS) assessment was completed on 8/30/23. The Annual MDS assessment, dated 11/29/23, had multiple incomplete sections and indicated it was "in process." 2. The Resident Assessment Task MDS tracking data indicated Resident 43's last MDS assessment was over 120 days old. Record review for Resident 43 was completed on 1/10/24 at 9:12 a.m. A Quarterly Minimum Data Set (MDS) assessment was completed on 8/23/23. The Annual MDS assessment, dated 11/22/23, had multiple incomplete sections and indicated it was "in process." During an interview with the Director of Nursing (DON) on 1/10/24 at 10:36 a.m., she indicated they were behind on the MDS assessments. They had some turnover in the MDS Coordinator position	F 0636	A desktop review is requested for this tag. A complete audit of all MDS's has been completed. Any existing MDS's needing to be completed or submitted have been done at this time. This included those for residents 8,25,29,17,19 and 42. DON or designee will run the OBRA QA due report to monitor for any late assessments. This will be done 5 days a week for 30 days, then 3 days a week for an additional 30 days, then once weekly for 30 days. The information will be presented at the quarterly QAP meeting and addressed. See Attachment This is done as of 2/1/2024	02/01/2024

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	recently and there had been some confusion and delays getting the assessments completed. 3.1-31(d)			
F 0638 SS=B Bldg. 00	483.20(c) Qrtly Assessment at Least Every 3 Months §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. Based on record review and interview, the facility failed to complete a Quarterly Minimum Data Set (MDS) assessment timely for 6 of 19 residents whose MDS assessments were reviewed. (Residents 8, 25, 29, 17, 19, and 42) Findings include: 1. The Resident Assessment Task MDS tracking data indicated Resident 8's last MDS assessment was over 120 days old. Record review for Resident 8 was completed on 1/10/24 at 9:12 a.m. An Annual Minimum Data Set (MDS) assessment was completed on 8/23/23. The Quarterly MDS assessment, dated 11/22/23, had multiple incomplete sections and indicated it was "in process." 2. The Resident Assessment Task MDS tracking data indicated Resident 25's last MDS assessment was over 120 days old. Record review for Resident 25 was completed on 1/10/24 at 9:12 a.m.	F 0638	A desktop review is requested for this tag. A complete audit of all MDS's has been completed. Any existing MDS's needing to be completed or submitted have been done at this time. This included those for residents 8,25,29,17,19 and 42. DON or designee will run the OBRA QA due report to monitor for any late assessments. This will be done 5 days a week for 30 days, then 3 days a week for an additional 30 days, then once weekly for 30 days. The information will be presented at the quarterly QAP meeting and addressed. See Attachment This is done as of 2/1/2024	02/01/2024

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	An Annual Minimum Data Set (MDS) assessment was completed on 8/24/23. The Quarterly MDS assessment, dated 11/22/23, had multiple incomplete sections and indicated it was "in process." 3. The Resident Assessment Task MDS tracking data indicated Resident 29's last MDS assessment was over 120 days old. Record review for Resident 29 was completed on 1/10/24 at 9:12 a.m. An Admission Minimum Data Set (MDS) assessment was completed on 9/1/23. The Quarterly MDS assessment, dated 11/29/23, had multiple incomplete sections and indicated it was "in process." 4. The Resident Assessment Task MDS tracking data indicated Resident 17's last MDS assessment was over 120 days old. Record review for Resident 17 was completed on 1/10/24 at 9:12 a.m. An Annual Minimum Data Set (MDS) assessment was completed on 8/30/23. The Quarterly MDS assessment, dated 11/29/23, had multiple incomplete sections and indicated it was "in process." 5. The Resident Assessment Task MDS tracking data indicated Resident 19's last MDS assessment was over 120 days old. Record review for Resident 19 was completed on 1/10/24 at 9:12 a.m. A Quarterly Minimum Data Set (MDS) assessment			

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	was completed on 8/30/23. The Quarterly MDS assessment, dated 11/29/23, had multiple incomplete sections and indicated it was "in process." 6. The Resident Assessment Task MDS tracking data indicated Resident 42's last MDS assessment was over 120 days old. Closed record review for Resident 42 was completed on 1/10/24 at 9:12 a.m. An Annual Minimum Data Set (MDS) assessment was completed on 8/16/23. The Quarterly MDS assessment, dated 11/15/23, had multiple incomplete sections and indicated it was "in process." During an interview with the Director of Nursing (DON) on 1/10/24 at 10:36 a.m., she indicated they were behind on the MDS assessments. They had some turnover in the MDS Coordinator position recently and there had been some confusion and delays getting the assessments completed. 3.1-31(d)(3)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the			

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	resident. (D) A member of food and nutrition services staff. (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. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, record review, and interview, the facility failed to ensure a care plan was reviewed and revised to include changes related to splint use for a resident with contractures for 1 of 16 resident care plans reviewed. (Resident 35) Finding includes: On 1/8/24 at 9:54 a.m., Resident 35 was observed in his bed. Both hands were contracted at the wrist (a fixed tightening of muscles that prevents normal movement of associated body part) and there were no splints in place. A sign above the bed indicated to place splints on both hands/arms in the morning and after dinner for 2-3 hours, unless he asked for them off. On 1/9/24 at 8:50 a.m. and 2:14 p.m., 1/10/24 at 8:32 a.m. and 9:58 a.m., the resident was observed without splints on his hands.	F 0657	A desktop review is requested for this tag. The care plan for resident #35 has been updated to include the splint placement and usage. Any resident with splint orders has been reviewed and care planned accordingly. Therapy recommendations for splints will be reviewed by DON or designee and physician notified to obtain an order for those residents. Care plans will be updated accordingly upon orders received from physician. This will be reviewed 5 days weekly for 30 days, then 3x weekly for 30 days, then weekly thereafter. Results to be presented at quarterly QAPI meeting for follow up. DON or designee are responsible.	02/01/2024

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	The resident's record was reviewed on 1/10/24 at 8:40 a.m. Diagnoses included, but were not limited to, cerebral palsy, moderate intellectual disabilities and contracture of muscle multiple sites. The Quarterly Minimum Data Set assessment, dated 9/20/23, indicated the resident was cognitively intact, and was dependent on staff assistance for all ADLs (activities of daily living). The current ADL Functional Status/ Rehabilitation Potential Care Plan indicated the resident had self care deficit related to impaired mobility and impaired cognitive abilities and weakness secondary to cerebral palsy with multiple contractures. Interventions included, but were not limited to, assist with repositioning and bed mobility, and assist with eating and drinking fluids. There was no intervention related to assisting with splint application. During an interview with RN 1 on 1/10/24 at 9:58 a.m., she indicated she was not aware if the resident wore splints. During an interview with Occupational Therapy Assistant 1 at that same time, she indicated the resident was supposed to wear the splints for 2-3 hours a day unless he declined. During an interview with the Director of Nursing on 1/10/24 at 10:09 a.m., she indicated Physician's Orders would be updated to include the splints and the care plan would be updated. 3.1-35(e)		See Attachment This is done as of 2/1/2024	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care			

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	Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure residents received the necessary treatment and services related to the lack of monitoring and assessments of skin discolorations for 1 of 1 residents reviewed for non-pressure skin conditions. (Resident 43) Finding includes: On 1/9/24 at 8:52 a.m., Resident 43 was lying in bed. There were 2 dark red/purple discolorations observed to her left forearm and 1 dark red/purple discoloration observed to her left wrist. On 1/10/24 at 1:10 p.m., Resident 43 was observed lying in bed. The same discolorations were still observed. Record review for Resident 43 was completed on 1/10/24 at 1:14 p.m. Diagnoses included, but were not limited to, dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 8/23/23, indicated the resident was cognitively impaired. The resident was an extensive 2+ assist for bed mobility, transfer and toilet use. She was an extensive 1 person assist for locomotion, dressing and personal hygiene. She was on hospice care. A Care Plan, dated 10/7/22 and revised 11/22/23,	F 0684	A desktop review is requested for this tag. Resident 43's discolorations have been addressed. The physician and family have been notified and this care plan updated. To prevent further nursing staff have been instructed on proper noting of skin issues. Skin assessments will now be completed by Day/Evening shifts to provide a clearer observation of the residents. (Insert Inservice & Test) DON or designee will review assessments and progress notes for any needed follow-ups. This will be done 5 days a week for 30 days, then 3 days a week for an additional 30 days, then once weekly for 30 days. The information will be presented at the quarterly QAP meeting and addressed. See Attachment This is done as of 2/1/2024	02/01/2024

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	indicated the resident was receiving antiplatelet therapy and was at an increased risk for bruising or bleeding. An intervention included to observe for signs of abnormal bleeding which included bruising. They were to document abnormal findings and notify the MD and hospice. A Progress Note, dated 1/11/24 at 2:29 a.m., indicated a skin assessment was completed. No new areas were observed. The record lacked any documentation the discolorations had been assessed or were being monitored. During an interview on 1/11/23 at 9:21 a.m., the Director of Nursing (DON) indicated she was unable to find any documentation the resident's discolorations were assessed and monitored. She would have the nurse measure them and she would investigate them. 3.1-37(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.			

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	§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to ensure a resident received the necessary treatment to prevent a decrease in range of motion related to a hand splint not in place as recommended and no Physician's order for splints for 1 of 1 residents reviewed for positioning and mobility. (Resident 35) Finding includes: On 1/8/24 at 9:54 a.m., Resident 35 was observed in his bed. Both hands were contracted at the wrist (a fixed tightening of muscles that prevents normal movement of associated body part) and there were no splints in place. A sign above the bed indicated to place splints on both hands/arms in the morning and after dinner for 2-3 hours, unless he asked for them off. On 1/9/24 at 8:50 a.m. and 2:14 p.m., 1/10/24 at 8:32 a.m. and 9:58 a.m., the resident was observed without splints on his hands. The resident's record was reviewed on 1/10/24 at 8:40 a.m. Diagnoses included, but were not limited to, cerebral palsy, moderate intellectual disabilities and contracture of muscle multiple sites. The Quarterly Minimum Data Set assessment, dated 9/20/23, indicated the resident was cognitively intact, and was dependent on staff assistance for all ADLs (activities of daily living).	F 0688	Resident 35 has an order for splinting placement at this time. The care plan for resident #35 has been updated to include the splint placement and usage. Any resident with splint orders has been reviewed and care planned accordingly. Therapy recommendations for splints will be reviewed by DON or designee and physician notified to obtain an order for those residents. Care plans will be updated accordingly upon orders received from physician. This will be reviewed 5 days weekly for 30 days, then 3x weekly for 30 days, then weekly thereafter. Results to be presented at quarterly QAPI meeting for follow up. DON or designee are responsible. See attached. Done as of 2/1/2024	02/01/2024

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GEORGE ADE MEMORIAL HEALTH CARE CENTER	3623 EAST STATE RD 16 BROOK, IN 47922

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	There was no Physician's Order in place for the use of splints. There was no documentation on the Treatment Administration Record when or if the splints were applied or removed. During an interview with RN 1 on 1/10/24 at 9:58 a.m., she indicated she was not aware if the resident wore splints. During an interview with Occupational Therapy Assistant 1 at that time, she indicated the resident was supposed to wear the splints for 2-3 hours a day unless he declined. During an interview with the Director of Nursing on 1/10/24 at 10:09 a.m., she indicated Physician's Orders would be updated to include the splints and the care plan would be updated. 3.1-42(a)(2)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, record review and interview, the facility failed to ensure a resident's pain was managed and monitored for 1 of 1 residents reviewed for pain. (Resident 19) Finding includes: During an interview with a family member of the	F 0697	A desktop review is requested for this tag. Resident 19 has expired; no other residents were affected by this citing at this time. Each resident now has orders to observe signs and symptoms of pain and notify physician as	02/01/2024

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	resident on 1/10/24 at 9:02 a.m., he indicated she would frequently complain of pain to her knees. On 1/10/24 at 1:20 p.m., Resident 19 was heard moaning in her room from the hall. The resident was observed lying in her bed, she was grimacing and indicated she was having pain. She was unable to state where the pain was but indicated she needed help. RN 1 indicated at that time, the resident would do that frequently and that was normal for her, she received scheduled pain medication. She indicated she would see if there was something else she could have. The resident's record was reviewed on 1/10/24 at 11:05 a.m. Diagnoses included, but were not limited to, dementia, osteoarthritis, cerebral vascular accident and depression. The resident also received hospice services. The Quarterly Minimum Data Set assessment, dated 8/30/23, indicated the resident had severe cognitive impairment, and had frequent pain for which she received scheduled medication. The scheduled Quarterly Pain Assessment due in November had not been completed. A Physician's Order, dated 6/10/23, indicated the resident received morphine sulfate (an opioid pain medication) 5 milligrams (mg)/0.25 milliliters twice daily for pain. The resident could also have the medication every 2 hours as needed for pain. A Physician's Order, dated 6/10/23, indicated the resident could have acetaminophen suppository, 650 mg every 6 hours as needed for pain. There was no order for oral acetaminophen. The current Pain Care Plan indicated the resident		needed. As needed (PRN) medications will proceed will non-pharmacological documentation. Those residents affected will have non-pharmacological interactions documented. So as to prevent further issues. This will be done 5 days a week for 30 days, then 3 days a week for an additional 30 days, then once weekly for 30 days. The information will be presented at the quarterly QAP meeting and addressed. See Attachment This is done as of 2/1/2024	

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	was at risk for pain related to osteoarthritis and chronic pain. Interventions included, but were not limited to, administer medications as ordered, observe for non-verbal signs of pain such as facial grimacing and crying, and offer non-pharmacological interventions such as back rub, warm blanket and position change. The January 2024 Medication Administration Record (MAR) indicated the resident had not received any as needed morphine sulfate or the acetaminophen suppository for pain. There was no indication any non-pharmacological interventions had been attempted to manage pain. During an interview with the Director of Nursing on 1/10/24 at 12:54 p.m., she indicated she had competed the Quarterly Pain Assessment that was due in November. She also indicated non-pharmacological interventions would be added to the MAR. 3.1-37(a)			
F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on record review and interview, the facility failed to promote antibiotic stewardship by ensuring the appropriate use of antibiotic therapy to reduce antibiotic resistance related to hospice	F 0881	A desktop review is requested for this tag. The antibiotic therapy for resident 43 has been completed. Hospice	02/01/2024

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	prescribing antibiotics for a urinary tract infection without a urinalysis and culture completed for 1 of 3 residents reviewed for antibiotic use. (Resident 43) Finding includes: Record review for Resident 43 was completed on 1/10/24 at 1:14 p.m. Diagnoses included, but were not limited to, dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 8/23/23, indicated the resident was cognitively impaired. The resident was an extensive 2+ assist for toilet use. She was on hospice care and received an antibiotic. A Physician's Order, dated 8/22/23-9/1/23 and again on 9/13/23-9/22/13, was for Cipro (antibiotic) 500 mg (milligrams) twice a day. A Physician's Order, dated 10/14/23, was for ceftriaxone (antibiotic) 1 gram injection 1 time only. A Physician's Order, dated 10/14/23-10/20/23, was for Augmentin (antibiotic) 500-125 mg twice a day. Review of the August, September and October 2023 Medication Administration Records (MARs) indicated the resident had received the antibiotics. The Revised McGeer Criteria for Infection Surveillance Checklist, dated 8/22/23, indicated the resident had a UTI (urinary tract infection). The resident had confusion and foul urine odor. The UTI criteria was not met for an antibiotic. The Revised McGeer Criteria for Infection Surveillance Checklist, dated 9/13/23, indicated		has been shown the proper application of antibiotic use as to meeting the Mcgeers criteria. Nursing staff have been inserviced on Mcgeers criteria for future utilization/ application of antibiotics. DON or designee to audit weekly antibiotic orders for proper application. This will be done 5 days a week for 30 days, then 3 days a week for an additional 30 days, then once weekly for 30 days. The information will be presented at the quarterly QAP meeting and addressed. See Attachment Done as of 2/1/2024	

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	the resident had a UTI. The resident had a fever. The UTI criteria was not met for an antibiotic. The Revised McGeer Criteria for Infection Surveillance Checklist, dated 10/13/23, indicated the resident had a UTI. The resident had confusion. The UTI criteria was not met for an antibiotic. There was no documentation to indicate a urinalysis had been completed on any of the above dates to indicate a UTI. There was no documentation to indicate the resident received the antibiotics for a true infection. During an interview on 1/11/24 at 12:56 p.m., the Director of Nursing (DON) indicated the resident had received antibiotics during August, September and October 2023 for a UTI. The resident had not met the criteria for an antibiotic. She had spoken to hospice and told them they cannot put residents on antibiotics unless they meet the criteria for a true infection.			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review, and interview, the facility failed to ensure resident equipment was safe and functional related to torn and ripped armrests on a resident's wheelchair for 1 of 1 random observations of resident equipment. (Resident 108) Finding includes: On 1/9/24 at 9:48 a.m., Resident 108 was observed	F 0921	A desktop review is requested for this tag. The noted wheelchair has been repaired with both arm rests replaced. Resident wheelchairs are observed, and repairs done as needed to maintain safe operation. Repair slips are utilized by the maintenance department to	02/01/2024

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	seated in her wheelchair. The armrests on both sides were ripped and torn. On 1/10/24 at 8:32 a.m., the resident was seated in the dining room, the arm rests on her wheelchair were ripped and torn. The resident's record was reviewed on 1/10/24 at 11:05 a.m. Diagnoses included, but were not limited to, dementia, osteoarthritis, cerebral vascular accident and depression. The resident also received hospice services. The Quarterly Minimum Data Set assessment, dated 8/30/23, indicated the resident had severe cognitive impairment, and had frequent pain which she received scheduled medication for. During an interview with Occupational Therapy Assistant 1 on 1/11/24 at 9:05 a.m., she indicated she had not previously noticed the torn armrests, but had notified maintenance they needed to be fixed that morning. During an interview with the Director of Nursing on 1/11/24 at 1:30 p.m., she indicated nursing or maintenance would normally identify a problem with a wheelchair. 3.1-19(e)		perform needed repairs. Wheelchairs are checked weekly and any noted repairs are given to the maintenance department to repair as indicated. Wheelchairs will be observed on a ongoing basis for proper operation and will be repaired as needed to maintain resident safety. Nursing staff and maintenance to report and maintain as needed. This is done as of 1/15/2024	
F 9999 Bldg. 00	3.1-25 Pharmacy services (b) The administration of drugs and treatments, including alcoholic beverages, nutrition concentrates, and therapeutic supplements, shall be as ordered by the attending physician and	F 9999	A desktop review is requested for this tag. In the review of resident 8 there were no noted adverse effects. Nurses and QMA's have been re-educated on proper PRN	02/01/2024

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	shall be supervised by a licensed nurse as follows: (8) Per required need (PRN) medications may be administered only upon authorization of a licensed nurse or physician. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. This State rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure a QMA (Qualified Medication Aide) received prior authorization from a licensed nurse before administering a PRN (as needed) medication to a resident for 1 of 5 residents reviewed for unnecessary medications. (Resident 28) Finding includes: Resident 28's record was reviewed on 1/10/24 at 10:27 a.m. Diagnoses included, but were not limited to, fibromyalgia, type 2 diabetes mellitus, and dementia. The Physician's Order Summary, dated 1/2024, indicated orders for ondansetron (a medication used to treat nausea/vomiting) 4 mg (milligrams) by mouth every 8 hours PRN and morphine sulfate (a narcotic pain medication) 20 mg/ml (milliliter) 0.5 ml sublingual every 4 hours PRN. The Medication Administration Records (MAR), dated 12/2023 and 1/2024, indicated the resident was given ondansetron on 12/14/23 at 9:21 p.m. by QMA 1. The resident received morphine from QMA 1 on 1/8/24 at 12:16 a.m., 12/1/23 at 4:20 a.m., and 12/29/23 at 12:56 a.m. The PRN administration		medication dispensing and administration QMA's have been inserviced of following appropriate medical administration protocol. A minimum of 10 residents per week on PRN will be reviewed. This will be done 5 days a week for 30 days, then 3 days a week for an additional 30 days, then once weekly for 30 days. The information will be presented at the quarterly QAP meeting and addressed. See Attachment Done as of 2/1/2024	

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	notes and progress notes lacked documentation to indicate a Nurse had assessed the resident or given authorization for the QMA to administer the PRN medications. During an interview on 1/11/24 at 10:22 a.m. with the Director of Nursing (DON), she indicated she would look into it. No further information was provided.			