STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included Investigation of Complaint IN00397631. Complaint IN00397631 - Substantiated. State and Federal deficiency related to the allegation is cited at F689. Survey dates: January 29, 30, 31, February 1 and 2, 2023 Facility number: 002657 Provider number: 155681 AIM number: 200308930 Census Bed Type: SNF/NF: 37 SNF: 35 Total: 72 Census Payor Type: Medicare: 28 Medicaid: 16 Other: 28 Total: 72 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 8, 2023.	F 0000		
F 0580 SS=E Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or			

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

Laurence Reed | Executive Director | 02/24/2023

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

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

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	admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to notify the physician for 3 of 20 residents reviewed for Notification of Change. (Residents 47, 39 and 40). Findings include: 1. The clinical record for Resident 47 was reviewed on 1/30/23 at 1:30 p.m. The diagnoses included, but were not limited to, dementia, exposure to COVID-19, and a communication deficit. The Quarterly MDS (Minimum Data Set) assessment, dated 12/2/22, indicated the resident was severely cognitively impaired. The physician's orders, dated 3/20/22, indicated the resident received furosemide 40 mg (milligram) tablet, twice a day for edema and Levsin (hyoscyamine sulfate) 0.125 mg tablet sublingual every 2 hours as needed for secretions. The nurse's note, dated 10/25/22 at 2:24 a.m., indicated the resident was crying tears and was unable to sleep all night. The resident was currently on antibiotics for a red like rash to abdomen however, her skin all over body was fire engine red and warm to touch. There was edema all over her body especially to the abdomen which was hard, distended, and tender. Her bowel sounds were positive, and the G tube (gastrostomy tube) had signs and symptoms of being in place. The tube feeding was turned off at that time. The resident's ble (Bilateral Lower	F 0580	The submission of this plan of correction does not indicate an admission by Autumn Woods Health Campus that the findings and allegations contained herein are accurate, true representations of the quality of care provided, and living environment provided to the residents of Autumn Woods Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. F580: Notification of change: 1. Residents 29, 47, 39, 17, 40 were affected. The provider was notified and new orders were given for each resident affected.	03/01/2023

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	Extremities) had swelling with +1 pitting edema and mild tenderness to touch. Her lung sounds were clear with mild expiratory rhonchi. The resident was having notable moments of holding her breath and her O2 (oxygen)would go down to lower 90's and her heart rate was increased. Staff requested the physician to assess the resident in the morning. A note along with a change of condition was placed in the physician's folder at that time. The clinical record lacked immediate notification to the physician. The nurse's note, dated 11/18/22 at 7:39 a.m., indicated a Hospice referral was made to a Hospice company. During an interview on 2/1/23 at 2:20 p.m., LPN (Licensed Practical Nurse) 5 indicated she would monitor for signs and symptoms that included, respiratory rate, listening to lung sounds, 02 saturation, functioning 02 concentrator, skin color, vital signs or any change in the resident's condition. She would immediately notify the doctor for a change in condition. During an interview on 2/2/23 at 9:06 a.m., the DON indicated when a resident had a change in condition, she would expect the physician to be called immediately or if the resident was on Hospice, they would be called first. 2. The clinical record for Resident 39 was reviewed on 1/30/23 at 12:42 p.m. The diagnoses included, but were not limited to, COVID-19 acute respiratory disease, contact with and (suspected) exposure to COVID-19, Alzheimer's disease with late onset, dementia, COPD (chronic obstructive pulmonary disease), seasonal allergic rhinitis, and personal history of other malignant neoplasm of		2. All residents have the potential to be affected. All residents' records reviewed for change of condition not reported to the provider. Staff nurses educated on provider notification guidelines. 3. As a measure of ongoing compliance, the DHS or designee will audit 5 resident records weekly x1 month, every other week x2 months, then monthly x3 months to ensure provider notification of change in condition has occurred. 4. Results from audits will be reviewed during the campus' monthly QAPI meeting to determine the ongoing frequency as to the monitoring plan. Findings suggestive of 100% compliance may result in cessation of the monitoring plan.	

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	bronchus and lung. The care plan, initiated on 12/7/22, indicated the resident had a potential for complications, functional and cognitive status decline related to respiratory disease and COPD. The interventions included, but were not limited to, assess for change in level of consciousness and coherency, and report changes, monitor lung sounds per orders or as needed, monitor oxygen saturation via pulse oximetry as ordered, and observe for and report signs of respiratory distress, including but not limited to restlessness, wheezing, dyspnea, difficulty with expectoration, diaphoresis, crackles, bubbling, tachycardia, cyanosis, and decreased breath sounds. The 5-Day MDS Assessment, dated 12/28/22, indicated the resident was severely cognitively impaired and experienced shortness of breath when lying flat. The nurse's note, dated 1/17/23 at 5:13 p.m., indicated the resident returned to the facility with her family member. The resident required the assist of two staff to get her into the building. Upon assessment, it was observed that the resident was very short of air, and lethargic. Her O2 saturation was 56% (percent, normal range greater than 90%) on room air, and her temperature was 99.1 F (Fahrenheit). O2 per nasal cannula was placed at 2 lpm (liters per minute) and the resident's family member set next to her to help keep her calm. The clinical record lacked documentation of any notification to the physician of the resident's change in condition. The nurse's note, dated 1/18/23 at 2:21 a.m.,			

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	indicated the resident was removing oxygen from her nose and complaining of difficulty breathing. When the oxygen was in place resident's O2 saturations were 95% to 96%, when removed her saturation dropped into the 80's, The resident also had increased respirations and congestion. The clinical record lacked documentation of any notification to the physician of the resident's respiratory status. The physician's note, dated 1/19/23 at 5:57 a.m., indicated the resident had been having a lot of cough and congestion over the last 3 to 4 days. She was tested for COVID-19 and was negative. She would not always leave the oxygen in place and her saturations would decrease when she took it off. Her chest x-ray showed no evidence of pneumonia. The physician indicated the resident had COPD with acute exacerbation and ordered decadron 6 mg IM (intramuscular), doxycycline 100 mg twice daily for 10 days, and prednisone 10 mg 1 four times daily for 3 days, then three times daily for 3 days, twice daily for 3 days and finally daily for 3 days. During an interview on 2/1/23 at 2:30 p.m., LPN 10 indicated for a resident exhibiting any respiratory symptoms the first thing they would do would be to test for COVID, and test for flu. She would then check their vitals and call the doctor. If a resident's oxygen saturation dropped she would administer oxygen and call the doctor and notify them of the desaturation, even if the oxygen saturation went back up. During an interview on 2/2/23 at 8:39 a.m., the DON indicated she would absolutely expect the physician to be notified via a phone call if the resident experienced a desaturation and they were			

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	experiencing respiratory symptoms. 3. The clinical record for Resident 40 was reviewed on 1/30/23 at 1:20 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance, psychotic disorder with delusions due to known physiological condition, adjustment disorder with other symptoms, and symptoms and signs involving appearance and behavior including but not limited to combative behavior. The care plan, initiated on 9/7/21 and last revised on 1/4/23, indicated the resident demonstrated signs and symptoms of depression as evidenced by score on the PHQ-9 (depression assessment). The interventions included, but were not limited to, if resident voices suicidal thoughts or ideations, with or without a plan, refer to clinical team and refer to psychiatric services as needed. The care plan, initiated on 10/3/22, indicated the resident had inappropriate behaviors including displaying aggression, mimicking, kicking the nurse, and pulling away. The goal was for the resident's behaviors not to result in the disruption of others environment. The interventions included, but were not limited to, determine the cause for inappropriate behavior and refer to physician as needed for intervention. The Quarterly MDS assessment, dated 12/28/22, indicated the resident was severely cognitively impaired, was moderately to severely depressed, but experienced no psychosis, hallucinations, delusions, or behaviors. The nurse's note, dated 1/28/23 at 3:45 a.m., indicated the resident had been yelling out all			

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	shift and was doing it when the nurse received report before her shift. The yelling had lasted all night and had increased in volume. The resident was having violent hallucinations and delusions. The resident indicated he was yelling because he had to kill some people because some people had to die. He then asked the nurse to kill him. He was having disorganized religious rants and was whistling in between yelling out. He had not slept at all and was refusing incontinence care and was even becoming physically violent to staff and his self when staff members attempted to provide incontinence care throughout the night. Staff had been unable to change him and his brief, pants, pad, and sheets were saturated. The resident had dementia and several psych diagnosis and was on psychiatric medications routinely. An event was completed and a note was put into the physicians folder. The nurse would pass the information along to the day shift nurse to continue to monitor and if needed call the on call physician. The nurse's note, dated 1/28/23 at 7:04 p.m., indicated the resident was having delusions and was yelling at people who were not in his room. He was whistling loudly and frequently. The nurse's note, dated 1/29/23 at 4:56 a.m., indicated the resident had been yelling for staff to help him. When the nurse tried to apply his oxygen for saturations of 87% to 90%, he got angry and refused. The nurse would give the information to the first shift nurse and monitor the resident. The clinical record lacked documentation of any notification to the physician from the onset of the resident's increased behaviors on 1/28/23 at 3:45 a.m. until the psychiatric NP was contacted on 1/29/23 at 9:19 p.m.			

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	The IDT (Interdisciplinary Team) note, dated 1/29/23 at 9:19 p.m., indicated the resident had refusal of care and hallucinations. The SSD was aware and the psychiatric NP was notified as well. The resident continued with orders for anti-psychotic medication as ordered and staff would continued to monitor. The nurse's note, dated 1/30/23 at 5:12 a.m., indicated the resident had completed his antibiotic for RSV. He continued with a congested cough and shortness of air with exertion and his saturations were 87% to 94% on room air. The resident was refusing his oxygen. He said he didn't feel good and felt like he was going to die soon. He was weak and could not sit up and had a very poor appetite. A note was placed in the physician's folder for him to evaluate the resident. The nurse's note, dated 1/30/23 at 3:57 p.m., indicated the psychiatric NP gave new orders for Ativan 0.5 mg every 6 hours as needed for anxiety. During an interview on 2/1/23 at 2:30 p.m., LPN (Licensed Practical Nurse) 10 indicated if they had a resident expressing suicidal or homicidal ideations they would notify the doctor by phone. It would be an immediate notification, and it would not be appropriate to leave the physician a note. During an interview on 2/2/23 at 8:40 a.m., the DON indicated she did not know why the physician was not called when the resident expressed suicidal and homicidal ideations. She contacted the employee when she was reviewing notes and had no response. When exhibiting those behaviors she would expect staff to call the physician immediately. Putting a note in the			

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	physician's folder was not appropriate. On 2/2/23 at 2:24 p.m., the DON provided a copy of an email document she sent to psychiatric provider. The email was dated 1/29/23 at 9:10 p.m. The DON indicated she emailed the provider informing them of the resident's behavior but the resident was not seen by the psychiatric provider until the following Monday which was 1/30/23. During an interview on 2/2/23 at 2:29 p.m., LPN 10 indicated the resident did have behaviors, but she did not believe the nurse told her about the incident of him expressing suicidal and homicidal ideations. She did not receive the information in report. She could recall from her shift the next day, that he was having some delusions. He was talking to someone but there wasn't any one in the room with him. She would have been more active in doing stuff if she'd known exhibiting the behaviors. She would be documenting more frequently on him and would have made a new or worsening behavior event. She would have called the physician immediately. The most current but undated Notification of Change in Condition policy and procedure was provided on 2/1/23 at 2:45 p.m. by the Clinical Support Nurse. The policy included, but was not limited to, "... The facility must... consult with the resident's physician... when... 2. a significant change in the resident's physical, mental or psychosocial status. 3. A need to alter treatment significantly... Sample reasons to notify the physician immediately but not limited to: 1. A deterioration in health, metal or psychosocial status in either life threatening conditions or clinical complications... 2. Need to alter treatment significantly... 6. Clinical complications such as development of a pressure area, onset of delirium			

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	or recurrent urinary tract infections... 3.1-5(a)(2)			
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in			

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	writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on record review and interview, the facility failed to issue Notice to Medicare Provider Non-coverage (NOMNC) for 2 of 3 residents reviewed for Medicare end of services. (Residents 300 and 301) Findings include: 1. Resident 300 was admitted to the facility for rehabilitative services under Medicare Part A on 12/2/22. Her last day of coverage was 12/20/22. No NOMNC letter could be located which indicated the resident was made aware her Medicare coverage was ending. 2. Resident 301 was admitted to the facility for rehabilitative services under Medicare Part A on 12/27/22. Her last day of coverage was 1/8/23 .	F 0582	F 582 Medicaid/Medicare Coverage/Liability Notice 1. Residents 300 and 301 were affected. Resident 300 was discharged home and has since expired. Resident 301 had NOMNC issued. 2. All residents discharged with remaining Medicare days have the potential to be affected. The Social Services Director (SSD) to be educated on completion of Notice of Medicare Non-Coverage (NOMNC) prior to discharge or change in payer source. All Medicare residents discharged since January 1,2023 have been reviewed for accuracy of NOMNC delivery.	03/01/2023

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	No NOMNC letter could be located which indicated the resident/responsible party was made aware her Medicare coverage was ending. During an interview on 1/31/23 at 10:45 a.m., the Social Worker indicated she was unable to locate the signed letters and she did not document her conversations with the families. 3.1-4(f)(3)		3. As a measure of ongoing compliance, the Executive Director (ED) or designee will perform discharge audits on 5 Medicare residents, as available, weekly x4 weeks, then every other week x2 months, then monthly x3 months to ensure that a signed NOMNC is on file. 4. Results from audits will be reviewed during the campus' monthly QAPI meeting to determine the ongoing frequency as to the monitoring plan. Findings suggestive of 100% compliance may result in cessation of the monitoring plan.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure weekly skin assessments accurately reflected the resident's skin status for 1 of 6 residents reviewed for skin impairments. (Resident 17) Finding included: The clinical record for Resident 17 was reviewed on 1/31/23 at 1:57 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, iron deficiency anemia, peripheral vascular disease, shortness of breath, chronic kidney disease, stage 3, and weakness. The Quarterly MDS (Minimum Data Set) assessment, dated 11/7/22, indicated the resident	F 0641	F641 Accuracy of Assessment 1. Resident 17 was affected. Resident had no adverse effects. Resident 17 had a skin assessment and preventive treatment ordered. 2. All residents have the potential to be affected. Nurses educated on guidelines for weekly skin observations. Skin assessments were performed on all residents. 3. As a measure of ongoing compliance, the DHS or designee will perform skin assessments on random shifts for 3 residents	03/01/2023

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	155681	A. BUILDING 00 B. WING	02/02/2023

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AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

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	was moderately cognitively impaired. The physician's order, dated 9/5/22, indicated staff were to cleanse the resident's wound with cleanser or normal saline, apply skin prep, and cover with a foam dressing as needed. Change the dressing as needed when the dressing becomes dislodged or soiled. On 9/8/22, the physician's order was updated to cleanse the coccyx with normal saline, pat dry, apply skin prep, allow to dry, and apply a foam dressing. Change every 5 days and as needed if soiled. Observe dressing to coccyx every shift. May peel back and view the area to monitor if the area had opened. The care plan dated 8/1/22 and revised on 11/8/22, indicated the resident was at risk for skin breakdown related to impaired mobility, incontinence, and the need for assistance with activities of daily living. The interventions included, but were not limited to, float heels as needed, pressure reducing cushion to chair, use moisture barrier product to perinea area as needed, pressure reducing mattress to bed, avoid shearing skin during positioning, turning, and transferring, encourage and assist the resident to turn and reposition for comfort and as needed, conduct weekly skin assessments, and pay particular attention to bony prominence's and keep linens clean and dry. Staff were to keep the resident as clean and dry as possible. Minimize skin exposure to moisture, and use a lifting device as needed for bed mobility. The Treatment Administration History for the weekly skin assessments, dated 9/1/22 to 9/30/22, indicated the resident had no skin impairments.		weekly x4 weeks, then every other week x2 months, then monthly x3 months to ensure weekly skin assessments have been documented accurately. 4. Results from audits will be reviewed during the campus' monthly QAPI meeting to determine the ongoing frequency as to the monitoring plan. Findings suggestive of 100% compliance may result in cessation of the monitoring plan. .	

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	The nurse's note, dated 9/5/22 at 3:55 p.m., indicated the resident had an open area to her right inner middle right buttock. The length was 0.75 cm (centimeters), and the width was 1 cm. The resident's sacral area and left buttock was red. No bleeding observed. The wound was cleaned with normal saline, patted dry and skin prep was applied followed by a form dressing which covers both the sacral area and left and right buttock. The IDT (Interdisciplinary Team) note, dated 9/6/22 at 8:37 a.m., indicated a new skin impairment was noted to the resident's right buttock. The nurse's note, dated 9/24/22 at 12:52 p.m., indicated the resident's dressing to the sacral area was observed to be wrinkled and was dated 9/17/22. The dressing was removed, and the wound was cleansed with wound cleanser patted dry then applied skin prep and covered with a foam dressing. The wound had declined in size and appearance. The nurse's note, dated 10/29/22 at 10:19 p.m., indicated the resident did not have a dressing to sacral area as ordered. The nurse completed the treatment to the area as open, and the area was on the verge of opening. The nurse's note, dated 11/5/22 at 12:16 p.m., indicated the resident's dressing was changed due to the resident complained of discomfort. The sacral area was not open today, and the treatment was completed as ordered. The resident's skin was over bone, and she had several bony areas. During an interview on 2/1/23 at 2:30 p.m., LPN 5 (Licensed Practical Nurse) indicated pressure ulcer prevention included, repositioning every 2 hours, elevate the heels off the bed, keep the			

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	resident clean and dry, monitor for infection, low air mattress, cushion in the resident's wheelchair and treatment as ordered by the physician. During an interview on 2/2/23 at 9:15 a.m., the DON (Director of Nursing) indicated when a wound was identified the nurse should assess the wound immediately. An event would be filled out and the physician would be called to seek treatment. During an interview on 2/2/23 at 2:15 p.m., the DON indicated the resident's skin impairment had healed on 9/8/22 according to the wound event documentation. She indicated she did not know why the nurse's notes indicated the resident had a wound and continued with treatment. She was unsure why the documentation did not match on the weekly skin assessment record. The Weekly Skin Observation policy dated 8/1/21, and revised on 3/16/22 was provided by the DON on 2/2/22 at 10:00 a.m. The policy included, but was not limited to, "...To monitor the effectiveness of interventions for pressure reduction, identify areas of skin impairment in the early development stage and implement preventative and/or treatment as indicated ..." 3.1-31(d)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent			

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	pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (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. Based on observation, record review, and interview, the facility failed to ensure clarification of a physician's order related to the skin assessment under a walking boot and accurate documentation of a weekly skin assessment for the presence of pressure ulcers for 1 of 6 residents reviewed for pressure ulcers. (Resident 29) Finding included: The clinical record for Resident 29 was reviewed on 1/31/23 at 7:10 a.m. The diagnoses included, but were not limited to, nondisplaced fracture of the medial malleolus of the left tibia, toxic encephalopathy, paroxysmal atrial fibrillation, congestive heart failure, chronic kidney disease, peripheral vascular disease, atherosclerotic heart disease, hypotension, chronic obstructive pulmonary disease, diverticulosis of intestine, hypokalemia, hypocalcemia, hypothyroidism, atrophy of thyroid, hyperlipidemia, anemia, asthma, disorientation, repeated falls, and the presence of a cardiac pacemaker. The Admission Scheduled 5 Day MDS (Minimum Data Set) assessment, dated 12/14/22, indicated the resident was cognitively intact. She required extensive assistance for bed mobility, transfer, locomotion on and off unit, toileting, and personal hygiene. She received oxygen therapy.	F 0686	F686 Treatment/Services to Prevent/Heal/Pressure ulcers 1. Resident 29 has been discharged. 2. All residents have the potential to be affected. All current residents have had skin assessments completed, current interventions have been verified in place, and skin care plans reviewed and updated as needed. All nursing staff have been provided education on guidelines for weekly skin observations, general skin and wound care, and pressure injury prevention. 3. As a measure of ongoing compliance, DHS/Designee will complete audits on 3 residents on random shifts to ensure pressure prevention measures are in place, weekly x 4 weeks, every other week x 2 months, and monthly x3 months. 4. Results from audits will be reviewed during the campus' monthly QAPI meeting to determine the ongoing frequency of the monitoring plan. Findings suggestive of 100% compliance may result in the cessation of the	03/01/2023

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	The care plan, dated 12/21/22, indicated the resident was at risk for skin breakdown related to decreased mobility, left ankle fracture, neuropathy, and peripheral vascular disease. The interventions included, but were not limited to, conduct weekly skin assessments, pay particular attention to the bony prominences, float the heels as needed, pressure reducing cushion to the chair, pressure reducing mattress to the bed. The care plan, dated 12/15/22, indicated the resident had a pressure ulcer. The interventions indicated to assess and record the condition of the skin surrounding the pressure ulcer, observe and report signs of infection, pressure reducing cushion to the chair, pressure reducing mattress, treatment per physician's order, conduct weekly skin assessments, with measurement, and observation of the pressure ulcer and record. The nurse's note, dated 12/7/22 at 8:41 p.m., indicated the resident arrived to the facility by private vehicle. The resident had an air cast (boot) to the left lower extremity (ankle). She was unsure if the cast could be removed for inspection at this time. The physician's order, dated 12/7/22, indicated to perform weekly skin assessments on Monday. The clinical record lacked documentation of the physician being contacted for verification for continual use of the CAM (controlled ankle motion) boot. The IDT (Interdisciplinary team's) note, dated 12/14/22 at 4:55 p.m., indicated the top of the left foot was assessed. The area measured 1.5 cm (centimeters) long by 3 cm wide by 0.2 cm deep.		monitoring plan.	

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	The left foot was examined and a DTI (deep tissue injury) to the left medial metatarsal was observed. The area measured 1.5 cm long by 1 cm wide. The Wound Management note, dated 12/14/22, indicated the pressure ulcer to the top of the left foot was a stage 2. The physician's order, dated 12/14/22, indicated to observe the left medial metatarsal dressing to the open area(s) every shift for draining on the dressing and dislodgement, three times a day. The physician's order, dated 12/14/22, indicated to observe the top of the left foot dressing to the open area(s) every shift for draining on dressing and dislodgement, three times a day. The nurse's note, dated 12/15/22 at 10:00 a.m., indicated the wound care center was called. The first available appointment was 1/3/22 at 8:00 a.m. The Weekly Skin assessment, dated 12/19/22, indicated the resident had no skin impairments. The nurse's note, dated 12/20/22 at 3:37 p.m., indicated the physician's office was called regarding the CAM boot. The physician's office indicated the resident could remove CAM boot at night and reapply in the morning. The Wound Management note, dated 12/20/22, indicated the resident had a stage 2 pressure ulcer to the second toe of the left foot measuring 1 cm long by 1 cm wide. There was light serous exudate. The Wound Management note, dated 12/20/22, indicated the resident had a stage 2 pressure ulcer to the third toe of the left foot measuring 0.8 cm			

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	long by 0.8 cm wide, with 100% granulation tissue. The Wound Management note, dated 12/20/22, indicated the resident had a stage one pressure ulcer to the second metatarsal head at the bottom of the left foot measuring 0.4 cm long by 1 cm wide and 100% covered with non granulation tissue. The nurse's note, dated 12/21/22 at 4:40 a.m., indicated the boot to the left lower extremity was removed after the shower and the foot was elevated as directed by the physician. The treatments to the toes and the bottom of foot were applied and left open to air to promote healing. The staff would reapply the boot when the resident was up and using the boot for protection from friction. The IDT note, dated 12/21/22 at 11:12 a.m., indicated the wound tracking was opened in wound management. The Wound Management note, dated 12/28/22, indicated the resident had a stage 2 wound to the left medial metatarsal was stage 2 and measured 0.7 cm long by 0.5 cm wide. There was light serous exudate and 100% slough. The Wound Management note, dated 12/28/22, indicated the resident had a stage 2 wound to the top of the left foot measured 0.7 cm long by 1.5 cm wide by 0.1 cm deep. There was light serous exudate with 100% granulation tissue. The Wound Management note, dated 12/28/22, indicated the resident had a stage 2 wound to the second toe on the left foot measured 0.2 cm long by 0.2 cm wide, with 100% granulation tissue.			

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	The Wound Management note, dated 1/4/23, indicated the wound to the second toe of the left foot had healed. The physician's order, dated 1/4/23, indicated to observe the dressing to the top of the left foot every shift for drainage on dressing or dislodgement, three times a day. The physician's order, dated 1/4/23 to 1/12/23, indicated to cleanse the wound to the top of the left foot with wound cleanser, pat dry with a clean gauze, apply thin layer of medihoney to wound bed, apply skin prep to peri wound, and cover with a dry dressing daily until resolved. The physician's order, dated 1/4/23 to 1/12/23, indicated to cleanse the wound to the top of the left foot with wound cleanser, pat dry with a clean gauze, apply thin layer of medihoney to wound bed, apply skin prep to peri wound, and cover with a dry dressing daily prn (as needed) dislodgement or strike through was present. The Wound Management note, dated 1/11/23, indicated the wound to the second toe of the left foot measured 0.3 cm long by 0.5 cm wide with 100% slough. The nurse's note, dated 1/11/23 at 9:18 a.m., indicated the area to the second toe of the left foot was from the walking boot, which was applying pressure and rubbing. The boot had to be worn during the day related to a recent ankle fracture. The boot was removed at night. The Wound Management note, dated 1/11/23, indicated the stage 2 wound to the medial side of the big toe of the left foot measured 1 cm long by 0.6 cm wide with 100% of non-granulation tissue.			

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	It was calloused and firm. The IDT note, dated 1/11/23 at 10:54 a.m., indicated the area to the great toe of the left foot was observed from the walking boot. The physician's order, dated 1/11/23 to 1/12/23, indicated to cleanse the area to the medial aspect of the left great toe with wound cleanser, pat dry with a clean gauze, paint with skin prep, cover with a dry dressing twice daily until resolved twice a day. The IDT note, dated 1/11/23 at 10:55 a.m., indicated the area to the left second toe was observed from the walking boot. The Wound Management note, dated 1/11/23, indicated the resident had a stage 2 facility acquired pressure ulcer to the medial side of the left foot. The wound measured 1 cm long by 0.6 cm wide. The physician's order, dated 1/11/23 to 1/18/23, indicated to cleanse the area to the top of the left second toe with wound cleanser, pat dry with a clean gauze, paint with skin prep, cover with a dry dressing twice daily until resolved. The physician's order, dated 1/12/23 to 1/18/23, indicated to cleanse the area to the medial aspect of the left great toe with wound cleanser, pat dry with a clean gauze, apply silver foam dressing on Monday, Wednesday, and Friday. The physician's order, dated 1/12/23 to 1/18/23, indicated to cleanse the wound to the top of the left foot with wound cleanser, pat dry with a clean gauze, apply silver foam dressing on Monday, Wednesday, and Friday, weekly.			

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	The Wound Management note, dated 1/18/23, indicated the wound to the top of the left foot measured 0.5 cm long by 1 cm wide. There was light exudate and 100% granulation tissue. The physician's order, dated 1/18/23 to 1/25/23, indicated to cleanse the area to the medial aspect of the left great toe with wound cleanser, pat dry with a clean gauze, apply silver foam dressing on Monday, Wednesday and Friday weekly. The physician's order, dated 1/18/23 to 1/30/23, indicated to cleanse the wound to the top of the left foot with wound cleanser, pat dry with a clean gauze, apply silver foam dressing on Monday, Wednesday and Friday weekly. The Wound Management note, dated 1/25/23, indicated the stage 2 pressure ulcer to the medial side of the left foot measured 0.5 cm long by 0.3 cm wide by 0.1 cm deep. There was light serosanguineous exudate present. The wound was covered by 90% epithelialization tissue and 10% granulation tissue. The Wound Management note, dated 1/25/23, indicated the wound to the big toe of the left foot had healed. The Wound Management note, dated 1/25/23, indicated the wound the the medial side of the big toe on the left foot measured 0.5 cm long by 0.3 cm wide by 0.1 cm deep with light serosanguineous exudate. There was 90% epithelial tissue and 10% granulation tissue. The nurse's note, dated 1/25/23 at 5:30 p.m., indicated the resident returned from the follow up at the wound care center with new orders.			

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	Dressing changes to the medial side of the left great toe to be 2 times weekly. The physician's order, dated 1/30/23, indicated to cleanse the area to the medial aspect of the left great toe with wound cleanser, pat dry with a clean gauze, apply silver foam dressing and secure with a dry dressing, once a day on Monday and Thursday. The physician's order, dated 1/30/23, indicated to cleanse the wound to the top of the left foot on Monday, Wednesday, and Friday with wound cleanser, pat dry with a clean gauze, apply silver foam dressing and secure with a dry dressing. The physician's order, dated 2/2/23, indicated to cleanse the top of the left foot and with wound cleanser, pat dry, and apply skin prep twice daily preventatively. The physician's order, dated 2/2/23, indicated to monitor the top of the left foot twice daily. During an interview on 2/2/23 at 10:40 a.m., LPN (Licensed Practical Nurse) 1 and LPN 2. LPN 1 indicated the Cam boot caused the pressure ulcers. Weekly skin assessments were conducted. The Cam boot was worn, by the resident, all of the time except for showers. They should have taken it off for a skin assessment. No hospital discharge orders could be found by the LPNs. The nurse should have called the doctor or the hospital for verification that the Cam boot could come off for skin assessments. The staff should have noticed the wounds earlier. LPN 2 indicated the second time the wounds were documented in Wound Management, it was for preventive care. During an observation of the wound on 2/2/23 at			

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	10:49 a.m., LPN 1 and LPN 2 entered the room. The resident was wearing socks. LPN 2 pulled the sock to the left foot off and the wound to the top of the left foot was observed to be healing with epithelial tissue surrounding. The wound to the bottom of the left foot had healed with scarring. The wounds to the toes, of the left foot, had healed. LPN 2 indicated skin prep was ordered preventatively for the wound to the top of the left foot. The Guidelines for Weekly Skin Observation policy, dated 3/16/22, was provided by the DON on 2/1/23 at 1:50 p.m.. The policy included, but was not limited to, "Purpose To monitor the effectiveness of intervention for pressure reduction, identify areas of skin impairment in the early development stage and implement other preventative and/or treatment measures as indicated... 4. The nurse completing the weekly skin check shall indicate the appropriate number (0,1,2) medication note..." The current Guidelines for General Skin and Wound Care policy, provided by the DON on 2/1/23 at 1:50 p.m., included, but was not limited to, "... 5. Evaluate the need for a pressure reduction surface for bed/chair and the need for elbow protection and/or heel floats/boots..." 3.1-40(a)(1)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			

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	155681	A. BUILDING 00 B. WING	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure appropriate interventions to prevent falls were implemented for 1 of 7 residents reviewed for accidents. (Resident B) Finding included: The clinical record for Resident B was reviewed on 1/30/23 at 1:46 p.m. The diagnoses included, but were not limited to, Parkinson's disease, dementia, pain in right shoulder, pain in right hip, osteoporosis, weakness, convulsions, unspecified fall, and difficulty in walking. The Annual MDS (Minimum Data Set) assessment, dated 2/28/22, indicated the resident was severely cognitively impaired and had 2 falls with injury since his last assessment. The care plan, initiated on 3/9/20 and last revised on 11/8/22, indicated the resident was at risk for falling related to decreased mobility, medications, non-compliance with interventions, and a history of falls. The care plan was updated with a new intervention to give the resident a weighted blanket while in bed. The IDT (Interdisciplinary Team) note, dated 3/4/22 at 9:55 a.m., indicated the resident fell on 3/3/22 at 10:15 p.m. The root cause was restlessness and anxiety. The new intervention was to give the resident a weighted blanket while in bed.	F 0689	F689 Free of Accident Hazards/ Supervision/ Devices 1. Resident B was affected. Resident's care plan was reviewed and updated to reflect current and appropriate fall interventions. No adverse effects noted. 2. All residents have the potential to be affected. All residents' fall care plan approaches reviewed and in place. Clinical staff were educated on location of care plan approaches inside electronic health record. Clinical staff and interdisciplinary team were provided education on fall interventions and root cause analysis. 3. As a measure of ongoing compliance, the DHS or designee will audit 3 residents weekly x1 month on random shifts to ensure fall care plan approaches are appropriate and in place, then every other week x2 months, then monthly x3 months. 4. Results from audits will be reviewed during the campus' monthly QAPI meeting to determine the ongoing frequency as to the monitoring plan. Findings suggestive of 100% compliance may result in cessation of the monitoring plan.	03/01/2023

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	The nurse's note, dated 9/14/22 at 2:40 p.m., indicated the resident was transferred to a recliner after lunch for a nap. The resident attempted to transfer himself out of the recliner and fell. The resident was placed in bed and had no further attempts at transferring himself. The IDT note, dated 9/15/22 at 10:02 a.m., indicated the resident was in the recliner in the dayroom in the reclining position. The resident was attempting to get out of the recliner and failed to put the recliner in a non-reclining position prior to attempting to transfer. The resident had cognitive impairment and stated he was attempting to go to bed. The new intervention was to encourage the resident to utilize the reclining position of his high back wheelchair. The nurse's note, dated 9/16/22 at 4:37 p.m., indicated the resident was sitting in his wheelchair in the living room when the nurse found him on the floor in front of his wheelchair face down on his stomach. He had an abrasion on his nose and a hematoma to his forehead. The nurse's note, dated 9/19/22 at 10:26 a.m., indicated the resident was in his wheelchair and was leaning forward reaching for an object when he fell forward out of the wheelchair. The resident had Parkinson's disease and at times had poor upper body control. He had a cognitive impairment. The new intervention identified was to to give the resident a lap weighted blanket while he was up in his wheelchair. The resident's fall care plan was updated on 9/19/22 with a new intervention to encourage a weighted blanket while he was in his wheelchair.			

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	The 5-day MDS (Minimum Data Set) assessment, dated 11/28/22, indicated the resident was moderately cognitively impaired and had falls prior to his admission. During an observation on 1/30/23 at 12:30 p.m., the resident was in his wheelchair at the dining table. Staff were assisting him to eat. He did not have a weighted blanket in place. During an observation on 1/30/23 at 1:47 p.m., the resident was lying abed with his eyes closed. His gray weighted blanket was lying over the back of his recliner. He did not have a weighted blanket provided for him in the bed. During an observation on 1/31/23 at 1:58 p.m., the resident was lying abed with his eyes closed. His gray weighted blanket was lying over the back of his recliner. He did not have a weighted blanket provided for him in the bed. During an observation on 1/31/23 at 2:54 p.m., the resident was lying abed with his eyes closed. His gray weighted blanket was lying over the back of his recliner with a pillow on top of it. He did not have a weighted blanket provided for him in the bed. During an observation on 2/1/23 at 8:18 a.m., the resident was sitting in his wheelchair at the dining table. He was wearing a gray sweatsuit and black shoes with brown socks. He did not have a weighted blanket on his lap. During an interview on 2/1/23 at 2:30 p.m., LPN (Licensed Practical Nurse) 10 indicated when a resident fell they tried to make new interventions and made sure all interventions were in place. For Resident B, they used a weighted blanket. He			

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	might be capable of recalling or following simple direction but remembering education or encouragement would not be appropriate interventions for him. During an interview on 2/1/23 at 2:33 p.m., CNA (Certified Nurse Aide) 11 indicated Resident B's care plan included an intervention of giving the resident a lap blanket. He was to use it when he was up in his wheelchair and also if he was in the bed. The most current Fall Management Program Guidelines policy, last reviewed on 3/16/22, provided on 2/1/23 at 2:45 p.m. by the Clinical Support Nurse, included, but was not limited to, "... 2. Should the resident experience a fall the attending nurse shall complete the 'Fall Event' This includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment yo identify possible contributing factors, interventions to reduce the risk of repeat episode, and a review by the IDT to evaluate thoroughness of the investigation and appropriateness of the interventions... 5. The resident care plan should be updated to reflect any new or change in interventions..." This Federal tag relates to Complaint IN00397631 3.1-45(a)(1)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his			

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	or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, record review and interview, the facility failed to maintain a resident's catheter bag at the proper height to prevent urine from draining back in to the bladder and potential Urinary Tract Infections (UTIs) for 1 of 4 residents reviewed for UTI. (Resident 19) Finding included: The clinical record for Resident 19 was reviewed	F 0690	F690 – Bowel/ Bladder/ Incontinence/ Catheter/ UTI 1. Resident 19 was affected. The resident was assessed by Clinical Support nurse and no symptoms of infection were noted. 2. All residents with catheters have the potential to be affected. All residents with catheters were assessed by Clinical Support	03/01/2023

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	on 2/1/23 at 9:00 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, hydronephrosis with renal and urethral calculous obstruction, personal history of malignant neoplasm of prostate and obstructive and reflux uropathy. The Quarterly Minimum Data Set assessment, dated 11/22/22, indicated the resident was severely cognitively impaired and utilized a supra-pubic catheter. The Interdisciplinary Team (IDT) note, dated 7/27/22 at 12:09 p.m., indicated there was brown drainage, redness and mild pain was observed to suprapubic cath (catheter) site. The physician was notified and gave orders for UA (urinalysis) and to start Cipro 500 mg (milligrams) BID (twice daily) for 10 days starting 7/28/22. The nursing note, dated 8/15/22 at 6:26 p.m., indicated the resident had a suprapubic cath which was red and had consistent clear drainage around placement area. The resident complained of discomfort at this area when touched. The physician was notified and a new order was received for Keflex 500 mg (milligrams) TID (3 times daily) for 10 days. The IDT note, dated 9/12/22 at 9:57 a.m., indicated the resident refused his medications on 9/10/22. A new order was obtained to check for a UTI as the resident had chronic urinary complications. The nursing note, dated 9/13/22 at 3:59 a.m., indicated the resident had complaints of nausea this shift. When the nurse attempted to administer the Zofran as ordered, the resident declined to take medication. A urine sample was sent to lab for urinalysis and were awaiting the		nurse and no symptoms of infection were noted. All clinical staff will receive education on urinary catheter care. 3. As a measure of ongoing compliance, the DHS or designee will complete audits of catheter positioning for 2 residents, on random shifts if available, weekly for 4 weeks, then every other week for 2 months, then monthly for 3 months. 4. Results from audits will be reviewed during the campus' monthly QAPI meeting to determine the ongoing frequency as to the monitoring plan. Findings suggestive of 100% compliance may result in cessation of the monitoring plan.	

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	results. The IDT note, dated 9/15/22 at 9:51 a.m., indicated the urinalysis was completed and reviewed and a culture was indicated. The urine culture, dated 9/16/22, was determined to be abnormal. The physician was notified and indicated no new orders due to the resident being asymptomatic and since the urine was collected 2 weeks ago, it was likely colonized. He indicated for staff to continue to observe without treatment. A urinalysis, dated 2/12/22, indicated the following results: - 10,000 - 50,000 CFU/ml (colony forming units per milliliter) mixed path - probable contaminant The physician was notified on 2/14/22 and ordered Augmentin 875 mg BID pending culture. A urinalysis, dated 6/29/22, indicated the following results: - Enterococcus faecalis greater than 100,000 cfu/ML and candida albicans. The physician was notified and a new order for Amoxicillin 500 mg TID times 10 days and when the antibiotic was completed, give Diflucan 200 mg QD (every day) times 4 days. A urinalysis, dated 7/27/22, was performed and indicated the following results: - urine clarity was turbid, had 3+ blood and 2+ protein, was positive for nitrates, had 3+ leukocytes and bacteria; and white blood count was 100+. The physician was notified and gave new orders for Cipro 500 mg BID until 8/7/22. A care plan, dated 3/31/22, indicated the resident used a suprapubic catheter for DX (diagnosis) of obstructive uropathy. Approaches included, but			

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	were not limited to, lab work completed per physician orders. Maintain a closed system with urinary bag below the residents bladder and cover. Observe tubing and avoid any obstructions. Observe for any signs of complication such as UTI, urethral trauma, strictures, bladder calculi or silent hydronephrosis and notify the doctor. A care plan, dated 11/22/22 indicated the resident demonstrated non-compliance with physician orders and/or plan of care as evidenced by: placing Foley catheter on floor, holding above bladder, manipulating bag, placing resident at higher risk for infection. Approaches included, but were not limited to, assess for need for a guardian or other legal oversight as needed. Monitor resident's ability to give informed consent and fluctuations in decision making. Encourage resident to participate in decision making by offering choices and discussion of advance directives. Educate resident regarding physician orders and risk and benefits of compliance. On 1/29/23 at 10:05 a.m., the catheter bag was hanging from the top rung of the enabler bar and there was urine in the catheter tubing from the resident's abdomen to the bag. The resident was laying down in bed at the time and his body was almost one (1) foot below the catheter bag. On 1/30/23 at 8:40 a.m.,the catheter bag was in the same place as observed on 1/29/23 at 10:05 a.m. and the resident was laying down in bed. There was urine in the tubing going from the resident's abdomen to the bag. On 2/2/23 at 8:20 a.m., the resident was sitting up on the edge of his bed with his catheter bag			

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	hanging on the top rail of enabler above the resident's bladder, urine was in the tubing just before going into the bag. During an observation of the staff putting the resident to bed from his wheelchair on 1/31/23 at 1:40 p.m., Certified Resident Care Assistant (CRCA) 9 placed the resident's catheter bag on the lower frame of the bed below the resident's bladder even when lying down. She indicated that the catheter bag should be below the resident's bladder so the urine would not drain back into the resident. During an interview with the resident on 1/29/23 at 10:05 a.m., he indicated he had no idea why he had a catheter, what it was or why it was hanging on his enabler rail. During an interview with the Director of Health Services (DHS) on 2/2/23 at 10:00 a.m., she indicated a resident's catheter should be placed below the resident's bladder, such as on the lower part of the bed frame, in order to prevent the urine from draining back into the bladder and possibly causing an infection. On 2/1/23 at 1:58 p.m., the DHS presented a copy of the facility's current policy on Urinary Catheter Care dated effective 3/16/22. The review of this policy at this time included, but was not limited to, "Overview: To prevent infection of the resident's urinary tract. SOP (Standard Operating Procedure) Details: ...4. The urinary drainage bag should be held or positioned lower than the bladder to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder..." 3.1-41(a)(2)			

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on record review and interview, the facility failed to appropriately assess and monitor respiratory symptoms for a resident displaying signs and symptoms of pneumonia and an upper respiratory infection (URI) for 1 of 7 residents reviewed for respiratory care. (Resident 39) Finding included: The clinical record for Resident 39 was reviewed on 1/30/23 at 12:42 p.m. The diagnoses included, but were not limited to, COVID-19 acute respiratory disease, contact with and (suspected) exposure to COVID-19, Alzheimer's disease with late onset, dementia, COPD (chronic obstructive pulmonary disease), seasonal allergic rhinitis, and personal history of other malignant neoplasm of bronchus and lung. The care plan, initiated on 12/7/22, indicated the resident had a potential for complications, functional and cognitive status decline related to respiratory disease and COPD. The interventions included, but were not limited to, assess for change in level of consciousness and coherency, and report changes, monitor lung sounds per orders or as needed, monitor oxygen saturation	F 0695	F695 – Respiratory/ Tracheostomy Care & Suctioning 1. Resident 39 was affected. Resident was assessed and medication ordered by provider. 2. All residents have the potential to be affected. All residents were assessed for respiratory symptoms. Nurses to be educated on completion of respiratory assessments. 3. As a measure of ongoing compliance, the DHS or designee will audit 3 residents with a respiratory change in condition, on random shifts as available, for notification, assessment data documentation, PRN use, and intervention implementation weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. Results from audits will be reviewed during the campus' monthly QAPI meeting to determine the ongoing frequency as to the monitoring plan. Findings	03/01/2023

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	via pulse oximetry as ordered, and observe for and report signs of respiratory distress, including but not limited to restlessness, wheezing, dyspnea, difficulty with expectoration, diaphoresis, crackles, bubbling, tachycardia, cyanosis, decreased breath sounds. The physician's orders, dated 11/18/22, indicated to provide COVID-19 testing per State and Federal regulations, and to monitor for new onset of signs or symptoms of COVID-19 including chills, cough, nausea, vomiting, diarrhea, shortness of breath, fatigue, headache, muscle/body aches, congestions, runny nose, sore throat, and/loss of taste or smell three times daily. The nurse's note, dated 12/11/22 at 10:45 a.m., indicated a radiology company called and indicated they needed insurance information before they were able to come out and perform a chest X-ray for the resident. The information was sent to the provider to proceed with the test. The clinical record lacked documentation of any respiratory symptoms or indications for the chest x-ray. The nurse's note, dated 12/11/22 at 11:28 p.m., indicated the resident's family member was refusing to let the resident go to the hospital. The resident's family member requested she be suctioned and she had been giving the resident over the counter Mucinex that she had brought in herself and the CNAs (Certified Nurse Aides) spotted her giving it to the resident. The nurse attempted to explain the effects of expectorants and suctioning with little verbalized understanding. The physician was made aware. The note lacked documentation of any respiratory assessment or symptoms.		suggestive of 100% compliance may result in cessation of the monitoring plan.	

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	The nurse's note, dated 12/12/22 at 2:30 p.m., indicated the resident had a chest x-ray report that showed patchy infiltrates in the right lower lobe. The resident was started on Doxycycline 100 mg for 10 days on 12/09/22. The IDT note, dated 12/13/2022 at 11:04 a.m., indicated the resident had a cough and congestion. A chest x-ray was obtained and reported the resident had infiltrates. An antibiotic and steroid were ordered. The nurse's note, dated 12/23/22 at 11:53 p.m., indicated the resident was tested for COVID-19 due to congestion and COVID exposure and had positive results. The 5-Day MDS (Minimum Data Set) Assessment, dated 12/28/22, indicated the resident was severely cognitively impaired and experienced shortness of breath when lying flat. The nurse's note, dated 1/16/23 at 5:01 p.m., indicated the resident was presenting with a productive cough and green sputum. The physician was contacted and gave orders for Mucinex 600 mg twice daily for 7 days and a chest x-ray. The nurse's note, dated 1/17/23 at 5:13 p.m., indicated the resident returned to the facility with her family member. The resident required the assist of two staff to get her into the building. Upon assessment, it was observed that the resident was very short of air, and lethargic. Her O2 (oxygen) saturation was 56% (percent, normal range greater than 90%) on room air, and her temperature was 99.1 F (Fahrenheit). O2 per nasal cannula was placed at 2 lpm (liters per minute) and			

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	the resident's family member set next to her to help keep her calm. The clinical record lacked documentation of any assessment of lung sounds or respiratory rate, or notification to the physician. The nurse's note, dated 1/18/23 at 2:21 a.m., indicated the resident was removing oxygen from her nose and complaining of difficulty breathing. When the oxygen was in place resident's O2 saturations were 95% to 96%, when removed her saturations dropped into the 80's, The resident also had increased respirations and congestion. The clinical record lacked documentation of any notification to the physician of the resident's respiratory status. The physician's note, dated 1/19/23 at 5:57 a.m., indicated the resident had been having a lot of cough and congestion over the last 3 to 4 days. She was tested for COVID-19 and was negative. She would not always leave the oxygen in place and her saturations would decrease when she took it off. Her chest x-ray showed no evidence of pneumonia. The physician indicated the resident had COPD with acute exacerbation and ordered decadron 6 mg IM (intramuscular), doxycycline 100 mg twice daily for 10 days, and prednisone 10 mg 1 four times daily for 3 days, then three times daily for 3 days, twice daily for 3 days and finally daily for 3 days. During an interview on 2/1/23 at 2:30 p.m., LPN (Licensed Practical Nurse) 10 indicated for a resident exhibiting any respiratory symptoms the first thing they would do would be to test for COVID, and test for flu. She would then check their vitals and call the doctor. They would			

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	document on an event and whatever the order reads. Every shift she would assess their lungs. If a resident's oxygen saturation dropped she would administer oxygen and call the doctor and notify them of the desaturation, even if the oxygen saturation went back up. During an interview on 2/2/23 at 8:39 a.m., the DON (Director of Nursing) indicated she would absolutely expect the physician to be notified via a phone call if the resident experienced a desaturation and they were experiencing respiratory symptoms. During an interview on 2/2/23 at 8:58 a.m., the DON indicated when a resident was having respiratory symptoms, there should be documentation of the respiratory assessments, and an event should be opened so they could monitor the resident's symptoms until they resolved. The most current but undated Notification of Change in Condition policy and procedure was provided on 2/1/23 at 2:45 p.m. by the Clinical Support Nurse. The policy included, but was not limited to, "... The facility must... consult with the resident's physician... when... 2. a significant change in the resident's physical, mental or psychosocial status. 3. A need to alter treatment significantly... Sample reasons to notify the physician immediately but not limited to: 1. A deterioration in health, metal or psychosocial status in either life threatening conditions or clinical complications... 2. Need to alter treatment significantly..." 3.1-47(a)(6)			

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F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, record review, and interview, the facility failed to ensure prompt intervention for a resident with dementia who was experiencing psychiatric delusions including suicidal and homicidal ideation for 1 of 4 resident's reviewed for Dementia Care. (Resident 40) Finding Included: The clinical record for Resident 40 was reviewed on 1/30/23 at 1:20 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance, psychotic disorder with delusions due to known physiological condition, adjustment disorder with other symptoms, and symptoms and signs involving appearance and behavior including but not limited to combative behavior. The care plan, initiated on 9/7/21 and last revised on 1/4/23, indicated the resident demonstrated signs and symptoms of depression as evidenced by score on the PHQ-9. The interventions included, but were not limited to, if resident voices suicidal thoughts or ideations, with or without a plan, refer to clinical team and implement measures to keep resident safe, provide medications per orders, monitor effects of anti-depressant and titrate to the lowest effective dose, observe mood, affect, and behaviors with all hands on care and contacts offer supportive contacts as needed, and	F 0744	F744 – Treatment/ Services for Dementia 1. Resident 40 was affected. Resident was evaluated by psych NP and changes were made to medication regimen. Resident's care plan was reviewed. 2. All residents with dementia have the potential to be affected. All residents with dementia reviewed for behaviors not addressed, care plans reviewed, and referred to provider for evaluation if indicated. Clinical staff were provided education on guidelines for mental health wellness program and guidelines for suicide threats. 3. As a measure of ongoing compliance, the DHS or designee will audit 3 residents with dementia weekly for 4 weeks, on random shifts then every other week for 2 months, then monthly for 3 months to ensure behaviors have been addressed and reported to MD as warranted. 4. Results from audits will be reviewed during the campus' monthly QAPI meeting to determine the ongoing frequency as to the monitoring plan. Findings	03/01/2023

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	refer to psychiatric services as needed. The care plan, initiated on 3/9/22 and last revised on 1/4/23, indicated the resident had impaired cognition and communication with associated short term memory impairment and risk for confusion, disorientation, altered mood, impaired or reduced safety awareness related to Alzheimer's dementia. The goal for the resident was to remain safe and not injure self secondary to impaired decision making. The interventions included, but were not limited to, calm resident if signs of distress develop during the decision making process, determine if decisions made by the resident endanger the resident or others and intervene if necessary, and re-direct resident when agitated behaviors are present or potential for injury is evident. The care plan, initiated on 10/3/22, indicated the resident inappropriate behaviors including displaying aggression, mimicking, kicking the nurse, and pulling away. The goal was for the resident's behaviors not to result in the disruption of others environment. The interventions included, but were not limited to, assess for unmet needs such as need for toileting, rest, food, companionship, etc., assist the resident to away from other residents as needed, determine the cause for inappropriate behavior and refer to physician as needed for intervention, encourage participation in structured activities as appropriate, observe for triggers of inappropriate behaviors and alter environment as needed. The care plan, initiated on 12/31/22 and last revised 1/4/23, indicated the resident demonstrated altered behaviors including delusions. The goal included the resident's delusions would not result in injury to self or		suggestive of 100% compliance may result in cessation of the monitoring plan.	

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	others. The interventions included, but were not limited to, administer medications per order, the resident's behaviors with all hands on care and contacts, observe for behavioral triggers and causal relationships to medical changes with all hands on care and contacts, and psychiatric services as needed. The Social Services Annual Review, dated 7/21/22 at 11:07 a.m., indicated the resident was alert and oriented with a diagnoses of dementia and required cueing at times. The resident had somewhat of a flat affect. He was quiet, usually only spoke if spoken to and stayed to himself. Resident did come out of his room and would passively participate in activities and will go outside with group. The resident sat with peers during meals. Staff would to continue to offer emotional and spiritual support. The nurse's note, dated 1/9/23 at 1:09 a.m., indicated the resident had not slept during the 12 hour shift or the prior 12 hours shift. The resident whistled at staff for 4 hours straight and talked and yelled at self and had conversations with himself all night long. He had a snack, a soda, and the CNA (Certified Nurse Aide) changed his linens after providing incontinence care. He received all routine medications including his trazodone with no effectiveness. The physician was notified and asked to review the resident's medications. The IDT note, dated 1/9/23 at 11:28 a.m., indicated the resident was having delusions. A new order was obtained for a urinalysis, CBC, and BMP. Social services was to notify the psychiatric nurse practitioner (NP). The nurse's note, dated 1/10/23 at 3:51 a.m.,			

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	indicated the physician ordered to increase the resident's trazodone to 50 mg daily. The nurse's note, dated 1/10/23 at 10:14 a.m., indicated the trazodone was changed back to 25 mg daily until blood work, urinalysis, and the nurse practitioner addressed the concerns of insomnia. If the lab results were within normal limited the physician agreed with the psychiatric NP following. The nurse's note, dated 1/11/23 at 3:14 a.m., indicated the resident had been awake all night. He had been awake in bed whistling randomly and got up for snacks. Staff had been unable to obtain the urinalysis due to the resident being incontinent. The nurse's note, dated 1/12/2023 at 12:05 p.m., indicated the resident was started on Macrobid 100 mg twice daily for 7 days related to his urinalysis results. The nurse's note, dated 1/19/23 at 6:53 a.m., indicated the physician ordered to continue the resident's Macrobid until a full 10 days and recheck the urinalysis. The nurse's note, dated 1/28/23 at 3:45 a.m., indicated the resident had been yelling out all shift and was doing it when the nurse received report before her shift. The yelling had lasted all night and had increased in volume. The resident was having violent hallucinations and delusions. The resident indicated he was yelling because he had to kill some people because some people had to die. He then asked the nurse to kill him. He was having disorganized religious rants and was whistling in between yelling out. He had not slept at all and was refusing incontinence care and was			

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	even becoming physically violent to staff and his self when staff members attempted to provide incontinence care throughout the night. Staff had been unable to change him and his brief, pants, pad, and sheets were saturated. The resident had dementia and several psych diagnosis and was on psychiatric medications routinely. An event was completed and a note was put into the physicians folder. The nurse would pass the information along to the day shift nurse to continue to monitor and if needed call the on call physician. The clinical record lacked documentation of any assessment of the resident having a plan for suicide, any ability to carry out a plan, removal of any items which could be harmful to the resident from the room, implementation of any increased monitoring or 1 on 1 supervision, or notification to the physician of the resident's statements and behaviors at the onset of the behaviors. The nurse's note, dated 1/28/23 at 7:04 p.m., indicated the resident was having delusions and was yelling at people who were not in his room. He was whistling loudly and frequently. The nurse's note, dated 1/29/23 at 4:56 a.m., indicated the resident had been yelling for staff to help him. When the nurse tried to apply his oxygen for saturations of 87% to 90%, he got angry and refused. The nurse would give the information to the first shift nurse and monitor the resident. The IDT note, dated 1/29/23 at 9:19 p.m., indicated the resident had refusal of care and hallucinations. The SSD (Social Services Director) was aware and the psychiatric NP was notified as well. The resident continued with orders for anti-psychotic medication as ordered and staff would continue to			

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	monitor the resident. The physician's note, dated 1/30/22 at 6:22 a.m., indicated the resident was back from hospital where he was admitted with RSV and pneumonia. He had finished his antibiotics, but still had some wheezes and some 02 requirement and would not leave his oxygen in place. The physician's note lacked documentation of any reference to the resident's behaviors. The nurse's note, dated 1/30/23 at 3:57 p.m., indicated the Psychiatric NP gave new orders for Ativan 0.5 mg every 6 hours as needed for anxiety. During an observation on 2/1/23 at 8:19 a.m., Resident 40 was lying in bed. He was yelling out, "Shut up!" when no one was in the room. A CNA entered the room and spoke to him for a moment and offered to dim the lights. The staff member dimmed the lights and left the room. The resident continued to mumble in his room. During an interview on 2/1/23 at 2:30 p.m., LPN (Licensed Practical Nurse) 10 indicated if they had a resident expressing suicidal or homicidal ideations they would put the resident on 15 minute checks, place them in one on one care, notify the doctor, and make a new event. She would notify the doctor by phone. It would be an immediate notification, and it would not be appropriate to leave the physician a note. During an interview on 2/2/23 at 8:40 a.m., the DON (Director of Nursing) indicated she did not know the physician was not called. She contacted the employee on Sunday when she was reviewing notes and had no response and had not received any return phone calls. When a resident made			

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	suicidal or homicidal statements she would expect 1 on 1 care to be implemented, and for staff to call the physician immediately. Putting a note in the physician's folder was not appropriate. On 2/2/23 at 2:24 p.m., the DON provided a copy of email document sent to psychiatric provider. The email was dated 1/29/23 at 9:10 p.m. The DON emailed the provider informing them of the resident's behavior. The DON indicated at this time the resident was not seen by the psychiatric provider until the following Monday, 1/30/23. During an interview on 2/2/23 at 2:33 p.m., LPN 10 indicated the resident did have behaviors, but she did not believe the nurse told her about the incident. She did not receive the information in report. He was having some delusions. He was talking to someone but there wasn't any one in the room. If she had known about his prior behavior she would have been more active in doing stuff. She would have been documenting more frequently on him, made a new or worsening event, and would have called the doctor immediately. The undated, but most current Guideline for Mental Health Wellness Program policy, provided on 2/1/23 at 2:45 p.m. by the Clinical Support Nurse, included, but was not limited to, "Procedures ... Behaviors that required interventions shall be defined as ... a. A behavior that jeopardizes or has the potential to jeopardize the health and safety of a resident or others including residents, visitors, or staff ... 6. Nursing staff shall document new or exacerbated behaviors on the 24 hour report ... and nursing progress notes ... 10. The Mental Health Wellness/Behavior Management Program shall consist of ... b. Communication to Social Service			

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	Director and Physician alerting them to new, exacerbated behaviors, current status, intervention effectiveness ..." The Guidelines for Suicide Threats Policy and Procedure, last revised 12/1/21, was provided on 2/2/23 at 3:20 p.m. by the Clinical Support Nurse. The policy included, but was not limited to, " ... Procedures 1. Resident threats of suicide should be taken seriously and must be reported immediately to the charge nurse. 2. The charge nurse shall notify the resident's attending physician, Director of Health Services, Director of Social Service and resident representative of such threats. 3. A staff member shall remain with the resident until the charge nurse arrives to examine the resident. a. The nurse should determine if the resident has a plan formulated. b. The nurse should determine if the resident is physically able to carry out a plan. c. The nurse shall determine if the resident need immediate transfer via 911. 4. Based on the resident assessment the charge nurse may assign 1:1 supervision ... or 15 minute checks ... to ensure the resident's safety until further instructions are received from the resident's attending physician. 5. Nursing service personnel will be informed of the suicide threat and to report changes in the resident's behavior immediately. 6. Items that pose a danger to the resident should be removed from the room. 7. Documentation of the incident will be recorded in the resident's medical record ..." 3.1-37(a)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any			

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	drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §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; §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; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §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.			

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	§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. Based on record review and interview, the facility failed to ensure residents were free of unnecessary psychotropic medications for 1 of 5 residents reviewed for unnecessary psychotropic medications. (Resident 39) Finding included: The clinical record for Resident 39 was reviewed on 1/30/23 at 12:42 p.m. The diagnoses included, but were not limited to, Alzheimer's disease with late onset, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance; anxiety; depression; and generalized anxiety disorder. The nurse's note, dated 11/17/22 at 11:59 a.m., indicated the resident arrived to the facility via a private family vehicle. The resident walked to unit with no assistance needed. She was extremely restless and staff were attempting to redirect the resident to lunch. The clinical record lacked documentation of any further behaviors or interventions for behaviors. The physician's order, dated 11/21/22 through 11/22/22, indicated the resident could receive Klonopin 0.5 (milligrams) mg four times daily as needed for anxiety. The nurse's note, dated 11/18/22 at 11:19 a.m., indicated behavioral health services were notified of the resident having behavioral issues. The	F 0758	F758 – Free from Unnecessary Psychotropic Drugs 1. Resident 39 was affected. Resident's medication reviewed by psychiatric NP and GDR initiated. Resident's care plan reviewed and updated. No adverse events noted. 2. All residents with psychotropic medication ordered have the potential to be affected. Residents with psychotropic medications ordered were reviewed to ensure appropriate diagnosis or documentation for use is present. All PRN psychotropic orders were reviewed for order to document prior intervention is in place. Nurses and QMAs were provided education on psychotropic medication use, gradual dose reductions, and controlled substances. 3. As a measure of ongoing compliance, the DHS or designee will audit 3 residents weekly x 4 weeks, on random shifts every other week x 2 months, then monthly x 3 months to ensure non-pharmacological interventions are attempted and documented prior to administration of PRN psychotropic and controlled substances administered were documented appropriately.	03/01/2023

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	Nurse Practitioner (NP) would be in to evaluate the resident and a one time order for Seroquel 25 mg was given. The care plan, initiated on 11/22/22, indicated the resident was at risk for adverse consequences related to receiving antianxiety medication. The interventions included, but were not limited to, administer medication per physician order, attempt non-pharmacological interventions prior to administering as needed anxiolytic, and provide the lowest effective dose possible. The physician's order, dated 11/22/22 through 11/29/22, indicated the resident could receive Klonopin 0.5 mg administer 0.25 mg three times daily as needed for anxiety. The nurse's note, dated 11/23/22 at 8:20 p.m., indicated the resident was very restless, agitated, exit seeking, was resisting care and needing one on one care for most of the shift. She defecated in a waste can and then put all her clothes in the waste can. The resident was given Klonopin but it did not help for long. The nurse's note, dated 11/27/22 at 2:01 p.m., indicated the resident had been restless for the entire shift. She had multiple attempts at getting out the double doors in the common area. She repeatedly stated that "mother was in that car in the parking lot and I have to get out there to her before she freezes to death." The resident was administered PRN (as needed) medication which little to no effect. The note lacked documentation of prior interventions attempted. Staff had to place the resident on 1 on 1 care to keep her from setting the door alarms off. The nurse's note, dated 11/28/22 at 9:04 a.m.,		4. Results from audits will be reviewed during the campus' monthly QAPI meeting to determine the ongoing frequency as to the monitoring plan. Findings suggestive of 100% compliance may result in cessation of the monitoring plan.	

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	indicated a new order was received for Risperdal 0.5 mg at bedtime and to discontinue the resident's Depakote per her family member's request. The nurse's note, dated 11/28/22 at 5:05 p.m., indicated the resident was very restless, very hard to redirect, and at times she started running toward doors and was almost falling. She removed her pants in the dining room at times and tried to totally disrobe in the common area. Klonopin was administered but did not help much. The note lacked documentation of specific interventions prior to the PRN medication administration. The resident required one on one care. The physician's order, dated 11/29/22 through 12/6/22, indicated the resident could receive Klonopin 0.5 mg three times daily as needed for anxiety. The nurse's note, dated 11/30/22 at 6:00 p.m., indicated the resident's Risperdal was increased to 0.5 mg in the morning and 1 mg at bedtime due to increased behaviors. The November MAR (Medication Record Review) indicated the resident received doses of her as needed Klonopin on 11/21/22 at 7:07 p.m., 11/25/22 at 10:00 p.m., 11/28/22 at 3:58 p.m., and 11/30/22 at 7:44 a.m., 10:26 a.m., and 3:12 p.m. for behaviors without documentation of prior intervention. The Resident's Controlled Drug Use Record sheet, indicated the resident received doses of her as needed Klonopin on 11/21/22 at 5:00 p.m., 11/22/22 at 7:00 p.m., 11/23/22 at 8:00 a.m. and 12:00 p.m., 11/25/22 at 8:00 a.m. and 12:00 p.m., and 11/29/22 at 8:00 a.m. and 12:00 p.m. without documentation on the resident's MAR of the medication			

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	administration or any prior intervention. The physician's order, dated 12/7/22 through 12/21/22, indicated the resident could receive Klonopin 0.5 mg three times daily as needed for anxiety. The nurse's note, dated 12/11/22 at 10:26 p.m., indicated the resident had continued to have increased behaviors and French kissed a male and female resident after dinnertime. The resident's were separated and the resident's family was made aware. The nurse attempted to keep the resident's clothing on her with no success. The physician was made aware. The note lacked documentation of specific interventions for the resident's behaviors. The nurse's note, dated 12/14/22 at 2:02 p.m., indicated the resident was difficult to redirect. She was into many different things and was safe and monitored by staff. The note lacked documentation of any specific interventions for the resident's behaviors. The nurse's note, dated 12/20/22 at 8:36 p.m., indicated the resident was wandering about the unit. She was easily redirected. As needed clonazepam was administered to the resident. The nurse's note, dated 12/21/22 at 4:05 a.m., indicated the resident awoke at 2:00 a.m. and was aimlessly searching for someone. The resident was redirected back to bed twice. No further non-pharmacological interventions were documented. The resident was given as needed Klonopin. The physician's order, dated 12/21/22 through 12/24/22, indicated the resident could receive			

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	Klonopin 0.5 mg three times daily as needed for anxiety. The physician's order, dated 12/24/22 through 1/4/23, indicated the resident could receive Klonopin 0.5 mg three times daily as needed for anxiety. The nurse's note, dated 12/26/22 at 8:30 p.m., indicated the resident had been in and out of all the rooms on the unit. Staff redirected the resident and replaced her mask several times. She had been very difficult to redirect. The resident was administered as needed medication. The note lacked documentation of specific interventions attempted. The 5-day MDS (Minimum Data Set) Assessment, dated 12/28/22, indicated the resident was severely cognitively impaired, had delusions, behaviors directed towards others, behaviors of wandering on a daily basis, and received anti-anxiety, anti-psychotic, and anti-depressant medications. The nurse's note, dated 12/29/22 at 4:41 p.m., indicated the resident had been all over the unit that day. She was very difficult to redirect. She grabbed things from the nursing carts and the desk, and removed tablecloths from the dining room tables. She received as needed medications per order. The note lacked documentation of specific interventions for the resident's behaviors. The nurse's note, dated 12/29/22 at 5:05 p.m., indicated the resident continued to be restless at all times. She continued to have impulsive behaviors and refused to comply with any redirection. She was invasive to others on unit, was grabbing others belongings, and continued			

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	to go into others room. She was difficult to redirect. The note lacked documentation of specific interventions. The December 2022 MAR indicated the resident's order for Klonopin 0.5 mg four times daily was administered on 12/3/22 at 2:40 p.m., 12/5/22 at 12:58 p.m., 12/6/22 at 12:06 p.m.,12/9/22 at 6:18 p.m., 12/10/22 at 12:49 p.m., 12/10/22 at 10:27 p.m., 12/12/22 at 4:55 p.m., 12/13/22 at 8:49 a.m., 12/13/22 at 4:12 p.m., 12/14/22 at 3:17 p.m., 12/15/22 at 1:24 p.m., 12/16/22 at 6:36 p.m., 12/17/22 at 2:22 p.m., 12/19/22 at 12:42 p.m., 12/20/22 at 11:56 a.m., 3:19 p.m., and 7:04 p.m., 12/21/22 at 3:08 p.m., 12/25/22 at 7:13 p.m., and 12/31/22 at 8:10 a.m. for behaviors without documentation of prior intervention. The Resident's Controlled Drug Use Record sheet, indicated the Klonopin 0.5 mg was administered on 12/1/22 at 3:00 p.m., 12/3/22 at 7:30 a.m., 12/4/22 at 6:30 a.m. and 2:45 p.m., 12/5/22 at 7:00 a.m., 12/6/22 at 6:15 p.m. and 11:50 p.m., 12/7/22 at 4:30 p.m. and 2:30 p.m., 12/11/22 at 6:30 a.m., 12/12/22 at 12:00 p.m., 12/16/22 at 1:30 p.m., 12/19/22 at 4:00 p.m., 12/21/22 at 8:00 a.m., 12/21/22 at 8:00 a.m. and another untimed administration, 12/22 at 8:00 a.m., 2:30 p.m., and 8:00 p.m., 12/23/22 at 8:00 a.m., 3:00 p.m., and 6:00 p.m., 12/24/22 at 8:00 a.m., 12:00 p.m., and 3:30 p.m., 12/26/22 at 12:30 p.m., 12/28/22 at 8:00 a.m., 12/29/22 at 8:00 a.m. and 12:00 p.m., 12/30/22 at 7:00 a.m. and 12:00 p.m., and 12/31/22 at 2:30 p.m., without documentation on the resident's MAR of the medication administration or any prior intervention. The nurse's note, dated 1/3/23 at 9:09 a.m., indicated the resident had been awake and all over the place that morning. She was pleasant, but getting into everything on the unit. She was given PRN medications per order, without positive			

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	results. The note lacked documentation of specific interventions attempted. The physician's order, dated 1/6/23 through 1/20/23, indicated the resident could receive 0.5 mg of Klonopin three times daily as needed. The physician's order, dated 1/21/23 through 2/4/23, indicated the resident could receive 0.5 mg of Klonopin three times daily as needed. The January 2023 MAR indicated the resident's Klonopin 0.5 mg three times daily as needed for anxiety was administered on 1/1/23 at 1:16 p.m., 1/3/23 at 6:21 a.m., 1/6/23 at 7:32 a.m., 1/8/23 at 9:25 p.m., 1/11/23 at 7:23 a.m. and 10:45 a.m., 1/13/23 at 4:07 p.m., 1/17/23 at 7:17 p.m., 1/18/23 at 4:20 p.m., 1/19/23 at 9:31 a.m., 1/22/23 a.m. at 1:00 a.m., 1/24/23 at 5:06 p.m., 12/27/23 at 7:08 p.m., an 1/29/23 at 3:15 p.m., for behaviors without documentation of prior interventions on the MAR. The Resident's Controlled Drug Use Record sheet, indicated the Klonopin 0.5 mg was administered on 1/3/23 at 12:00 p.m., 1/4/23 at 7:00 a.m. and 1:30 p.m., 1/5/23 at 1:00 p.m. and 7:00 p.m., 1/7/23 at 7:30 a.m. and 12:00 p.m., 1/86/23 at 7:00 a.m. and 12:00 p.m., 1/9/23 at 7:00 a.m. and 12:00 p.m., 1/10/23 at 7:00 a.m., 1:30 p.m., and 6:30 p.m., 1/11/23 at 8:00 p.m., 1/12/23 at 8:00 a.m. and 12:00 p.m., 1/14/23 at 7:30 a.m. and 1:30 p.m., 1/15/23 at 7:00 a.m., 12:30 p.m., and 7:00 p.m., 1/16/23 at 8:00 a.m. and 12:00 p.m., 1/17/23 at 8:00 a.m. and 12:00 p.m., 1/18/23 at 8:00 a.m. and 12:00 p.m., 1/20/23 at 4:45 p.m., 1/21/23 at 8:00 a.m., 1/22/23 at 8:00 a.m. and 6:00 p.m., 1/23/22 at 7:00 a.m. and 4:30 p.m., 1/24/23 at 5:00 p.m., 1/25/23 at 1:00 p.m., 5:00 p.m., and 9:00 p.m., 1/26/23 at 8:00 a.m., 12:00 p.m., and 4:00 p.m., 1/27/23 at 8:00 a.m., 1/28/23 at 6:30 a.m.,			

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	1/29/23 at 6:30 a.m., 1/30/23 at 8:00 a.m., and 1/31/23 at 8:00 a.m. and 12:00 p.m. without documentation on the resident's MAR of the medication administration or any prior intervention. During an interview on 2/1/23 at 2:30 p.m., LPN (Licensed Practical Nurse) 10 indicated how they handled resident behaviors depended on what the type of behavior was. With dementia, a lot of times they got distracted in a crowd, and she would move the resident to a quieter area, if needed she would provide 1 on 1 care, and try to realize what their needs were. She would see if they needed to use the bathroom or get a drink, and she would check for incontinence. They would document it under a new or worsening event. They also did the nurse's notes for behaviors. She would document how many times it happened, what it was, and what interventions were provided. She would document if interventions were effective. If they had a medication it would be given after they had exhausted all interventions and they didn't help. They did not use a lot of PRN medications and they did not pursue psychotropic medication use. During an interview on 2/2/23 at 2:29 p.m., LPN 10 indicated the resident's typically did not have as needed psychotropic medication, but if they did it would be the same as any as needed medication. They usually discouraged the use of as needed psychotropic medications, but if she did give one, she would document why it was given, what behavior was occurring, what intervention they attempted before giving the medication, and if it was effective. The documentation would be in the progress notes and on the MAR for the PRN administration. Narcotic medications would be signed out on both the controlled substance			

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	record and the MAR. Every time they administered a PRN medication they would document the administration on the resident's MAR. During an interview on 2/2/23 at 2:44 p.m., the DON indicated her expectation for the administration of PRN medications, would be for staff to monitor the resident for signs and symptoms of anxiety. Shortness of breath and anxiousness Resident 39's big signs of anxiety. They tried to use non-pharmacological interventions, such as diversional activities, 1 on 1 care, and crocheting. The resident liked to paint and draw as well and when all of the non-pharmacological interventions were ineffective they would use the klonopin as a last resort. She would expect to see a progress note and then on the order it should indicate what prior intervention staff had tried. The documentation on the MAR should include prior interventions, and was to be completed every time they administered the PRN medication. The Psychotropic Medication Usage and Gradual Dose Reductions policy, last revised 11/7/22, provided on 2/1/23 at 2:45 p.m. by the Clinical Support Nurse, included, but was not limited to, "... 1. Residents shall receive psychotropic medications only if designated medically necessary by the prescriber, with appropriate diagnosis or documentation to support its usage... 7. Orders for PRN medications will have designated purpose for use. Administration of PRN medications will be documented in the eMAR and indicate prior interventions to include non-pharmacological interventions..." The Controlled Substances policy, last revised 11/18, provided on 2/2/23 at 3:00 p.m., by the			

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	Clinical Support Nurse, included, but was not limited to, "... E. Accurate accountability of the inventory of all controlled drugs is maintained at all times. When a controlled substance is administered, the licensed staff administering the medication immediately enters the following information on the accountability record and the medication administration record.... 1. Date and time of administration... 2. Amount administered... 3. Remaining quantity... Initials of the staff member administering the dose..." 3.1-48(a)(4)			
F 0886 SS=D Bldg. 00	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of			

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	asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in			

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	testing efforts, such as obtaining testing supplies or processing test results. Based on record review and interview, the facility failed to ensure the residents were COVID-19 tested in accordance with their policy for 3 of 3 residents reviewed. (Residents 39, 23, and 29) Findings include: 1. The clinical record for Resident 39 was reviewed on 1/30/23 at 12:42 p.m. The diagnoses included, but were not limited to, COVID-19 acute respiratory disease, contact with and (suspected) exposure to COVID-19, Alzheimer's disease with late onset, dementia, COPD (chronic obstructive pulmonary disease), seasonal allergic rhinitis, and personal history of other malignant neoplasm of bronchus and lung. The care plan, initiated on 12/7/22, indicated the resident had a potential for complications, functional and cognitive status decline related to respiratory disease and COPD. The interventions included, but were not limited to, assess for change in level of consciousness and coherency; and report changes, monitor lung sounds per orders or as needed, monitor oxygen saturation via pulse oximetry as ordered, and observe for and report signs of respiratory distress, including but not limited to restlessness, wheezing, dyspnea, difficulty with expectoration, diaphoresis, crackles, bubbling, tachycardia, cyanosis, decreased breath sounds. The physician's orders, dated 11/18/22, indicated to provide COVID-19 testing per State and Federal regulations, and to monitor for new onset of signs or symptoms of COVID-19 including chills, cough, nausea, vomiting, diarrhea, shortness of breath,	F 0886	F886 -COVID-19 Testing 1. Residents 23, 29, 39 were affected. Resident 29 has been discharged. Residents 39 was COVID tested and found to be negative. Resident 23 was tested and treated for COVID 19 during hospital stay. 2. All residents have the potential to be affected. All residents assessed for symptoms of COVID and COVID tested in accordance with policy and procedure. All clinical staff were provided education on COVID testing. 3. As a measure of ongoing compliance, the DHS or designee will assess 3 residents for COVID symptoms weekly x4 weeks, every other week x 2 months, then monthly x 3 months to ensure COVID testing has been performed per policy. 4. Results from audits will be reviewed during the campus' monthly QAPI meeting to determine the ongoing frequency as to the monitoring plan. Findings suggestive of 100% compliance may result in cessation of the monitoring plan. d.	03/01/2023

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	fatigue, headache, muscle/body aches, congestions, runny nose, sore throat, and/loss of taste or smell three times daily. The nurse's note, dated 12/11/22 at 10:45 a.m., indicated a radiology company was called and indicated they needed more insurance information before they were able to come out and perform the resident's chest X-ray. The nurse's note, dated 12/11/22 at 11:28 p.m., indicated the resident's family member requested staff to suction the resident. The note lacked documentation of any respiratory assessment or symptoms. The nurse's note, dated 12/12/22 at 2:30 p.m., indicated the resident had a chest x-ray report that showed patchy infiltrates in the right lower lobe. The resident was started on Doxycycline 100 mg (milligrams) for 10 days on 12/09/22. The IDT (Interdisciplinary Team) note, dated 12/13/22 at 11:04 a.m., indicated the resident had a cough and congestion. A chest x-ray was obtained and reported the resident had infiltrates. An antibiotic and steroid were ordered. The clinical record lacked documentation of any COVID testing prior to 12/23/22. The nurse's note, dated 12/23/22 at 11:53 p.m., indicated the resident was tested for COVID-19 due to congestion and COVID exposure and had positive results. During an interview on 2/1/23 at 2:30 p.m., LPN (Licensed Practical Nurse) 10 indicated if a resident had respiratory symptoms the first thing they would do would be to test for COVID-19 and			

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	155681	A. BUILDING 00 B. WING	02/02/2023

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	influenza. 2. The clinical record for Resident 23 was reviewed on 1/30/23 at 1:25 p.m. The diagnosis included, but was not limited to, allergic rhinitis, unspecified. A physician's note. dated 12/14/22 at 6:50 a.m., indicated the resident had a bit of cough with some yellow like sputum. She was not really having any shortness of breath that was worse than it had been. No fevers per the staff. An examination indicated the lung sounds were decreased but no rales were heard and had some cough. He diagnosed her as having bronchitis and ordered a chest X-ray (CXR) and started her on an antibiotic. A nursing note. dated 12/14/22 at 2:43 p.m., indicated the resident continued with a nonproductive cough and noted the new orders. An Interdisciplinary Team note, dated 12/14/22 at 10:19 p.m., indicated the resident was noted with an antibiotic ordered for bronchitis and was afebrile at this time. Will continue to monitor. The review of the Respiratory Line Surveillance and the Tests" section of the clinical record lacked documentation to indicate the resident was tested for possible COVID infection. A care plan, dated 4/23/21, indicated the resident was at risk for exposure to the COVID-19 virus. Approaches included, but were not limited to, medications as ordered. Labs as ordered. Place on droplet/contact precautions when required, per policy. Observe and report signs of respiratory distress (restlessness, wheezing, dyspnea, difficulty with expectoration, diaphoresis, crackles, bubbling, tachycardia, cyanosis,			

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	decreased breath sounds). Monitor lung sounds as ordered or as needed. 3. The clinical record for Resident 29 was reviewed on 1/31/23 at 7:10 a.m. The diagnoses included, but were not limited to, pneumonia due to pseudomonas, paroxysmal atrial fibrillation, heart failure, chronic kidney disease, peripheral vascular disease, atherosclerotic heart disease, hypotension, chronic obstructive pulmonary disease, asthma, and the presence of a cardiac pacemaker. The Admission Scheduled 5 Day MDS assessment, dated 12/14/22, indicated the resident was cognitively intact. She required extensive assistance for bed mobility, transfer, locomotion on and off unit, toileting, and personal hygiene. She received oxygen therapy. The care plan, dated 12/21/22, indicated the resident had potential for complications, functional and cognitive status decline related to respiratory disease related to COPD (chronic obstructive pulmonary disease). The interventions indicated to administer oxygen per orders, assess for a change in the level of consciousness and coherency, labs as ordered, monitor lung sounds per orders or as needed, monitor oxygen saturation by pulse oximetry as ordered, observe and report signs of respiratory distress, and respiratory therapy per orders. The nurse's note, dated 12/7/22 at 8:41 p.m., indicated the resident arrived to the facility by private vehicle. The physician's order, dated 12/7/22, indicated COVID testing per current State and Federal requirements. Provider approved testing per current requirements.			

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The nurse's note, dated 1/9/23 at 8:54 a.m., indicated a note was left for the physician related to wheezing. A new order was received for a chest x-ray and to increase duo nebs to every 6 hours.

The nurse's note, dated 1/9/23 at 2:21 p.m., indicated the lungs were clear on the chest x-ray.

The clinical record lacked documentation of a Covid-19 test being performed at that time.

The nurse's note, dated 1/11/23 at 11:43 p.m., indicated the periodic non-productive cough continued. Every 6 hour duo-nebulizers were administered as ordered. The PRN Mucinex was also administered as directed and upon request this shift. The lung sounds were diminished in the bases. The oxygen saturation was 100% (percent) with supplemental oxygen.

The nurse's note, dated 1/14/23 at 9:30 p.m., indicated the non-productive cough continued. The resident's temperature was 99.4 degrees Fahrenheit.

The nurse's note, dated 1/15/23 at 5:30 p.m., indicated the breathing treatments were continued as ordered. The resident had a slight non-productive cough. Oxygen was administered by nasal cannula as ordered.

The nurse's note, dated 1/17/23 at 3:04 a.m., indicated the resident remained afebrile. Routine breathing treatments were administered as ordered every 6 hours. The resident had a minimal cough and congestion which was reported. The PRN Mucinex was also given upon request from the resident. Oxygen was in place by nasal cannula with saturations of 96% on 2 lpm (liters per

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	minute). The nurse's note, dated 1/21/23 at 11:44 p.m., indicated the resident refused the midnight and 6:00 a.m., nebulizer treatments for sleep. The nurse contacted the physician with a new order to schedule the duo nebulizer treatments to twice daily and as needed. The orders were changed to better accommodate the resident's sleeping hours. The physician's order, dated 1/21/23, indicated ipratropium-albuterol solution for nebulization, 0.5 mg (milligrams)-3 mg(2.5 mg base)/3 mL (milliliters) inhaled twice daily. The physician's order, dated 1/21/23, indicated ipratropium-albuterol solution for nebulization, 0.5 mg (milligrams)-3 mg(2.5 mg base)/3 mL inhaled twice daily PRN. During an interview on 2/2/23 at 8:17 a.m., the DON (Director of Nursing) indicated when a resident had signs or symptoms of an illness, a POC (rapid) test would be performed. The symptoms for testing were a fever, a cough, diarrhea, runny nose, and congestion, which was what started the last outbreak. If they had only one of those symptoms, they would be tested. During an interview on 2/2/23 at 10:15 a.m., LPN 3, indicated the symptoms of Covid-19 she would monitor a resident for a fever, a cough, crackling lung sound, shortness of breath, fatigue, malaise, any change from their usual. She would test a resident if they had one or more of these symptoms. During an interview on 2/2/23 at 10:20 a.m., LPN 4, indicated the symptoms she would monitor a resident monitor for fatigue, a fever, respiratory			

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	issues, or a cough. She would test them if they had respiratory issues or a fever. The current COVID-19 Mandatory Staff & Resident Testing policy was provided by the DON on 1/30/23 at 1:00 p.m. The policy included, but was not limited to, "Residents and staff, with even mild symptoms of COVID-19, should receive a viral test (POC) for COVID-19 as soon as possible..."			