STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 00 B. WING	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLISON POINTE HEALTHCARE CENTER	5226 E 82ND ST INDIANAPOLIS, IN 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 the Investigation of Complaint IN00365380 and IN00365813 Complaint IN00365380 - Substantiated. Federal/state deficiencies related to the allegations are cited at F0684 and F0725. Complaint IN00365813 - Substantiated. Federal/state deficiencies related to the allegations are cited at F0607, F0695, and F0725. Survey dates: October 27 and 28, 2021 Facility number: 000172 Provider number: 155272 AIM number: 100267130 Census Bed Type: SNF/NF: 124 Total: 124 Census Payor Type: Medicare: 5 Medicaid: 95 Other: 24 Total: 124 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 5, 2021	F 0000	Preparation execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts or alleged or conclusions set forth on the State of Deficiencies. The plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The plan of correction is submitted in order to respond to the allegation of non-compliance cited during survey on October 28th 2021. Please accept this plan of correction as the provider's credible allegation of compliance. The facility would like to request a desk review for this survey.	
F 0607 SS=D Bldg. 00	483.12(b)(1)-(3) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures			

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

Any deficiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, Based on interview and record review, the facility failed to implement written policies and procedures to investigate abuse, neglect, and exploitation of residents and misappropriation of resident property by not having witness statements signed or dated at the time is was written and not including in the statements a description of what was witnessed, seen or heard, for 1 of 3 residents reviewed for abuse. (Resident D) Findings include: An incident involving Resident D and CNA (Certified Nursing Assistant) 9 was reported to the State Department of Health on 10/20/21. It indicated, Resident D reported CNA 9 "exclaimed, 'You shouldn't be pissing in your diaper'. Resident D felt degraded by this comment and that he makes these comments routinely. The resident's roommate stated she has heard this comment". The immediate action taken by the facility was "...employee was immediately placed on leave pending further investigation" The investigation file for the above incident was	F 0607	1) 1.Resident D (Dawson) was not harmed by the deficient practice. 2) 2.All residents have the potential to be affected. An audit was completed of all investigations within the last 3 months to validate all witness statements were signed and dated and to validate that the description of what was witnessed, seen, or heard is included in the statements. 3) 3.IDT team were educated on Abuse & Neglect & Misappropriation of Property policy with emphasis on ensuring witness statements are signed, dated, and include descriptions of what was witnessed, seen, or heard. 4) 4. The Regional Director of Clinical Operations (RDCO) or Regional Director of Operations (RDO) will review all investigations weekly to validate statements from staff, witnesses, accused perpetrator, and the victim for the event. This will be an ongoing	11/23/2021

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	received on 10/28/21 at 4:13 p.m. by RDCO (Regional Director of Clinical Operations). The investigation file contained, but not limited to: witness statements from Resident D and Resident H; 3 staff phone interviews; and a phone interview from CNA 9. Resident D's witness statement dated 10/20/21 and taken by SS (Social Service) 10 indicated, "Stated on 10/18/21 CNA(sic) came in room (night shift) and she needed to (sic)changed. He was changing her and making her feel bad(sic) about him having to perform care. He did clean her up. She did not want CNA back in room." The witness statement from Resident D did not contain the time the interview was conducted, lacked a signature from Resident D, and did not contain a description of what was heard by Resident D to make her feel badly. An interview with Resident D was conducted on 10/28/21 at 2:27 p.m. Resident D indicated, CNA 9 "has always had an attitude towards me and has always put me down. He told me I shouldn't have to s--- on myself and I should be able to get up and use the bedside commode instead of pissing in a diaper". Resident H's witness statement dated 10/20/21 and taken by SS 10 indicated, "(sic, Resident H's name) stated CNA (sic) came in room (sic) was cleaning roommate and she overheard him making (sic, Resident D's name) feel bad(sic) about him having to clean her up. Stated staff here is nice but he is not friendly. She does not want CNA (sic) to take care of her either". An interview with SS 10 was conducted on 10/28/21 at 3:09 p.m. She indicated, when she was taking down Resident D's witness statement		practice of this facility for 90days. All findings from the review will be reported to the QAPI committee monthly and the QAPI will determine when compliance is achieved or if further monitoring needs to be completed.	

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	she never asked the resident if she felt like the treatment she received from CNA 9 was abuse. SS stated, when taking the witness statement from Resident D, she voiced CNA 9 had said something to the effect of "why cant you use the bedside commode" and "why cant you get up". SS 10 did not include Resident D's description of what she heard on the witness statement. SS also indicated, Resident H had voiced that she too had heard CNA 9 say something to the effect of "why cant you get up and use the bedside commode". SS 10 did not included Resident H's description of what she heard CNA 9 say to Resident D. The 3 staff member phone interviews were typed onto a single piece of paper with staff member names and whether or not they were aware of any concerns or abuse allegations. The time and date of these statements was not recorded nor were signatures obtained from the staff members who were questioned. The witness statement for CNA 9 was typed onto a single piece of paper and stated, "Called (sic, name of CNA 9)- informed of suspension and allegation--(sic, name of CNA 9) unaware of any allegations or concerns-denies allegation". The witness statement did not indicated a date or time the phone call occurred. A signature from CNA 9 could not be obtained as the facility has been unsuccessful in reaching him since the day of the phone call. An Indiana Abuse & Neglect $ Misappropriation of Property policy was received on 10/28/21 at 4:13 p.m. from RDCO. It indicated, "2. A Suspected Abuse...d. Statements will be obtained from staff related to the incident, including victim, person reporting incident, accused			

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	perpetrator and witnesses. This statement should be in writing, signed, and dated at the time it is written. Supervisors may write the statement for a person giving a statement about the incident to them and the person giving the statement must sign and date it, or a third party may witness the statements. e. Statements should include the following: i. First-hand knowledge of the incident ii. A description of what was witnessed, seen or heard..." This Federal tag relates to complaint IN00365813. 3.1-13(i) 3.1-27(b)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review the facility failed to timely and accurately complete admission orders for care, medications, and diet for 3 of 3 residents reviewed for admission (Resident C, F and G). Findings include: 1. The clinical record for Resident F was reviewed on 10/27/21 at 2:45 p.m. The	F 0684	1) 1.Resident C, F, and G could not be identified due to confidentiality. 2) 2. All residents have the potential to be affected. An audit was completed on all admissions within the last 2 weeks to validate that all admission orders were entered accurately and completely. All findings were	11/23/2021

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	Resident's diagnosis included, but were not limited to, hypertension and diabetes. She was admitted to the facility on 10/16/21. The discharge documentation provided from the acute rehabilitation hospital to the facility indicated that upon discharge from the hospital her diagnosis included hyperglycemia (high blood sugar), hypertension, dysphagia (trouble swallowing) due to recent stroke, and solid pseudopapillary carcinoma (cancer of the pancreas). She was to receive the following care and medications: The medications were listed as follows: 1. acetaminophen 325mg (milligrams) 2 tablets as needed for pain or fever, 2. albuterol 2.5mg/3ml(milliliters) per nebulizer every 2 hours as needed for shortness of breath, 3. amantadine (medication to control movements of body) 100 mg twice daily, 4. amlodipine (heart medication) 10 mg daily, 5. aspirin 81 mg 2 tablets daily, 6. atorvastatin (medication for high cholesterol) 40 mg daily at bedtime, 7. bacitracin ointment applied topically daily, 8. bisacodyl (laxative) 10 mg rectal suppository daily as needed for constipation, 9. chlorhexidine 4% topical soap to be applied topically every evening, 10. cholecalciferol (vitamin D) 1000 units- 1 tablet daily 11. Docusate Sodium (stool softener) 100 mg- 1 capsule daily, 12. doxycycline hyclate (antibiotic) 100 mg-- 1 tablet daily, 13. insulin lispro- to be given 4 times daily per sliding scale, 14. labetalol (drug to treat high blood pressure) 200 mg- 2 tables 3 times daily,		reported to the Medical Director. 3) 3.All licensed nurses were educated on facilities policy “Admission Evaluation” with an emphasis on timeliness of entering new admission orders. 4) 4. DON or designee will ensure that all admission orders are entered and sent to pharmacy in a timely manner. The evening shift supervisor will validate all admissions that arrive after 5 pm. Manager on duty will be responsible for validating weekend admissions. Admissions will be reviewed in clinical morning meeting for accuracy of orders and to ensure pharmacy delivery. This is an ongoing facility practice. The DON/designee will report all findings to the monthly QAPI committee for no less than 6 months. The QAPI committee will determine when compliance is achieved or if further monitoring is required.	

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	15. lidocaine jelly- applied topically up to 6 times daily for urinary discomfort, 16. lisinopril (drug to treat high blood pressure) 20 mg- 2 tablets daily, 17. Lovenox (blood thinner) 40 mg- inject .4 ml daily, 18. methylphenidate (stimulant) 5 mg- 1 tablet 2 times daily, 19. MiraLAX (fiber)- 1 packet daily as needed for constipation, 20. prostat (supplement) 30 ml daily, 21. multivitamin with minerals 1 time daily, 22. nystatin (antifungal medication) tablet 4 times daily, 23. omeprazole (medication for gastric reflux) 20 mg daily, 24. ondansetron (medication for nausea) 4 mg- 1 tablet every 6 hours as needed for nausea or vomiting, 25. fluoxetine (antidepressant) 20 mg 1 time daily, 26. senna (laxative) 8.6 mg- 2 tablets 2 times daily, 27. ascorbic acid (vitamin C) 500 mg 1 time daily, She was also to receive blood sugar checks 4 times a day, before meals and at bedtime. Her gastrostomy tube was to be flushed with 150 ml of water 3 times daily for hydration and patency. She was to receive 240 ml of Glucerna (nutritional supplement)1.5 3 times a daily if she ate less than 50 % of her meal and 240 ml at bedtime routinely. The medication information included that she was to continue taking her doxycycline until 10/17/21. During an interview on 10/28/21 at 3:15 p.m.,			

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	QMA (Qualified Medication Aide) 9 indicated she had worked the evening that Resident F was admitted and that she arrived at the facility between 8 and 9 p.m. Her Order Summary Report for October 2021 was provided by the RDCO (Regional Director of Clinical Operations) on 10/27/21 at 3:49 p.m. It indicated the physician's orders for her to receive a bolus of 240 ml of Glucerna 1.5 3 times daily if she ate less than 50 % of meals was to start on 10/18/21. The physician's orders for her medications, as listed on the discharge instructions from the acute rehabilitation hospital were entered on 10/17/21 with a start date of 10/18/21, except for the acetaminophen, ducolox suppositories, and insulin lispro per sliding scale, ondansetron, MiraLAX, labetalol hcl, and lidocaine gel, which were to start on 10/17/21. A physician's order, dated 10/17/21, indicated that she was to receive doxycycline hyclated 100 mg daily prophylactically for urinary tract infections. It did not include a stop date on 10/17/21 as indicated in the medication information from the rehabilitation hospital. The October 2021 MAR (Medication Administration Record) indicated that she had received her first dose of labetalol hcl on 10/17/21 at hs (hour of sleep) with a recorded blood pressure of 136/96. She had an accucheck completed for the first time while at the facility on 10/17/21 at 9:00 p.m., with a reading of 146, requiring no insulin be administered. She did not receive any of the other medications, ordered for her upon discharge from the acute rehab hospital on 10/16/21 until 10/18/21.			

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	An interview on 10/29/21 at 2:34 p.m., RP (Registered Pharmacist) 22 indicated he could not determine when the admission orders had been sent to the pharmacy, but that the first physician's orders for her medications had been entered into the computer system on 10/17/21 at 11:00 p.m. 2. The clinical record for Resident G was reviewed on 10/27/21 at 1:50 p.m. The Resident's diagnosis included, but were not limited to, depression and anxiety. He was admitted to the facility on 10/16/21 at 4:00 p.m. The discharge instruction provided from the acute care hospital to the facility indicated that upon discharge from the hospital his diagnosis included gastrointestinal bleeding, erosive esophagitis (inflammation of the esophagus), acute blood loss anemia, and depression with anxiety. He was to receive the following care and medications: The medications were listed as follows: 1. folic acid 1 mg tablet daily with the next dose due on 10/17/21 in the morning, 2. multivitamin tablet daily with the next dose due on 10/17/21 in the morning, 3. nicotine 21mg/24hr extended-release patch with the next dose due on 10/17/21 in the morning, 4. pantoprazole (medication to treat gastric reflux and a damaged esophagus) 40 mg tablet 2 times daily with the next dose due on 10/16/21 in the evening, 5. quetiapine (antipsychotic medication) 25 mg tablet 1 time daily at bedtime with the next dose due on 10/16/21 at bedtime, 6. sucralfate (antacid) suspension 1 gram per 10 ml- give 10 ml before each meal and at bedtime			

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	with the next dose due 10/16/21 at 9:00 p.m., 7. thiamine (vitamin) 100 mg tablet 1 time daily with the next dose due 10/17/21 in the morning, and 8. hydroxyzine (antihistamine) 50 mg capsule to be taken every 8 hours as needed for anxiety with the next dose due whenever needed. He was to receive a regular diet and Ensure Plus as a nutritional supplement with lunch and dinner. His Order Summary Report for October 2021 was provided by the RDCO on 10/27/21 at 3:49 p.m. It indicated that his nicotine patch, thiamin, and sucralfate were to start being administered on 10/17/21. His hydroxyzine was to start being given on 10/18/21, and his multivitamin tablet and omeprazole were to start being given on 10/19/21. It did not contain an order for quetiapine or for him to receive Ensure Plus as a nutritional supplement. A physician's order, dated 10/17/21, indicated he was to get sucralfate 1 gram tablet by mouth each evening for gastric reflux disease. As of 10/25/21, there was no documentation in the clinical record as to why the dosage and administration time had been changed from the original discharge instructions of sucralfate suspension 1gram per 10 ml, with 10 ml (1 gram) to be given before each meal and at bedtime. The October 2021 MAR indicated he had received his first nicotine patch on 10/17/21 at 8 p.m. His first dose of folic acid, multivitamin, omeprazole, pantoprazole, sucralfate, and thiamin were not admistered until 10/19/21. An interview on 10/29/21 at 2:34 p.m.,			

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	RP(Registered Pharmacist) 22 indicated that the first physician's orders for his medications had been entered into the computer system for physician's orders on 10/17/21 in the morning and had sporadically been entered through out 10/17/21 and 10/18/21 3. The clinical record for Resident C was reviewed on 10/27/21. Resident C's diagnoses included, but not limited to, contusion, laceration and hemorrhage of the brain stem, Moyamoya disease (rare blood vessel disorder which reduces the blood flow to the brain), and aphagia (difficulty or inability to swallow). Resident C was admitted to the facility on 10/15/21. The admission MDS (Minimum Data Set) dated 10/15/21 indicated, Resident C required supervision and assistance of 1 person for eating. Resident C's 10/15/21 care plan indicated, he had an ADL (Activities of Daily Living) self care deficit requiring assistnace with ADLs. The interventions included, but not limited to: observe and anticipate resident's needs: thirst, food, body positioning, pain, toileting needs, and requires assistance with eating. A physician's order dated 10/17/2021 indicated, Resident C was to have a regular diet. Resident C's admitting orders on 10/15/21 did not contain a dietary order and the diet order placed on 10/17/21 was placed after he had been in the facility for over 24 hours. A point of care report received on 10/28/21 at 10:41 a.m. from RDCO (Regional Director of Clinical Operations) indicated, Resident C consumed the following amounts of his meals: 10/16/21 76% - 100% of a meal at 12:28 p.m.			

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	No further intakes for 10/16/21 were documented. 10/17/21 76% - 100% of a meal at 8:06 p.m. No further intakes for 10/17/21 were documented. A point of care report received on 10/27/21 at 4:03 p.m. from MDSC (Minimum Data Set Coordinator) indicated, Resident C consumed the following amounts of fluid: 10/16/21 240 ml (milliliters) at 4:53 a.m. and 360 ml at 12:29 p.m. No further intakes were documented for this day. 10/17/21 320 ml at 8:07 p.m. No further intakes were documented on this day. An interview with FM (family member of Resident C) 6 was conducted on 10/27/21 at 2:16 p.m. FM 6 indicated, the first time she could visit Resident C was on 10/18/21 and noticed Resident C looked dry. She stated his mouth was dry and his lips were cracked. While visiting with Resident C, she stated Resident C's roommate told her that the facility did not feed Resident C the entire weekend nor did they provide him anything to drink and they only provided incontinent care once a day. FM 6 stated, when she had arrived and saw how dry Resident C appeared, she asked 3 different people for a glass of water for Resident C, but no one ever returned with the water. She had brought him a mountain dew since it was his favorite and she said he drank the entire 20 oz bottle at once. He choked a few times because he was drinking it so fast. When his lunch tray arrived, he drank all the koolaide and two cups of tap water that she got herself. She stated, "he smelled so bad" when I got there so, I gave him a bath and noticed he was wearing two incontinent undergarments.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	During an interview on 10/28/21 at 10:45 a.m., NP (Nurse Practitioner) 7 indicated that the nurses entered the admission orders into the computer system upon a resident's admission. The nurses were very busy, and they did not always have time to go over the entire discharge packet. It was her understanding that they used the discharge instruction medications list to enter admission orders. She was not aware that Resident C's dietary order was addressed until 10/17/21. During an interview on 10/28/21 at 1:50 p.m., LPN (Licensed Practical Nurse) 3 indicated that on the weekends the nurses do all the order input into the computer system when there is an admission. The time involved doing an admission for a resident varies with each resident, the more medications a resident was to receive, the longer it would take to complete the admission process. The resident admission process could take a few of hours to complete, depending on what else happens when the nurse was completing it, as the nurse is also responsible for the other residents on the unit. The most important part of the admission to finish quickly was the medication entry so that the pharmacy could be made aware of what medications the resident would need. The pharmacy was pretty good about getting the medications to the facility quickly after they were notified. There was also an EDK (Emergency Drug Kit) available to start medications for the resident prior to them arriving from the pharmacy. The medications would not come up on the electronic MAR to be given until they were entered into the computer system.			

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	On 10/28/21 at 3:30 p.m., the Executive Director indicated the facility census for 10/16/21 was 123 residents in house. During an interview on 10/28/21 at 4:10 p.m., the RDCO indicated that if an admission is unable to be completed by the admitting nurse, then the following shift should continue to complete the admission process. On 10/27/21 at 11:35 a.m., the MDSC (Minimum Data Set Coordinator) provided the scheduled, as worked, for 10/16/21 which indicated that on that day, 3 licensed nurses worked in the building on the day shift with an additional licensed nurse in orientation to the facility, 2 licensed nurses who worked in the building on the evening shift, and 1 licensed nurse who worked in the building on the night shift. On 10/27/21 at 4:55 p.m., the RDCO provided the Admission Evaluation policy, reviewed 5/29/2019, which read "...Definitions: Admission: the first 24 hours the resident is in the facility or returning to the facility. Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. A systematic evaluation is completed by a licensed nurse upon admission/ readmission to assist in determining the most effective and appropriate care needs of each resident admitted to the center. Procedure...2. Prioritized resident needs with appropriate interventions to include but not limited to: a. Meet immediate physical needs including assessment of pain b. Provide social and			

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	emotional support c. consider elopement risk for residents who are cognitively impaired and ambulatory d. provide toileting needs f. complete medication reconciliation g. consider last meal eaten and provide hydration..." This Federal tag relates to Complaint IN000365380. 3.1-37			
F 0695 SS=G 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 interview and record review, the facility failed to apply a BiPAP (bilevel positive airway pressure) machine as ordered by the physician. This resulted in the respiratory distress and hospitalization of 1 of 3 residents reviewed for respiratory care (Resident B). Findings include: The clinical record for Resident B was reviewed on 10/27/21 at 11:45 p.m. The Resident's diagnosis included, but were not limited to, sleep apnea and respiratory failure.	F 0695	1) 1.Resident B (Barnett) no longer resides at the facility. 2) 2. All residents requiring BiPAP therapy have the potential to be affected. An audit was completed on all residents requiring BiPAP to ensure residents are having BiPAP applied and documented per physician orders. 3) 3. All licensed nurses and respiratory therapists were educated on the facilities "CPAP/BiPAP" policy with an	11/23/2021

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	A Quarterly MDS (Minimum Data Set) Assessment, completed 7/31/12, indicated that he needed extensive assistance with personal hygiene and did not exhibit episodes of rejection of care. A physician's order, dated 4/12/21, indicated he was to use a BiPAP machine every night for obstructive sleep apnea. A care plan, revised on 5/11/21, indicated he had asthma related to chronic obstructive pulmonary disease with a goal to remain free of complication of asthma. The interventions included, but were not limited to, monitor vital signs, skin color, pulse oximetry, airway functioning and degree of restlessness which may indicated hypoxia (low oxygen in blood). A care plan, revised on 7/26/21, indicated that he was to receive BiPAP therapy due to his obstructive sleep apnea and acute respiratory failure. The goal was for him to adhere to the BiPAP regimen with interventions including, but not limited to, encourage resident's uses of BiPAP. The October 2021 TAR (Treatment Administration Record) indicated that his BiPAP machine had been used nightly except for on 10/16/21, when he had refused it, and 10/23/21, when there were no initials indicating it has been applied or refused. A nurses note, dated 10/24/21 at 5:48 a.m., indicated the LPN (Licensed Practical Nurse) 2 had been called to the room due to him being short of breath. She applied his BiPAP machine.		emphasis on ensuring BiPAP is placed and documented per physician orders. 4) 4.The evening shift supervisor will validate that all BiPAPs are placed per physician orders. DON or designee will review 24 hour report and MAR/TAR documentation in clinical meeting to ensure documentation of BiPAP placement or refusal is present. This is an ongoing facility practice. The DON/designee will report all findings to the monthly QAPI committee for no less than 6 months. The QAPI committee will determine when compliance is achieved or if further monitoring is required.	

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	His oxygen saturation was 84%. Oxygen was placed on resident and his oxygen saturations increased to 90% and stayed between 90% and 91%. She had notified convergence (physician's service). A Convergence narrative note, dated 10/24/21 at 5:55 a.m., indicated Resident B was having dyspnea (shortness of breath). His oxygen saturation was 84%. He had a history of hypoxic respiratory failure as well as obstructive sleep apnea and was supposed to be wearing a BiPAP but wasn't. Even when the BiPAP was applied the oxygen saturation was not above 90 so oxygen needed to be added. A stat (right away) chest x-ray and labs were ordered. A nurses note, dated 10/24/21 at 7:30 a.m., indicated he was having shortness of breath and was anxious. He had thick white secretions from his mouth ad his breathing was labored with abdominal distension. He was receiving 5 liters of oxygen and his oxygen saturation was 98%. He was being sent the emergency room for treatment. A Convergence note, written by PA (physician's assistant) 8 at 10/24/21 at 10:54 a.m., read "In ER [sic] pending dispo[sic], may be admitted due to acute hypoxic respiratory failure. He needs to wear his BiPAP at nighttime. He is at high risk for acute decompensation without the use of BiPAP" The acute care hospital history and physical, dated 10/24/21, was obtained on 10/28/21 at 9:00 a.m. It indicates that he was taken to the acute care hospital via ambulance on 10/24/21 due to extreme shortness of breath, abdominal			

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	distension, and increased oral secretion. The assessment and plan included problem 1 of acute hypoxic respiratory failure. He had arrived at the acute care hospital with dyspnea. A chest x-ray done in the emergency department showed bibasilar atelectasis (partial or complete collapse of the lung) and possible early infiltrates accentuated by low lung volumes. During an interview on 10/27/21 at 3:22 p.m., CNA (Certified Nursing Assistant) 6 indicated that Resident B could not really use his hands or arms. He uses a BiPAP at night and he would be unable to place the BiPAP mask on himself or remove it. During an interview on 10/28/21 at 8:42 a.m., CNA 4 indicated that she did not feel that he could completely remove the BiPAP mask without assistance. During an interview on 10/28/21 at 9:46 a.m., the DNS (Director of Nursing Services) and the RDCO (Regional Director of Clinical Operations) indicated that the nurses were responsible for putting on the BiPAP masks. During an interview on 10/28/21 at 1:25 p.m., LPN 2 indicated that she was the nurse who had gone to assist Resident B on 10/24/21 at 5:48 a.m. She had been the only licensed nurse in the facility for the night shift of 10/23/21 through the morning of 10/24/21. She had worked on the other unit that night but had informed the staff of his unit that if they needed any assistance, they could call her. She had been to his room to care for him prior to when the staff on the unit called her due to him having shortness of breath. When			

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	she entered the room his BiPAP was not on, and the mask was not anywhere in his bed. She put it on him when she entered the room. She had a hard time getting his oxygen saturation to come up from 84% so she had also applied oxygen to assist him. His oxygen saturations came up to 90% with the use of the oxygen. She had stayed with him until he was stable and then called convergence to notify them of the change in his condition. She was not normally assigned to his unit, however had cared for him on occasions. He normally wore a his BiPAP mask at night. She had seen him attempt to remove his BiPAP by breaking the seal the mask forms by opening his mouth or turning his head from side to side, however, did not believe he could not remove the mask completely from his face due to his overall physical condition. When she cared for him, as his assigned nurse, she would assure his BiPAP mask was on when she started her shift. At times the evening shift had already applied it and sometimes she would apply it. The order for the BiPAP would come up on the computer screen telling the nurse to apply it on the night shift. There were usually 2 nurses for the night shift, however she was the only nurse that night, which was unusual. During an interview on 10/28/21 at 3:30 p.m., the Executive Director indicated the facility census on 10/23/21 was 126 residents in house. On 10/27/21 at 4:55 p.m., the RDCO provided the CPAP/ BiPAP policy, effective 9/10/21, which read "...Purpose: 1. A method for decreasing CO2 [carbon dioxide] sleep apnea 2. To prevent or correct atelectasis 3. to improve oxygenation 4. to assist in reducing pulmonary edema. Procedure: 1. Obtain the physician's order. 2. Verify the correct order of the CPAP/			

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	BiPAP settings. 3. Check the resident identity. 4. Identify yourself and explain the procedure to the resident...6. Connect CPAP/ BiPAP device delivery tubing to pressure generator...8. Set CPAP/ BiPAP setting per order..Evaluation...2. monitor pulse oximetry as ordered...4. Monitor resident's ability to manipulate device and face mask. Recording and Reporting: 1. Respiratory assessment findings. 2. CPAP/ BiPAP settings. 3. Pulse oximetry. 4. Client Response. 5. Change in physician's orders. 6. Report to physician: sudden changes in client's respiratory status and worsening pulse oximetry value..." This Federal tag relates to Complaint IN000365813 3.1-47(a)(6)			
F 0725 SS=D Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:			

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	(i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on interview and record review, the facility failed to have sufficient licensed nursing staff to timely completed the admission process for new residents of the facility and to apply a BiPAP machine timely, resulting in a resident being admitted to an acute care hospital for acute respiratory failure, for 1 of 3 residents reviewed for respiratory care and 2 of 3 residents reviewed for new admissions (Resident B, F, and G). See F0695 for additional information regarding Resident B and F0684 for additional information regarding Resident F, and G. Findings include: On 10/27/21 at 11:35 a.m., the MDSC (Minimum Data Set Coordinator) provided the nursing schedules, as worked for 10/16/21 and 10/23/21 and the list of admitted to the facility in the last 30 days. On 10/27/21 at 11:21 a.m., the SSA (Social Services Assistant) provided the facility bed board (list of resident in rooms) for 10/22/21 which indicated the census on that day was 125 residents in house, and that 12 of those residents were receiving ventilator (machine which assists residents to breath) care. On 10/28/21 at 3:30 p.m., the Executive Director indicated the facility census for	F 0725	1. 1. Resident B no longer resides at the facility. Resident F and G could not be identified due to confidentiality. 2. 2. All residents have the potential to be affected by the deficient practice. The facility will staff at or above the minimum staffing requirement for daily census to meet resident needs and determined by the facility assessment. 3. 3. The ED, DON, and scheduler was in-serviced on the staffing requirements identified for the building. 4. The staffing schedule will be reviewed daily with the Administrator, DON, and Human Resources manager. Resources manager and staffing coordinator to validate appropriate staffing numbers and identify the distribution of staff based on resident needs. The DON/designee will report all findings to the monthly QAPI committee for no less than 6 months. The QAPI committee will determine when compliance is achieved or if further monitoring is	11/23/2021

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	10/16/21 was 123 residents in house and on 10/23/21 there were 126 residents in house. The schedule, as worked, on 10/16/21 indicated that on that day, 3 licensed nurses worked in the building on the day shift with an additional licensed nurse in orientation to the facility, 2 licensed nurses who worked in the building on the evening shift, and 1 licensed nurse who worked in the building on the night shift. The licensed nurse to resident ratio for that day was .39 licensed nursing hours per resident. The admission list indicated there were 5 residents admitted to the facility on 10/16/21, 3 of which were admitted on the evening shift. This included Resident F and Resident G. The schedule as worked on 10/23/21, indicated that on Saturday, 5 licensed nurses worked in the building on the day shift, 2 licensed nurses worked on the evening shift, and 1 licensed nurse worked in the building on the night shift. The licensed nurse to resident ration for that day was .50 nursing hours per resident. During an interview on 10/28/21 at 2:30 p.m., the Staffing Coordinator indicated that she had been instructed that there should never be just one nurse scheduled for the night shift in the building. 1. The clinical record for Resident B was reviewed on 10/27/21 at 11:45 p.m. The Resident's diagnosis included, but were not limited to, sleep apnea and respiratory failure. A physician's order, dated 4/12/21, indicated he was to use a BiPAP machine every night for obstructive sleep apnea.		required.	

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The October 2021 TAR (Treatment Administration Record) indicated that his BiPAP machine had been used nightly except for on 10/16/21, when he had refused it, and 10/23/21, when there were no initials indicating it has been applied or refused.

A nurses note, dated 10/24/21 at 5:48 a.m., indicated the LPN (Licensed Practical Nurse) 2 had been called to the room due to him being short of breath. She applied his BiPAP machine. His oxygen saturation was 84%. Oxygen was placed on resident and his oxygen saturations increased to 90% and stayed between 90% and 91%. She had notified convergence (physician's service).

A Convergence narrative note, dated 10/24/21 at 5:55 a.m., indicated Resident B was having dyspnea (shortness of breath). His oxygen saturation was 84%. He had a history of hypoxic respiratory failure as well as obstructive sleep apnea and was supposed to be wearing a BiPAP but wasn't. Even when the BiPAP was applied the oxygen saturation was not above 90 so oxygen needed to be added. A stat (right away) chest x-ray and labs were ordered.

A nurses note, dated 10/24/21 at 7:30 a.m., indicated he was having shortness of breath and was anxious. He had thick white secretions from his mouth and his breathing was labored with abdominal distension. He was receiving 5 liters of oxygen and his oxygen saturation was 98%. He was being sent the emergency room for treatment.

A Convergence note, written by PA (physician's assistant) 8 at 10/24/21 at 10:54 a.m., read "In

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	ER [sic] pending dispo[sic], may be admitted due to acute hypoxic respiratory failure. He needs to wear his BiPAP at nighttime. He is at high risk for acute decompensation without the use of BiPAP" The acute care hospital history and physical, dated 10/24/21, was obtained on 10/28/21 at 9:00 a.m. It indicates that he was taken to the acute care hospital via ambulance on 10/24/21 due to extreme shortness of breath, abdominal distension, and increased oral secretion. The assessment and plan included problem 1 of acute hypoxic respiratory failure. He had arrived at the acute care hospital with dyspnea. A chest x-ray done in the emergency department showed bibasilar atelectasis (partial or complete collapse of the lung) and possible early infiltrates accentuated by low lung volumes. During an interview on 10/28/21 at 9:46 a.m., the DNS (Director of Nursing Services) and the RDCO (Regional Director of Clinical Operations) indicated that the nurses were responsible for putting on the BiPAP masks. During an interview on 10/28/21 at 1:25 p.m., LPN 2 indicated that she was the nurse who had gone to assist Resident B on 10/24/21 at 5:48 a.m. She had been the only licensed nurse in the facility for the night shift of 10/23/21 through the morning of 10/24/21. She had worked on the other unit (ventilator unit) that night but had informed the staff of his unit that if they needed any assistance, they could call her. She had been to his room to care for him prior to when the staff on the unit called her due to him having shortness of breath. When she entered the room his BiPAP was not on, and the mask was not			

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	anywhere in his bed. She put it on him when she entered the room. She had a hard time getting his oxygen saturation to come up from 84% so she had also applied oxygen to assist him. His oxygen saturations came up to 90% with the use of the oxygen. She had stayed with him until he was stable and then called convergence to notify them of the change in his condition. She was not normally assigned to his unit, however had cared for him on occasions. He normally wore a his BiPAP mask at night. She had seen him attempt to remove his BiPAP by breaking the seal the mask forms by opening his mouth or turning his head from side to side, however, did not believe he could not remove the mask completely from his face due to his overall physical condition. When she cared for him, as his assigned nurse, she would assure his BiPAP mask was on when she started her shift. At times the evening shift had already applied it and sometimes she would apply it. The order for the BiPAP would come up to be signed off as completed on the night shift. There were usually 2 nurses for the night shift, however she was the only nurse that night, which was unusual. 2. The clinical record for Resident F was reviewed on 10/27/21 at 2:45 p.m. The Resident's diagnosis included, but were not limited to, hypertension and diabetes. She was admitted to the facility on 10/16/21. The discharge documentation provided from the acute rehabilitation hospital to the facility indicated that upon discharge from the hospital her diagnosis included hyperglycemia (high blood sugar), hypertension, dysphagia (trouble swallowing) due to recent stroke, and solid pseudopapillary carcinoma (cancer of the			

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	pancreas). She was to receive the following care and medications: The medications were listed as follows: 1. acetaminophen 325mg (milligrams) 2 tablets as needed for pain or fever, 2. albuterol 2.5mg/3ml(milliliters) per nebulizer every 2 hours as needed for shortness of breath, 3. amantadine (medication to control movements of body) 100 mg twice daily, 4. amlodipine (heart medication) 10 mg daily, 5. aspirin 81 mg 2 tablets daily, 6. atorvastatin (medication for high cholesterol) 40 mg daily at bedtime, 7. bacitracin ointment applied topically daily, 8. bisacodyl (laxative) 10 mg rectal suppository daily as needed for constipation, 9. chlorhexidine 4% topical soap to be applied topically every evening, 10. cholecalciferol (vitamin D) 1000 units- 1 tablet daily 11. Docusate Sodium (stool softener) 100 mg- 1 capsule daily, 12. doxycycline hyclate (antibiotic) 100 mg-- 1 tablet daily, 13. insulin lispro- to be given 4 times daily per sliding scale, 14. labetalol (drug to treat high blood pressure) 200 mg- 2 tables 3 times daily, 15. lidocaine jelly- applied topically up to 6 times daily for urinary discomfort, 16. lisinopril (drug to treat high blood pressure) 20 mg- 2 tablets daily, 17. Lovenox (blood thinner) 40 mg- inject .4 ml daily, 18. methylphenidate (stimulant) 5 mg- 1 tablet 2 times daily, 19. MiraLAX (fiber)- 1 packet daily as needed for constipation, 20. prostat (supplement) 30 ml daily,			

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	21. multivitamin with minerals 1 time daily, 22. nystatin (antifungal medication) tablet 4 times daily, 23. omeprazole (medication for gastric reflux) 20 mg daily, 24. ondansetron (medication for nausea) 4 mg- 1 tablet every 6 hours as needed for nausea or vomiting, 25. fluoxetine (antidepressant) 20 mg 1 time daily, 26. senna (laxative) 8.6 mg- 2 tablets 2 times daily, 27. ascorbic acid (vitamin C) 500 mg 1 time daily, She was also to receive blood sugar checks 4 times a day, before meals and at bedtime. Her gastrostomy tube was to be flushed with 150 ml of water 3 times daily for hydration and patency. She was to receive 240 ml of Glucerna (nutritional supplement)1.5 3 times a daily if she ate less than 50 % of her meal and 240 ml at bedtime routinely. Resident F's Order Summary Report for October 2021 was provided by the RDCO (Regional Director of Clinical Operations) on 10/27/21 at 3:49 p.m. It indicated the physician's orders for her to receive a bolus of 240 ml of Glucerna 1.5 3 times daily if she ate less than 50 % of meals was to start on 10/18/21. The physician's orders for her medications, as listed on the discharge instructions from the acute rehabilitation hospital were entered on 10/17/21 with a start date of 10/18/21, except for the acetaminophen, ducolox suppositories, and insulin lispro per sliding scale, ondansetron, MiraLAX, labetalol hcl, and lidocaine gel, which were to start on 10/17/21.			

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	The October 2021 MAR (Medication Administration Record) indicated that Resident F had received her first dose of labetalol hcl on 10/17/21 at hs (hour of sleep) with a recorded blood pressure of 136/96. She had an accucheck completed for the first time while at the facility on 10/17/21 at 9:00 p.m., with a reading of 146, requiring no insulin be administered. She did not receive any of the other medications, ordered for her upon discharge from the acute rehab hospital on 10/16/21 until 10/18/21 3. The clinical record for Resident G was reviewed on 10/27/21 at 1:50 p.m. The Resident's diagnosis included, but were not limited to, depression and anxiety. He was admitted to the facility on 10/16/21 at 4:00 p.m. The discharge instruction provided from the acute care hospital to the facility indicated that upon discharge from the hospital his diagnosis included gastrointestinal bleeding, erosive esophagitis (inflammation of the esophagus), acute blood loss anemia, and depression with anxiety. He was to receive the following care and medications: The medications were listed as follows: 1. folic acid 1 mg tablet daily with the next dose due on 10/17/21 in the morning, 2. multivitamin tablet daily with the next dose due on 10/17/21 in the morning, 3. nicotine 21mg/24hr extended-release patch with the next dose due on 10/17/21 in the morning, 4. pantoprazole (medication to treat gastric reflux and a damaged esophagus) 40 mg tablet 2			

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	times daily with the next dose due on 10/16/21 in the evening, 5. quetiapine (antipsychotic medication) 25 mg tablet 1 time daily at bedtime with the next dose due on 10/16/21 at bedtime, 6. sucralfate (antacid) suspension 1 gram per 10 ml- give 10 ml before each meal and at bedtime with the next dose due 10/16/21 at 9:00 p.m., 7. thiamine (vitamin) 100 mg tablet 1 time daily with the next dose due 10/17/21 in the morning, and 8. hydroxyzine (antihistamine) 50 mg capsule to be taken every 8 hours as needed for anxiety with the next dose due whenever needed. Resident G's Order Summary Report for October 2021 was provided by the RDCO on 10/27/21 at 3:49 p.m. It indicated that his nicotine patch, thiamin, and sucralfate were to start being administered on 10/17/21. His hydroxyzine was to start being given on 10/18/21, and his multivitamin tablet and omeprazole were to start being given on 10/19/21. It did not contain an order for quetiapine or for him to receive Ensure Plus as a nutritional supplement. The October 2021 MAR indicated he had received his first nicotine patch on 10/17/21 at 8 p.m. His first dose of folic acid, multivitamin, omeprazole, pantoprazole, sucralfate, and thiamin were not admistered until 10/19/21. On 10/28/21 at 8:40 a.m., an attempt to reach the nurse on duty during Resident F and Resident G's admissions with no success. During an interview on 10/22/21 at 1:50 p.m., LPN (Licensed Practical Nurse) 3 indicated that on the weekends the nurses do all the order input			

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	into the computer system when there is an admission. The time involved doing an admission for a resident varies with each resident, the more medications a resident was to receive, the longer it would take to complete the admission process. The admission process for a resident could take a few of hours to complete, depending on what else happens when the nurse was completing it, as the nurse is also responsible for the other residents on the unit. The most important part of the admission to finish quickly was the medication entry so that the pharmacy could be made aware of what medications the resident would need. The pharmacy was pretty good about getting the medications to the facility quickly after they were notified. There was also an EDK (Emergency Drug Kit) available to start medications for the resident prior to them arriving from the pharmacy. The medications would not come up on the electronic MAR to be given until they were entered into the computer system. During an interview on 10/28/21 at 4:10 p.m., the RDCO indicated that if an admission is unable to be completed by the admitting nurse, then the following shift should continue to complete the admission process. She was unsure what had happened during Resident F and Resident G's admission process. An interview on 10/29/21 at 2:34 p.m., RP (Registered Pharmacist) 22 indicated he could not determine when the admission orders for Resident F had been sent to the pharmacy, but that the first physician's orders for her medications had been entered into the computer system on 10/17/21 at 11:00 p.m. Resident G's			

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	first physician's orders for his medications had been entered into the computer on the morning on 10/17/21 and had been sporadically entered though out 10/17/21 and 10/18/21. This Federal tag relates to Complaint IN000365813 and IN000365380. 3.1-17(a)			