STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 00 B. WING	02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

(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. Survey dates: February 9, 10, 13, 14, and 15, 2023 Facility number: 000178 Provider number: 155280 AIM number: 100273840 Census Bed Type: SNF/NF: 69 Total: 69 Census Payor Type: Medicare: 21 Medicaid: 39 Other: 9 Total: 69 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 17, 2023.	F 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.** **We respectfully request a desk review to verify satisfaction of compliance with the alleged survey deficient practices.**	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Vanessa Roll, RN	Administrator	02/28/2023

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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	comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.			
	Based on observation, interview, and record review, the facility failed to develop care plans for	F 0656	It is the policy of this facility to develop and implement a	03/16/2023

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	a resident that received an anticoagulant medication and a resident that had a diagnosis of PTSD (Post Traumatic Stress Disorder) for 2 of 17 residents reviewed for care plans. (Residents 35 and 3) Findings include: 1. Resident 35 was observed sitting in a chair in the common area of the dementia unit on 02/13/23 at 9:43 A.M. The resident had fallen earlier that morning and had a small laceration on the right side of her head that was sutured and open to air. The resident's clinical record was reviewed on 02/13/23 at 10:00 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 01/09/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, dementia, diabetes, and a blood clot in the venous system of the skull. The resident received an anticoagulant medication on seven of seven days of the assessment review period. During an interview on 02/14/23 at 3:08 P.M., RN 4 indicated nursing staff should monitor a resident that received an anticoagulant medication for bleeding and bruising every shift. The resident's current MD orders included an open-ended order, with a start date 04/08/21, for Eliquis (an anticoagulant), 5 mg (milligrams). Give one tablet by mouth every morning and at bedtime for a non-occlusive clot in the sigmoid sinus. The resident's February 2023 EMAR (Electronic Medication Administration Record) indicated the resident received the medication every day as ordered.		comprehensive person-centered care plan for each resident. Resident #35 & #3 received no negative outcome as a result of the alleged deficient practice. Resident #35 care plan has been updated. Resident #3 has had further evaluation on 2/20/23 by Nurse Practitioner that revealed the PTSD diagnosis on PASSR was incorrect. A new PASSR has been requested to accurately reflect the resident on 2/27/23. Any resident who receives anticoagulation or has a diagnosis of PTSD have the potential to be impacted by this alleged deficient practice. All residents receiving anticoagulation or has a diagnosis of PTSD have been reviewed 2/27/23 by the Administrator. Any concerns were addressed. No negative outcome has occurred due to the alleged deficit practice. MDS coordinator and Social Service Director was in-serviced by the Administrator and or designee on 2/27/23 on the facility expectation for care plan development for anticoagulation and addressing any PTSD diagnosis. Any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. MDS coordinator and Social Service Director have completed 100% audit of resident receiving anticoagulation and have dx of	

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	The resident's Complete Care Plan was provided by the Administrator on 02/15/23 at 9:58 A.M. and lacked a care plan for the anticoagulant medication. During an interview on 02/15/23 at 11:40 A.M., the Administrator indicated if a resident was receiving an anti-coagulant medication, they should have a care plan for anticoagulant medication usage. 2. The clinical record for Resident 3 was reviewed on 02/14/23 at 1:39 P.M. A Quarterly MDS assessment, dated 01/08/23, indicated the resident was moderately cognitively impaired. The active diagnoses included, but were not limited to, epilepsy, anemia, seizure disorder, anxiety, and PTSD. The Complete Care Plan for Resident 3 was provided by the Administrator on 02/14/23 at 2:50 P.M. The resident's clinical record lacked a care plan for PTSD. During an interview on 02/14/23 at 2:31 P.M., the Social Service Director and Administrator indicated if a resident had a diagnosis for PTSD they should be care planned for it. They were unsure what Resident 3's PTSD was related to. The resident had never had any triggers or outbursts since living in the facility. She had received psychiatry services. During an interview on 02/14/23 at 3:06 P.M., RN 4 indicated the resident was alert and oriented. She required extensive assistance with care. She had no behaviors and was pleasant with staff. The current facility policy titled, "Care Plans" dated, 02/02/15, was provided by the Administrator on 02/15/23 at 9:14 A.M. The policy indicated, "...It is the intent of the facility that		PTSD to ensure care plans are in place. Administrator and or designee will utilize audit tool “documentation compliance” to ensure anticoagulants are care planned and review of diagnosis to ensure appropriate care planning. The competency tool will be used to monitor compliance and become part of the CQI agenda as part of the QAPI process. This audit will be completed five days a week for 4 weeks, then weekly for 4 weeks, then once a month for 4 months, quarterly thereafter until 95% compliance is achieved. Any concerns will be addressed as discovered. If any patterns are identified at the monthly QAPI meeting, an action plan will be written by the QAPI committee. Any written action plan will be monitored by the Administrator monthly until resolved and substantial compliance is achieved. 3/16/2023	

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	each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care..." 3.1-35(a)			
F 0684 SS=E 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 observation, interview, and record review, the facility failed to follow manufacturer's guidelines related to insulin pen usage; and following the physician's orders related to blood glucose level monitoring and vital sign hold parameters for a residents blood pressure and heart rate for 4 of 6 residents observed for Quality of Care. (Residents 42, 7, 67, and 74) Findings include: 1.a. Medication administration was observed on 02/13/23 at 10:50 A.M., on Unit 3 with LPN (Licensed Practical Nurse) 3. The nurse checked Resident 42's blood sugar level and prepared the Novolog insulin pen for administration. She donned gloves, touched her computer, used keys to unlock the medication cart, removed the insulin pen from the cart, cleaned the end of the pen with alcohol and applied the needle. The needle was covered with a solid white non-transparent needle cap. The nurse primed the pen with 2 units of	F 0684	It is the policy of this facility follow to follow manufactures guidelines related to insulin pens usage; following flood glucose level monitoring and vital sign hold parameters for a resident's blood pressure and heart rate. Resident #42, #7, #67, & #74 received no negative outcome as a result of the alleged deficient practice. LPN #3 has been reinserviced with return demonstration of priming an insulin pen in accordance with manufactures guidelines on 2/20/23. Any resident who receives insulin pen medication or receives blood glucose/heart rate/ or blood pressure monitoring orders have the potential to be impacted by this alleged deficient practice. All	03/16/2023

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	insulin, holding the pen upright with the needle cap in place being unable to visualize the needle tip. She went into the resident's room and administered the insulin. During an interview on 02/13/23 at 11:00 A.M., following the insulin administration, LPN 3 indicated the purpose of priming the insulin pen was to make sure the resident received the proper amount of insulin. They held the pen upright when priming. She indicated she should have removed the needle cap when priming the insulin pen. The Vitals record for blood sugar values for Resident 42 was provided by the SSD (Social Services Director) on 02/15/23 at 12:16 P.M. The record indicated the resident had no critical blood sugar values for January or February 2023. During an interview on 02/15/23 at 12:32 P.M., the MDS (Minimum Data Set) Coordinator indicated they did not have a policy related to insulin pen usage, they just followed the manufacturer's guidelines The Novolog package insert, dated 11/2021, was provided by the SSD on 02/15/23 at 12:16 P.M., and indicated, "...Recommended Storage...Unused NOVOLOG...should be stored in a refrigerator between...36 (degrees) F (Fahrenheit) to 46 F...Screw the needle tightly onto your...Pen...Pull off the inner needle cap...Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing...Turn the dose selector to select 2 units...Hold...Pen with the needle pointing up. Tap the cartridge gently with our finger a few times to make any air bubbles collect at the top of the cartridge...Keep the needle pointing upwards,		residents with insulin pens and vital sign perimeter monitoring orders have been reviewed 2/28/23 by the Administrator. Any concerns were addressed. No negative outcome has occurred due to the alleged deficit practice. Nursing Staff was in-serviced by the Administrator and or designee on 3/1/2023 on the manufacture's guidelines related to insulin pens and the facility guidelines for "Normal Vital Sign Perimeters". Any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. Administrator and or designee will utilize audit tool "documentation compliance" to ensure vital signs are obtained per the physician's order and within perimeters. The competency tool will be used to monitor compliance and become part of the CQI agenda as part of the QAPI process. This audit will be completed for 1 nurse five days a week for 4 weeks, then 1 nurse weekly for 4 weeks, then once a month for 3 months, quarterly thereafter until 95% compliance is achieved. DON or designee will utilize an insulin pen competency checklist, to ensure nurses administer insulin in accordance with manufactures guidelines. The competency tool will be used to monitor compliance and become	

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	press the push-button all the way in...A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure...". 1.b. The clinical record for Resident 42 was reviewed on 02/10/23 at 2:20 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 01/25/23, indicated the resident was cognitively impaired. The diagnoses included, but were not limited to, stroke, hypertension, diabetes, aphasia, depression, and respiratory failure. An open-ended physician's order, with a start date of 08/02/22, indicated the resident's blood glucose level was to be checked before meals and at bedtime, at 5:00 A.M., 11:00 A.M., 4:00 P.M., and 9:00 P.M.. The physician was to be notified if the blood glucose level was less than 60 or greater than 500. An open-ended physician's order, with a start date of 08/09/22, indicated the staff were to administer Novolog per sliding scale with meals at 7:00 A.M., 12:00 P.M., and 5:00 P.M. The December 2022 and January 2023 EMAR/ETAR lacked documentation that the resident's blood glucose was monitored on the following dates and times: - 12/02/22 at 9:00 P.M., - 12/03/22 at 5:00 A.M. and 5:00 P.M., - 12/09/22 at 4:00 P.M. or 5:00 P.M., - 12/16/22 at 5:00 A.M., - 12/17/22 at 5:00 A.M., - 01/05/23 at 4:00 P.M. or 5:00 P.M., - 01/17/23 at 5:00 P.M., - 01/18/23 at 9:00 P.M., - 01/19/23 at 5:00 A.M., - 01/27/23 at 5:00 A.M.,		part of the CQI agenda as part of the QAPI process. This audit will be completed for 1 nurse five days a week for 4 weeks, then 1 nurse weekly for 4 weeks, then once a month for 4 months, quarterly thereafter until 95% compliance is achieved. Any concerns will be addressed as discovered. If any patterns are identified at the monthly QAPI meeting, an action plan will be written by the QAPI committee. Any written action plan will be monitored by the Administrator monthly until resolved and substantial compliance is achieved.	

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	- 01/28/23 at 5:00 A.M. and - 01/29/23 at 5:00 P.M. The clinical record lacked documentation that the blood glucose levels were monitored, the medications were administered, or the physician was notified. There was no documentation that the resident was out of the building. 2. The clinical record for Resident 7 was reviewed on 02/15/23 at 2:45 P.M. A Quarterly MDS assessment, dated 01/18/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, diabetes, heart failure, and Parkinson's disease. The resident received insulin injections seven of the seven days of the assessment review period. An open-ended physician's order, with a start date of 08/02/22, indicated staff were to check the resident's blood sugar four times a day and notify the physician if the blood sugar was below 60 or above 500. The resident's January 2023 EMAR was provided by the Administrator on 02/15/23 at 2:33 P.M. The EMAR lacked documentation of the blood sugar readings on the following dates and times: - 01/04/23 at 5:00 A.M., - 01/05/23 at 4:00 P.M. or at 5:00 P.M. - 01/17/23 at 4:00 P.M. or at 5:00 P.M. - 01/18/23 at 8:00 P.M. or at 9:00 P.M. - 01/19/23 at 5:00 A.M. - 01/29/23 at 7:00 A.M., 12:00 P.M., 5:00 P.M. - 01/30/23 at 4:00 P.M., and - 01/31/23 at 5:00 A.M. 3. During an observation on 02/15/23 at 10:57 A.M., Resident 67 was lying in bed, awake. An Admission MDS assessment, dated 11/30/22,			

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	indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, thrombocytopenia, hypertension, atrial fibrillation, renal insufficiency, diabetes, and depression. She required extensive assistance of two or more staff for toileting and personal hygiene. She was frequently incontinent of bowel and bladder. An open-ended physician's order, with a start date of 01/20/23, indicated the staff were to administer amlodipine 5 mg (milligrams), once a day for hypertension. The medication was to be held if the resident's systolic (top number) blood pressure was less than 110 or the heart rate was less than 60. The clinical record included the January and February 2023 EMAR/ETAR lacked documentation the resident blood pressure and heart rate were monitored prior to administration of the medication. 4. During an observation on 02/15/23 at 10:49 A.M., Resident 74 was sitting in a wheelchair in the dining room. The clinical record for Resident 74 was reviewed on 02/14/23 at 1:25 P.M. An Admission MDS assessment, dated 02/06/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, acute respiratory failure, anemia, atrial fibrillation, hypertension, diabetes, anxiety, and respiratory failure. An opened-ended physician's order, with a start date of 02/03/23, indicated staff were to administer metoprolol 50 mg, twice a day for hypertension between 8:00 A.M. to 10:00 A.M. and 8:00 P.M. to			

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	10:00 P.M. An open-ended physician's order, with a start date of 02/07/23, indicated staff were to administer amiodarone 200 mg once a day for atrial fibrillation at 8:00 A.M. The medication was to be held if the resident's systolic blood pressure was less than 100 or the heart rate was less than 60. The February EMAR/ETAR lacked documentation the heart rate was monitored prior to administration from 02/07/23 through 02/15/23. During an interview on 02/14/23 at 3:08 P.M., RN 4 indicated If a medication required vital signs to be administered prior to the administration the nurse would assess the vitals. If the medication was to be held the nurse would not administer the medication and document in the EMAR and progress note. If the physician was to be notified of the medication being held, she would document in a progress note that they were notified. If the EMAR didn't trigger for a vital to be checked and the order indicated that it should have been then she would document in a vitals report and a progress note. The residents' blood glucose levels should be monitored per the physician's order. The current undated, facility policy titled "Physician Orders---(Following Physician Orders)", indicated, "...It is the policy of the facility to follow the orders of the physician..." 3.1-47(a)(1) 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity			

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	§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 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, interview, and record review, the facility failed to administer treatments for a Stage 2 pressure ulcer for 1 of 1 resident reviewed for pressure ulcers. (Resident 63) Findings include: Resident 63's wound was observed with RN 6 on 02/13/23 at 10:19 A.M. The resident had an implanted pain stimulator under the skin on her left lower back/hip area. The wound was on the skin directly over the top of the implanted device and was approximately 1.5 cm (centimeters) in diameter. The wound bed was dark pink, with a very small amount of white slough (dead tissue) present. The skin around the wound was lighter pink. There was no drainage or signs of infection. RN 6 indicated the family was looking into getting the device removed. The resident's clinical record was reviewed on 02/15/23 at 11:46 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 11/02/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, spinal stenosis, anemia, diabetes,	F 0686	It is the policy of this facility to ensure treatments that are administered for pressure ulcers are documented on the treatment administration record and staged appropriately. Resident #63 did not experience any negative outcome as a result of the alleged deficient practice. Resident #63 received an updated skin assessment to accurate stage the pressure ulcer 2/28/23. Any resident who has a pressure ulcer has the potential to be impacted by this deficient practice. All residents with pressure ulcers have been reviewed 2/28/23. Any concerns were addressed. No negative outcome has occurred due to the alleged deficit practice. All nursing was in-serviced by the Administrator on 3/1/23 on the policies entitled “Pressure Ulcer Assessment and Staging”. Any employee who fails to comply with	03/16/2023

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

(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
	malnutrition, schizophrenia, and unspecified dementia. The resident required extensive staff assistance for all ADLs (Activities of Daily Living). The resident was at risk for pressure ulcers. The resident had four unhealed Stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.) pressure ulcers, one venous ulcer, and one skin tear. The implemented interventions included, but were not limited to, pressure reducing devices for the chair and bed, and nutrition or hydration interventions to manage skin problems. A Weekly Wound Evaluation report indicated the resident's wound was a blister that was first identified on 11/27/22. The wound measured 1.2 cm x (by) 1.4 cm. There was a scant amount of clear drainage. There were no signs of infection, and a treatment was in place. The December 2022 ETAR (Electronic Treatment Administration Record) was provided by the Administrator on 02/15/23 at 11:26 A.M. An MD order indicated the treatment was to cleanse the wound and apply betadine and a foam dressing every shift. The ETAR lacked documentation the treatment was administered on the following dates and shifts: - 12/05/22 on day shift, - 12/06/22 on night shift, - 12/07/22 on day shift, - 12/11/22 on day and night shift, - 12/12/22 on night shift, - 12/13/22 on night shift, - 12/15/22 on night shift, - 12/21/22 on day and night shift, and - 12/24/22 on day shift.		the points of the in-service may be further educated and/or progressively disciplined as indicated. DON and or designee will utilize QAPI tool entitled “Pressure Ulcer” to monitor compliance and become part of the CQI agenda as part of the QAPI process. This audit will be completed for all residents with pressure ulcers five a day week for 4 weeks, then weekly for 4 weeks, then once a month for 4 months, then quarterly until 95% compliance is achieved. Any concerns will be addressed as discovered. If any patterns are identified at the monthly QAPI meeting, an action plan will be written by the QAPI committee. Any written action plan will be monitored by the Administrator monthly until resolved and substantial compliance is achieved.	

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	During an interview on 02/15/23 at 12:54 P.M., Licensed Practical Nurse 5 indicated treatments should be administered as ordered and documented as administered on the ETAR. If the treatment wasn't administered, nursing staff should document the reason it wasn't done. There shouldn't be blanks on the ETAR. The current facility policy, titled "Pressure Ulcer Assessment and Staging", with an issued date of 07/01/11, was provided by the Administrator on 02/15/23 at 12:00 P.M. The policy indicated, "...When a pressure area is identified...a treatment program will be initiated and monitored..." 3.1-40(a)(2)			
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 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			

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	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, interview, and record review, the facility failed to follow the physician's orders for a UTI related to antibiotic medication administration for 1 of 5 residents reviewed for UTI. (Resident 67) Findings include: During an observation on 02/15/23 at 10:57 A.M., Resident 67 was lying in bed, awake. Her television was on. She had no concerns at that time. An Admission MDS (Minimum Data Set) assessment, dated 11/30/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, thrombocytopenia, hypertension, atrial fibrillation, renal insufficiency, diabetes, and depression. She required extensive assistance of two or more staff for toileting and personal hygiene. She was frequently incontinent of bowel and bladder. A Progress Note, dated 01/29/23 at 5:01 P.M., indicated the resident had exhibited some	F 0690	It is the policy of this facility to ensure services aimed at treating urinary tract infections for those residents with active infection. Resident #67 no longer has a UTI, nor experienced any negative outcome as a result of the alleged deficient practice. Any resident who has a UTI with ATB orders has the potential to be impacted by this deficient practice. All residents with current antibiotic orders have been reviewed 2/27/23. Any concerns were addressed. No negative outcome has occurred due to the alleged deficit practice. All nursing was in-serviced by the Administrator on 3/1/23 on the policies entitled “Antibiotic stewardship” and “Physician orders- following physician orders”. Any employee who fails to comply with the points of the in-service may be further educated	03/16/2023

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	confusion that shift, with some aggression towards staff during care. Her urine was foul-smelling. A new order was obtained for a urinalysis. A physician's order, dated 02/03/23 through 02/10/23, indicated the resident was to take cefuroxime axetil (an antibiotic medication) 250 mg (milligrams), twice a day, for a UTI (Urinary Tract Infection). The February 2023 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) lacked documentation the resident had received the cefuroxime axetil on the following dates and times: - 02/05/23 at 6:00 A.M., - 02/06/23 at 6:00 A.M. and 6:00 P.M., and - 02/08/23 at 6:00 P.M. During an interview on 02/14/23 at 3:08 P.M., RN 4 indicated a resident's medication administrations were documented in the EMAR. If there was a blank in the EMAR, it could have meant that the nurse accidentally missed signing out the medication or the medication wasn't given. A Care Plan titled, "Antibiotic Therapy r/t (related to) UTI" with a start date of 02/06/23 included an intervention, but was not limited to, "...Administer medication as ordered..." The current facility policy titled, " Medication Administration" was undated and provided by the Dietary Manager on 02/15/23 at 11:25 A.M. The policy indicated, "...To ensure that resident medications are administered in a timely manner and documentation is completed to substantiate administration..."		and/or progressively disciplined as indicated. DON and or designee will utilize QAPI tool entitled “Documentation Compliance” to monitor compliance and become part of the CQI agenda as part of the QAPI process. This audit will be five a day week for 4 weeks, then weekly for 4 weeks, then once a month for 4 months, then quarterly until 95% compliance is achieved. Any concerns will be addressed as discovered. If any patterns are identified at the monthly QAPI meeting, an action plan will be written by the QAPI committee. Any written action plan will be monitored by the Administrator monthly until resolved and substantial compliance is achieved.	

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	3.1-41(a)(2)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on record review and interview, the facility	F 0755	It is the practice of this facility to	03/16/2023

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	failed to follow the physician's orders related to insulin administration for 2 of 3 residents for pharmacy services reviewed. (Residents 7 and 42) Findings include: The clinical record for Resident 7 was reviewed on 02/15/23 at 2:45 P.M. A Quarterly MDS assessment, dated 01/18/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, diabetes, heart failure, and Parkinson's disease. The resident received insulin injections seven of the seven days of the assessment review period. An open-ended physician's order, with a start date of 03/07/22, indicated the resident was to receive 6 units of Insulin Glargine (long acting insulin) at 8:00 A.M. and 8:00 P.M. The January 2023 EMAR lacked documentation of the Glargine insulin administration on the following dates and times: - 01/18/23 at 8:00 P.M., and - 01/29/23 at 8:00 A.M. During an interview on 02/14/23 at 3:08 P.M., RN 4 indicated a resident's medication administrations were documented in the EMAR. If there was a blank in the EMAR, it could have meant that the nurse accidentally missed signing out the medication or it wasn't given. If a medication required vital signs to be administered prior to the administration the nurse would assess the vitals. If the medication was to be held the nurse would not administer the medication and document in the EMAR and progress note. If the physician was to be notified of the medication being held, she would document in a progress note that they		ensure residents have physician orders followed related to insulin administration. Resident #7 and #42 has been reviewed and has no negative outcome to the alleged deficient practice. All residents with insulin orders have the potential to be affected by this finding. 100% audit was completed of these residents on 2/27/23. Any concerns were addressed. Nursing education was held on 3/1/23 by the Administrator to review the “Physician orders-following physician orders” policy and procedure. Any staff who fail to comply with the points of the inservice will be further educated DON/Designee will review daily, Monday-Friday, using the audit tool, “Documentation Compliance”, to ensure insulin administration is documented and become part of the CQI agenda as part of the QAPI process. Any concerns will be addressed as discovered. This audit will be completed 5x week x4 weeks, Weekly x4, Monthly x 3 months, then quarterly thereafter until 95% is achieved. DON will report findings of the audit to the QAPI committee monthly x 4; then quarterly thereafter. If any patterns are identified when the results are presented to the QAPI committee at the monthly meeting, an action plan will be	

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	were notified. If the EMAR didn't trigger for a vital to be checked and the order indicated that it should have been then she would document in a vitals report and a progress note. The residents' blood glucose levels should be monitored per the physician's order. 2. The clinical record for Resident 42 was reviewed on 02/10/23 at 2:20 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 01/25/23, indicated the resident was cognitively impaired. The diagnoses included, but were not limited to, stroke, hypertension, diabetes, aphasia, depression, and respiratory failure. An open-ended physician's order, with a start date of 8/09/22, indicated the staff were to administer Novolog (an insulin medication) 5 units, with meals. The December 2022 and January 2023 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) lacked documentation the resident had received the insulin on the following dates and times: - 12/03/22 at 5:00 P.M., - 12/09/22 at 5:00 P.M., - 01/05/23 at 5:00 P.M., - 01/17/23 at 5:00 P.M., and - 01/29/23 at 5:00 P.M. The clinical record lacked documentation that the medications were administered, or the physician was notified. There was no documentation that the resident was out of the building. The current facility policy titled, " Medication Administration" was undated and provided by the Dietary Manager on 02/15/23 at 11:25 A.M. The		written by the QAPI committee. Any written action plan will be monitored by the Administrator monthly until resolved and compliance has been achieved.	

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	policy indicated, "...To ensure that resident medications are administered in a timely manner and documentation is completed to substantiate administration..." 3.1-25(b)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on observation, interview, and record review, the facility failed to follow the physician's medication administration hold parameters related to a resident's blood pressure for 1 of 7 residents reviewed for unnecessary medications. (Resident 17)	F 0757	It is the practice of this facility to ensure the facility follows the physician medication hold perimeters. Resident #17 has not had any adverse effects from the alleged deficient practice.	03/16/2023

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	Findings include: During an observation on 02/14/23 at 12:45 P.M., Resident 17 was sitting in a wheelchair in his room. The clinical record for Resident 17 was reviewed on 02/13/23 at 9:39 A.M. A Quarterly MDS assessment, dated 01/02/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, Parkinson's disease, anemia, hypertension, non-Alzheimer's dementia, seizure disorder, anxiety, and depression. An open-ended physician's order, with a start date of 07/14/22, indicated the staff were to administer enalapril maleate 5 mg once a day, for hypertension at 8:00 A.M. The medication was to be held if the resident's systolic blood pressure was less than 100 and the staff were to notify the provider. The January and February 2023 EMAR/ETAR lacked documentation that the medication was held the following days when the systolic blood pressure was less than 100: - 01/09/23, the blood pressure was 88/60, - 01/21/23, the blood pressure was 99/68, - 01/29/23, the blood pressure was 92/54, and - 02/05/23, the blood pressure was 90/64. The clinical record lacked documentation that the physician was notified of the blood pressures. An open-ended physician's order, with a start date of 07/23/22, indicated the staff were to administer carvedilol 3.125 mg, twice a day for hypertension at 8:00 A.M. and 8:00 P.M. The		2/28/23 Administrator reviewed 100% of residents with medication hold perimeters. Any concerns were addressed. Nursing education was held on 3/1/23 by the Administrator to review the “physician orders-following physician orders” policy and procedure. Any staff who fail to comply with the points of the inservice will be further educated. Administrator/Designee will implement an audit tool “documentation compliance” to monitor compliance with adhering to hold perimeters to ensure orders are followed. This audit will become part of the CQI agenda as part of the QAPI process. This audit will be completed 5x a week x4 weeks, Weekly x4, Monthly x 3, then quarterly thereafter until 95% compliance is achieved. Any concerns will be addressed as discovered. DON will report findings of the audit to the QAPI committee monthly x 4; then quarterly thereafter until QAPI deems compliance has been achieved. If any patterns are identified at the monthly QAPI meeting, an action plan will be written by the QAPI committee. Any written action plan will be monitored by the Administrator monthly until resolved and substantial compliance is achieved.	

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	medication was to be held if the resident's systolic blood pressure was less than 100 and the staff were to notify the provider. The January and February 2023 EMAR/ETAR lacked documentation that the blood pressure was held the following dates when the systolic blood pressure was less than 100 or that the blood pressure was monitored at the 8:00 P.M. medication administration time: - 01/09/23 at 8:00 A.M. the blood pressure was 88/60, - 01/21/23 at 8:00 A.M. the blood pressure was 99/68, - 01/29/23 at 8:00 A.M. the blood pressure was 92/54, and - 02/05/23 at 8:00 A.M. the blood pressure was 90/64. The clinical record lacked documentation that the physician was notified of the resident's blood pressures. The current facility policy titled, " Medication Administration" was undated and provided by the Dietary Manager on 02/15/23 at 11:25 A.M. The policy indicated, "...To ensure that resident medications are administered in a timely manner and documentation is completed to substantiate administration..." 3.1-48(a)(6)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include			

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	the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to store medications appropriately related to insulin pens for 1 of 2 medication carts reviewed. (Cart 2) Findings include: On 02/15/23 at 12:38 P.M., Medication Cart 2, located on the second floor, was observed with LPN (Licensed Practical Nurse) 2, and contained the following: - A Novolog insulin pen for Resident 7, labeled with an opened-date of 01/10/23. The "Do not use after" space on the label was left blank. The pen was half full. LPN 2 indicated insulin pens were good for 30 days (2/9/23), the resident was on a	F 0761	It is the practice of this facility to store medications, insulin pens, appropriately. Resident #7 and #42 has not had any adverse effects from the alleged deficient practice. 2/28/23, all medication carts have been audited to ensure insulin pens are stored appropriately. Any concerns were addressed. Nursing education was held on 3/1/23 by the Administrator to review the “Novolog Recommended Storage” guidelines. Any staff who fail to comply with the points of the inservice will be further educated.	03/16/2023

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	sliding scale for insulin, and had not received any that day. The vitals record for Resident 7 was reviewed on 02/15/23 at 2:40 P.M., and indicated the resident had no critical blood sugar values in February 2023. - A Novolog insulin pen for Resident 42 was undated and unused. LPN 2 indicated the new pen should have been kept in the refrigerator until needed. The plastic bag containing the pen was labeled and indicated to keep the pen refrigerated until opened. The resident had a second Novolog pen in the drawer that was over 3/4 full and labeled appropriately. The vitals record for Resident 42 was reviewed on 02/15/23 at 2:44 P.M., and indicated the resident had no critical blood sugar values in February 2023. The Novolog package insert, dated 11/2021, was provided by the SSD (Social Services Director) on 02/15/23 at 12:16 P.M., and indicated, "...Store unused NovoLog...Pen...in the refrigerator...Unused NovoLog...Pen stored at room temperature should be thrown away after 28 days..." The current, undated facility policy, titled "MEDICATION STORAGE IN THE FACILITY" was provided by the Administrator on 02/15/23 at 2:05 P.M. The policy indicated, "...Medications...are stored safely, securely, and properly following the manufacturer or supplier recommendations...Medications requiring storage 'in a cool place' are refrigerated unless otherwise directed on the label...Outdated...drugs...will be immediately withdrawn from stock. They will be		DON/Designee will implement an audit tool, “documentation compliance” to monitor compliance with insulin pen storage to ensure pens are being stored properly. This audit will become part of the CQI agenda as part of the QAPI process. This audit will be completed 5x a week x4 weeks, Weekly x4, Monthly x 4, then quarterly thereafter until 95% compliance is achieved. Any concerns will be addressed as discovered. DON will report findings of the audit to the QAPI committee monthly x 3; then quarterly thereafter until QAPI deems compliance has been achieved. If any patterns are identified at the monthly QAPI meeting, an action plan will be written by the QAPI committee. Any written action plan will be monitored by the Administrator monthly until resolved and substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 00 B. WING	02/15/2023

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	disposed of according to drug disposal procedures...Facility staff will assure that the multidose vial is stored following manufacturer's suggested storage conditions..." 3.1-25(j) 3.1-25(o)			
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. Based on record review and interview, the facility failed to follow the physician's orders related to laboratory services for 1 of 5 residents reviewed for unnecessary medications. (Resident 56) Findings include: The clinical record for Resident 56 was reviewed on 02/14/23 at 3:29 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 01/10/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, stroke, anemia, heart failure, hypertension, diabetes, hyponatremia, and hyperlipidemia. The EMAR/ETAR (ELECTRONIC MEDICATION ADMINISTRATION RECORD/ELECTRONIC TREATMENT ADMINISTRATION RECORD) for January 2023 was provided by the Administrator on 02/14/23 at 3:22 P.M. The record indicated the following physician's order for labs:	F 0770	It is the practice of this facility to provide or obtain laboratory services to meet the needs of our residents. Resident 56 has not had any adverse reactions related to the alleged deficient practice. By 3/10/23, All resident's lab orders will have been audited to ensure physician orders for labs have been followed by the Director of Nursing/Designee. Any concerns were addressed. Nursing education was held on 3/1/23 by the Administrator to review the "Lab Monitoring Completion Guideline" policy and procedure. Any staff who fail to comply with the points of the inservice will be further educated. DON/Designee will implement an	03/16/2023

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	- CMP (Comprehensive Metabolic Panel), osmolality of urine, protein and creatine urine, sodium level, uric acid level, urinalysis, one time only for Kidney function, with a start date of 01/09/2023. The test results were provided by the Administrator on 02/14/23 at 3:22 P.M. The blood specimen was drawn on 01/09/23. The results were reported on 01/10/23 and indicated the testing had not been performed due to the specimen sample being hemolyzed (condition of a specimen that had broken blood cells dissolved in it). The facility needed to make a new requisition for a redraw on the next routine lab day. During an interview on 02/14/23 at 2:54 P.M., the Administrator indicated if a lab was drawn and the specimen was not good, they should have redrawn the blood specimen or contacted the physician, and it should have been documented in the Progress Notes. The Progress Notes were provided by the Administrator on 02/14/23 at 3:22 P.M. The clinical record lacked documentation the facility completed the redraw of the requested lab orders and that the physician had been notified of the failed test. The current undated Lab Monitoring policy provided by the Administrator on 02/14/23 at 3:22 P.M., and indicated, "...Purpose...To ensure that laboratory services are being performed as ordered...Process...Documentation that the attending and ordering physician were notified of lab results..." The current undated policy for following		audit tool to monitor compliance with laboratory orders to ensure orders are completed. This audit will become part of the CQI agenda as part of the QAPI process. This audit will be completed 5x a week x4 weeks, Weekly x4, Monthly x4, then quarterly thereafter until 95% compliance is achieved. Any concerns will be addressed as discovered. DON will report findings of the audit to the QAPI committee monthly x 3; then quarterly thereafter until QAPI deems compliance has been achieved. If any patterns are identified at the monthly QAPI meeting, an action plan will be written by the QAPI committee. Any written action plan will be monitored by the Administrator monthly until resolved and substantial compliance is achieved.	

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	physician's orders was provided by the Administrator on 02/14/23 at 3:22 P.M., and indicated, "...It is the policy of the facility to follow the orders of the physician..." 3.1-25(b)			