STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE KOKOMO	3518 S LAFOUNTAIN ST KOKOMO, IN 46902

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00373762 and IN00373364. Complaint IN00373762 - Substantiated. Federal/state deficiencies related to the allegations are cited at F550, F677, F679, F684, F692 and F695. Complaint IN00373364 - Substantiated. Federal/state deficiencies related to the allegations are cited at F609, F660, F755 and F760 . Survey dates: March 3 and 4, 2022. Facility number: 000025 Provider number: 155064 AIM number: 100274850 Census Bed Type: SNF/NF: 66 Total: 66 Census Payor Type: Medicare: 13 Medicaid: 32 Other: 21 Total: 66 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed March 15, 2022.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified			

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

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

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	existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, interview and record	F 0550	**F550**	03/23/2022

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review, the facility failed to provide privacy for a resident's catheter drainage bag for 1 of 1 randomly observed resident with an indwelling urinary (Foley) catheter. (Resident G)

Finding includes:

During an observation, on 3/4/22 at 1:22 p.m., the resident was in his wheelchair leaving the dining room. His urinary catheter drainage bag was under his wheelchair and was not covered. Yellow urine was visible inside the bag. Other residents, two CNAs and LPN 2 were present in the dining room.

The record for Resident G was reviewed on 3/3/22 at 1:06 p.m. Diagnoses included, but were not limited to, Covid-19, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, disorder of kidney and ureter, obstructive and reflex uropathy.

A care plan, dated as revised 1/10/22, indicated the resident needed assistance with activities of daily living. He did not have a care plan for indwelling catheter care.

A physician's order, dated 2/16/22, included Foley catheter care every day and night.

During an interview, on 3/4/22 at 1:24 p.m., LPN 2 indicated the collection bag needed to be covered for dignity reasons. LPN 2 asked the CNA to put a dignity bag over the catheter drainage bag.

A current facility policy, titled "Urinary Catheter Care," dated as revised on 2/24/19 and provided by the Executive Director on 3/4/22 at p.m., indicated "...To establish guidelines to reduce the risk of or prevent infection in residents with an indwelling catheter...."

This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

1) Immediate actions taken for those residents identified: Resident G's urinary drainage bag was immediately placed inside a dignity bag. Resident G's care plan was updated to reflect presence of an indwelling catheter.

2) How the facility identified other residents: All residents who have indwelling catheters have the potential to be affected; therefore, this plan of correction applies to those residents.

3) Measures put into place/ System changes: Staff was

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	The facility policy did not address the provision of privacy for Foley catheter drainage bags. This Federal Tag relates to Complaint IN00373762. 3.1-3(t)		**re-educated on resident rights/exercise of rights, including but not limited to, provision of privacy for resident's with indwelling catheters.** **How the corrective actions will be monitored: DON, or designee, will conduct rounds at least 5 X a week times 4 weeks to ensure provision of privacy. Any identified concerns will be promptly addressed with the responsible individual(s).** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: March 23, 2022**	
F 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged			

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	violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review, the facility failed to report a significant medication error which resulted in two emergency room visits to the Indiana Department of Health for 1 of 3 residents reviewed for medication administration (Resident B). Finding includes: During an interview, on 3/3/22 at 4:06 p.m., a friend of the resident indicated a concern regarding the resident had been overdosed on medication and the medication error was not reported.	F 0609	F609 **1) Immediate corrective action(s) for those residents affected by the deficient practice: Resident B no longer resides in the facility; therefore, no further corrective action could be taken for this resident.** **2) Plan / Process to identify other residents potentially affected by the same deficient practice and corrective**	03/23/2022

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	The record for Resident B was reviewed on 3/3/22 at 11:58 a.m. Diagnoses included, but were not limited to, Covid 19, cirrhosis of the liver with ascites, pseudocysts of the pancreas, bipolar disorder and hypertension. A physician's order, dated 2/6/22, indicated morphine sulfate solution 100 mg (milligram) per 5 ml (milliliter), to give 0.25 ml by mouth every 4 hours as needed for pain. A Narcotic count sheet for morphine, dated 2/11/22 at 1:00 p.m., indicated 0.5 ml of morphine solution was signed out. A progress note, dated 2/11/22 at 1:53 p.m., indicated the resident had a change in mental status, the resident complained of pain, the pain medication was given and the resident went unresponsive. The physician was notified and an order to send the resident to the hospital for evaluation was received. An emergency room progress note, dated 2/11/22 at 2:06 p.m., indicated the resident was only responsive to sternal rub. The resident was given 0.5 mg dose of morphine at 1:00 p.m., and went unresponsive so EMS (emergency medical services) was called and brought the resident to the emergency room. He was given Narcan with a positive response. Suspect his decrease in responsiveness was due to the morphine. The clinical impression was an adverse effect of a drug. A progress note, dated 2/11/22 at 8:52 p.m., indicated the resident was not responding to verbal stimulus. A call was placed to his responsible party, 911 was called and the resident was transported to the hospital.		**action(s) to be taken: All residents have the potential to be affected by not reporting unusual occurrences; therefore, this plan of correction applies to all residents.** **3) Facility measures and systemic changes to ensure the deficient practice does not recur: Administrator has been re-educated on Reporting of Alleged Violations, including but not limited to, reporting of significant medication errors.** **The Administrator will review all occurrences with IDT, ongoing, to determine if the incident is considered an unusual occurrence.** **Regional Nurse Consultant/Regional Vice President of Operations, or designee, will review resident occurrences in an effort to ensure all necessary situations are reported to IDOH as a reportable unusual occurrence. This review will be conducted weekly X 4 weeks, and then monthly X 2 months.** **4) Facility plans to monitor corrective actions & sustain compliance; Integrate QA Process:**	

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	An emergency room progress note, dated 2/11/22 at 9:07 p.m., indicated the resident was just discharged from their ER two hours ago. The resident presented with a similar issue, was here earlier after becoming unresponsive after a dose of morphine. He was given Narcan in the ER and responded. The residents heart rate was tachy at 99 per minute and his blood pressure low at 90/65 and respirations were 10 per minute. The resident was unresponsive. The resident responded to Narcan, the same thing he was at the ER for three hours ago. Since the resident responded to the Narcan, suspect the facility either needs to decrease his dose or increase the time between doses. During an interview, on 3/3/22 at 2:50 p.m., the DON indicated on 2/11/22 the resident was given a dose of Morphine sulfate concentrate of 0.5 ml (milliliter) instead of the physician ordered 0.25 ml and went to the emergency room twice. A medication error was not completed since she was not aware of the incorrect dose given until the time of the interview. She also was not aware the resident was given Narcan at the hospital. A current facility policy, titled "Medication Administration Policy," dated as revised on 1/1/2015 and received from the DON on 3/4/22 at 10:16 a.m., indicated "...MEDICATION/TREATMENT/ERRORS... If a medication and/or treatment error occurs, the licensed nurse will...Immediately notify the attending physician...Describe the error and the resident's response in the Nurse's notes...Complete an Incident Report...identify the error on the 24 Hour Report...Monitor the resident's status...Class II medications are under double lock...Any discrepancy must be reported		**The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: March 23, 2022**	

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	immediately to the Director of Nursing or his/her designee...." This Federal Tag relates to Complaint IN00373364. 3.1-13(g)(1)(D)			
F 0660 SS=D Bldg. 00	483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and			

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	resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge			

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	plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.			
	Based on observation, interview and record review, the facility failed to have a discharge plan in place for 1 of 3 residents reviewed for discharge planning (Resident E). Finding includes: During an observation, on 3/3/22 at 11:21 a.m., Resident E was lying in bed, in his room, he did not have clothes on. He only had a blanket covering his pelvic area, his hair was sticking straight up, he had not shaved and had hair all over his neck and back. The resident asked what the big deal was about saying hello to him. During an interview, on 3/3/22 at 11:24 a.m., LPN 4 indicated sometimes Resident E could be nice although after he got off the Covid unit he did not allow care. The resident would sleep a lot and didn't go to the dining room anymore. His van which he had been living in was impounded and he came from some other city. The record for Resident E was reviewed on 3/3/22 at 1:37 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, malaise, very low level of personal hygiene, a history of Covid 19, vitamin d deficiency and nicotine dependence. A care plan, dated 12/15/21, indicated the resident had a behavior problem and was obsessed with his van and wanting to call 911 and the Indiana	F 0660	**F660** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified: Resident E was interviewed by SSD to determine discharge plans. SSD is working on Resident E's discharge to a facility of resident's choice.** **2) How the facility identified other residents: All residents with the intention of having a short term stay that do not have a discharge care plan have the potential to be affected; therefore, this plan of correction applies to those**	03/23/2022

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	State Police department. The interventions included, but were not limited to, for the Social Services Director (SSD) to contact the Indiana State Police and find out about the resident's van and speak with the proper authorities. A physician's progress note, dated 1/31/22 at 12:01 p.m., indicated the resident continued to state he would like to discharge home. During an interview, on 3/3/22 at 1:45 p.m., the Social Services Director (SSD) indicated the resident came to the facility from a hospital and started asking about his van. The facility did not have a contact person for the resident. She had talked with someone from the Veterans Administration about the resident although she did not document the conversation. She indicated the resident's plan was to stay at the facility long term although she did not document the resident's preference. She indicated the facility was not able to locate the resident's van. During an interview, on 3/3/22 at 2:57 p.m., the Director of Nursing (DON) indicated there was not a discharge care plan for this resident. The facility policy indicated discharge planning started at admission and at the 72 hour care plan it would be reviewed. She indicated there was no 72 hour care plan documented in the progress notes. A current facility policy, titled "Baseline Care Plan," dated as revised on 11/17/17 and received from the Executive Director (ED) on 3/3/22 at 3:00 p.m., indicated "...To develop a baseline care plan within 48 hours of admission to direct the care team while a comprehensive care plan is developed that incorporates the resident's goals, preferences, and services that are to be furnished to attain or maintain the resident's highest		**residents. The care plans of the identified residents have been reviewed and revised, as necessary.** **3) Measures put into place/ System changes: SSD was re-educated on the discharge planning process, including but not limited to, conducting a care plan within 5 days of admission to initiate discharge planning, following up with potential discharges weekly and documenting such in a progress note.** **How the corrective actions will be monitored: ED, or designee, will audit the charts of new admissions to ensure a discharge care plan has been scheduled and completed 3 X a week for 4 weeks, then twice a week X 4 weeks.** **The charts of residents who will potentially be discharging will be audited 3 X a week times 4 weeks, then 2 X a week for 4 weeks to ensure discharge planning is being documented.** **4) The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or**	

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	practicable physical, mental, and psychosocial well-being...Upon admission, the admitting nurse will initiate the development of the baseline care plan as part of the admission assessment. The baseline care plan will continue to be developed by the interdisciplinary team and be completed within 48 hours of admission...The Baseline Care Plan should include...Discharge needs of the resident...As a best practice, the interdisciplinary team should attempt to schedule an initial meeting with the resident and/or resident representative within 5 days of admission to review the baseline plan of care and make updates or revisions as indicated based on feedback and input of the resident and/or representative prior to the development of the comprehensive care plan...." A current facility policy, titled "Comprehensive Care Plan," dated as revised on 11/17/17 and received from the ED on 3/3/22 at 3:00 p.m., indicated "...To develop a comprehensive care plan that directs the care team and incorporates the resident's goals, preferences and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being...The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, 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 comprehensive care plan must describe the following... The resident preference and potential for future discharge, including the resident's desire to return to the community and an any referrals to local contact agencies and/or other appropriate entities...Discharge plans in the comprehensive care plan, as appropriate...An explanation should be included in a resident's		**patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: March 23, 2022**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan...." This Federal tag relates to Complaint IN00373364. 3.1-36(a)(3)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;			
	Based on record review and interview, the facility failed to ensure a resident needing assistance with ADL's (activity of daily living) was provided scheduled showers for 1 of 4 residents reviewed for ADL's. (Resident G) Finding includes: The record for Resident G was reviewed on 3/3/22 at 1:06 p.m. Diagnoses include, but were not limited to, Covid-19, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, obstructive and reflex uropathy and weakness. A physician's order, dated 2/28/22, indicated the resident was to have a bed bath or shower every Tuesday and Friday. A care plan, dated 1/10/22, indicated the resident needed staff assistance with bathing and showering. The goal included the resident would improve in the current level of function.	F 0677	F677 *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified: Resident G was given a shower at the time of survey.**	03/23/2022

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	The POC (Plan of Care) report indicated the resident's showers were given on the following dates: 1/6/22, 1/21/22, 2/3/22, 2/17/22, 2/22/22, 2/24/22 and 2/28/22. The resident was missing 10 showers from 1/1/22 through 2/28/22. During an interview, on 3/4/22 at 12:24 p.m., the resident indicated when he was admitted, he was told he would be given 2 or 3 showers a week. He stated he was lucky to get 1 shower. The CNAs would tell the resident they were short staffed and could not give him a shower. During an interview, on 3/4/22 at 1:27 p.m., the Director of Nursing (DON) indicated residents normally get a shower based on their preference and usually a twice a week. A policy for ADL care was not provided at the time of the exit conference. This Federal tag relates to Complaint IN00373762. 3.1-38(a)(2)(A) 3.1-38(b)(2)		**2) How the facility identified other residents: All residents have the potential to be affected; therefore, this plan of correction applies to those residents. The facility completed an audit to identify any dependent resident who needs assistance with grooming and personal hygiene. Facility staff provided grooming and personal care including showers, as needed.** **3) Measures put into place/ System changes: Staff was re-educated on ADL care provided for dependent residents, including but not limited to, providing ADL's to dependent residents for provided showers and ensuring showers are provided according to schedule.** **How the corrective actions will be monitored: DON, or designee, will audit shower records 3 X a week for 4 weeks, then 2 X a week for 4 weeks.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive**	

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			months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: March 23, 2022**	
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.			
	Based on observation, interview and record review, the facility failed to provide resident identified activities of choice for 1 of 3 residents reviewed for activities (Resident D). Finding includes: During an observation, on 3/3/22 at 10:42 a.m., Resident D was lying in bed, in her room, she was awake and she was looking around and touching her hands together. She indicated she did not get out of bed. There was no music on in her room, no books, magazines and no activity pages in the room.	F 0679	**F679** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or*	03/23/2022

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	The record for Resident D was reviewed on 3/3/22 at 12:56 p.m. Diagnoses included, but were not limited to, diverticulitis of the large intestine, secondary neoplasm of the brain, malignant neoplasm of the right bronchus or lung, anorexia, cerebral infarction without residual deficits and low back pain. A care plan, revised on 1/18/22, indicated the resident was capable of independently choosing programs in which to participate. The interests included one to one activities on Tuesday, Thursday, Saturday and Sunday, music, reading, crossword puzzles, television and word search. The interventions included, but were not limited to, evaluate the plan and adjust as needed, encourage programs of interest as they occur and provide a monthly schedule of group programs. A care plan, dated 11/24/21, indicated the resident had a diagnoses of depression. The interventions included, but were not limited to, encourage participation in activities of choice and interest and to observe for signs and symptoms of depression such as loss of interest in activities or hobbies once pleasurable. During an interview, on 3/3/22 at 1:17 p.m., the activity director indicated the resident did receive some one-one activities from the staff. She indicated the resident would get little packets which had crossword puzzles and stuff. During on observation with the activity director, on 3/3/22 at 1:22 p.m., Resident D did not have any activity packet in her room, she did not have music playing and there was no television. The activity director checked the drawers and other areas of the room and could not find any activity materials in the resident's room. The resident did		*executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified: Resident D no longer resides in the facility; therefore, no further corrective action could be taken for this resident.** **2) How the facility identified other residents: All residents have the potential to be affected; therefore, this plan of correction applies to those residents.** **3) Measures put into place/ System changes: Activity Director was educated on activities meeting interest/needs of each resident, including but not limited to, providing resident identified activities of choice and having a reflecting care plan.** **How the corrective actions will be monitored: ED, or designee, will audit activity care plans 2 X a week times 4 weeks then weekly X 4 weeks. Additionally, ED, or designee, will conduct random rounds 2 X a week for 4 weeks, then weekly X 4 weeks, to validate that residents have activity**	

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	have a Bible on her bedside table. The resident spoke to the activity director and indicated she wanted to contact her daughter. During an observation with the activity director, on 3/3/22 at 1:25 p.m., the activity packet was just three printed pages which had a coloring page and word searches. The packets did not include anything to write or color with. A current facility policy, titled "Activities Programs," revised on 11/7/19 and received from the Executive Director on 3/3/22 at 3:00 p.m., indicated "...To provide an ongoing program of activities designed to appeal to the residents' interests and to enhance his or her highest practicable level of physical, mental, and psychosocial well-being...The Activity Director, trained staff, or volunteer will...Identify and involve each resident in an ongoing program of activities that is designed to appeal to his or her interests and needs...Enhance the resident's highest practicable level of physical, mental, and psychosocial well-being by offering a program of activities that provides the following...A heightened sense of well-being...Promotion of feelings of self-esteem, pleasure, comfort, education, creativity, success, and independence...That promotes educational or intellectual thought and requires thinking...age and gender-specific...Produce something useful and provide purpose...Relate to previous work...Allow for opportunities for creativity and creative expression...A minimum of 4-7 organized activities will be scheduled daily...The program of activities will include a combination of large and small groups, one to one's, and self-directed activities...The program of activities will include a system that allows the activity staff to develop, implement, and evaluate the resident's interests		**items in their rooms.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: March 23, 2022**	

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	and involvement in the activities provided and adjust the daily programming as needed in order to meet the needs of the residents...." This Federal tag relates to Complaint IN00373762. 3.1-33(a)			
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 record review and interview, the facility failed to ensure a resident's laboratory testing was completed timely as ordered for 1 of 6 residents reviewed for quality of care. (Resident C) Finding includes: The record for Resident C was reviewed on 3/3/22 at 12:25 p.m. Diagnoses included, but were not limited to, Covid-19, type 2 diabetes mellitus, acute respiratory failure with hypoxia, hypertension, acute kidney failure and cognitive communication deficit. A Lab Report, dated 2/5/22, indicated the resident had an elevated potassium (mineral in the body which helped regulate fluid balance, muscle contractions and nerve signals) level. The potassium level was 6.5. The normal range for potassium was 3.5-5.5.	F 0684	**F684** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for**	03/23/2022

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	A progress note, dated 2/7/22 at 10:01 a.m., indicated the resident had abnormal lab results. The physician and resident were notified of the results. The physician was to review the abnormal labs and notify staff of any new orders. A physician's order, dated 2/7/22, indicated to obtain a BMP (Basic Metabolic Panel) stat (urgent). The stat BMP lab was completed on 2/7/22. The physician was not notified of the abnormal results from the stat lab until 2/9/22. The physician then ordered to recheck the CMP stat and call the MD with the results. A physician's order, dated 2/9/22, indicated to obtain a one-time only lab test CMP for hyperkalemia (a high level of the electrolytes potassium in the blood which could lead to dangerous and possible deadly changes in the heart rhythms). When the order for the repeat CMP lab was entered, on 2/9/22, it was not included the lab was ordered as stat. The lab company did not attempt to obtain the lab until 2/11/22 since it was not marked stat. A progress note, dated 2/11/22 at 3:15 p.m., indicated a Code Blue (critical status of a resident) was called. The resident was last seen at 2:35 p.m., and there were no concerns. When 911 arrived at 3:25 p.m., the resident was placed on a monitor, was intubated, was given emergency medication and CPR (Cardiopulmonary Resuscitation) was continued. The resident was pronounced deceased at 3:55 p.m. The Coroner came to the		**those residents identified: Residents C no longer resides in the facility; therefore, no further corrective action could be taken for this resident.** **2) How the facility identified other residents: All residents with lab orders have the potential to be affected; therefore, this plan of correction applies to those residents.** **3) Measures put into place/ System changes: Nursing staff was re-educated on quality of care, including but not limited to, ensuring laboratory testing are completed in a timely manner and ensuring laboratory testing is completed as ordered.** **4) How the corrective actions will be monitored: DON, or designee, will review laboratory testing and the documentation relative to laboratory testing at least 5 days a week X 4 weeks, then 3 days a week X 4 weeks to ensure laboratory testing is completed according to physician orders.**	

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	facility and verbalized to release the body due to Covid related issues. During an interview, on 3/4/22 at 10:18 a.m., the Director of Nursing (DON) indicated she was not aware the physician indicated he wanted the CMP lab order to be a stat order on 2/9/22. During an interview, on 3/4/22 at 11:16 a.m., the DON indicated the when the lab company arrived on 2/11/22, the resident refused to let the lab draw his blood. The NP entered the order wrong on 2/9/22 and did not order the lab to be stat. The lab should be notified of all stat orders. The stat labs were usually completed within 4 hours. The lab should have drawn the CMP on 2/9/22 and the physician should have been called with the results. During an interview, on 3/4/22 at 12:40 p.m., LPN 4 indicated she was responding to a nurse needing help. Resident C had coded and they provided CPR and 911 was called. The resident was at his baseline at lunch. The coroner indicated it was most likely a blood clot related to Covid. During an interview, on 3/4/22 at 1:25 p.m., the Executive Director (ED) indicated according to the lab results reviewed by the physician it looked like there was an order on 2/9/22 to recheck the CMP stat and call the physician with the results. The CMP lab did not get completed on 2/9/22. A current policy, titled, "Physician Notification of Laboratory/Radiology/Diagnostic Results" received by the Don on 3/4/22 at 11:45 a.m., indicated, "...A licensed nurse is responsible for assuring the laboratory is notified of physician's orders for testing. A request is to be completed and lab to be drawn on next scheduled lab draw		**The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: March 23, 2022**	

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	day UNLESS "Stat" or "Same Day" order is received..."STAT" or "Same Day" orders will be called to the laboratory service by the nurse who transcribe the order. A nurse is responsible for monitoring the receipt of test results. Test results should be reported to the physician or other practitioner who ordered them...In the event a physician does not respond promptly to attempts to convey critical laboratories results, the alternate physician or Medical Director will be notified...Unless other parameters are ordered by physician...Potassium <3.0 or >5.1...." This Federal tag relates to Complaint IN00373762. 3.1-37(a)			
F 0692 SS=G Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the			

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	health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to identify a significant weight loss, notify the physician of the weight loss and implement interventions to prevent further weight loss for 1 of 6 residents reviewed for nutrition. (Resident F) Resident F had a 17% weight loss in 14 days. Finding includes: The record was reviewed on 3/3/22 at 12:25 p.m. Diagnoses included, but were not limited to, Covid-19, type 2 diabetes mellitus, congestive heart failure, severe protein-calorie malnutrition, hypertension, cardiomyopathy and acute kidney failure. A physician's order, dated 1/11/22, indicated to give furosemide (a diuretic medication) 40 mg (milligrams) tablet orally 2 times a day for edema (swelling). A physician's order, dated 1/11/22, indicated to give Spironolactone (a diuretic medication) 25 mg tablet orally one time a day. A physician's order, dated 1/14/22, indicated a LCS (Low Concentrated Sugar), NAS (No Added Salt), regular texture and regular consistency diet. A physician's order, dated 1/14/22, indicated a House Supplement 2.0 give 120 ml (milliliter) orally two times a day for nutritional supplement. A care plan, dated 1/11/22, indicated the resident was at risk for nutritional problems. The interventions included, but were not limited to, provide and serve the diet as ordered, notify the medical provider and the resident representative of any unplanned weight changes.	F 0692	**F692** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified: Residents F no longer resides in the facility; therefore, no further corrective action could be taken for this resident.** **2) How the facility identified other residents: An audit of the last 180 days weights was conducted by the RD. This plan of correction applies to those residents identified as having a significant weight change during the previous 180 days.** **3) Measures put into place/ System changes: Nursing staff**	03/23/2022

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	A care plan, dated 1/11/22, indicated the resident was to consume foods with a regular consistency and a regular texture diet. The interventions included, but were not limited to, monitor and record intake every shift, monitor weight as indicated and to provide the diet as ordered. The resident had the following weights: a. On 1/13/22, the weight was 182.0 pounds. b. On 1/14/22, the weight was 180.2 pounds. c. On 1/15/22, the weight was 180.8 pounds. d. On 1/16/22, the weight was 180.0 pounds. e. On 1/17/22, the weight was 179.8 pounds. f. On 1/18/22, the weight was 179.6 pounds. g. On 1/19/22, the weight was 175.4 pounds. h. On 1/19/22, the weight was 169.0 pounds. i. On 1/20/22, the weight was 169.0 pounds (which is a 7% weight loss since 1/13/22) j. On 1/21/22, the weight was 171.2 pounds. k. On 1/22/22, the weight was 169.8 pounds. l. On 1/24/22, the weight was 158.0 pounds (which is a 13% weight loss since 1/13/22) m. On 1/25/22, the weight was 157.8 pounds. n. On 1/26/22, the weight was 155.2 pounds. o. On 1/27/22, the weight was 150.2 pounds (which is a 17% weight loss since 1/13/22) The progress notes between 1/20/22 and 1/27/22 did not include the weight loss, notification to the physician or any nutrition notes. A progress note, dated 1/27/22 at 11:05 a.m., indicated the physician was notified of the residents significant weight loss. The physician ordered the resident to be sent to the emergency room with a diagnosis of a 30 pound weight loss, orthostatic hypotension and intravascular depletion.		**was re-educated on nutrition/hydration status maintenance, including but not limited to, identifying significant weight losses, notifying the physician of a weight loss and implementing interventions to prevent further weight loss.** **4) How the corrective actions will be monitored: DON, or designee, will review weights and the documentation relative to weights at least 5 days a week X 4 weeks, then 3 days a week X 4 weeks to identify those residents who have experienced significant weight change, and to ensure physician notification of the same, with implementation of recommended interventions.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: March 23, 2022**	

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	During an interview, on 3/4/22 at 1:27 p.m., the DON (Director of Nursing) indicated the physician should have been notified of the residents significant weight loss prior to 1/27/22. They also should have asked the physician if any changes were needed for the diuretics. A current policy, titled "Weight Assessment and Intervention," dated 2020 and received from the ED (Executive Director) on 3/3/22 at 3:00 p.m., indicated "...Weights are monitored monthly or more often as recommended by the interdisciplinary care team. The goal is to ensure adequate parameters of nutritional status are maintained by preventing unintentional weight loss. Weight data will used as one step in determining if changes to the nutritional plan of care are needed to prevent or slow unintentional weight loss within the limits of the resident's clinical condition...Any weight change of 5% or more since the previous weight assessment shall be re-taken the next day to confirm. If the weight is verified, nursing will notify the appropriate designated individuals such as the physician, Registered Dietitian, Dining Services Manager, or other member of the interdisciplinary team within 24 hours. Verbal notification must be confirmed in writing...The threshold for significant unplanned and undesired weight loss shall be based on the following criteria...1 month severe loss greater than 5%...." This Federal tag relates to Complaint IN00373762. 3.1-46(a)(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including			

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	155064	A. BUILDING 00 B. WING	03/04/2022

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	tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.			
	Based on record review and interview, the facility failed to ensure oxygen orders were in place for 2 of 6 residents reviewed for oxygen. (Resident C and F) Findings include: 1. The record for Resident C was reviewed on 3/3/22 at 12:25 p.m. Diagnoses included, but were not limited to, Covid-19, type 2 diabetes mellitus, acute respiratory failure with hypoxia, hypertension, acute kidney failure and cognitive communication deficit. A care plan, dated 1/11/22, indicated the resident had altered respiratory status and difficulty breathing. The interventions included, but were not limited to, to apply O2 with humidity via nasal prongs at 3L (liters) continuously. There was not a physician's order for the use of oxygen located in the resident's record. During the record review, oxygen was documented as used on the following days without an order: 1/15/22, 1/16/22, 1/17/22, 1/18/22, 1/19/22, 1/20/22, 1/21/22, 1/23/22, 1/24/22, 1/25/22, 1/26/22, 1/27/22, 2/1/22, 2/2/22, 2/3/22, 2/6/22 and 2/9/22. During an interview, on 3/4/22 at 10:18 a.m., the	F 0695	F695 *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified: Resident F and Resident C no longer reside in the facility; therefore, no further corrective action could be taken for these residents.** **2) How the facility identified other residents: All residents who utilize oxygen have the**	03/23/2022

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	Director of Nursing (DON) indicated the resident did not have a physician's order to apply oxygen. The staff could put O2 on in an emergency situation or as a nursing measure but must notified the physician and receive an order. 2. The record for Resident F was reviewed on 3/3/22 at 12:25 p.m. Diagnoses included, but were not limited to, Covid-19, type 2 diabetes mellitus, congestive heart failure, severe protein-calorie malnutrition, hypertension, cardiomyopathy and acute kidney failure. A care plan, dated 1/25/22, indicated the resident had altered respiratory status and difficulty breathing. The interventions included, but were not limited to, to apply O2 with humidity via nasal prongs at 2L continuously. There was not a physician's order for the use of oxygen located in the resident's record. During the record review, oxygen was documented as used on the following days without an order: 1/12/22 and 1/14/22. During an interview, on 3/4/22 at 1:27 p.m., the DON indicated the resident did not have a physician's order for oxygen. They needed to have a physician's order for wearing oxygen. A current facility policy for oxygen administration was not provided at the time of the exit conference. This Federal tag relates to Complaint IN00373762. 3.1-47(a)(6)		**potential to be affected; therefore, this plan of correction applies to those residents.** **3) Measures put into place/ System changes: Nursing staff was re-educated on respiratory/tracheostomy care and suctioning, including but not limited to, ensuring oxygen orders are in place for residents who need oxygen.** **4) How the corrective actions will be monitored: DON, or designee, will review oxygen orders 3 times a week X 4 weeks, then 2 times a week X 4 weeks to ensure all necessary orders are present.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: March 23, 2022**	

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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 observation, interview and record review, the facility failed to correctly sign out a controlled medication, to notify the Director of Nursing of a discrepancy in the narcotic count	F 0755	**F755** *This Plan of Correction is the*	03/23/2022

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	and to maintain a correct count for 1 of 3 residents reviewed for medication administration (Resident B). Finding includes: The record for Resident B was reviewed on 3/3/22 at 11:58 a.m. Diagnoses included, but were not limited to, Covid 19, cirrhosis of the liver with ascites, pseudocysts of the pancreas, bipolar disorder and hypertension. A narcotic log, dated 2/2022, indicated the resident had morphine sulfate 30 ml (milliliter). The following was signed out on the narcotic log for the morphine: a. The count on 2/15/22 at 2:00 a.m., indicated the resident had 22.5 ml of morphine and 0.125 ml was given with a balance of 22.375 ml remaining. b. The count on 2/15/22 at 8:00 a.m., indicated 0.125 ml was administered with a balance of 22.50 ml remaining. c. On 2/15/22, a note indicated the count was corrected and the remaining balance was changed to 21.00 ml which was 1.5 ml less than the previous entry and no doses were administered. The sheet had two sets of initials. d. On 2/18/22, a 0.125 ml dose was signed out, not timed and the previous balance was 21.00 ml. The new balance indicated 20.75 ml remained. The correct balance should have been 20.875 ml. e. On 2/19/22, a 0.125 ml dose was signed out at 5:00 a.m. The previous balance was listed at 20.75 ml and the remaining balance was listed as 20.575 ml. The subtraction should have resulted in 20.625 ml remaining. f. The ongoing count from 2/18/22 was not correct.		*center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified: The narcotic count was identified as correct per narcotic sheet and medication by DON and a second nurse at time of finding for Resident B.** **2) How the facility identified other residents: All residents who have orders for narcotics have the potential to be affected; therefore, this plan of correction applies to those residents.** **3) Measures put into place/ System changes: Nursing staff was re-educated on pharmacy services, procedures, pharmacist and records, including but not limited to,**	

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	During an interview, on 3/3/22 at 2:50 p.m., the Director of Nursing (DON) indicated she was not aware the count of morphine was not correct on 2/15/22 and one of the signatures on the corrected count was the evening supervisor who was no longer employed at the facility. The staff were supposed to call the DON immediately for any incorrect narcotic count. The DON looked at the narcotic sheet and noted the count was not correct from 2/18/22 until present and the staff were not correctly subtracting the 0.125 ml dose. A current facility policy, titled "Narcotic/Controlled Substances-Counting," dated as revised on 11/26/17 and received from the Executive Director on 3/3/22 at 4:27 p.m., indicated "...To count controlled substances with a partner and to verify the accuracy of the log sheets...Knowledge of correct response should an error be discovered in the controlled substance count...Always participate in the counting of the controlled substances at the beginning and ending of your shift. Never say, 'go ahead without me and I'll sign'...Always note the integrity of any liquid form of controlled substances to ensure that the bottle has NOT been tampered with nor that he solution appears diluted in any manner...Verbally state medication count to the person with the sign-out record...Repeat count if count and sign-out logs disagree...Recount medication...If the count and sign-out sheet still disagree, check the sign-out entries to detect a prior error in recording or count...Check the resident's medication records and nurse's notes for doses that might have been given and not recorded...Question personnel responsible for administration...Enter the correct count...Report the incorrect count to nursing supervisor, Director of Nursing, or administrative staff present...."		**ensuring narcotics are signed out, notifying the DON if there is a discrepancy in the narcotic count and maintaining a correct count.** **4) How the corrective actions will be monitored: DON, or designee, will review narcotic count sheets for accuracy 3 times a week X 4 weeks, then 2 times a week X 4 weeks. Any issues of concerns will be promptly addressed with the responsible individual(s).** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: March 23, 2022**	

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	A current facility policy, titled "Medication Administration Policy," dated as revised on 1/1/2015 and received from the DON on 3/4/22 at 10:16 a.m., indicated "...MEDICATION/TREATMENT/ERRORS... If a medication and/or treatment error occurs, the licensed nurse will...Immediately notify the attending physician...Describe the error and the resident's response in the Nurse's notes...Complete an Incident Report...identify the error on the 24 Hour Report...Monitor the resident's status...Class II medications are under double lock...Any discrepancy must be reported immediately to the Director of Nursing or his/her designee...." This Federal Tag relates to Complaint IN00373364. 3.1-25(e)(3)			
F 0760 SS=G Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.			
	Based on interview and record review, the facility failed to ensure the correct dose of an opioid was administered to a resident for 1 of 3 residents reviewed for medication administration (Resident B). Resident B had two Emergency Room (ER) visits and required the administration of Narcan (a medication to reverse the effects of opioids). Finding includes: During an interview, on 3/3/22 at 4:06 p.m., a friend of the resident indicated a concern regarding the resident had been overdosed on medication and the medication error was not reported.	F 0760	**F760** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or*	03/23/2022

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	The record for Resident B was reviewed on 3/3/22 at 11:58 a.m. Diagnoses included, but were not limited to, Covid 19, cirrhosis of the liver with ascites, pseudocysts of the pancreas, bipolar disorder and hypertension. A physician's order, dated 2/6/22, indicated morphine sulfate solution 100 mg (milligram) per 5 ml (milliliter), to give 0.25 ml by mouth every 4 hours as needed for pain. A Narcotic count sheet for morphine, dated 2/11/22 at 1:00 p.m., indicated 0.5 ml of morphine solution was signed out. A Medication Administration Record, dated 2/11/22, did not have any doses of morphine entered as being administered. A progress note, dated 2/11/22 at 1:53 p.m., indicated the resident had a change in mental status, the resident complained of pain, the pain medication was given and the resident went unresponsive. The physician was notified and an order to send the resident to the hospital for evaluation was received. An emergency room progress note, dated 2/11/22 at 2:06 p.m., indicated the resident was only responsive to sternal rub. The resident was given 0.5 mg dose of morphine at 1:00 p.m., and went unresponsive so EMS (emergency medical services) was called and brought the resident to the emergency room. He was given Narcan with a positive response. Suspect his decrease in responsiveness was due to the morphine. The clinical impression was an adverse effect of a drug. A progress note, dated 2/11/22 at 8:52 p.m.,		*executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified: Resident B no longer resides in the facility; therefore, no further corrective action could be taken for this resident.** **2) How the facility identified other residents: All residents with orders for opioids/narcotic medications have the potential to be affected. Therefore, this plan of correction applies to all of those residents.** **3) Measures put into place/ System changes: Licensed nursing staff has been re-educated on Residents are Free of Significant Med Errors, including but not limited to, ensuring administration of the correct dose of all medications administered.** **The Director of Nursing, or designee, will conduct random audits of at least 5 resident's eMARs weekly X 4 weeks to ensure correct administration of medications, including correct doses. Thereafter, random audits will be conducted on at least 2 resident's eMARs weekly X 8**	

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	indicated the resident was not responding to verbal stimulus. A call was placed to his responsible party, 911 was called and the resident was transported to the hospital. An emergency room progress note, dated 2/11/22 at 9:07 p.m., indicated the resident was just discharged from their ER two hours ago. The resident presented with a similar issue, was here earlier after becoming unresponsive after a dose of morphine. He was given Narcan in the ER and responded. The residents heart rate was tachy at 99 per minute and his blood pressure low at 90/65 and respirations were 10 per minute. The resident was unresponsive. The resident responded to Narcan, the same thing he was at the ER for three hours ago. Since the resident responded to the Narcan, suspect the facility either needs to decrease his dose or increase the time between doses. During an interview, on 3/3/22 at 2:50 p.m., the DON indicated on 2/11/22 the resident was given a dose of Morphine sulfate concentrate of 0.5 ml (milliliter) instead of the physician ordered .25 ml and went to the emergency room twice. A medication error was not completed since she was not aware of the incorrect dose given until the time of the interview. She also was not aware the resident was given Narcan at the hospital. A current policy, titled, "Medication Administration Policy", revised on 1/1/2015 and received from the DON on 3/4/22 at 10:16 a.m., indicated,"...Only a licensed nurse (RN, LPN) may...prepare...administer...and/or record the administration of medications...Medication must be administered in accordance with a physician's order...the right resident, right medication, right dosage, right route and right time...If a medication		**weeks. Any identified concerns will be promptly addressed with the responsible individual(s).** **4) The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **Date of Compliance: March 23, 2022**	

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	and/or treatment error occurs, the licensed nurse will...immediately notify the attending physician...Describe the error and the resident's response in the Nurse's notes...Complete the Incident Report...Identify the error on the 24 Hour Report...Monitor the resident's status...." This Federal Tag relates to Complaint IN00373364. 3.1-48(c)(2)			