STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155154	A. BUILDING 00 B. WING	04/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00351561. Complaint IN00351561- Substantiated. No deficiencies related to the allegations were cited. Survey dates: April 12, 13, 14, 15, 16 and 19, 2021 Facility number: 000074 Provider number: 155154 AIM number: 100290050 Census Bed Type: SNF/NF: 59 SNF: 5 Total: 64 Census Payor Type: Medicare: 12 Medicaid: 39 Other: 13 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on April 26, 2021.	F 0000	Please accept State Form 2567 Plan of Correction for the Complaint Survey ending April 19, 2021. The facility also asks that the 2567 serve as our letter of credible allegation of compliance. The facility respectfully requests a desk review in lieu of a post survey revisit on or after May 19, 2021.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview and record review, the facility failed to determine it was safe	F 0554	**F554** It is the policy of this facility to allow residents to exercise their	05/19/2021

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

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	for a resident to exercise the right to self-administer medication for 1 of 1 resident observed to have medication unattended in the room (Resident 3). Finding includes: During an observation, on 04/16/2021 at 2:20 p.m., Resident 3 was lying in bed with her eyes closed. Following an alert by knocking on the door, the resident opened her eyes. A clear pill cup with a small white pill was sitting on her over-the-bed table in front of her. When questioned, Resident 3 indicated the pill, in the clear cup, was her Baclofen (a medication to treat muscle spasticity). The resident stated the nurse frequently left her medication in the room with her to take. The record for Resident 3 was reviewed on 04/16/21 at 2:45 p.m. Diagnoses included, but were not limited to, multiple sclerosis (disease of the brain and spinal cord), diabetes mellitus and contracture of the muscle on the right foot and ankle. A physician's order, initiated on 02/12/2021, indicated to give Baclofen 10 mg (milligrams) three times a day at 6:00 a.m., 2:00 p.m. and 8:00 p.m. The record was not observed to contain an assessment to determine the resident's safety in self-administering medications, a physician order to self- administer medications or a plan of care to do so. A current facility policy, titled "Self Administration of Medications," dated as reviewed on 1/2015 and provided by the Administrator on 04/19/21 at 10:00 a.m., indicated "...It is the policy of this facility to respect the		right to self administer medications when determined safe. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Residents who are deemed safe to administer medications have the potential to be affected by the deficient practice. · Resident 3 was assessed and deemed safe to self administer medications. Care plan has been updated and physician order obtained. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by this deficient practice. · DNS/designee completed a full house audit to determine if other residents would be appropriate for self administration of medication. Those identified will have care plan updated and physician order obtained. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The DNS/designee will review the facility activity report	

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	wishes of alert, competent resident to self-administer prescribed medications, as allowable under state regulations. The facility will provide instruction for all residents choosing to and capable of self-administration...If a resident desires to participate in self-administration, the Interdisciplinary Team will assess the competence of the resident to participate by completing the 'Self-Administration of Medication Assessment' observation...A physician order will be obtained specifying the resident's ability to self-administer mediations and, if necessary, listing which medications will be included in the self-administration plan...The licensed nurse will instruct the resident regarding proper administration of medication...The resident will be assessed for continued self-administration of medications quarterly and with any significant change of condition...The resident's care plan will be updated to include self-administration...." 3.1-11(a)		daily to identify potential residents who could self administer medications and obtain an assessment and update the care plan and obtain physician order. · Nursing staff were educated on the facility Self administration policy by the DNS/designee by 5-19-2021. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · Daily nursing QA tool will be utilized daily x 4 weeks, weekly x 4 weeks, monthly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **Date of correction**: 5-19-2021	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview and record	F 0558	**F 558** It is the policy of this	05/19/2021

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	review, the facility failed to ensure call lights were in reach for 4 of 19 residents reviewed for accommodation of needs. (Resident 57, 33, 49 and 44) Findings include: 1. During an observation, on 04/12/21 at 11:19 a.m., Resident 57 was observed laying in bed. The call light was on the floor between the bed and the wall. During an observation, on 04/16/21 at 3:06 p.m., Resident 57 was observed sitting up, in a wheelchair, in her room. She indicated she wanted to get out of the chair and lay down. Her call light cord was observed running down the wall and under the bed, out of Resident 57's reach. The record for Resident 57 was reviewed on 04/14/21 at 9:06 a.m. Diagnoses included, but were not limited to, fracture of left femur shaft (upper leg bone), acquired absence of right leg below the knee and stiffness of the left knee. A care plan, initiated on 11/18/19, indicated Resident 57 was a fall risk and the call light was to be in reach. During an interview, on 04/16/21 at 3:09 p.m., LPN 3 indicated the call light should have been in reach. 2. During an observation, on 04/12/21 at 9:52 a.m., Resident 33 was observed laying in bed, the call light was not in reach. During an interview, on 04/12/21 at 9:54 a.m., RN 2 located the call light between the wall and the bed, on the floor. She indicated the call light should		facility to residents receive services in the facility with reasonable accommodation of needs and preferences. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Residents 57, 49, and 44 were affected by the deficient practice. · Resident identified as 33 was not listed on the resident identified and the facility respectfully requested that the 2567 be updated to reflect accurate information. · Call lights for residents 57, 44, and 49 call lights were placed within reach and each call light have a clip attached to ensure proper placement. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents who are able to utilize the facility call light system could be affected by the alleged deficient practice. · All staff were educated by the DNS/designee by 5-19-2021 on the importance of ensuring residents have access to the facility call light system. · A facility audit was completed to ensure all resident's	

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	have been in reach. 3. During an observation, on 04/12/21 at 11:30 a.m., Resident 49 was observed laying in bed, her call light was not in reach. The record for Resident 49 was reviewed on 04/14/21 at 8:14 a.m. Diagnosis included, but were not limited to, partial traumatic amputation of right foot, acute osteomyelitis (an infection in the bone) of the right ankle and foot and muscle weakness. A care plan, initiated on 12/27/20, indicated Resident 49 was at risk for falling and the call light was to be in reach. During an interview, on 04/12/21 at 11:31 a.m., RN 2 indicated the call light should have been in reach. 4. During an observation, on 04/14/21 at 11:35 a.m., Resident 44 was observed laying in bed, his call device was not in reach. The record for Resident 44 was reviewed on 04/13/21 at 10:00 a.m. Diagnosis included, but were not limited to, functional quadriplegia (the inability to move), muscle weakness and epilepsy (a seizure disorder). A care plan, initiated 11/16/21, indicated the resident used a breath call light (a device used by breathing into it) to alert staff. A care plan, initiated 11/13/20, indicated "...Call light in reach...." During an interview, on 04/14/21 at 11:39 a.m., the Infection Preventionist indicated the call device should have been in reach of the resident.		call lights were in place and to ensure clips were in place. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · All staff were educated by the DNS/designee by 5-19-2021 on the importance of ensuring residents have access to the facility call light system. · Managers/all staff make daily rounds to ensure call lights are within reach. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · Daily Nursing QA tool will be utilized daily x 4 weeks, weekly x 4, and monthly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance **Date of correction**: 5-19-2021	

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	During an interview, on 04/13/21 at 2:16 p.m., the Executive Director indicated the facility did not have a policy which addressed keeping the call light in reach of the resident. 3.1-3(v)(1)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure a resident was assessed and treated for constipation for 1 of 5 residents reviewed for bowel and bladder. (Resident 32) Finding includes: The record for Resident 32 was reviewed on 04/14/21 at 9:13 a.m. Diagnoses included, but were not limited to, hypothyroidism, muscle weakness and constipation. A physician's order, initiated on 02/23/21, indicated the resident was receiving Colace (a stool softener) 100 milligrams every day. A physician's order, initiated on 02/23/21, indicated to give Bisacodyl (a medication for constipation) 10 milligrams (mg) rectally daily as needed for constipation.	F 0684	**F684** It is the policy of this facility to ensure residents are assessed for constipation. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 32 plan of care and orders have been updated. Resident has been assessed and treated for constipation. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents who have not had a BM in 3 days could be	05/19/2021

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	A physician's order, initiated on 02/23/21, indicated to give Miralax (a medication for constipation) 17 grams once a day as needed. A care plan, initiated on 02/19/16, indicated the resident was at risk for constipation. The target goal was for the resident to have a soft formed bowel movement at least every three days. The interventions included, but were not limited to, abdominal assessments, give medications as ordered and notify the physician if no bowel movement after the third day. A report, titled "Vitals Report," was reviewed on 04/15/21 at 11:36 a.m. The report indicated Resident 32 did not have a documented bowel movement from 03/08/21 to 03/13/21 (6 days) and from 03/17/21 to 03/20/21 (4 days). There were no bowel assessments found in the resident's record, for the period of 03/08 to 03/13/21 or 03/17 to 03/20/21. There were no notes found, in the record, to indicated the physician had been notified. The Medication Administration Record, for March 2021, was reviewed and did not indicated any as needed medications were administered for constipation. During an interview, on 04/15/21 at 02:28 p.m., the Director of Nursing indicated if a resident did not have a bowel movement in three days a bowel assessment was to be completed and the physician was to be notified. During an interview, on 04/15/21 at 2:57 p.m., the Director of Nursing indicated the resident's bowel		affected by the deficient practice. · All licensed nurses and nursing staff were educated by the DNS/designee by 5-19-21 on the facility Bowel policy. · The DNS reviewed all residents for Bowel management to ensure residents have had a bowel movement within 3 days. Residents identified MD will be notified per policy and plan of care updated. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · All licensed nurses and nursing staff were educated by the DNS/designee by 5-19-2021 on the Bowel policy. · The DNS/designee will review resident bowel report daily, if concerns are noted resident's physician will be contacted and resident plan of care will be updated. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · Bowel QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the	

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	movement issues had been noticed and the resident was started on a toileting program. A current facility policy, titled "Bowel Elimination," last dated on 1/2015 and provided by the Executive Director on 04/19/21 at 12:00 p.m., indicated "...Bowel movements will be recorded on the...record daily by direct care staff..A resident bowel report will be completed by the assigned charge nurse of resident(s) who have not had a bowel movement for 3 consecutive days...Any resident not having a bowel movement for 3 consecutive days will be given a laxative or stool softener, as prescribed by the physician, at the end of the 3rd day...." 3.1-37(a)		Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **Date of correction**: 5-19-2021	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to maintain a safe environment for 2 of 19 residents reviewed for accidents and hazards. (Resident 19 and 44) Findings include: 1. During an observation, of Resident 19's room on 04/12/21 at 4:11 p.m., the resident's foot board on the twin bed was noted to have three nails	F 0689	**F689** It is the policy of this facility that the resident's environment stays as free of accident hazards as possible. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	05/19/2021

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	sticking out, above the mattress level, and it was cracked across the top of the foot board, leaving a large piece of wood like material loose across the length of the foot board. During an interview, on 04/12/21 at 04:14 p.m., the RN Infection Preventionist indicated it should not have been left that way and it should have been reported. 2. During an observation, on 04/14/21 at 11:35 a.m., Resident 44 was observed laying in bed, his fall mat was leaned against the dresser. The record for Resident 44 was reviewed on 04/13/21 at 10:00 a.m. Diagnosis included, but were not limited to, functional quadriplegia (the inability to move), muscle weakness and epilepsy (a seizure disorder). A care plan, initiated 11/13/21, indicated Resident 44 was a fall risk due to complications of a spinal fusion, functional quadriplegia, debility, seizure disorder, a Foley catheter and a history of falls. The floor mat was to be on the floor at the bedside. During an interview, on 04/14/21 at 11:39 a.m., the Infection Preventionist indicated the mat should have been on the floor at the bedside. A job description, titled "Maintenance Supervisor," provided by the Executive Director on 4/16/21 at 2:21 p.m., indicated "...ESSENTIAL POSITION FUNCTIONS...Inspects and repairs any damage to...resident rooms...." 3.1-45(a)(1) 3.1-45(a)(2)		· Resident 19 foot board was replaced immediately when reported. · Resident 44 floor mat was placed next to the bed immediately. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents with footboards and fall mats have the potential to be affected by the deficient practice. · All staff will be educated by the DNS/designee about the facility maintenance repair request forms. · All nursing staff were educated on resident profiles and importance of fall interventions being in place. · A facility audit was completed on 5-7-2021 of all foot boards and those needing repaired were completed immediately. · A facility audit was completed on 5-7-2021 to ensure all residents who need floor mats were placed per care plan. · An audit will be completed to ensure resident profiles match care plan approaches by 5-19-2021. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	

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			· All staff were educated by the DNS/designee maintenance repair request policy by 5-19-2021. · All nursing staff were educated on resident profiles and importance of fall interventions being in place by 5-19-2021. · The Maintenance director will review maintenance requests daily and prioritize appropriately. · Managers/Staff will round daily to ensure resident fall interventions are in place and foot boards are secured. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · Accident QA tool will be utilized daily x 4 weeks, weekly x 4, and monthly x 6, up to one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **Date of correction**: 5-19-2021	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic			

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	jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, interview and record review, the facility failed to ensure a nutritional formula was labeled with a date and time it was initiated and failed to label or store supplies used for gastrointestinal delivery of nutritional formula for 2 of 4 residents receiving nutrition through a Gastronomy Tube (G-tube). (Resident 53 and 38) Findings include: 1. During an observation of Resident 53's G-tube infusion it was noted the nutritional formula, Jevity, was not labeled with a start date, time or nurse's initials and a 60 milliliter syringe (a syringe used to provide water flushes, medication administration and G-tube nutrition) was not dated to show when it was opened and put into use. The record for Resident 53 was reviewed on 04/13/21 at 11:52 a.m. Diagnoses included, but	F 0693	**F693** It is the policy of this facility to ensure nutritional formulas are labeled and dated, and g-tube supplies stored appropriately. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Residents 53 and 38 could have been affected by the deficient practice. · Residents 53 and 38 Enteral supplies were replaced and appropriately labeled. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	05/19/2021

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	were not limited to, failure to thrive, anorexia (an eating disorder) and severe protein-calorie malnutrition. A physician's order, initiated on 11/20/20, indicated to give Jevity 1.5 continuously every shift. During an interview, on 04/12/21 10:33 a.m., RN 4 indicated the Jevity should have had a date and time the infusion was started. 2. During an observation of Resident 38, on 04/13/21 at 11:22 a.m., a 60 milliliter (ml) syringe was found laying on the bedside table. It contained approximately 5 milliliters of clear fluid and was not in a protective package nor was it dated to show when it had been opened. Another 60 syringe was found lying on the dresser, also without a protective package and no date to indicated when it had been opened. During an interview, on 04/13/21 at 11:26 a.m., the RN Infection Preventionist indicated staff should not use either syringe and they should have been in packaging and dated. A current facility policy, titled "Enternal Nutrition-Gastrostomy or Jejunostomy Tube," dated 01/2010 and provided by the Executive Director on 04/15/21 at 4:02 p.m., indicated "...Label feeding bag with date, time and initials...." 3.1-44(a)(2)		· All residents with g-tubes have the potential to be affected by the deficient practice. · All licensed nurses will be educated by the DNS/designee on the Skills validation for enteral feedings by 5-19-2021. · An audit of all residents' Enteral supplies was completed and appropriately labeled by 5-19-21. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · All licensed nurses will be educated by the DNS/designee on the Skills validation for enteral feedings by 5-19-2021. · Daily rounds will be made by nurse managers to ensure enteral feedings are labeled/dates and supplies for g-tubes stored appropriately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · Enteral feeding QA tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director.	

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	155154	A. BUILDING 00 B. WING	04/19/2021

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			· If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **Date of correction**: 5-19-2021	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the kitchen failed to ensure the correct amount of sanitizer was used in a 3 compartment sink, defrosted meats in the walk-in refrigerator were labeled and dated, a cardboard box of cookie packages were stored off the floor in the dry pantry area and a door going to the outside environment was kept closed. This deficient practice had the potential to affect 60 out of 65	F 0812	**F812** It is the policy of this facility to ensure food is procured, stored/prepared/served in accordance with professional standards for food service safety. **What corrective action(s) will be accomplished for those residents found to have been**	05/19/2021

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	residents who received meals from the kitchen. Findings include: During an observation of the kitchen with the Kitchen Manager, on 04/12/2021 at 9:27 a.m., the following was observed: 1. The no-rinse Quat sanitizer (a registered sanitizer which is effective against foodborne organisms) used in the 3 compartment sink was tested by the Kitchen Manager using a piece of litmus paper (paper used to indicate the pH of or amount of sanitizer in a solution). He immersed the end of the litmus paper in the sanitizing water and indicated the pH was 50 ppm (parts per million) and was supposed to be between 150 ppm and 400 ppm. 2. In the walk-in refrigerator, there were chicken and beef defrosting without a label and date. The Kitchen Manager indicated the meats should have had a dated label when removed from freezer and placed in walk-in refrigerator to defrost. 3. In the dry goods pantry, a cardboard box of cookie packages were stored on the floor. The Kitchen Manager indicated the cookies should not have been on the floor. 4. A door in the back of the kitchen was observed propped open to the outside environment approximately 12 to 15 inches. The Kitchen Manager indicated the door should have been closed tightly. A current policy, titled "Food Storage Policy," dated 5/18 and provided by the Registered Dietician on 04/12/2021 at 3:35 p.m., indicated "...7. Food is stored a minimum of 6" off floor...all foods		**affected by the deficient practice?** · The thawing meat was labeled after identified. · The 3-compartment sink was drained, and the correct amount of sanitizer level was obtained after identified. · The back door was closed after identified. · The boxes on the storage room floor were removed after identified. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · 60 of 65 who eat meals at the facility could be affected by the deficient practice. · All Culinary staff will be educated by the RD/designee on professional standards for food service safety by 5-19-2021. · The RD will complete a short sanitation form daily to identify similar concerns. · All thawing meat was observed to ensure appropriate labeling and identification. · All boxes stored on the floor were discarded. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · All Culinary staff will be	

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	should be...labeled and dated...." A current policy, titled "Manual Dishwashing," dated 07/15 and provided by the ED on 04/12/2021 at 4:12 p.m., indicated "...sanitizer must be mixed at the appropriate concentration...." A current document, titled "2017 food code," dated 07/15 and provided by the ED (Executive Director) on 04/12/2021 at 4:12 p.m., indicated "...outer openings of a food establishment shall be protected against the entry of insects and rodents by...3) solid closing, tight-fitting doors...." A current document, titled "ECOLAB Oasis 146 Multi-Quat Sanitizer," undated and provided by the ED (Executive Director) on 04/19/2021 at 4:30 p.m., indicated the disinfectant solution should be between 150 - 400 ppm. 3.1-21(i)(3)		educated by the RD/designee on professional standards for food service safety by 5-19-2021. · Daily rounds will be made by RD/designee using the short sanitation form to include labeling of thawing meat, no boxes stored on floor and ensuring back door remains closed. · RD/Designee will test the water in the 3 compartment sink to ensure the correct sanitizer solution. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · Short Sanitation QA tool will be utilized daily x 4 weeks, weekly x 4 weeks, and monthly thereafter up to one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **Date of correction**: 5-19-2021	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in			

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	accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.			

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	§483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on observation, interview and record review, the facility failed to ensure the resident's medical record reflected the care and services provided for 1 of 1 residents who refused a medication (Resident 49) and failed to accurately document medication administration in the Medication Administration Record (MAR) for 3 of 5 residents reviewed for accurate documentation. (Residents 53, 49, 44) Findings include: 1. During observation of the Medication Administration pass, on 04/16/2021 at 9:41 a.m., LPN 1 was observed to prepare medications for Resident 49. Included in the medications was Lasix (a diuretic) 40 milligrams (mg). Resident 49	F 0842	**F842** It is the policy of this facility to ensure the residents record reflects the care and services provided and accurately document medication administration. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Residents 53, 49, 44 and 3 were affected by the deficient practice. · All licensed staff will be educated by the DNS/designee on the Skills validation for medication	05/19/2021

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	was sitting, in the hallway outside of her room, in a wheelchair. LPN 1 indicated the resident was on her way to a doctor appointment. After placing all of the resident's medications in a clear cup and pouring the resident water, LPN 1 offered the medications to the resident. The resident was heard to ask, "Is my water pill in there?" The LPN indicated it was. Resident 49 was then heard to say she did not want the water pill because she was going out for her doctor appointment. LPN 1 disposed of the Lasix 40 mg tablet appropriately and administered the remainder of the medications to the resident. The record for Resident 49 was reviewed on 04/16/2021 at 10:20 a.m. Diagnoses included, but were not limited to heart failure, chronic obstructive pulmonary disease and diabetes mellitus. A physician's order indicated to give Lasix 40 mg daily, between the hours of 7:00 a.m. to 11:00 a.m. During reconciliation of the medications for Resident 49, on 04/16/2021 at 10:21 a.m., Lasix 40 mg was observed initialed by LPN 1 on the MAR (Medication Administration Record) indicating the medication had been administered. The MAR for Resident 49 was again reviewed, on 04/19/2021 at 9:38 a.m. and found to remain initialed as administered by LPN 1 on 04/16/2021.2. The record for Resident 53 was reviewed on 04/13/21 at 11:52 a.m. Diagnoses included, but were not limited to, diabetes, hypertension and pain. A review of the April 2021 MAR had the following missing documentation: On April 9, 2021, the blood sugar result for		administration by 5-19-2021. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents who receive services at the facility could be affected by the deficient practice. · All licensed staff will be educated by the DNS/designee on the Skills validation for medication administration by 5-19-2021. · The DNS/designee will review the previous day medication administration records and ensure staff are documenting accurately. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · All licensed nurses will be educated by the DNS/designee on the Skills validation for medication administration by 5-19-2021. · The DNS/designee will review the previous day medication administration records and ensure staff are documenting accurately · Staff found not to complete documentation accurately will be educated up to and including termination. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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	7:00-11:00 a.m. was missing documentation. On April 9, 2021, the amlodipine (a medication for hypertension) was missing documentation. On April 9, 2021, the atorvastatin (a medication for high cholesterol) was missing documentation. On April 9, 2021, the Eliquis (a medication given to help prevent clots) was missing documentation. On April 9, 2021, the hydorchlorothiazide (a diuretic) was missing documentation. On April 9, 2021, the vitamin D3 was missing documentation. 3. The record for Resident 49 was reviewed on 04/14/21 at 8:14 a.m. Diagnoses included, but were not limited to, diabetes, anemia and hypertension. A review of the April 2021 MAR had the following missing documentation: On April 7th, 9th and 11th, the blood sugar results were missing documentation. On April 9th and 11th, the Levemir (a medication to treat diabetes) were missing documentation. On April 9, 2021, the gabapentin (a medication used to treat neuropathy) was missing documentation. 4. The record for Resident 44 was reviewed on 04/13/21 at 10:00 a.m. Diagnoses included, but were not limited to, epilepsy, muscle weakness and hypertension. A review of the March 2021 MAR had the		· EMAR QA tool will be utilized daily x 4 weeks, weekly x 4 weeks, monthly and thereafter for up to one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · Licensed nursing staff will be educated up to and including termination when incomplete/inaccurate documentation is found. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **Date of correction**: 5-19-2021	

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	following missing documentation: On March 7th, 9th, 14th, 21st and 22nd, the active liquid protein (a supplement) was missing documentation. On March 16, 2021, the atorvastatin was missing documentation. On March 7th, 9th, 13th, 17th, 20th, 24th and 28th, the sodium chloride nasal drops was missing documentation. On March 3rd, 7th, 9th, 14th, 16th, 21st, 22nd and 30th, the Baclofen (a muscle relaxer) was missing documentation. On March 7th, 8th and 9th, the normal saline flushes to the PICC line (an intravenous access site) was missing documentation. On March 7th, 13th, 20th, 24th and 28th, the docusate sodium (a laxative) was missing documentation. During an interview, on 04/19/21 at 02:25 p.m., the Director of Nursing indicated they (the facility) were aware of the issues relating to not documenting medication and/or treatment administration on the medication and/or treatment record. During an interview, on 04/19/21 at 4:52 p.m., the Executive Director indicated there was no facility policy addressing documenting medications/treatments after they had been administered. A facility policy and procedure, regarding guidance when resident's refused medications,			

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	was requested, on 04/19/2021 at 9:10 a.m., however no policy and procedure was received prior to or at the time of exit. 3.1-50(a)(2)			