STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00403143 and IN00404720. Complaint IN00403143 - Federal/State deficiencies related to the allegations are cited at F677 and F695. Complaint IN00404720 - Federal/State deficiencies related to the allegations are cited at F684 and F842. Survey dates: March 29 and 30, 2023 Facility number: 000135 Provider number: 155230 AIM number: 100266820 Census Bed Type: SNF/NF: 91 SNF: 7 Total: 98 Census Payor Type: Medicare: 9 Medicaid: 82 Other: 7 Total: 98 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 4, 2023	F 0000	Dear Brenda Buroker, Attached is Rosebud Village's plan of correction for complaint survey completed on 3/30/2023. Rosebud Village is requesting paper compliance for all deficiencies written in the 2567. Please accept the plan of correction as written. Thank you, Kari Alcorn, HFA Executive Director Rosebud Village	
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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kari	Alcorn	04/21/2023

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

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	carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain good grooming, oral care, personal hygiene, and nail care for residents who are unable to carry out activities of daily living (ADLs) for 3 of 4 residents reviewed for activities of daily living. (Resident C, Resident D, and Resident F) Findings include: 1. The clinical record for Resident C was reviewed on 3/29/23 at 3:24 p.m. The diagnoses included, but were not limited to, end stage renal disease, dementia, diabetes mellitus, major depressive disorder, and gastrostomy (feeding tube) status. An ADL care plan, revised 3/2/23, indicated Resident C required assistance with ADLs including bed mobility, transfers, eating, and toileting. The approach was listed to assist with bathing as needed per resident preference and offer showers two times per week. A Quarterly Minimum Data Set (MDS) assessment, dated 2/14/23, indicated Resident C needed total assistance with one staff for personal hygiene and bathing. An observation conducted of Resident C, on 3/29/23 at 11:45 a.m., with his hair appearing greasy. An observation conducted of Resident C, on 3/29/23 at 3:58 p.m., with his hair still appearing	F 0677	**What corrective action(s) will be accomplished for those residents found to have been affected by deficient practice:** · Residents C, D, and F will be offered ADL care per policy and preference, ADL care will include but is not limited to hair washing, nail trimming and cleaning, oral care and complete bed baths or showers. **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken:** · Any resident that is dependent for care has the potential to be affected by the alleged deficient practice. · An audit will be completed to ensure that all dependent residents receive ADL care per plan of care. · All nursing staff will be in-serviced on providing ADL care to dependent residents by Director of Nursing or Designee by April 22, 2023. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur:** · All nursing staff will be	04/22/2023

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	greasy. An observation conducted of Resident C, on 3/30/23 at 10:48 a.m., with his hair still appearing greasy. The ADL charting for bathing was reviewed and indicated the following date(s) to where Resident C was documented as having a bath: - A shower on 2/2/23, - A shower of 2/6/23, - A complete bed bath on 2/13/23, - A shower on 2/16/23, - A shower on 2/20/23, - A complete bed bath on 2/23/23, - A complete bed bath on 3/9/23, - A complete bed bath on 3/13/23, - A complete bed bath on 3/20/23, & - A complete bed bath on 3/27/23. 2. The clinical record for Resident D was reviewed on 3/30/23 at 1:40 p.m. The diagnoses included, but was not limited to, dementia, weakness, diabetes mellitus, and osteoarthritis. An ADL care plan, revised 3/14/23, indicated Resident D required assistance with ADLs including bed mobility, transfers, eating, and toileting. The approach was listed to assist with bathing as needed per resident preference, offer showers two times per week, and assist with oral care at least two times daily. A Quarterly MDS assessment, dated 2/16/23, indicated Resident D was cognitively intact, required extensive assistance with dressing and personal hygiene, and total assistance for bathing.		in-serviced on providing ADL care to dependent residents by Director of Nursing or Designee by April 22, 2023. · Director of Nursing or Designee will conduct rounds daily to ensure ADL care is provided per policy and preference. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place:** · Complaint Survey Plan of Correction tool will be completed as a monitoring tool. This tool will monitor but is not limited to: resident ADL care(bathing/showering, nail care, oral care and hair cleaning). This tool will be completed weekly x4, monthly x2, and quarterly for 6 months by the Director of Nursing Services or designee. If a threshold of 95% is not met, the results will be reviewed by the CQI committee and an action plan will be developed.	

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	An observation and interview conducted of Resident D, on 3/29/23 at 12:07 p.m., indicated she preferred to have bed baths, but the staff do not provide her with a "full" bed bath, and it's "scattered" on when she received a bed bath. She had an automatic toothbrush that family provided for her to brush her teeth, but it was in the nightstand and the nursing staff does not provide nor offer oral care. Resident D indicated "it's been a while" since oral care was provided. Resident D's hands were observed to where she had 2 long fingernails and the others were filed down by Resident D. She indicated "it's hard to keep the dirt out from underneath them". The ADL charting for bathing was reviewed and indicated the following date(s) to where Resident D was documented as having a bath: - A complete bed bath on 2/4/23, - A complete bed bath on 2/18/23, - A complete bed bath on 2/22/23, - A complete bed bath on 3/8/23, - A complete bed bath on 3/11/23, - A complete bed bath on 3/15/23, - A complete bed bath on 3/18/23, & - A complete bed bath on 3/26/23. 3. The clinical record for Resident F was reviewed on 3/30/23 at 11:54 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, dementia, diabetes mellitus, weakness, and atrial fibrillation. The ADL care plan, revised 2/24/23, indicated Resident F required assistance with ADLs including bed mobility, transfers, eating, and toileting. The approach was listed to assist with bathing as needed per resident preference, offer showers two times per week, and assist with			

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dressing/grooming/hygiene as needed.

A Significant Change MDS assessment, dated 3/1/23, indicated Resident F was cognitively intact, required extensive assistance with dressing and personal hygiene, and total assistance for bathing.

An observation and interview with Resident F, on 3/29/23 at 12:27 p.m., indicated she liked her nails trimmed and filed. Resident F's nails appeared longer with growth and indicated she could not recall the last time staff trimmed her nails. Her niece would come in and trim her nails for her.

The ADL charting for bathing was reviewed and indicated the following date(s) to where Resident F was documented as having a bath:

- A complete bed bath on 2/2/23,
- A complete bed bath on 2/6/23,
- A complete bed bath on 2/16/23,
- A complete bed bath on 2/27/23,
- A complete bed bath on 3/2/23,
- A complete bed bath on 3/9/23,
- A complete bed bath on 3/13/23,
- A complete bed bath on 3/16/23, &
- A complete bed bath on 3/23/23.

A podiatry note, dated 12/20/22, indicated resident refused treatment due to "Niece just trimmed nails yesterday".

A policy titled "NURSING", reviewed 02/2012, was provided by the Executive Director (ED), on 3/30/23 at 2:48 p.m. The policy indicated the following, "...1. GENERAL RESIDENT CARE...a. Bathe or assist to bathe resident at least 2 times per week or per state regulations...b. Provide or assist in shampoo at least 1 time per week or as

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	needed...c. Provide or assist in oral care at least 2 times per day or as needed...." This Federal tag relates to complaint number IN00403143. 3.1-38(a)(3)(A) 3.1-38(a)(3)(B) 3.1-38(a)(3)(C) 3.1-38(a)(3)(E)			
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 change in condition was followed up with regarding a resident with vomiting with a gastrostomy tube for 1 of 3 residents reviewed for change in condition. (Resident B) Findings include: The clinical record for Resident B was reviewed on 3/29/23 at 2:40 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes mellitus, irritable bowel syndrome without diarrhea, epilepsy, reflux uropathy, weakness, ileus, muscle weakness, and gastrostomy tube [feeding tube] status.	F 0684	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Resident B no longer resides at the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents have the potential to be affected by the alleged deficient practice. · Licensed nurses will be in-serviced on following up on	04/22/2023

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	A Significant Change Minimum Data Set (MDS) assessment, dated 2/15/23, indicated Resident B required extensive assistance with bed mobility, total assistance with dressing, eating, personal hygiene, bathing, and toilet use. Resident B exhibited weight loss and had a feeding tube. An anonymous interview conducted during the survey indicated a resident had a change in condition that sounds concerning regarding a resident that ended up passing away recently. A progress note, dated 3/11/23 at 1:14 a.m., indicated the following, "...Res [resident] roommate called staff to rm [room], stating that her roommate didn't sound like she was breathing well. Upon assessing resident, res had audible, coarse breath sounds. Res assisted into upright sitting position, and Sp02 checked, and was noted to be between 40-60% on RA [room air]...Received order from resident on-call...to send to ER [emergency room] for eval [evaluation]...Call placed to 911, and EMS [emergency medical services] arrived within just a few mins [minutes]. Upon EMS entering rm, resident was noted to have stopped breathing...res was pronounced deceased at 12:55 a.m...." There were no previous progress notes, dated 3/10/23, to indicated Resident B had any concerns with her condition prior to passing away. Interview conducted with Resident B's former roommate, Resident G, on 3/29/23 at 2:00 p.m., indicated Resident B was coughing more in a different tone the day prior to her passing away. Resident B vomited twice that day. Resident G stated she went to sleep around 11:00 p.m., on 3/10/23, and she woke up, after 12:00 a.m., on		resident change of conditions including documentation and physician notification of changes of conditions. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Licensed nurses will be in-serviced on following up on resident change of conditions including documentation and physician notification of changes of conditions. · Director of Nursing or Designee will review facility activity report daily to identify any change in conditions, and notify physician as needed. **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:** · Complaint Survey Plan of Correction tool will be completed as a monitoring tool. This tool will monitor but is not limited to: reviewing residents with change of conditions, documentation of change of condition and physicians notification. This tool will be completed weekly x4, monthly x2, and quarterly for 6 months by the Director of Nursing Services or designee. If a threshold of 95% is not met, the	

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	3/11/23, and went to the bathroom. Resident G noticed a gurgling noise and went to Resident B's side of the room and noticed the gurgling noise was coming from her chest. Resident G turned on the call light and the CNA (Certified Nursing Assistant) came in first, followed by the nurse, and "it all started". Resident G indicated more loose stools have occurred with Resident B in the past few months. An interview conducted with Nurse 2, on 3/29/23 at 4:02 p.m., indicated Resident B's abdomen was always distended. She would vomit at times, and we would hold the gastrostomy tube feedings. An interview conducted with the Director of Nursing (DON), on 3/29/23 at 4:10 p.m., indicated Resident B never had a full bowel obstruction. She would continue to have abdominal distension. The Nurse Practitioner worked her up several times and we attempted to try a different feeding solution to see if that would help with her situation. An interview conducted with CNA 3, on 3/30/23 at 10:30 a.m., indicated she worked first shift on 3/10/23. Resident B did not vomit during her shift and having loose stools was rather normal. There didn't appear to be a change in Resident B's condition during day shift. An interview conducted with Nurse 4, on 3/30/23 at 10:42 a.m., indicated she worked day shift on 3/10/23. Resident B was having loose stools, which was normal for them. Resident B had a distended abdomen, but the Nurse Practitioner was aware of that. Resident B didn't have any episodes of vomiting during day shift. An interview conducted with CNA 5, on 3/30/23 at		results will be reviewed by the CQI committee and an action plan will be developed.	

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12:00 p.m., indicated on her last round, before the end of her shift on 3/10/23 at 10:00 p.m., Resident B had vomited and had a large loose bowel movement. Another CNA assisted with cleaning Resident B and when they proceeded to roll Resident B, she kept continuously having a loose bowel movement, which wasn't normal for Resident B. She would have loose bowel movements but it going continuously was not normal. CNA 5 reported the situation to Nurse 6 about Resident B vomiting and having 3 bowel movements back-to-back. CNA 5 indicated when she got report from day shift, they had told her Resident B had vomited earlier that day, 3/10/23, so CNA 5 was continuously checking on Resident B throughout the shift. When CNA 5 reported the vomiting and excessive loose stools to Nurse 6, he instructed us to clean Resident B and Nurse 6 paused the feeding for Resident B's feeding tube.

An interview conducted with Nurse 6, on 3/30/23 at 10:57 a.m., indicated he did not notice Resident B being sick. The CNAs reported to me that Resident B had gotten sick in the previous shift and was having diarrhea on our shift (evening time). Nurse 6 went in to assess Resident B and she was resting without distress and appeared peaceful. Nurse 6 administered a medication for the diarrhea and over 30 minutes later he got a call from the roommate and that's when Nurse 6 found Resident B in distress. Nurse 6 administered anti-diarrhea medication around 11:10 p.m. on 3/10/23 and Resident B "seemed okay" then. Resident B didn't have vomiting on his shift that started at 6:00 p.m. on 3/10/23.

There was no documentation in Resident B's clinical record to reflect any change in her condition, episodes of vomiting, excessive loose stools, or disconnecting the gastrostomy tube

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	feeding prior to the passing of Resident B on 3/11/23 at 12:55 a.m. There was no follow up documented regarding Resident B's change in condition. A policy titled "Documentation Guidelines for Nursing", revised 7/2020, was provided by the Executive Director on 3/30/23 at 2:48 p.m. The policy indicated the following, "...PURPOSE: To accurately document in an organized manner all information related to the resident in the medical record...3. Hot Charting...A hot charting event will be opened in EMR [electronic medical record] based upon resident's status i.e., any change or condition that requires follow up assessment and documentation...4. SBAR [situation, background, assessment, recommendation]...Completed for any change in resident condition that requires assessment with physician notification...." This Federal tag relates to complaint number IN00404720. 3.1-37(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.			
	Based on observation, interview, and record	F 0695	**What corrective action(s) will be accomplished for those**	04/22/2023

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	review, the facility failed to ensure oxygen tubing was contained when not in use along with a date, a humidifier bottle was labeled, and had water for use for 3 of 4 resident reviewed for respiratory services. (Resident C, Resident E, and Resident F) Findings include: 1. The clinical record for Resident C was reviewed on 3/29/23 at 3:24 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, end stage renal disease, dementia, diabetes mellitus, major depressive disorder, and gastrostomy (feeding tube) status. A hospital document, dated 3/19/23, indicated discharge orders for oxygen at 2 liters via nasal cannula continuous. An observation conducted of Resident C, on 3/29/23 at 12:30 p.m., with no dates on the humidifier bottle or nasal cannula. There was no bag for his nasal cannula. An observation conducted of Resident C, on 3/29/23 at 3:58 p.m., with no dates on the humidifier bottle or nasal cannula. There was no bag for his nasal cannula. 2. The clinical record for Resident E was reviewed on 3/30/23 at 1:48 p.m. The diagnoses included, but were not limited to, encephalopathy, chronic obstructive pulmonary disease, diabetes mellitus, chronic kidney disease, and congestive heart failure. A respiratory care plan, revised 2/17/23, indicated Resident E was at risk for impaired gas exchange. The approach was to apply oxygen at 2 liters via nasal cannula.		**residents found to have been affected by the deficient practice?** · Residents C, E, and F were provided with new oxygen tubing, storage bag for oxygen tubing, and humidifier water, dates were placed on storage bag and humidifier water. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Any resident with oxygen orders/equipment has the potential to be effected by the alleged deficient practice. · All residents with oxygen orders/equipment were reviewed to ensure that that tubing was changed, a storage bag was provided with date and humidifier water was dated and present for those residents' requiring humidification. · Nursing staff will be educated by the DNS or designee on identification of supplies in need of changing. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not reoccur?** · All licensed nurses will be educated on the Specialized Medical Services policy including	

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	An observation conducted of Resident E, on 3/29/23 at 12:23 p.m., of an oxygen concentrator along with a humidifier bottle dated for 3/26/23. The oxygen tubing was without a bag nor date along with the nasal cannula making contact with the floor. An observation conducted of Resident E, on 3/29/23 at 4:00 p.m., of the nasal cannula making contact with the floor and without a bag. 3. The clinical record for Resident F was reviewed on 3/30/23 at 11:54 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, dementia, diabetes mellitus, weakness, and atrial fibrillation. A respiratory care plan, revised 2/24/23, indicated Resident F was at risk for impaired gas exchange. The approach was listed to apply oxygen at 3 liters via nasal cannula. An observation conducted of Resident F, on 3/29/23 at 12:27 p.m., of an oxygen concentrator along with a humidifier bottle dated for 3/20/23. The oxygen tubing was without a bag nor date. A policy from "Specialized Medical Services", undated, was provided by the Executive Director (ED), on 3/30/23 at 2:48 p.m. The policy indicated the following, "...Oxygen Concentrator...Procedure...8) If prescribed, attach the humidifier bottle to the oxygen outlet connection, and ensure there is water in the bottle...Daily Maintenance...1) Check the water level in the humidity bottle. Change the bottle as needed or every 7 days...Oxygen Devices...1) Nasal cannula...e. Change out weekly and PRN [as needed]...f. Place in a labeled bag when not in		but not limited to checking the humidification level and changing out as needed or every 7 days, changing tubing as needed or every 7 days, placing tubing in labeled bag with date when not in use and changing bag as needed or every 7 days. · Director of Nursing or Designee will complete rounding daily to ensure oxygen storage bags are available and dated, are placed appropriately and humidifier water is available and dated. **How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place?** · Complaint Survey Plan of Correction tool will be completed as a monitoring tool. This tool will monitor but is not limited to: ensuring all residents with oxygen orders/equipment have needed supplies available and dated per policy. This tool will be completed weekly x4, monthly x2, and quarterly x6 months by the Director of Nursing Services or designee. If a threshold of 95% is not met, the results will be reviewed by the CQI committee, and an action plan will be developed.	

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	155230	A. BUILDING 00 B. WING	03/30/2023

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	use...." This Federal tag relates to Complaint number IN00403143. 3.1-47(a)(6)			
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 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			

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	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. §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 interview and record review, the facility failed to ensure a resident's change in condition	F 0842	**What corrective action(s) will be accomplished for those residents found to have been**	04/22/2023

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	was documented in the clinical record for 1 of 3 residents reviewed for change in condition. (Resident B) Findings include: The clinical record for Resident B was reviewed on 3/29/23 at 2:40 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes mellitus, irritable bowel syndrome without diarrhea, epilepsy, reflux uropathy, weakness, ileus, muscle weakness, and gastrostomy tube [feeding tube] status. A Significant Change Minimum Data Set (MDS) assessment, dated 2/15/23, indicated Resident B required extensive assistance with bed mobility, total assistance with dressing, eating, personal hygiene, bathing, and toilet use. Resident B exhibited weight loss and had a feeding tube. A progress note, dated 3/11/23 at 1:14 a.m., indicated the following, "...Res [resident] roommate called staff to rm [room], stating that her roommate didn't sound like she was breathing well. Upon assessing resident, res had audible, coarse breath sounds. Res assisted into upright sitting position, and Sp02 checked, and was noted to be between 40-60% on RA [room air]...Received order from resident on-call...to send to ER [emergency room] for eval [evaluation]...Call placed to 911, and EMS [emergency medical services] arrived within just a few mins [minutes]. Upon EMS entering rm, resident was noted to have stopped breathing...res was pronounced deceased at 12:55 a.m...." There were no previous progress notes, dated 3/10/23, to indicated Resident B had any concerns with her condition prior to passing away.		**affected by the deficient practice?** · Resident B no longer resides at the facility. **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 the alleged deficient practice. · Licensed nurses will be in-serviced on following up on resident change of conditions including documentation and physician notification of changes of conditions. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not reoccur?** · Licensed nurses will be in-serviced on following up on resident change of conditions including documentation and physician notification of changes of conditions. · Director of Nursing or Designee will review daily activity report and ensure appropriate documentation is completed and physician notified when a change of condition occurs. **How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur, i.e., what quality**	

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	Interview conducted with Resident B's former roommate, Resident G, on 3/29/23 at 2:00 p.m., indicated Resident B was coughing more in a different tone the day prior to her passing away. Resident B vomited twice that day. Resident G stated she went to sleep around 11:00 p.m., on 3/10/23, and she woke up, after 12:00 a.m., on 3/11/23, and went to the bathroom. Resident G noticed a gurgling noise and went to Resident B's side of the room and noticed the gurgling noise was coming from her chest. Resident G turned on the call light and the CNA (Certified Nursing Assistant) came in first, followed by the nurse, and "it all started". Resident G indicated more loose stools have occurred with Resident B in the past few months. An interview conducted with CNA 5, on 3/30/23 at 12:00 p.m., indicated on her last round, before the end of her shift on 3/10/23 at 10:00 p.m., Resident B had vomited and had a large loose bowel movement. Another CNA assisted with cleaning Resident B and when they proceeded to roll Resident B, she kept continuously having a loose bowel movement, which wasn't normal for Resident B. She would have loose bowel movements but it going continuously was not normal. CNA 5 reported the situation to Nurse 6 about Resident B vomiting and having 3 bowel movements back-to-back. CNA 5 indicated when she got report from day shift, they had told her Resident B had vomited earlier that day, 3/10/23, so CNA 5 was continuously checking on Resident B throughout the shift. When CNA 5 reported the vomiting and excessive loose stools to Nurse 6, he instructed us to clean Resident B and Nurse 6 paused the feeding for Resident B's feeding tube. An interview conducted with Nurse 6, on 3/30/23		**assurance program will be put into place?** · Complaint Survey Plan of Correction tool will be completed as a monitoring tool. This tool will monitor but is not limited to: reviewing residents with change of conditions, documentation of change of condition and physicians notification. This tool will be completed weekly x4, monthly x2, and quarterly x6 months by the Director of Nursing Services or designee. If a threshold of 95% is not met, the results will be reviewed by the CQI committee and an action plan will be developed.	

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	at 10:57 a.m., indicated he did not notice Resident B being sick. The CNAs reported to me that Resident B had gotten sick in the previous shift and was having diarrhea on our shift (evening time). Nurse 6 went in to assess Resident B and she was resting without distress and appeared peaceful. Nurse 6 administered a medication for the diarrhea and over 30 minutes later he got a call from the roommate and that's when Nurse 6 found Resident B in distress. Nurse 6 administered anti-diarrhea medication around 11:10 p.m. on 3/10/23 and Resident B "seemed okay" then. Resident B didn't have vomiting on his shift that started at 6:00 p.m. on 3/10/23. There was no documentation in Resident B's clinical record to reflect any change in her condition, episodes of vomiting, excessive loose stools, or disconnecting the gastrostomy tube feeding prior to the passing of Resident B on 3/11/23 at 12:55 a.m. A policy titled "Documentation Guidelines for Nursing", revised 7/2020, was provided by the Executive Director on 3/30/23 at 2:48 p.m. The policy indicated the following, "...PURPOSE: To accurately document in an organized manner all information related to the resident in the medical record...3. Hot Charting...A hot charting event will be opened in EMR [electronic medical record] based upon resident's status i.e., any change or condition that requires follow up assessment and documentation...4. SBAR [situation, background, assessment, recommendation]...Completed for any change in resident condition that requires assessment with physician notification...." This Federal tag relates to Complaint number IN00404720.			

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	3.1-50(a)(1) 3.1-50(a)(2)			