DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155383	A. BUILDING 00 B. WING	05/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WASHINGTON HEALTHCARE CENTER	8201 W WASHINGTON ST INDIANAPOLIS, IN 46231

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00379668. Complaint IN00379668 - Unsubstantiated due to lack of evidence. Survey dates: May 5, 6, 9 and 10, 2022. Facility number: 000393 Provider number: 155383 AIM number: 100289340 Census Bed Type: SNF/NF: 36 Total: 36 Census Payor Type: Medicare: 1 Medicaid: 30 Other: 5 Total: 36 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 17, 2022.	F 0000	F 0000 The submission of this plan of correction does not indicate an admission by Washington Healthcare that the findings and allegations contained herein are an accurate and true representation of the quality of care provided to the residents of this facility. This facility recognizes its obligation to provide legally and medically necessary care and service to its residents in an economic and safe manner. The facility herby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only. This facility respectfully requests from the Department a desk review for paper compliance. The facility will provide additional information as needed to identify compliance.	
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.			

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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	Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were coded accurately to reflect the Pre-Admission Screen and Resident Review (PASRR) status for 2 of 2 residents reviewed for PASRR (Residents 14 and 25). Findings include: 1. On 5/5/22 at 2:00 p.m., Resident 14's medical record was reviewed. Resident 14 had a Resident Review (PASRR) Level II assessment completed on 9/24/19. The PASRR indicated Resident 14 had a PASRR condition, " ...if you admit to a Medicaid certified nursing facility, or if you are currently in a Medicaid-certified nursing facility, the facility will need to document your PASRR condition in the Minimum Data Set (MDS) assessment record. The facility should mark yes for question A1500 on the MDS, 'Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?' Also, your specific PASRR condition(s) should be checked in question A1510, 'Level II Preadmission Screening and Resident Review (PASRR) Conditions' ...." The most recent Annual MDS assessment was, dated 3/2/22, and was not coded as directed on the PASRR to reflect Resident 14's PASRR qualification/status. During an interview on 5/9/22 at 2:53 p.m., the Social Service Director indicated she coded Section A of the MDS. When the discrepancy was brought to the SSD's attention, she indicated Resident 14's PASRR status should have been coded as indicated from the Level II	F 0641	The facility will ensure this requirement is met through the following actions: 1. Resident 14 had no negative effects related to alleged deficient practice. Resident 14 Annual MDS assessment dated 3/2/22, has been modified and resubmitted to reflect Resident 14's PASRR qualification/status. 2. All residents assessments with Level 11 have the potential to be affected. SSD will review PASRR information with each resident when completing MDS assessment to ensure accurate coding on MDS by 5/23/22 3. The SSD and MDS have been educated on accurate completion of the MDS coding for PASRR Level 11 qualification/status according to RAI guidelines, which is the facilities guide for practice. 4. SSD/Designee will complete audit 1x monthly x's 6 months on annual MDS assessments to assure coding is accurate for Level II. All findings from audits will be forwarded to QA committee for further audits or recommendations based on outcomes. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any audits will be forwarded for review at the facilities monthly QA	05/23/2022

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	determination. 2. On 5/5/22 at 10:54 a.m., Resident 25's medical record was reviewed. Resident 25 had a PASRR assessment completed on 9/24/19 which indicated ... "you [Resident 25] have a PASRR condition, if you admit to a Medicaid certified nursing facility, or if you are currently in a Medicaid-certified nursing facility, the facility will need to document your PASRR condition in the Minimum Data Set (MDS) assessment record. The facility should mark yes for question A1500 on the MDS, 'Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?' Also, your specific PASRR condition(s) should be checked in question A1510, 'Level II Preadmission Screening and Resident Review (PASRR) Conditions' ...." The most recent Annual MDS assessment was, dated 3/22/22, and was not coded as directed on the PASRR to reflect Resident 25's PASRR qualification/status. During an interview on 5/9/22 at 2:53 p.m., the Social Service Director (SSD) indicated she coded Section A of the MDS. When the discrepancy was brought to the SSD's attention, she indicated Resident 25's PASRR status should have been coded as indicated from the Level II determination.		meetings. Frequency and duration of the audits will be adjusted as needed or recommended from the QA committee.	
F 0687 SS=D Bldg. 00	483.25(b)(2)(i)(ii) Foot Care §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and			

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	good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.			
	Based on observations, interviews, and record reviews, the facility failed to ensure a resident's foot was assessed and referred to podiatry as needed to prevent overgrowth and the potential for sores related to overgrown toenails for 1 of 1 resident reviewed for foot care (Resident 38). Findings include: On 5/9/22 at 10:59 a.m., the pressure ulcer on Resident 3's right heel was observed with LPN 6. LPN 6 removed Resident 38's sock and while the pressure ulcer was observed to be less than the size of a nickel, and was scabbed over, clean and the skin was intact. The resident's toenails were grossly overgrown, thick, and yellow. On her right foot, the big toenail was yellow, thick, and raised with cracks and jagged edges. The third toenail was overgrown to the point it curled under the toe and pressed on the bottom of her toe pad. When LPN 6 touched the toenail to assess it, Resident 38 groaned and pulled her foot away. Her toenail was tender to touch. At this time, LPN 6 was asked to remove the sock from Resident 38's left foot. On the left foot, her first, second, and third toenails were grossly overgrown, and when they were touched, Resident 38th groaned and pulled her foot away. The third toenail on her left foot also curled under and pressed against the bottom of her toe pad. LPN 6 indicated she did not know	F 0687	This facility will ensure that the requirement is meant by the following actions: 1.Resident #2 suffered no ill effects by alleged deficient practice. Res #2 was seen by podiatrist on5 5/13/22. Res is now on routine podiatry list. 2. All residents have the potential to be affected. See below for corrective and preventative measures. 3. Licensed nurse have been educated on "Documentation guidelines for Nursing specifically Resident Assessments Foot Care (part of weekly summary). SSD educated on requirements of outside services. Specifically facilities current policy titled "Podiatry Services" 4. To ensure compliance, the SSD/designee completed an audit of all residents and dates of services for podiatry by 5/20/22. Anyone found to not have been	05/24/2022

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	if or when the podiatrist would have seen Resident 38, but she would put in a new request for a podiatry to come and evaluate Resident 38. On 5/9/22 at 11:42 a.m., Resident 38's medical record was reviewed. Resident 38 was profoundly developmentally delayed due to her current diagnoses, which included, but were not limited to Cerebral palsy, Down Syndrome, and severe intellectual disability. Her most recent comprehensive assessment was a significant change Minimum Data Set (MDS) assessment, dated 4/15/22, and indicated Resident 38 was totally dependent on staff for all aspects of her daily routine, care, and activities of daily living which included personal hygiene, bathing and grooming. She had a current physician order, dated 5/11/09, which indicated she could be seen by podiatry on a routine basis and as needed in between. She had a current comprehensive care plan, dated 5/4/18, for refusing ancillary services such as podiatry, (as well as eye, audiology and dental), the care plan had not been revised since its creation in 2018. The record lacked documentation of Resident 38's refusals of podiatry services, nursing attempts to cut her toenails, and/or referrals to the physician related to her toenails During an interview on 5/9/22 at 11:19 a.m., the Social Service Director (SSD) indicated the podiatrist usually came every month and saw a group of regularly scheduled residents. At this time, she checked the list, and indicated Resident 38th was not on the "regularly visited" list. The		seen as required will be added to next visit. SSD or designee will track podiatry visits monthly by obtaining list for that monthly visit to assure all residents are seen in timely manner. Nursing will audit 1 weekly summary per day x's 4weeks, then 2 weekly summaries per week x's 4 weeks, then 1 weekly summary x's 4 weeks with findings forwarded for review at the facilities monthly QA meetings. Frequency and duration of the audits will be adjusted as needed or recommended by the QA committee.	

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	SSD did not know why or how Resident 38 was not on the list, but she would add her for the next visit. During a second observation on 5/9/22 at 1:30 p.m., LPN 5 went to assess Resident 38's toenails to ensure no sores had developed under the toenails. When LPN 5 was asked if she observed Resident 38's toenails during the regularly schedule pressure ulcer treatments, LPN 5 demonstrated on Resident 38's foot; she lifted the leg and pulled the resident's sock down over the heel, but not completely off, and motioned with her hand as she explained, "usually, we just pull her sock down and wipe the area [the scabbed over pressure sore] like this." LPN 5 indicated her full foot may not have always been visualized, and LPN 5 indicated she never cut resident's toenails, she always referred them to podiatry. During an interview on 5/9/22 at 2:20 p.m., the Administrator indicated she called the podiatrist company and was told that Resident 38 had an outstanding bill with the company, which is why she had not been seen, and there was not documentation that she had been seen in the past year. Regardless of an outstanding bill, it would be the Administrator's expectation that nursing staff should assesses her full foot, which included her toenails and refer the resident to podiatry, and or notify the physician, or the nurses should attempt to cut the residents toenails themselves and document the outcome. On 5/9/22 at 2:25 p.m., the Administrator provided a copy of current facility policy titled, "Podiatry Services," dated 1/2015. The policy indicated, "Residents are provided with proper treatment and care for foot disorder. The facility maintains an outside resource to provide podiatry services			

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	to meet the needs of each resident. Podiatry care is provided as ordered by a physician. Podiatry services are available on a routine basis and as needed. The health record will indicate the services provided by the Podiatrist, Doctor of Medicine or Doctor of Osteopathy. All residents requiring podiatry care outside the facility shall be assisted with the necessary arrangements as indicated." On 5/9/22 at 2:33 p.m., the Regional Director of Clinical Services (RDCS) provided a copy of current facility policy titled, "Documentation Guidelines for Nursing," dated 7/2020. The policy indicated, "Purpose: to accurately document in an organized manner all information related to the resident in the medical record ... Resident Assessments Completed Weekly ... Foot Care (part of weekly summary)...." At this time the RDCS indicated resident's feet should be fully assessed and documented on at least weekly. 3.1-47(a)(7)			
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 ensure a fall intervention was in place as ordered by the physician to prevent the potential for accidents	F 0689	The facility will ensure this requirement is met through the following actions.	05/24/2022

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	and an actual fall for 1 of 2 residents reviewed for accidents (Resident 2). Findings include: On 5/5/22 at 9:59 a.m., Resident 2 was initially observed. She laid in bed. Her bed was in the lowest position and a fall mat was on the floor. There was no wedge cushion in place, she was not wearing hipsters, and her call light and over-bed table with personal items were out of reach. On 5/5/22 at 11:44 a.m., Resident 2's medical record was reviewed. She had current physician orders which included but were not limited to a wedge pillow to the open side of her bed while in bed and hipsters on at all times. She had a comprehensive care plan, dated 11/3/21, which indicated Resident 2 had a history of falls and was at risk for additional falls. Interventions for this plan of care included but were not limited to check and change every 1 hours for incontinence, hipsters on at all times as tolerated, and to place the call light within reach. During a follow up observation, on 5/5/22 at 11:51 a.m., Resident 2 was observed in bed. There was no wedge cushion in place and ordered by the physician. Her call light remained out of reach, she wriggled in bed, her legs pushed up and down, and she moaned and groaned. On 5/5/22 at 11:56 a.m., Licensed Practical Nurse (LPN) 8 entered Resident 2's room and adjusted her pillow. LPN 8 did not put her call light in place or check the resident to see if she was incontinent		1. Resident 2 was not harmed or suffered any ill effects from the alleged deficient practice. 2.All residents who are at risk for falls have the potential to be affected. Please see corrective action below. All residents that currently reside in the facility will have an audit complete to assure their is a fall intervention in place 3. The policy for "Fall Management Program" and "Physicians Orders Policy" was reviewed and no changes were indicated at this time. Licensed nursing staff will be educated on both policies to include post fall assessment 4.Nursing will audit 1 weekly summary per day x's 4weeks, then 2 weekly summaries per week x's 4 weeks, then 1 weekly summary x's 4 weeks with findings forwarded for review at the facilities monthly QA meetings. Frequency and duration of the audits will be adjusted as needed or recommended by the QA committee.	

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at that time.

On 5/5/22 at 12:20 p.m., Resident 2 was heard as she continued to call out with moans and groans. She was observed laying on her stomach, face down on the floor. She had fallen out of bed onto the right side of the floor and landed on the fall mat. Her mattress and brief were observed wet with urine as she had been incontinent. There was no nurse at the nurse's station, no nurse visible down the hall. No Certified Nursing Assistants, (CNAs) were available, so an observer alerted a staff member that Resident 2 was on the floor.

On 5/5/22 at 12:25 p.m., LPN 8 entered Resident 2's room, observed the resident on the floor, and exited the room without conducting a full assessment. She did not check the resident for injuries, assess her vital signs, check her range of motion for indications of fractures, and did not speak to Resident 2 to assure her help was on the way. She did not stay with the resident until additional help came. Outside of Resident 2's doorway, in the hall, LPN 8 indicated to an incoming staff member that she would need two more people and the Hoyer lift to help get Resident 2 off the floor. The Director of Nursing (DON) came to the room to help and at this time indicated full fall interventions for Resident 2 included, but were not limited to, having a wedge cushion, fall matt, bed in the lowest position, frequent checks for incontinence and/or signs symptoms of pain/anxiety.

On 5/9/22 at 2:33 p.m., the Regional Director of Clinical Services (RDCS) provided a copy of current facility policy titled, "Fall Management Program," dated 11/2017. The policy indicated, " ...It is the policy of American Senior Communities to ensure residents residing within the facility

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	receive adequate supervision and or assistance to prevent injury related to falls ... Facilities must implement comprehensive, resident-centered fall prevention plans for each residents at risk for falls or with a history of falls ... Post Fall: Any resident experiencing a fall will be assessed immediately by the charge nurse for possible injuries and necessary treatment will be provided ...." On 5/9/22 at 2:33 p.m., the RDCS provided a copy of current facility policy titled, "Physician Orders Policy," dated 2/2022. At this time the RDCS indicated, while the policy did not explicitly say, nursing staff should follow physician orders, it was the her expectation and the facility policy that once orders are put in, and electronically signed, the automatically generate to the MAR (Medication Administration Record [or TAR, Treatment Administration Record] if the nurses initialed that the medication, or treatment was provided/in place, this it was expected it should have been completed, such as ensuring Resident 2's wedge cushion or barrier pillow was in place to prevent a fall. 3.1-45(a)(2)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview, and record review, the facility failed to ensure insulin pens were primed prior to use and a contaminated pill was not provided to a resident for 1 of 2 resident reviewed for medication administration resulting in a medication error rate of 7.69 percent (Resident	F 0759	The facility will ensure this requirement is met through the following actions. 1. Resident 18 was not harmed or suffered any ill effects from the	05/24/2022

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	18). Findings include: On 5/10/22 at 7:28 a.m., Licensed Practical Nurse (LPN) 5 prepared medications for Resident 18. She dropped a Vitamin D pill on top of the South Medication Cart. She put a glove on, picked it up, and placed it in the medication cup. She continued pulling medications for Resident 18 and she placed the subsequent pills on top of the contaminated pill in the same medication cup. She removed a Lispro Insulin (fast-acting medication to treat a blood sugar disorder) Pen (an injection delivery system) from the medication cart, placed a sterile needle on the end, and dialed the physician ordered amount into the pen, 10 units. She did not prime (procedure to fill the needle with medication) the needle with insulin. She placed the insulin pen on the medication cart. She removed a Lantus Solostar Insulin (long-acting medication to treat a blood sugar disorder) Pen from the medication cart, placed a sterile needle on the end and dialed the physician ordered amount into the pen, 45 units. She did not prime the needle with insulin. She placed the insulin pen on the medication cart. LPN 5 gave the medication cup to Resident 18, and he swallowed the medications. LPN 5 swabbed the resident's left side of his abdomen with alcohol and injected the Lispro insulin, then she swabbed the right side of his abdomen and injected the Lantus insulin. During an interview, on 5/10/22 at 8:10 a.m., LPN 5 indicated she should have given a new Vitamin D pill after dropping it on the medication cart and		alleged deficient practice. 2.All residents who receive medication from licensed nurse have the potential to be affected. Please see corrective action below. 3. The policy for "Infection Prevention and Control Prevention" was reviewed with all licensed nursing staff. Nurse #5 has been re-educated with skill competency sheet "Insulin Pen Administration" completed. All Licensed nurses that are employed by the facility will have skills validations completed on utilizing insulin pens and re-educated on medication pass. 4.To ensure compliance DON/Designee will complete ten skills validation observations utilizing Insulin Pen Administration and Medication Pass 3x's weekly x's 4 weeks, 2x's weekly x's 8wks, then 1 x weekly x's 12 weeks with audits being forwarded for review to QA committee Frequency and duration of the audits will be adjusted as needed or recommended by the QA team.	

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	the insulin pens should have been primed prior to dosing the resident with insulin. During an interview, on 5/10/22 at 9:43 a.m., the Director of Nursing (DON) indicated if a pill was dropped on top of the medication cart it should have been tossed and the nurse should have gotten a new pill. The pill was considered contaminated if it touches the cart. The insulin pens should have been primed with two units of insulin to ensure the entire dose was given. A current nursing skill competency sheet, titled, "Insulin Pen Administration," dated 6/2018, was provided by the DON, on 5/10/22 at 11:02 a.m., A review of this document indicated, " ...Attach pen needle by twisting the needle onto end of insulin pen, pull off and remove outer pen needle protective cap and cover. Prime the pen by dialing 2 units. Push the end of the pen to push out the 2 units (A small drop of insulin should be visible. If insulin does not appear, repeat) ...." A current policy, titled, "Infection Prevention and Control Prevention Policy," dated 3/2022, was provided after the entrance conference. A review of the policy indicated, " ...Prevention of spread of infections is accomplished by use of hand hygiene, respiratory etiquette, standard and transmission-based precautions ...." 3.1-48(c)(1)			
F 0760 SS=E 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 record review and interview, the facility failed to ensure residents who received	F 0760	The facility will ensure this requirement is met through the	05/24/2022

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	anticoagulant medication regimen were monitored, orders were reconciled to the correct dose, and failed to follow their policy for physician notification for 2 of 5 residents reviewed for significant medication errors (Residents 10 and 20). Findings include: 1. On 5/9/22 at 10:00 a.m., Resident 10' clinical record was reviewed. Resident 10 had diagnoses which included but were not limited, to Atrial Fibrillation (A-Fib) (an irregular and often very rapid heart rhythm that can lead to blood clots in the heart). Resident 10 had the following orders for PT/INR labs however the record lacked documentation that PT/INRs were obtained as ordered: 3/16/2022 daily through 3/23/2022. 3/25/2022 daily through 4/10/2022 On 5/10/2022 at 2:15 p.m., the DON indicated that the order for daily labs should have been ordered one time per week and the order was transcribed incorrectly. The DON provided resident 10 lab results with the following lab dates for PT/INRs missing: 3/19/2022 3/20/2022 3/23/2022 3/26/2022 3/27/2022 3/28/2022 3/30/2022 3/31/2022 4/2/2022 4/3/2022 4/4/2022 4/6/2022		following actions. 1. Resident 10 and 20 was not harmed or suffered any ill effects from the alleged deficient practice. 2.All residents who coumadin have the potential to be affected. Resident 10 and 20 orders for the anticoagulant and lab monitoring were reviewed and verified by the MD on 5/17/22. Please see corrective action below. 3. The policy for "Coumadin/Warfarin Monitoring and Tracking Log" was reviewed with all licensed nursing staff for re-education. 4.To ensure compliance DON/Designee will complete audit on Monitoring and Tracking log 5x's weekly x's 8weeks, then 3x's weekly x's 8 weeks, then 1xweekly x's 8 weeks with audits being forwarded to QA Committee monthly for review and further recommendations.	

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4/7/2022
4/8/2022
4/9/2022
4/10/2022
4/21/2022
4/24/2022

2. On 5/9/22 at 2:15 p.m., Resident 20's medical record was reviewed. Resident 20 had diagnoses which included but were not limited to vascular implant (a specialized class of medical textiles which act as an artificial conduit or substitute for a diseased artery), and a history of A-Fib.

Resident 20 had the current physician orders for Warfarin:
a. an order dated 3/17/2022 for Warfarin 6 mg (milligrams) with instructions to give 6.5 mg by mouth daily with a discontinuation date of 3/22/2022
b. an order dated 3/23/2022 for Warfarin 6 mg, with instructions to give 6.5 mg by mouth daily with a discontinuation date of 4/7/2022

Resident 20's MAR (Medication Administration Record) was reviewed and indicated, "give 6 mg of Warfarin daily with an additional note ... Amount to administer 6.5 mg" from 3/17/2022 through 3/22/2022. The MAR (Medication Administration Record) order stated to give 6 mg of Warfarin daily with an additional note "Amount to administer 6.5mg" from 3/23/2022 through 4/7/2022. The MAR indicated that 6 mg was administered instead of 6.5 mg during the listed time frames.

During an interview on 5/10/2022 at 2:15 p.m., the DON indicated the written orders were a transcription error and could not account for the additional 0.5 mg that was to be administered

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	along with the 6 mg. Resident 20 had lab orders to obtain Prothrombin Time/International Normalized Ratio (PT/INRs) (blood test to determine time blood takes to clot) every Tuesday and Thursday with a start date of 3/17/2022 through 4/8/2022. The DON provided Resident 20's PT/INR labs which had been completed by the lab on 5/10/2022 at 2:15 p.m. The PT/INRs on the following dates were missing: 3/29/2022 3/31/2022 During an interview on 5/9/22 at 10:33 a.m., Licensed Practical Nurse (LPN) 5 indicated the lab may come in early or late. Staff should not administer the next dose of anticoagulant medication until PT/INR results were received and the Nurse Practitioner was notified as indicated or required. LPN 5 indicated if she noticed any abnormal bruising or bleeding that she would hold the Warfarin and notify the physician. LPN 5 indicated the facility utilized a "Coumadin Flowsheet" to manage residents that were prescribed warfarin/coumadin. During an interview on 5/9/22 at 10:38 a.m. LPN 6 indicated labs may be done during the day. The lab was sometimes late. Staff would administer the next Warfarin dose even if the lab results had not been received. LPN 6 indicated the lab was short staffed which often caused the delay. The facility has received labs as late as 3 a.m., so the physician would be notified the next morning of the results. The lab would also call and inform the facility if they would not be in on time to schedule arrangements for the following day and staff should utilize the "Coumadin Flowsheet" to manage residents taking warfarin.			

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	On 5/10/22 at 1:54 p.m., the Don provided a copy of current facility policy titled, "Coumadin/Warfarin Monitoring and Tracking Log," dated 1/20/2016 with a revision date of 11/2019 indicated, " ...It is the policy of American Senior Communities that require Coumadin Therapy are receiving adequate monitoring." 3.1-48(c)(2)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record	F 0761	The facility will ensure this	05/24/2022

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	review, the facility failed to ensure tubersol (tuberculous screening solution) was not expired and injected intradermally (superficial injection) into resident's skin for 8 of 8 newly admitted residents reviewed for tuberculous (TB) screening (Resident 24, 28, 34, 37, 39, 189, 190, and 191). The facility failed to ensure a medication had a pharmacy label and failed to ensure a resident's alcohol beverages were not stored in a cabinet with facility chemicals (Resident 26). Findings include: 1. On 5/10/22 at 11:03 a.m., the Director of Nursing (DON) provided a tour of the medication storage room. A refrigerated vial of tubersol (tuberculous screening solution), the lot number 27201, was observed to be open on dated 2/16/22. The DON indicated there were no other vials of tubersol in the facility and this one was expired. On 5/10/22 at 11:52 a.m., medical records were reviewed for resident's admitted on and after 3/16/22. On 3/21/22, Resident 190 was admitted to the facility. The same day, a TB screening test was administered from a tubersol vial, the lot number was 27201. On 4/14/22, the second TB screening test was administered. The documentation for the second TB screening test was incomplete. There was no administration site, tubersol lot number, tubersol manufacturer's name, and no expiration date documented. On 3/25/22, Resident 28 was admitted to the facility. The same day, a TB screening test was administered from a tubersol vial, the lot number was 27201. On 4/8/22, the second TB screening test was administered from the same tubersol vial		requirement is met through the following actions. 1. Residents 24, 28, 34, 37, 39, 189, 190, and 191was not harmed or suffered any ill effects from the alleged deficient practice. The vial of Tubersol was discarded. The case of beer was removed from storage area and relocated in med room. Unlabeled suppositories was discarded. 2.All residents who receive PPD had the potential to be affected. For staff education, see below. 3. The policy for Storage and Expiration Dating of Medications, Biologicals and (TB): Resident Screening was reviewed and no changes were indicated at this time. Licensed nursing staff will be educated on these policies. To ensure compliance DON/Designee will audit medication refrigerator and storage areas 3x's weekly x's 8 weeks and 2x weekly x's 4 weeks. All findings will be discussed, logged and tracked at the facilities monthly QAPI meetings. Frequency and duration of the reviews will be adjusted as needed or recommended by the QAPI team.	

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	with the same lot number. On 4/14//22, Resident 37 was admitted to the facility. On 3/31/22, a TB screening test was administered from a tubersol vial, the lot number was 27201. On 4/14/22, the second TB screening test was administered from the same tubersol vial with the same lot number. On 3/16/22, Resident 24 was admitted to the facility. The same day, a TB screening test was administered from a tubersol vial, the lot number was 27201. On 3/17/22, Resident 139 was admitted to the facility. The same day, a TB screening test was administered from the tubersol vial, the lot number was 27201. On 3/25/22, Resident 189 was admitted to the facility. The same day, a TB screening test was administered from the tubersol vial, the lot number was 27201. On 4/6/22, Resident 34 was admitted to the facility. On 4/7/22, a TB screening test was administered from the tubersol vial, the lot number was 27201. On 5/6/22, Resident 191 was admitted to the facility. The same day, a TB screening test was administered from the tubersol vial, the lot number was 27201. During an interview, on 5/10/22 at 12:08 p.m., the DON indicated the expired vial of tubersol should have been disposed of and a new vial ordered. Tubersol was only good for 28 days after it was opened. During an interview, on 5/10/22 at 2:29 p.m., the			

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DON indicated the facility could get a new tubersol ordered. They could review and provide chest x-rays for the newly admitted residents. Her expectation was for the staff to order a new tubersol vial before the current tubersol vial expired.

On 5/10/22 at 3:26 p.m., a review of the Federal Drug Administration (FDA) for the tubersol insert was completed. A review of the information indicated, " ...A vial of tubersol which has been entered and in use for 30 days should be discarded. Do not use after expiration date ...."

A current policy, titled, " ...Tuberculosis (TB): Resident Screening," dated 12/2011, was provided by the DON on 5/10/22 at 3:31 p.m. A review of the policy indicated, " ...All residents will be screened for TB in accordance with state and federal regulations including but not limited to prior to admission, upon admission ...one-step administer on day of admission ...two-step administer on day of admission and schedule second step one to three weeks after first step ...."

A current policy, titled, " ...Storage and Expiration Dating of Medications, Biologicals," dated 1/1/22, was provided by the DON on 5/10/22 at 3:31 p.m. A review of the policy indicated, " ...If a multi-dose vial of an injectable medication has been opened or accessed (e.g. needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial ...."

2. During a medication storage room tour, on 5/10/22 at 11:09 a.m., 4 medication suppositories were observed on a refrigerated shelf. There was no pharmacy label to identify the medication name, resident name, dosage, or expiration date.

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On 5/10/22 at 11:10 a.m., the DON indicated the 4 suppositories were Bisacodyl (laxative) and there should have been a pharmacy label for the medications.

A current policy, titled, " ...Storage and Expiration Dating of Medications, Biologicals," dated 1/1/22, was provided by the DON on 5/10/22 at 3:31 p.m. A review of the policy indicated, " ...Facility should destroy and reorder medications and biologicals with ...missing labels ...."

3. During a medication storage room tour, on 5/10/22 at 11:10 a.m., a large can of beer was observed in the medication refrigerator. It was on the bottom shelf of the door away from the medications. The DON indicated there was no resident name on it. She indicated the only resident who got beer was Resident 26.

On 5/10/22 at 11:12 a.m., an opened cardboard case of beer was observed in a cabinet with several containers of Drugbuster (solution to destroy medications), one spray container of toilet cleaner, and 2 spray containers of disinfectant.

On 5/10/22 at 11:14 a.m., the DON indicated Resident 26's beer should not have been stored with the facility's solutions to destroy medications, toilet cleaner, and disinfectant.

3.1-25(j)
3.1-25(o)
3.1-21(i)(3)