STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/01/2021

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00333205, IN00334979 and IN00336029. This visit included a Residential COVID-19 Quality Assurance Walk Through. Complaint IN00333205 - Unsubstantiated due to lack of evidence. Complaint IN00334979 - Substantiated. State residential findings related to the allegation are cited at R0214. Complaint IN00336029 - Substantiated. State residential findings related to the allegations are cited at R0297 and R306. Survey dates: March 31st and April 1st, 2021. Facility number: 012263 Residential Census: 66 These state residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 12, 2021	R 0000	Unsubstantiated.	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.			

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

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	Based on observation, interview, and record review, the facility failed to prevent a pressure ulcer of a resident at risk for skin breakdown, complete follow-up assessments, track wound progression, and document notification to the physician regarding a wound for 1 of 3 residents reviewed for wounds (Resident M). Findings include: On 3/31/21 at 11:20 a.m., the Executive Director (ED), provided an untitled list, undated, which indicated Resident M had a coccyx wound. On 4/1/21 at 10:35 a.m., Resident M was observed lying in bed on her right side, eyes closed. On 4/1/21 at 10:42 a.m., a pressure wound on Resident M's coccyx was observed after she was rolled to her side by Licensed Practical Nurse (LPN) 14 and Certified Nursing Assistant (CNA) 8. The pressure wound was open to air and appeared circular in appearance, with depth. LPN 14 was observed to measure the wound upon request and indicated it was approximately 1.0 centimeter (cm) wide by 0.7 cm deep, she did not probe the depth of the wound for accuracy. LPN 14 indicated she was not sure of the treatment orders for the wound and was observed to apply calmoseptine to the buttocks and coccyx. CNA 8 indicated Resident M did not usually have a bandage over the wound. Resident M's record was reviewed on 4/1/21 at 11:30 a.m. Diagnoses on Resident M's profile included, but were not limited to, Alzheimer's disease, dementia, and left hip fracture. A Physician's order in Resident M's electronic	R 0214	Please reference the enclosed "Plan of Correction for the March 31st and April 1st, 2021 complaint survey" I am respectfully requesting paper compliance for this survey. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the true facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and executed because it is required by the Federal and state laws. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? When a wound or skin issue is identified the licensed nurse is to call the physician immediately to get orders and ensure the orders are on the MAR/TARS. Family and DON notified as well. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? A full skin audit was done on the residents that could be at risk by nursing administration. All Licensed nurses educated on the steps to prevent wounds. An audit was performed by Nursing administration on 4/12/2021 to ensure residents with wound care treatments were complete and accurate per physician orders.	05/12/2021

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	medical record, dated 12/29/18, indicated Eucerin Cream (moisture barrier) apply topically to affected area(s) daily as needed. A Medication Administration Record (MAR) for Resident M, dated March 2021, indicated the resident record lacked documentation to indicated Eucerin Cream had been administered. A Nursing Progress Note for Resident M, dated 3/10/21 at 9:53 p.m., indicated a stage 2 pressure ulcer (a sore expanding into deeper layers of the skin, usually tender and painful) was observed on the patient's coccyx. The ulcer measured 0.6 inches x 0.6 inches. The area was cleansed with NS (normal saline) and calmoseptine ointment applied. The record lacked documentation to indicate the physician, or family had been notified of the ulcer, or resident had an order for normal saline or calmoseptine ointment. A Nursing Progress Note for Resident M, dated 3/11/21 at 1:51 p.m., indicated a stage 2 pressure ulcer observed on the patient's coccyx. The ulcer measured 0.6 inches x 0.6 inches. Cleansed with NS and calmoseptine ointment applied. The record lacked documentation to indicate the physician, or family had been notified of the ulcer, or resident had an order for normal saline or calmoseptine ointment. A Nursing Progress Note for Resident M, dated 3/12/21 at 9:43 p.m., indicated "resident with open area coccyx.... staff needs to change more frequently and lie down after lunch. barrier cream applied with changes this evening. appears very tender to touch." The record lacked documentation to indicate the physician, or family had been notified of the ulcer, or resident had an order for calmoseptine ointment.		Any issues identified were immediately addressed. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Education will be provided by the DON to the nursing staff on 4/20/2021 in regard to following residents plan of care and wound orders and steps to take to ensure residents get the proper treatment, completing wound care treatments to ensure residents at risk for pressure ulcers and/or have pressure ulcers receive the necessary treatment and services to promote healing, prevent infection and prevent new ulcers from developing. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Licensed nursing staff to do weekly audits with showers for next month on high-risk residents to observe for skin breakdowns. Weekly audits to ensure wound care is completed by nursing and/or outside home health services. This audit will occur via visual inspection of the resident, any issues identified will be addressed immediately results will be discussed with nursing administration monthly. This will be completed by 5/12/2021.	

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A Nursing Progress Note for Resident M, dated 3/13/21 at 8:29 p.m., indicated, "small open area coccyx remains- very tender to touch. barrier cream applied with brief changes. staff to put to bed after each meal to help with healing. husband aware." The record lacked documentation to indicate the physician had been notified of the ulcer, or resident had an order for calmoseptine ointment.

A Nursing Progress Note for Resident M, dated 3/16/21 at 8:27 p.m., indicated the resident went out today to see the doctor, no new orders at this time. The hospice nurse was here to see the resident this evening, she was informed of a small open area on the coccyx and informed her that staff was putting barrier cream on her as a nursing measure. Hospice to write order for cream and its usage.

A handwritten Physician's Order for Resident M, dated 3/16/21, indicated, per hospice nurse verbal order for calmoseptine (moisture barrier) to coccyx area prn (as needed) with incontinence care.

A MAR for Resident M, dated March 2021, indicated the resident record lacked documentation to indicate calmoseptine had been added to the profile or had been administered.

Hospice Visit Notes for Resident M, dated 3/11/21, 3/16/21, 3/25/21, and 4/1/21, indicated the resident's ability to respond to pressure related discomfort was slightly limited. The resident could respond to verbal commands but could not always communicate discomfort or need to be turned. Skin was occasionally moist requiring an extra linen change approximately

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	once a day. Mobility very limited, unable to make frequent or significant body position changes independently. Incontinent of bowel and bladder. Review of skin, "no problems identified." The notes lacked documentation related to Resident M's pressure ulcer. A Nursing Progress Note for Resident M, dated 3/18/21 at 6:09 p.m., indicated small open area still present to coccyx area, barrier cream applied with each brief change. Resident M's record lacked documentation from 3/19/21 - 3/27/21 of the pressure ulcer being monitored or treated. A Nursing Progress Note for Resident M, dated 3/27/21 at 4:07 p.m., indicated applying barrier cream to buttocks with brief change, area on coccyx remains open and slightly enlarging in size. Will ask hospice if there is anything else to do for coccyx to help it heal. A Nursing Progress Note for Resident M, dated 3/30/21 at 7:50 p.m., indicated small open area remains on coccyx area. Barrier cream being applied with each change and staff to lie her down after meals off her back to keep pressure off wound. A Nursing Progress Note for Resident M, dated 3/31/21 at 9:25 p.m., indicated "resident in bed assessed open area on coccyx area is the size of an eraser resident grimaced when perineal care was given. Writer applied calmoseptine to surrounding area, contacted [hospice] no answer." Resident M's record lacked Skin Integrity Monitoring Forms.			

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	A Care Plan for Resident M, completed on 7/24/19, indicated the resident required total assistance for activities of daily living to include bed mobility, transfers with a mechanical lift, assistance to the dining room and being fed, being out of bed in a Broda chair (tilt-in-space positioning chair) to prevent falls, personal hygiene, and toileting. On 4/1/21 at 10:56 a.m., LPN 4 indicated, she was the unit manager in charge of Resident M's care. An open wound appeared on Resident M's coccyx on 3/10/21 and was documented by an agency nurse as measuring 0.6 x 0.6 inches. The resident had no routine treatment orders except for Eucerin cream, but staff used calmoseptine as a preventative. LPN 4 indicated she had not seen Resident M's pressure wound on her coccyx, but the resident was under Hospice care. The hospice nurse was made aware of the wound on 3/16/21 and gave orders to continue barrier cream. LPN 4 indicated, there were no further measurements of the wound after the initial measurements were taken. Facility staff nurses could measure wounds, but they did not manage wounds, and it was the responsibility of hospice, or an outside wound management company to care for resident wounds. Hospice was supposed to come weekly to follow residents, but she did not know how often Resident M had been seen. Measurements of Resident M's pressure wound should have been done every 1-2 days to see if it was improving or getting worse. On 4/1/21 at 11:32 a.m., the Director of Nursing (DON) indicated, when a resident developed a wound, staff usually called an outside agency to debride (remove damaged tissue) and/or treat, as the nursing staff in the facility did not do invasive treatments. Resident M was on Hospice services,			

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	and they should have been managing her wound. Hospice was asked to provide the DON a weekly measurement, but the DON would have to request copies as there was no current documentation of hospice visits available on the resident record. On 4/1/21 at 1:40 p.m., the DON indicated, Resident M's wound was not measured or monitored per the Skin Integrity Oversight policy, as it was a new policy to the company as of March 1, 2021 and staff had not been trained or given the documentation tools and forms to use as of that date. The DON indicated, she had been on leave of absence in March and her designees LPN 4 had not followed the previous wound policy to include documentation of progression, measurements, notification to the physician of the wound or worsening of the wound, treatment orders, or updating of the service plan. On 4/1/21 at 1:40 p.m., the DON provided a Skin Integrity Oversight policy, implementation date 3/6/21, and indicated the policy was the one currently being used by the facility. The policy indicated, "Purpose: The purpose of the skin integrity oversight policy is to define how to safely manage skin conditions for residents living in our communities ...Procedure: Wellness will perform ongoing monitoring of resident's skin and obtain or provide care as indicated on the Care Plan or Treatment Records. Reports will be provided to the Regional Wellness Director. 1. Review: Caregiver will observe, and report changes in the skin for residents who are receiving bathing assistance according to the following procedure: a. If a concern is identified, notify the nurse and document on the Skin Integrity Monitoring form and the 24-hour			

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	Report Sheet for follow up. b. If immediate treatment is required, nurse [supervisor] will contact appropriate people [Wellness Director, Physician, and/or family]. 2. Follow-up: Wellness Director of Designee will: a. Review Skin Integrity Monitoring form ...b. Complete an incident report ...c. Notify the physician and family of the skin condition ...d. As indicated, refer wound care needs to Home Health/Hospice for treatment after obtaining physician approval. e. Update resident's Care Plan and implement treatment. f. Discuss progress with outside healthcare provider during visits. Stage of wound to be determined by outside healthcare provider. g. Monitor treatment and progress. h. Document in resident's Progress Notes. i. If wound care is required by community nurses, an immediate telephone call will be placed to your Regional. Reporting: Wellness Director or Designee will: a. Weekly, complete Integrity Tracking Summary of open areas only [pressure ulcers ...]. b. Regional Wellness Director will be notified on weekly of the number of acquired/non-acquired wounds. c. Regional Wellness Director will monitor progress of Skin Integrity Tracking for each community ..." On 4/1/21 at 11:20 a.m., the ED provided an Administration of Medication policy, dated 1/18/19, and indicted the policy was the one currently being used by the facility. The policy indicated, "Medications are administered in accordance with written orders of the attending Healthcare provider ...Current medications are listed on the MAR [Medication Administration Record] ...Topical medications used in treatments will be listed on the MAR, or Treatment Administration Record [TAR] using the same format and procedures as the MAR ...The resident MAR is initialed by the person			

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	administering the medication ..." This State Residential Finding relates to Complaint IN00334979.			
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure a resident at risk for stroke received a prescription medication for reducing the risk of stroke for 1 of 3 residents reviewed medication administration (Resident D). Findings include: During a confidential interview, it was indicated, Resident D had not received her prescription for Plavix (a blood thinning medication that can help prevent stroke, heart attack and other heart problems), and Resident D had a history of strokes. The issue had been brought to the attention of the facility many times, before they finally realized Resident D was missing her prescription and began to administer it. Resident D went several weeks without the medication. During an interview on 3/31/21 at 2:55 p.m., the Director of Nursing (DON), indicated Resident D came to the facility with a list of medications from home. At that time, Plavix was not one of the listed medications, and when the facility	R 0297	Please reference the enclosed "Plan of Correction for the March 31st and April 1st, 2021 complaint survey" I am respectfully requesting paper compliance for this survey. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the true facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and executed because it is required by the Federal and state laws. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? When a new resident is admitted to facility all residents' physicians will be contacted to ensure we have all the correct medications. If the resident gives medications to nurse that is not on MAR/TAR	05/12/2021

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	reconciled her medication list with the resident's primary doctor, no irregularities were noted. Several weeks later, it was brought the facilities attention, Resident D should have been receiving Plavix due to her history of stroke, but the medication had been prescribed by her neurologist, and not her primary care doctor which was why it was missed during the admission reconciliation. The medication was confirmed by her neurologist, ordered and administered after 8/20/21. During an interview on 4/1/21 at 10:37 a.m., the Executive Director (ED), indicated, there had been a mix up with Resident D's medication. It was brought to our attention that a certain anti-stroke medication was not given for a week or two. It was a concern because of the potential for complications for not receiving an anti-stroke medication. There was not anything we could do except admit the error, correct the problem and move on. On 3/31/21 at 10:00 a.m., Resident D's medical record was reviewed. Resident D admitted to the facility on 2/1/20 with diagnosis to include, but were not limited to, HTN (hypertension, high blood pressure), and Chronic Renal Impairment stage 3. An admission nursing assessment dated 2/5/2020 indicated, Resident D self-administered her own medication, and was not taking any blood thinning medication. On 4/1/21 at 10:49 p.m., the DON provided a copy of Resident D's medication list and corresponding MAR (Medication Administration Record). A list of medications dated 1/20/2020,		residents MD will be contacted to ensure that the medication should be given or not MD to send written orders. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Licensed nurse to have second nurse check MAR to ensure medication list sent with resident is correct on MAR/TAR. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Nursing administration will check MARS/TARS and medication list sent with resident is correct on MAR/TARS How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Monthly audits for new residents will be performed by nursing administration to ensure all orders are correct on MARS/TARS. This will be in place by 5/12/2021.	

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	did not include Plavix. A list of medication dated, 8/20/2020 included Plavix. During a follow up interview on 4/1/21 at 10:50 a.m., the DON indicated, there were too many doctors involved with Resident D's care, and they doctors were not communicating well with each other, so the prescription for Plavix fell through the cracks and was missed. This State Residential Finding relates to Complaint IN00336029.			
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on observation, interview, and record review, the facility failed to ensure the required destruction of a medication and failed to maintain a pharmacy label without additional handwriting on the label for 1 of 3 residents reviewed for medication administration (Resident N).	R 0306	R306 Please reference the enclosed "Plan of Correction for the March 31st and April 1st, 2021 complaint survey" I am respectfully requesting paper compliance for this survey. Preparation and/or	05/12/2021

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	Findings include: On 3/31/21 at 11:44 a.m., during an observation of medication administration, Licensed Practical Nurse (LPN) 6 was observed removing Lisinopril 20 mg (for treatment of blood pressure) for Resident N. She used a pill cutter and cut the pill in half to supply the ordered dosage of 10 mg. She put the remaining half of the Lisinopril back into the multi-dosing card and taped it shut. She indicated she did not want to waste the medication and was afraid the resident's insurance might not refill it when needed. She wondered why the pharmacy did not supply the Lisinopril 10 mg as ordered. During the medication administration for Resident N, on 3/31/21 at 11:44 a.m., handwriting was observed on the pharmacy label for Lisinopril 20 mg. The handwritten words were, "dose = 10 mg cut in 1/2." On 3/31/21 at 12:05 p.m., Resident N's record was reviewed. Her diagnosis included, but was not limited to, hypertension, anemia, anxiety, and leukopenia. Her physician's orders included, but were not limited to, Lisinopril 10 mg, take one tablet by mouth daily. Start date was 10/08/2020. On 3/31/21 at 12:48 p.m., the Director of Nursing (DON) indicated a medication that has been cut in half, should not have been returned to the multi-dosing card, and taped it shut. The nurse should have wasted it and called the pharmacy to get the right dose. On 4/1/21 at 1:40 p.m., the DON indicated the		execution of this plan of correction does not constitute admission or agreement by the provider of the true facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and executed because it is required by the Federal and state laws. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The nurse involved was educated by the DON on the policy and procedures of medication administration and medication packaging and labeling. All nursing staff was educated on 4/20/2021 on policy and procedure as well as state regulations. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? When resident has medication changes licensed nurse is to place a medication change label on packaging if medication discontinued the medication will be removed from cart immediately, orders will be faxed to pharmacy then call pharmacy to ensure the correct dosage is sent to facility. What measures will be put into place or what systemic changes the facility will make to ensure that	

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		A. BUILDING 00 B. WING	04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	staff should not write on the pharmacy label, they should have put a sticker on it indicating, the directions were changed, refer to the chart. Then, they should have checked the Medication Administration Record (MAR) for the correct dosage changes. A current policy, titled, "Medication Administration of [sic]", dated 8/1/2017, was provided by the Executive Director (ED) on 3/31/21 at 11:20 a.m. A review of the policy indicated, " ...Prior to administration, the medication and dosage schedule on the MAR is compared with the medication label. If the label and the MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the Healthcare provider's orders are checked for correct dosage schedule ...Administration of partial tablets is clearly identified or highlighted on the resident's MAR ...Where possible, the provider pharmacy is requested to package half tablets ...." A current policy, titled, "Medication Packaging and Labeling, dated 8/1/2017, was provided by the DON on 4/1/21 at 1:50 p.m. A review of the policy indicated, " ...All medications and treatments (including over-the-counter) will be labeled consistent with the prescriber's order by a professional that is licensed to dispense medication such as a pharmacist ...Staff must not alter the medication label ...." This State Residential Finding relates to Complaint IN00336029.		the deficient practice does not recur? All licensed nursing staff was in serviced on policy and procedures all new licensed nursing staff will be educated upon hire. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Corrective actions will be monitored to ensure the alleged deficient practice will no reoccur. The nursing administration will do weekly audits for 60 days to ensure new medications are current on MARS/TARS and correct medications are in the cart. This change will be completed by 5/12/2021.	
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash			

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	their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review, the facility failed to ensure all staff members wore the correct masks (personal protective equipment) and wore them correctly during a pandemic for 2 of 2 random staff members observered. Findings include: On 3/31/21 at 10:03 a.m., Housekeeper 5 was observed wearing a cloth mask in the resident 200 hallway. She was within 6 feet of Resident E's daughter and pulled her cloth mask down to talk with her, this was just prior to the daughter entering Resident E's room. On 3/31/21 at 12:20 p.m., Housekeeper 5 was observed wearing a cloth mask in the resident 100 hallway. During an interview, on 4/1/21 at 9:53 a.m., Housekeeper 5 indicated she was wearing a surgical mask now, and she previously wore the cloth mask because it was provided by the facility, and thought it was ok to wear at work. On 4/1/21 at 1:55 p.m., the front desk Receptionist 15 was observed as she pulled down her mask to cough while talking to a family member, they were within six feet of each other. She indicated she had allergies and could not cough while her mask was on. On 4/1/21 at 1:57 p.m., Housekeeper 5 indicated she worked on the second and third floors yesterday while wearing a cloth mask to clean resident rooms. She sees almost all the residents	R 0414	R414 Please reference the enclosed "Plan of Correction for the March 31st and April 1st, 2021 complaint survey" I am respectfully requesting paper compliance for this survey. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the true facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and executed because it is required by the Federal and state laws. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? That staff member was given education on mask and policy and procedures. All staff educated on wearing surgical mask and state regulations. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Staff mask will be checked by charge nurse to ensure proper mask is worn by staff. If a staff member is noted to have on improper mask it will be replaced with a surgical mask. What measures will be put into	05/12/2021

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	everyday as they might leave or just come back while she cleans their rooms. She indicated Resident U did not leave the room yesterday, and it takes about 25 minutes to clean a room. During an interview, on 3/31/21 at 3:19 p.m., the Director of Nursing (DON) indicated surgical masks are required for all employees. They are available everywhere. A current policy, titled, "PPE Policy (COVID)," dated 3/20/2020, was provided by the facility. A review of the policy indicated, " ...The purpose of the COVID-19 Personal Protective Equipment policy is to outline how to implement the use of PPE to respond safely during a pandemic such as COVID-19...Cloth Face Covering...Only permitted while being worn over a surgical/N95 mask ...Surgical Mask ...At all time while in community...."		place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Education/in-services will be performed monthly concerning mask to ensure all staff is educated. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Charge nurse to ensure all staff have on proper mask before start of shift if not one will be provided. This will be corrected by 5/12/2021.	