STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	02/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00		F 0000		

This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00423921, IN00427027, and IN00427373.

Complaint IN00423921-No deficiencies related to the allegations are cited.

Complaint IN00427027-No deficiencies related to the allegations are cited.

Complaint IN00427373-No deficiencies related to the allegations are cited.

Survey dates: February 5, 6, 7, 8, 9, and 12, 2024.

Facility number: 000316
Provider number: 155491
AIM number: 100286370

Census Bed Type:
SNF/NF: 92
Total: 92

Census Payor Type:
Medicare: 2
Medicaid: 82
Other: 8
Total: 92

These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.

Quality review completed on February 13, 2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Benjamin Meier	Executive Director	02/21/2024

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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F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other			

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	appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on interview and record review, the facility failed to develop a care plan, for blood pressure medications, for a resident with hypertensive heart disease. This affected 1 of 28 residents reviewed for care plan development. (Resident 21) Findings include: Resident 21's record was reviewed on 2/07/24 at 1:36 p.m. The record indicated Resident 21 had diagnoses that included, but were not limited to, presence of cardiac pacemaker, pulmonary hypertension, and hypertensive heart disease without heart failure. Current physician's orders indicated the resident received the following medications: Amlodipine 10 milligrams by mouth, one time a day, for hypertensive heart disease without heart failure, hold if systolic blood pressure is less than 110, with a start date of 12/11/23. Lisinopril 20 milligrams by mouth, one time a day, for hypertensive heart disease without heart failure, with a start date of 10/16/23. Clonidine 0.1 milligrams by mouth, two times a day, hold for systolic blood pressure less than 150 and/or diastolic blood pressure less than 80, for	F 0656	**F656 Develop/Implement Comprehensive Care Plan** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1 Resident 21 continues to reside at the facility and does not have any adverse effects from identified deficient practice. 2 Cardiac care plan was initiated at the time of identification. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1 All residents with cardiac disease or receiving cardiac medication have the potential to be affected. 2 RAI Specialist/designee will educate MDS coordinator on Comprehensive Care Plan policy on/by 2/23/24. 3 RAI Specialist/designee will audit all current residents with a cardiac diagnosis to ensure	02/23/2024

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	hypertensive heart disease without heart failure, with a start date of 10/20/23. Furosemide 20 milligrams by mouth, two times a day for high blood pressure, started 8/20/23. There was no care plan in the clinical record for the use of blood pressure medications. On 2/12/24 at 11:30 a.m., the Director of Nurses indicated they did not have a care plan for blood pressure medications so they developed one today. On 2/12/24 at 11:30 a.m., the Director of Nurses provided a policy for "Care Plans - Comprehensive". The policy included, but was not limited to: "Policy Statement: An individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident...3. Each resident's Comprehensive Care Plan has been designed to: a. Incorporate identified problem areas...." 3.1-35(a) 3.1-35(b)(1)		comprehensive care plans in place on/by 2/23/24. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1 RAI Specialist will audit all new admissions weekly x4 then monthly x6 months to ensure compliance with development of comprehensive care plans. 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? 1 For quality assurance, the ED or Designee will review any findings 5 days a week during clinical meeting, with subsequent correction action and education for identified staff members. 2 Findings will be reported at the QA meeting monthly x6 months and will continue until 100% compliance is achieved.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for			

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	the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to ensure each resident and their representative(s) are invited to care plan meetings for 1 of 3 residents reviewed for care plan meetings. (Resident 40) Findings include: The clinical record of Resident 40 was reviewed on 2-9-24 at 10:10 a.m. It indicated she has been a resident of the facility for over one year. A review of her most recent Minimum Data Set (MDS) assessment, dated 12-12-23, indicated she was cognitively intact. In an interview with Resident 40 on 2-5-24 at 2:33 p.m., she indicated she could not recall being asked to participate in a care plan meeting or previously participating in a care plan meeting and would like to do so.	F 0657	**F657 Care Plan Timing and Revision** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1 Resident 40 continues to reside at the facility and does not have any adverse effects from identified deficient practice. 2 SSD/designee to have care conference on/by 2/23/24 with resident 40. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1 All residents have the	02/23/2024

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	In a review of care plan meeting notes, the clinical record reflected Resident 40 had participated in care plan meetings on 8-10-23, 10-3-23 and 12-11-23, but did not participate or attend a care plan meeting on 9-13-23. A review of the "IDT [interdisciplinary team] Care Plan Conference Summary," for 9-13-23, the the form queried if the resident was "unable to attend," what other methods were offered to review the care plan. The response provided by the facility was, "IDT review of care plan." For the query of, "Was family/representative in attendance?", the response was listed as "no." For the query of "If family/representative did not attend, indicate when they were notified of the care conference by what means and were alternative care conference times or methods offered?" Response was, "IDT review of care plan." In an interview on 2-8-24 at 2:20 p.m., with the Director of Nursing (DON), she indicated the facility has a new Social Services Designee (SSD), who has been employed for approximately one month. The DON indicated the former SSD maintained a log for care plan meetings. She indicated she would reach out to her to seek additional information. In a subsequent interview with the DON on 2-9-24 at 10:40 a.m., she indicated the facility was able to obtain a copy of the care plan meeting log from the former SSD. The DON indicated, "It doesn't look like there are dates of when she reached out to the families or residents to schedule the meetings. I can't really tell you why it looks like some of the residents, especially on the vent unit, may not have been included."		potential to be affected. 2 Social Services consultant/designee will educate SSD on Resident/Family Participation in care conference policy on/by 2/23/24. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1 SSD will utilize care conference log to document communication with resident, resident family, date, time, location, and attendees invited with each meeting. 2 Care conference invites will be scanned into the resident medical record weekly. 3 SSD/designee will complete audits weekly x4 weeks then monthly x6 months to ensure care conference documentation is present in the medical record. 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? 1 For quality assurance, the ED or Designee will review any findings 5 days a week during clinical meeting, with subsequent correction action and education for identified staff members. 2 Findings will be reported at the QA meeting monthly x6	

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	In review of the care plan meeting log for Resident 40, it indicated on/about 12-11-23, the SSD had notified the resident and her representative of the upcoming care plan meeting, conducted on 12-13-23. The log had no notations reflecting the advance notice of care plan meetings of 8-10-23, 9-13-23 or 10-3-23. On 2-12-24 at 9:59 a.m., the DON provided a copy of a policy entitled, "Resident/Family Participation 72 Care Review-Assessment/Care Plans." This policy had a revision date of 6-1-18 and was indicated to be the current policy utilized by the facility. It indicated, "Each resident and his/her family members are encouraged to participate in the development of the resident's comprehensive assessment and care plan. The resident and his/her family, and/or the legal representative (sponsor), are invited to attend and participate in the resident's assessment and care planning conference...The Comprehensive Care Conference is scheduled after the completion of the Comprehensive Care Plan and quarterly...Give seven (7) days advance notice of the care planning conference to the resident and interested family members for all conferences. Such notice is made by mail and/or telephone. The Social Services Director or designee is responsible for contacting the resident's family and for maintaining records of such notices. Notices include: The date of the conference; The time of the conference; The location of the conference; The name of each family member contacted; The date and time of the family was contacted; The method of contacting the family (e.g., mail, telephone, email, etc.); Input from family members when they are not able to attend; Input from the resident when he/she is not able to attend...The date and signature of the individual making the		months and will continue until 100% compliance is achieved.	

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	contact." 3.1-35(c)(2)(C)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview, observations, and record review, the facility failed to ensure a dependent resident had facial hair to their preferences for 1 of 3 residents reviewed for activities of daily living. (Resident 28) Findings include: The clinical record for Resident 28 was reviewed on 2/8/2024 at 1:45 p.m. The medical diagnosis included muscle weakness. An annual Minimum Data Set Assessment, dated 12/23/2023, indicated Resident 28 was moderately cognitively impaired. An interview and observation of Resident 28 on 2/6/2024 at 11:02 a.m. indicated she was in her wheelchair. She has some noticeable facial hair upon her upper lip. She stated she used to be able to take care of it by herself, but she's been needing more help recently and prefers to not have facial hair. An interview with Unit Manager 3 on 2/7/2024 at 1:00 p.m. indicated that Resident 28 needs extensive assistance with activities of daily living and utilizes a mechanical lift for transfers.	F 0677	**F677 ADL Care Provided for Dependent Residents** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1 Resident 28 continues to reside at the facility and does not have any adverse effects from identified deficient practice. 2 Resident facial hair was removed upon identification. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1 All residents dependent on ADL care have the potential to be affected. 2 DNS/designee will educate nursing staff on ADL policy on/by 2/23/24. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?	02/23/2024

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	An observation on 2/9/2024 at 11:35 a.m., indicated Resident 28 was sitting in the dining room with other residents listening to music. She continued to have noticeable facial hair upon her upper lip. An interview with the DON on 2/9/2024 at 12:00 p.m. indicated the direct care staff would be responsible for ensuring facial hair is groomed to preferences for residents needing assistance with activities of daily living. A policy entitled, "Activities of Daily Living (ADLs)", was provided by the DON on 2/9/2024 at 10:35 a.m. the policy indicated, " ...A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and person and oral hygiene ..." 3.1-38(a)(2)(A)		1 DNS/designee will complete random walk- through observations for dependent residents on the preference of facial hair weekly x4 weeks then monthly x6 months. 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? 1 For quality assurance, the ED or Designee will review any findings 5 days a week during clinical meeting, with subsequent correction action and education for identified staff members. 2 Findings will be reported at the QA meeting monthly x6 months and will continue until 100% compliance is achieved.	
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 observation, record review and interview, the facility failed to administer pain medication according to the physician's orders, for 1 of 3 medication administration pass	F 0684	**F684 Quality of Care** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	02/23/2024

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	opportunities. (Resident 41) Findings include: During a medication pass observation, on 2/08/24, at 8:58 a.m., QMA 4 prepared hydrocodone (narcotic pain medication)and acetaminophen 5/325 milligrams (mg), 1 tablet, and 1/2 of a hydrocodone/acetaminophen 5/375 mg tablet and administered the medication to resident 41. The medication as given equaled 7.5 mg of hydrocodone and 487.5 mg of acetaminophen which was 162.5 mg more than the prescribed order for acetaminophen for each medication administration. The physician's order, dated 5/12/23, indicated the following order: "Hydrocodone-Acetaminophen Oral Tablet 7.5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours for pain" Resident 41's record was reviewed on 2/12/24 at 11:45 a.m. and indicated diagnoses that included, but were not limited to, rheumatoid arthritis with rheumatoid factor of multiple sites, fibromyalgia (widespread pain), and chronic pain syndrome. On 2/12/24 at 10:45 a.m., the Director of Nurses (DoN) indicated the hydrocodone/acetaminophen 7.5/325 are on back order, so the pharmacy is sending a card of hydrocodone 5 milligram tablets, and hydrocodone 5 milligram tablets split in half. She said the physician is aware of the shortage, when pharmacy sent us the pills, they didn't know how long it would take to get the order in, and they will change the 325 mg part of the acetaminophen until pharmacy gets the order in. Ideally she is supposed to receive the 7.5/325.		1 Resident 41 continues to reside at the facility and does not have any adverse effects from identified deficient practice. 2 Transcription error was corrected at the time of identification to match discrepancy in Tylenol administration. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1 All residents receiving Hydrocodone/Acetaminophen have the potential to be affected. 2 DNS/designee educated nursing staff on Medication Administration/transcription policy on/by 2/23/24. 3 DNS/designee audited all current Hydrocodone/Acetaminophen orders for transcription accuracy on/by 2/23/24. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1 DNS/designee to complete random transcription audits for Hydrocodone/Acetaminophen orders weekly x4 weeks then monthly x6 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what	

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	On 2/12/24 at 11:20 a.m., the DoN indicated it was a transcription error in their electronic health records. 3.1-37(a)		quality assurance program will be put into place? 1 For quality assurance, the ED or Designee will review any findings 5 days a week during clinical meeting, with subsequent correction action and education for identified staff members. 2 Findings will be reported at the QA meeting monthly x6 months and will continue until 100% compliance is achieved.	
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 interview, observations, and record review, the facility failed to ensure fall interventions of nonskid strips were in place for 1 of 6 residents reviewed for falls. (Resident 15) Findings include: The clinical record for Resident 15 was reviewed on 2/5/2024 at 1:45 p.m. The medical diagnosis included traumatic brain injury. A fall care plan with an interventions, dated 4/29/2021, indicated Resident 15 was to have nonskid strips in front of his toilet to avoid slippage.	F 0689	**F689 Free of Accident/Hazards/Supervision/ Devices** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1 Resident 15 continues to reside at the facility and does not have any adverse effects from identified deficient practice. 2 Non-skid strips were added in front of resident toilet at the time of identification.	02/23/2024

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MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

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	An interview and observation on 2/5/2024 at 1:00 p.m., indicated Resident 15 did not have nonskid strips in front of his toilet. He stated in the morning he gets himself out of bed and he feels like the floor is too slick beside his bed and in the bathroom. He stated he is afraid of falling and he is supposed to have those "black strips" on the floor. An observations on 2/5/2024 at 1:25 p.m. after CNA 2 had left the bathroom in Resident 15's room indicated that Resident 15 did not have nonskid strips in front of his toilet. A policy entitled, "Fall Management", was provided by the DON on 2/9/2024 at 10:35 a.m. The policy indicated, " ...A care plan will be developed at time of admission with specific care plan interventions to address each resident's fall risk factors ..." 3.1-45(a)(2)		How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1 All residents with falls have the potential to be affected. 2 DNS/designee will educate nursing staff on Fall Management policy on/by 2/23/24. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1 DNS/designee to audit all new falls 5x/week in daily clinical meeting to ensure fall interventions are implemented in the room. 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? 1 For quality assurance, the ED or Designee will review any findings 5 days a week during clinical meeting, with subsequent correction action and education for identified staff members. 2 Findings will be reported at the QA meeting monthly x6 months and will continue until 100% compliance is achieved.	
F 0761 SS=D	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals			

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	155491	A. BUILDING 00 B. WING	02/12/2024

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MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

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Bldg. 00	§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 review, the facility failed to ensure each medication in the medication cart was appropriately labeled, including directions for use, for 1 of 4 medication cart observations. (Resident 31) Findings include: During a medication cart observation of the 300 hall with LPN 3 on 2-12-24 at 10:30 a.m., a "Basaglar Pen," of 100 units per milliliter strength, was observed lying in an upper drawer, without a	F 0761	**F761 Label/Store Drugs and Biologicals** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1 Resident 31 continues to reside at the facility and does not have any adverse effects from identified deficient practice. 2 DNS discarded insulin pen at the time of identification.	02/23/2024

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	protective bag nor directions for use present. The pen did have the name of Resident 31 present, along with the expiration date, the lot number and a handwritten date of "12-28" on the pen. In an interview with LPN 3 at this time, he indicated he could not locate a bag for this medication which typically has the above information, as well as the specific directions for use. LPN 3 indicated it appeared with the date of 12-28-23 as the open date, the medication should have been discarded due to expiration date of greater than a month. An additional eight (8) pens of the same medication were located in the refrigerator of the 300 hall medication storage room. These pens were labeled with directions for use on the plastic bags they were found in. A review of Resident 31's clinical record indicated he had an order, originated on 8-30-23, for glargine insulin Solution 100 units per milliliter to inject 10 units subcutaneously (under the skin) one time a day for diabetes. A review of his medication administration record indicated this medication was given daily at bedtime and was administered routinely. On 2-12-24 at 11:33 a.m., the Director of Nursing (DON) provided a copy a policy entitled, "Storage of Medications." This policy had a revision date of November, 2020, and was indicated to be the current policy utilized by the facility. This policy indicated, "The facility stores all drugs and biologicals in a safe, secure, and orderly manner...The nursing staff is responsible for maintaining medication storage..Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing..." On 2-12-24 at 11:50 a.m., the DON provided a		How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1 All residents receiving insulin have the potential to be affected. 2 DNS/designee will educate nursing staff on Storage of Medications policy on/by 2/23/24. 3 DNS/designee will audit all medication carts on/by 2/23/24 to ensure all insulin pens are appropriately labeled. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1 DNS/designee to complete medication cart audits weekly x4 then monthly x6 months to ensure insulin pens have appropriate label. 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? 1 For quality assurance, the ED or Designee will review any findings 5 days a week during clinical meeting, with subsequent correction action and education for identified staff members. 2 Findings will be reported at the QA meeting monthly x6	

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	listing of medication expiration dates of commonly used medications. This document had a revision date of May, 2023. It indicated glargine insulin, also known as Toujeo, Lantus or Basaglar, can be used for up to 56 days at room temperature after it is opened. 3.1-25(j) 3.1-25(k)(5)		months and will continue until 100% compliance is achieved.	
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;			

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	(ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §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.			

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	Based on interview and record review, the facility failed to ensure Weekly Nursing Summary Assessment for 1 of 2 residents reviewed for Weekly Nursing Summary Assessment accuracy. (Resident 16) Findings include: The clinical record for Resident 16 was reviewed on 2/8/2024 at 1:35 p.m. The medical diagnosis included dementia. An Annual Minimum Data Set Assessment, dated 12/23/2023, indicated Resident 16 was moderately cognitively impaired. Review of Resident 16's Medication Administration Record for January 2024 indicated Resident 16 received as needed (or PRN) Tylenol for pain on 1/5/2024 and 1/17/2024. A Weekly Nursing Summary Assessment for Resident 16, dated 1/6/2024, indicated Resident 16 did not received any PRN pain medication in the last seven days. A Weekly Nursing Summary Assessment for Resident 16, dated 1/20/2024, indicated Resident 16 did not received any PRN pain medication in the last seven days. A policy entitled, "Documentation in the Medical Record", was provided by the DON on 2/9/2024 at 10:35 a.m. The policy indicated, " ...Each resident's medical record shall contain an accurate representation of the actual experiences of the resident's progress through complete, accurate, and timely documentation ..." 3.1-50(a)(2)	F 0842	**F842 Resident Records** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1 Resident 16 continues to reside at the facility and does not have any adverse effects from identified deficient practice. 2 Identified documentation discrepancy cannot be changed to reflect accurate information on evaluation. 3 Late entry placed in chart to reflect that resident did receive 2 doses of Tylenol during the assessment period. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1 All residents have the potential to be affected. 2 DNS/designee educated nursing staff on Documentation in the Medical Record policy on/by 2/23/24. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1 DNS/designee to complete weekly summary audits for accuracy of documentation weekly x4 weeks then monthly x6	02/23/2024

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			months. Audits will coincide with the facility weekly summary schedule. 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? 1 For quality assurance, the ED or Designee will review any findings 5 days a week during clinical meeting, with subsequent correction action and education for identified staff members. 2 Findings will be reported at the QA meeting monthly x6 months and will continue until 100% compliance is achieved.	