

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/20/2023
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NAME OF PROVIDER OR SUPPLIER OAK GROVE CHRISTIAN RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP COD 221 W DIVISION ST DEMOTTE, IN 46310
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: November 13, 14, 15, 16, 17 and 20, 2023.</p> <p>Facility number: 010823 Provider number: 155667 AIM number: 200236630</p> <p>Census Bed Type: SNF/NF: 54 Residential: 33 Total: 87</p> <p>Census Payor Type: Medicare: 10 Medicaid: 28 Other: 16 Total: 54</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on 11/28/23.</p>	F 0000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>Oak Grove Christian Retirement Village desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on January 12, 2024. The facility respectfully requests paper compliance. Please accept the attached as our credible allegation of compliance.</p>	
F 0550 SS=D Bldg. 00	<p>483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>§483.10(a)(1) A facility must treat each</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rosemary Weeks	VP Operations	12/15/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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	<p>resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident's dignity was maintained related to an uncovered urinary catheter bag for 1 of 1 residents reviewed for dignity. (Resident 21)</p> <p>Finding includes:</p>	F 0550	<p>The community was alleged to be out of compliance by failing to ensure a resident's dignity was maintained related to an uncovered urinary catheter bag.</p> <p>I. <u>Specific Corrective Actions:</u> Resident 21's catheter bag was</p>	01/12/2024

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F 0561 SS=D Bldg. 00	<p>On 11/13/23 at 10:24 a.m. and again on 11/14/23 at 11:42 a.m., Resident 21 was observed lying in bed. A urinary catheter bag was hanging on the side of the bed with visible urine in the bag. There was not a covering over the bag. The bag was visible from the doorway.</p> <p>Record review for Resident 21 was completed on 11/14/23 at 11:45 a.m. Diagnoses included, but were not limited to, stroke, neurogenic bladder, anxiety, and depression.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 9/18/23, indicated the resident was cognitively moderately impaired. The resident had an indwelling urinary catheter.</p> <p>Interview with RN 1 on 11/14/23 at 11:47 a.m., indicated the resident's catheter bag should have been covered with a dignity bag.</p> <p>3.1-3(a)</p> <p>483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.</p> <p>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent</p>		<p>immediately covered with a dignity bag.</p> <p>II. <u>Identification and correction of others:</u> There were no other residents with exposed urinary catheter bags. In future all urinary catheter bags will be covered with a dignity bag.</p> <p>III. <u>Systemic Changes:</u> All staff were educated on the use of dignity bags to cover urinary catheter bags.</p> <p>IV. <u>Monitoring:</u> An audit of urinary catheter bags will be completed by the DON/designee weekly for 4 weeks, then monthly for at least 5 months or until substantial compliance. The DON/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. [Attachment: Catheter Bags CQI & QA Tracking Log]</p>	

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	<p>with his or her interests, assessments, and plan of care and other applicable provisions of this part.</p> <p>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.</p> <p>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident's preference was honored related to not receiving a beverage of choice per her request for 1 of 2 residents reviewed for choices. (Resident 1)</p> <p>Finding includes:</p> <p>On 11/15/23 at 9:23 a.m., Resident 1 was sitting at a table by the nurse's station. The resident asked LPN 1 if she could have some hot chocolate. LPN 1 indicated she would have to ask the resident's nurse. LPN 1 was observed asking RN 1 if the resident could have some hot chocolate. RN 1 indicated the resident would have to wait until the resident's daughter arrived to the facility to assist her with the hot chocolate. The resident would spill it on herself without assistance. LPN 1 then went back and told the resident she would have to wait until her daughter got there to assist her with the hot chocolate.</p>	F 0561	<p>The community was alleged to be out of compliance by failing to ensure a resident's preference was honored related to not receiving a beverage of choice per the resident's request.</p> <p><u>I. Specific Corrective Actions:</u> Resident 1 was immediately provided with the requested beverage and the nurse in question was educated to always fulfill a resident's request, not tell the resident he/she would have to wait. Team member was immediately educated.</p> <p><u>II. Identification and correction of others:</u> There were no other residents identified with a preference that was not fulfilled.</p> <p><u>III. Systemic Changes:</u> All staff were educated on</p>	01/12/2024
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F 0623 SS=D Bldg. 00	<p>Record review for Resident 1 was completed on 11/15/23 at 9:21 a.m. Diagnoses included, but were not limited to tardive dyskinesia (movement disorder that causes involuntary facial tics), heart failure, hypertension, and depression.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 8/28/23, indicated the resident was cognitively moderately impaired. The resident required supervision of 1 person for eating.</p> <p>A Care Plan, dated 6/27/23, indicated the resident had an alteration in ADL (activities of daily living) self-performance and mobility related to impaired mobility. An intervention included for staff to provide assistance as needed for eating.</p> <p>Interview with RN 1 on 11/15/23 at 9:55 a.m., indicated the resident needed assistance with her hot chocolate. The resident had a tendency to shake and would spill it on herself. The resident would have to wait for her daughter to get there to help her. She could not help her herself because she did not have the time.</p> <p>Interview with the Director of Nursing (DON) on 11/15/23 at 10:00 a.m., indicated RN 1 should have assisted the resident with some hot chocolate. If the RN did not have time then she should have found another staff member to assist the resident.</p> <p>3.1-3(u)(1)</p> <p>483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-</p>		<p>ensuring all residents' preferences are honored at the time of the request.</p> <p>IV. Monitoring: A random audit of resident requests will be completed by the Activities Coordinator/designee weekly for 4 weeks, then monthly for at least 5 months or until substantial compliance. The Activities Coordinator/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. [Attachment: Resident Request CQI & QA Tracking Log]</p>	

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	<p>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.</p> <p>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p>			

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	<p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <ul style="list-style-type: none"> (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the</p>				

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	<p>notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).</p> <p>Based on record review and interview, the facility failed to ensure a resident and/or their Responsible Party were notified in writing related to a transfer to the hospital for 2 of 3 residents reviewed for hospitalization. (Residents 48 and 55)</p> <p>Findings include:</p> <p>1. Resident 48's record was reviewed on 11/14/23 at 11:56 a.m. Diagnoses included, but were not limited to, dementia, anxiety and depression. The resident resided on the memory care unit.</p> <p>The Quarterly Minimum Data Set assessment, dated 9/5/23, indicated the resident required limited staff assistance for bed mobility, transfers and eating, and extensive staff assist for toileting.</p> <p>Progress Notes dated 8/5/23, indicated the resident was sent to the hospital for evaluation following a fall. The resident returned later that day. On 8/6/23, the resident was sent back to the hospital for additional evaluation after complaining of pain to her hip from the fall.</p>	F 0623	<p>The community was alleged to be out of compliance by failing to ensure a resident and/or their responsible party were notified in writing related to a transfer to the hospital.</p> <p><u>I. Specific Corrective Actions:</u> Residents 48's and 55's documentation of transfer were completed as a late entry. Team members who completed the discharge were educate on transfer/discharge requirements.</p> <p><u>II. Identification and correction of others:</u> All transfers to the hospital for the past 14 days were reviewed for proper documentation.</p> <p><u>III. Systemic Changes:</u> Licensed nursing staff and medical records were educated regarding the completion of the proper documentation upon a resident's</p>	01/12/2024
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	<p>There was a lack of documentation any hospital transfer form had been completed or the State transfer form had been provided in writing to the resident or his responsible party for the hospital transfers on 8/5 or 8/6/23.</p> <p>Interview with the Director of Nursing (DON), on 11/15/23 at 10:52 a.m., indicated there were no transfer or State forms completed for those two days.2. The closed record for Resident 55 was reviewed on 11/16/23 at 9:55 a.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and arthritis.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 10/2/23, indicated the resident was cognitively intact.</p> <p>A Progress Note, dated 10/6/23 at 12:12 a.m., indicated the resident was yelling out in pain and had a large amount of blood coming from his right hip incision. The Nurse Practitioner was notified, and the resident was sent to the Emergency Room.</p> <p>There was a lack of documentation any hospital transfer form had been completed or the State transfer form had been provided in writing to the resident or his responsible party.</p> <p>Interview with the Director of Nursing (DON) on 11/16/23 at 2:18 p.m., indicated the resident had been sent out 911 and there was no paper work sent at that time. She was unable to provide any further documentation.</p> <p>3.1-12(a)(6)(ii) 3.1-12(a)(6)(iii)</p>		<p>transfer to the hospital. Medical Records will conduct an audit of transfer/discharges for proper documentation.</p> <p>IV. Monitoring: An audit of hospital transfers will be completed by the Medical Records Coordinator/designee weekly for 4 weeks, then monthly for at least 5 months or until substantial compliance. The Medical Records Coordinator/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. [Attachment: Hospital Transfer CQI & QA Tracking Log]</p>		

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F 0641 SS=A Bldg. 00	<p>483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.</p> <p>Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to pressure ulcer staging and diabetic medication use for 2 of 18 MDS assessments reviewed. (Residents 37 and 32)</p> <p>Findings include:</p> <p>1. Resident 37's record was reviewed on 11/16/23 at 10:15 a.m. Diagnoses included, but were not limited to, Parkinson's disease, anemia, and a stage 4 sacral pressure ulcer.</p> <p>The Significant Change MDS assessment, dated 10/25/23, indicated the resident had significant cognitive impairment and was dependent on staff assistance for bed mobility, toileting and transfers. The resident had one stage 2 pressure ulcer.</p> <p>A Pressure Ulcer Care Plan indicated the resident had a stage 4 pressure ulcer on his sacrum.</p> <p>Interview with the MDS Nurse, on 11/16/23 at 11:15 a.m., indicated she was unsure why the pressure ulcer had been coded as a stage 2. She indicated she would correct it. 2. Resident 32's record was reviewed on 11/14/23 at 2:00 p.m. Diagnoses included, but were not limited to, epilepsy, type two diabetes without complications, hypertension, and vitamin D deficiency.</p>	F 0641	<p>The community was alleged to be out of compliance by failing to ensure the MDS comprehensive assessment was accurately completed related to pressure ulcer staging and diabetic medication use versus insulin.</p> <p>I. <u>Specific Corrective Actions:</u> Resident 37's pressure ulcer coding was corrected to indicate the current stage. Resident 32's MDS error was corrected and modified to indicate insulin was not taken. The MDS nurse was educated on correct coding of pressure areas and diabetic medication.</p> <p>II. <u>Identification and correction of others:</u> There were no other residents with incorrect MDS coding.</p> <p>III. <u>Systemic Changes:</u> The MDS Nurses were re-educated to check pressure ulcer staging and diabetic medication versus insulin drugs.</p> <p>IV. <u>Monitoring:</u> An audit of MDSs related to correct pressure ulcer staging and diabetic medication use will be completed by MDS/designee weekly for 4 weeks, then monthly for at least 5 months or until substantial compliance.</p>	01/12/2024
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F 0655 SS=D Bldg. 00	<p>The Quarterly MDS assessment, dated 8/25/23, indicated insulin was given.</p> <p>The current Physician's Order Summary indicated the resident's medications included Glipizide (oral anti-diabetic medication) 5 milligram (mg) tablet, Tradjenta (oral anti-diabetic medication) 5 mg tablet, and Trulicity (injectable anti-diabetic medication) 0.75 mg/0.5 ml subcutaneous pen injector. There was no insulin ordered.</p> <p>Interview with MDS Coordinator on 11/15/23 at 12:07 p.m., indicated Trulicity was being coded as insulin. The MDS error would be corrected and modified as the resident did not take insulin.</p> <p>483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-</p> <ul style="list-style-type: none"> (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- <ul style="list-style-type: none"> (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. 		MDS/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. [Attachment: MDS CQI & QA Tracking Log]	

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	<p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <p>(i) Is developed within 48 hours of the resident's admission.</p> <p>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <p>(i) The initial goals of the resident.</p> <p>(ii) A summary of the resident's medications and dietary instructions.</p> <p>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.</p> <p>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.</p> <p>Based on record review and interview, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours of admission for 1 of 18 residents reviewed for care plans. (Resident 48)</p> <p>Finding includes:</p> <p>Resident 48's record was reviewed on 11/14/23 at 11:56 a.m. The resident was admitted to the facility on 6/14/23. Diagnoses included, but were not limited to, dementia, anxiety and depression. The resident resided on the memory care unit.</p> <p>The Quarterly Minimum Data Set assessment, dated 9/5/23, indicated the resident required limited staff assistance for bed mobility, transfers,</p>	F 0655	<p>The community was alleged to be out of compliance by failing to ensure a baseline care plan was developed and implemented within 48 hours of admission.</p> <p>I. <u>Specific Corrective Actions:</u> Resident 48's baseline care plan was immediately developed and implemented. Team member responsible was educated regarding baseline care plans.</p> <p>II. <u>Identification and correction of others:</u> All new admissions for the past 14 days were reviewed to ensure baseline care plans were developed and implemented.</p>	01/12/2024
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F 0656 SS=D Bldg. 00	<p>and eating, and extensive staff assist for toileting.</p> <p>The Admission Care Plan was initiated on 7/15/23. There were no care plans prior to that date, including a baseline care plan within 48 hours of admission.</p> <p>Interview with the Medical Records Coordinator, on 11/15/23 at 11:15 a.m., indicated there was no baseline care plan completed for the resident.</p> <p>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</p>		<p>III. Systemic Changes: Licensed nursing staff and MDS were educated on the requirement to develop and implement a baseline care plan within 48 hours of admission.</p> <p>IV. Monitoring: An audit of new admissions for baseline care plans will be completed by the MDS Coordinator/designee weekly for 4 weeks, then monthly for at least 5 months or until substantial compliance. The MDS Coordinator/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. [Attachment: Baseline Care Plan CQI & QA Tracking Log]</p>	

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	<p>practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(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).</p> <p>(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.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(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 appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed.</p> <p>Based on observation, record review, and interview, the facility failed to develop and implement a care plan for a resident with denture problems for 1 of 20 resident care plans reviewed. (Resident 1)</p>	F 0656	<p>The community was alleged to be out of compliance by failing to develop and implement a care plan for a resident with denture problems.</p> <p>I. <u>Specific Corrective Actions:</u></p>	01/12/2024
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	<p>Finding includes:</p> <p>On 11/13/23 at 10:21 a.m., and 11/15/23 at 9:17 a.m., Resident 1 was observed not wearing her dentures.</p> <p>Record review for Resident 1 was completed on 11/15/23 at 9:21 a.m. Diagnoses included, but were not limited to tardive dyskinesia (movement disorder that causes involuntary facial tics), heart failure, hypertension, and depression.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 8/28/23, indicated the resident was cognitively moderately impaired. The resident required supervision of 1 person for eating. The assessment did not have the section checked for broken or loosely fitting dentures.</p> <p>The record lacked any documentation of a dental care plan.</p> <p>Interview with RN 1 on 11/15/23 at 9:55 a.m., indicated the resident's dentures did not fit and that was why she was not wearing them. The resident had tardive dyskinesia (movement disorder that causes involuntary facial tics) and played with her dentures while in her mouth by pushing them out with her tongue. She was unsure if the resident had a Care Plan that addressed her denture issues.</p> <p>Interview with the Director of Nursing on 11/15/23 at 11:51 a.m., indicated they should have had a care plan in place to address the resident's dentures as related to the resident having tardive dyskinesia, sometimes resulting in having problems wearing her dentures.</p> <p>3.1-35(a)</p>		<p>The care plan for resident 1's dentures was immediately developed and implemented.</p> <p>II. Identification and correction of others: The care plans for all residents with dentures were reviewed for appropriateness and implementation. No other deficiencies were identified.</p> <p>III. Systemic Changes: Licensed nursing staff and Social Services were educated related to developing and implementing care plans for dentures and resident refusals.</p> <p>IV. Monitoring: An audit related to denture care plans will be completed by the SS Manager/designee weekly for 4 weeks and then monthly for at least 5 months or until substantial compliance. The SS Manager/designee will report findings to the QAPI committee monthly for review, recommendations, and tracking. [Attachment: Denture Care Plan CQI & QA Tracking Log]</p>	

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F 0677 SS=D Bldg. 00	<p>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;</p> <p>Based on observation, record review, and interview, the facility failed to ensure the necessary care and services were provided to a dependent resident related to assistance with dentures daily for 1 of 3 residents reviewed for activities of daily living. (Resident 1)</p> <p>Finding includes:</p> <p>On 11/13/23 at 10:21 a.m., Resident 1 was observed sitting in a wheelchair in her room. The resident did not have any teeth. A sign was taped on the front of her dresser that indicated to put the resident's dentures in her mouth every morning. The sign also indicated the dentures were in a yellow cup in the bathroom. The dentures were then observed to be inside a yellow cup on the bathroom sink.</p> <p>On 11/15/23 at 9:17 a.m., Resident 1 was observed sitting in a wheelchair by the nurses's station. The resident did not have her dentures in. At 9:19 a.m., the resident's dentures were observed in the yellow cup on top of her bathroom sink.</p> <p>On 11/15/23 at 10:59 a.m., Resident 1 was observed sitting in a wheelchair in her room. The resident had her dentures in her mouth. The resident was talking with her daughter. The resident's dentures appeared to be staying in place in her mouth while she was talking. The resident indicated the dentures felt good. The resident's daughter indicated she would prefer</p>	F 0677	<p>The community was alleged to be out of compliance by failing to ensure the necessary care and services were provided to a dependent resident related to assistance with dentures daily.</p> <p>I. Specific Corrective Actions: Resident 1 was immediately asked if he/she wanted to wear the dentures and a care plan was put in place regarding refusal to wear the dentures.</p> <p>II. Identification and correction of others: All residents with dentures were reviewed for care plans related to wearing of their dentures.</p> <p>III. Systemic Changes: Nursing staff were educated on updating care plans for refusals and resident's rights. C.N.A.s were educated to report refusals to the nurse.</p> <p>IV. Monitoring: An audit of denture care plans will be completed by the SS Manager/designee weekly for 4 weeks, then monthly for at least 5 months or until substantial compliance. The SS Manager/designee will report findings to QAPI committee monthly for review,</p>	01/12/2024
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	<p>that the facility attempted to put the resident's dentures in every day and that was why she put the sign up on her dresser.</p> <p>Record review for Resident 1 was completed on 11/15/23 at 9:21 a.m. Diagnoses included, but were not limited to tardive dyskinesia (movement disorder that causes involuntary facial tics), heart failure, hypertension, and depression.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 8/28/23, indicated the resident was cognitively moderately impaired. The resident required supervision of 1 person for eating. The assessment did not have the section checked for broken or loosely fitting dentures.</p> <p>The record lacked any documentation of a dental care plan.</p> <p>A CNA Resident Care Guide, dated 6/27/23, indicated the resident had dentures. There were no indications the resident was unable to wear them.</p> <p>The record lacked any documentation the resident refused to wear her dentures or that she had problems wearing them and keeping them in.</p> <p>Interview with RN 1 on 11/15/23 at 9:55 a.m., indicated the resident's dentures did not fit and that was why she was not wearing them. The resident's daughter put the sign up in her room because she wanted the resident to wear them. The resident had tardive dyskinesia (movement disorder that causes involuntary facial tics) and played with her dentures while in her mouth by pushing them out with her tongue. She was unaware the dentures were in the residents bathroom, she thought the resident's daughter</p>		<p>recommendations, and tracking. [Attachment: Denture Care Plan CQI & QA Tracking Log]</p>	

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F 0684 SS=D Bldg. 00	<p>took them home a long time ago. She was unsure if the CNAs documented when the resident was unable to wear her dentures or not because she could not see CNA documentation.</p> <p>Interview with CNA 1 on 11/15/23 at 10:55 a.m., indicated she sometimes was able to put the resident's dentures in and sometimes the resident would refuse them. Sometimes the resident indicated she had a sore on her gums and they hurt so she didn't want to wear her dentures. She did not let the nurse know the resident was unable to wear her dentures because she had a sore on her gums or document anywhere when the resident refused them.</p> <p>Interview with the Director of Nursing on 11/15/23 at 11:51 a.m., indicated the CNAs should be letting the nurse know when the resident had problems with her dentures and didn't or couldn't wear them. They should have had a care plan in place to address the resident's dentures as related to the resident having tardive dyskinesia, sometimes resulting in having problems wearing her dentures.</p> <p>3.1-38(a)(3)(C)</p> <p>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.</p>			
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	<p>Based on record review and interview, the facility failed to ensure a resident received the necessary treatment and services related to the lack of a thorough assessment completed after a fall for 1 of 1 residents reviewed for falls. (Resident 32)</p> <p>Finding includes:</p> <p>Record review for Resident 32 was completed on 11/14/23 at 2:00 p.m. Diagnoses included, but were not limited to, hemiplegia following cerebral infarct affecting left nondominant side, epilepsy, type 2 diabetes mellitus without complications, constipation, hypertension, and vitamin D deficiency.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 8/25/23, indicated bed mobility, dressing, transfers, and toileting required extensive assistance. Eating required supervision, and hygiene required limited assistance. The resident also required a wheelchair, cane, and crutches.</p> <p>Progress Notes, dated 10/16/23, indicated the CNA report sheet listed 1 assist, left side weakness, wheelchair bound, and bed pan at night for the resident.</p> <p>Interview with the DON on 11/15/23 at 2:32 p.m. indicated she was unaware of any recent fall.</p> <p>A Fall Report, provided by the Director of Nursing (DON) on 11/15/23 at 3:00 p.m., indicated the resident had a fall on 11/11/23 at 9:00 p.m. The fall was documented by agency staff.</p> <p>There was no post fall follow-up assessment documented on Resident 32.</p>	F 0684	<p>The community was alleged to be out of compliance by failing to ensure the necessary care and services were provided to a dependent resident related to assistance with dentures daily.</p> <p>I. <u>Specific Corrective Actions:</u> Resident 1 was immediately asked if he/she wanted to wear the dentures and a care plan was put in place regarding refusal to wear the dentures.</p> <p>II. <u>Identification and correction of others:</u> All residents with dentures were reviewed for care plans related to wearing of their dentures.</p> <p>III. <u>Systemic Changes:</u> Nursing staff were educated on updating care plans for refusals and resident's rights. C.N.A.s were educated to report refusals to the nurse.</p> <p>IV. <u>Monitoring:</u> An audit of denture care plans will be completed by the SS Manager/designee weekly for 4 weeks, then monthly for at least 5 months or until substantial compliance. The SS Manager/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. [Attachment: Denture Care Plan CQI & QA Tracking Log]</p>	01/12/2024

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F 0695 SS=D Bldg. 00	<p>Interview with the DON on 11/15/23 at 3:32 p.m., indicated the resident did have a fall on 11/11/23 at 9:00 p.m. The fall was documented by agency staff. Documentation indicated the physician was notified. No fall follow-up assessment was completed. There should have been a fall follow-up completed.</p> <p>A facility policy, titled, "Post Fall Assessment Policy" and received as current from the DON on 11/20/23, indicated, "... After a Fall ... Observe for delayed complications of a fall for approximately forty-eight [48] hours after an observed or suspected fall, and will document findings in the medical record"</p> <p>3.1-37(a)</p> <p>483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident received the proper care and treatment for respiratory services related to an empty oxygen humidifier bottle and oxygen tubing not changed as ordered for 1 of 1 residents reviewed for respiratory care. (Resident 20)</p>	F 0695	F 695 The community was alleged to be out of compliance by failing to ensure a resident received the proper care and treatment for respiratory services related to an empty oxygen humidifier bottle and oxygen tubing not changed as ordered.	01/12/2024

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F 0756 SS=D	<p>Finding includes:</p> <p>On 11/15/23 at 2:19 p.m. and 11/16/23 at 2:40 p.m., Resident 20 was observed in her bed. Her oxygen concentrator was on, the nasal cannula in place and flowing at 2 liters per minute. The nasal cannula tubing was connected to the humidifier bottle on the concentrator. The humidifier bottle was empty and the date on the tubing was 11/8.</p> <p>The resident's record was reviewed on 11/16/23 at 2:20 p.m. Diagnoses included, but were not limited to, dementia, heart failure and chronic obstructive pulmonary disease. She resided on the memory care unit.</p> <p>The Quarterly Minimum Data Set assessment, dated 10/11/23, indicated the resident was severely cognitively impaired and required extensive staff assistance for bed mobility, transfers and toileting. She used oxygen while in the facility.</p> <p>The current Physician's Orders indicated to change respiratory equipment, oxygen tubing, humidifier (water bottle) weekly.</p> <p>The November 2023 Treatment Administration Record indicated the respiratory equipment had been changed on 11/12.</p> <p>Interview with LPN 1 on 11/16/23 at 2:44 p.m., indicated oxygen equipment was supposed to be changed on Sunday nights. She indicated she would change the equipment at that time.</p> <p>3.1-47(a)(6)</p> <p>483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act</p>		<p>I. <u>Specific Corrective Actions:</u> Resident 20 immediately received a new oxygen humidifier bottle and new oxygen tubing.</p> <p>II. <u>Identification and correction of others:</u> All residents on oxygen were checked for full humidifier bottles and tubing changed as ordered.</p> <p>III. <u>Systemic Changes:</u> All nursing staff were educated on changing oxygen humidifier bottles before empty and on changing oxygen tubing as ordered.</p> <p>IV. <u>Monitoring:</u> An audit of oxygen humidifier bottles and oxygen tubing will be completed by the DON/designee weekly for 4 weeks, then monthly for at least 5 months or until substantial compliance. The DON/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. [Attachment: Oxygen disposable equipment CQI & QA Tracking Log]</p>		

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Bldg. 00	<p>On</p> <p>§483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>§483.45(c)(2) This review must include a review of the resident's medical chart.</p> <p>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.</p> <p>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.</p> <p>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.</p> <p>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p> <p>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the</p>			

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	<p>pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.</p> <p>Based on record review and interview, the facility failed to ensure each resident's medication regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being related not following up on pharmacy recommendations in a timely manner for 1 of 5 residents reviewed for unnecessary medications. (Resident 48)</p> <p>Finding includes:</p> <p>Resident 48's record was reviewed on 11/14/23 at 11:56 a.m. The resident was admitted to the facility on 6/14/23. Diagnoses included, but were not limited to, dementia, anxiety and depression. The resident resided on the memory care unit.</p> <p>The Quarterly Minimum Data Set assessment, dated 9/5/23, indicated the resident required limited staff assistance for bed mobility, transfers and eating, and extensive staff assist for toileting.</p> <p>Current Physician's Orders included Pantoprazole (a proton pump inhibitor used to treat acid reflux) 40 milligrams (mg) daily for gastric problem and Sertraline (an antidepressant) 50 mg daily for dementia.</p> <p>A Consultant Pharmacist Communication to Nursing form, dated 6/30/23, indicated to clarify the diagnoses for Sertraline as dementia without behaviors was not an appropriate diagnosis.</p> <p>A Consultant Pharmacist Communication to Physician form, dated 8/24/23, recommended to discontinue Pantoprazole 40 mg daily due to</p>	F 0756	<p>The community was alleged to be out of compliance by failing to ensure each resident's medication regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical and psychosocial well-being related to not following up on pharmacy recommendations in a timely manner.</p> <p>I. <u>Specific Corrective Actions:</u> Resident 48's medication regimen was clarified by the DON regarding a change in diagnosis. The NP declined to discontinue the medication due to a diagnosis of GI Bleed.</p> <p>II. <u>Identification and correction of others:</u> There were no other residents found with unresolved pharmacy recommendations.</p> <p>III. <u>Systemic Changes:</u> Licensed nursing staff and the NP were educated on appropriate follow-through on pharmacy recommendations.</p> <p>IV. <u>Monitoring:</u> An audit of pharmacy recommendations will be completed by the DON/designee weekly for 4 weeks, then monthly for at least 5 months or until substantial compliance. The DON/designee will report findings to QAPI committee monthly for</p>	01/12/2024

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F 0757 SS=D Bldg. 00	<p>adverse effects from long term use, and to consider using Tums instead if acid suppression was still needed.</p> <p>There was no indication the Communication forms had been reviewed or recommendations were accepted or declined.</p> <p>Interview with the Director of Nursing, on 11/17/23 at 1:35 p.m., indicated the diagnosis for Sertraline had been changed on 11/13/23 to anxiety and depression. This was almost five months after the recommendation was made.</p> <p>Telephone interview with the Nurse Practitioner on 11/17/23 at 1:54 p.m., indicated he recalled seeing the recommendation to discontinue the Pantoprazole, but did not want to discontinue the medication due to the resident's condition. He indicated he had documented her condition in his progress notes, but did not address the recommendation made.</p> <p>3.1-25(i)</p> <p>483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-</p> <p>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or</p> <p>§483.45(d)(2) For excessive duration; or</p> <p>§483.45(d)(3) Without adequate monitoring; or</p>		<p>review, recommendations, and tracking. [Attachment: Pharmacy CQI & QA Tracking Log]</p>	

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	<p>§483.45(d)(4) Without adequate indications for its use; or</p> <p>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>Based on record review and interview, the facility failed to ensure each resident's medication regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being related to not monitoring the pulse prior to medication administration with ordered parameters for 1 of 5 residents reviewed for unnecessary medications. (Resident 24)</p> <p>Finding includes:</p> <p>The record for Resident 24 was reviewed on 11/14/23 at 2:00 p.m. Diagnoses included, but were not limited to, hypertension, dementia, and hyperlipidemia.</p> <p>The Admission Minimum Data Set assessment, dated 10/31/23, indicated the resident was cognitively impaired.</p> <p>The Physician's Order Summary, dated 11/2023, indicated an order for metoprolol succinate ER (extended release) (an antihypertensive medication) 50 mg (milligrams) daily. Hold if heart rate less than 60 or blood pressure less than 100/50.</p> <p>The Medication Administration Record (MAR),</p>	F 0757	<p>The community was alleged to be out of compliance by failing to ensure each resident's medication regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical and psychosocial well-being related to not monitoring the pulse prior to medication administration with ordered parameters.</p> <p>I. <u>Specific Corrective Actions:</u> Resident 24's medication order was updated to include heart rate monitoring documentation. Team member was educated to include monitoring for certain medications.</p> <p>II. <u>Identification and correction of others:</u> An audit was completed of resident's medication administration records to ensure medications requiring monitoring had orders to monitor in place. No other residents deficiencies were identified.</p> <p>III. <u>Systemic Changes:</u> All licensed nursing staff were educated to ensure monitoring</p>	01/12/2024
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F 0812 SS=F Bldg. 00	<p>dated 11/2023, indicated the resident's blood pressure was documented prior to the administration of the metoprolol medication. There was lack of any documentation the heart rate had been monitored.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 11/14/23 at 3:38 p.m., indicated she had been able to obtain some heart rate monitoring from the vital signs section of the chart, however, the readings were not consistent with the medication administration time and multiple days were missing. The medication order had been recently changed and it had not been put in the computer system correctly to include the heart rate monitoring documentation.</p> <p>3.1-48(a)(1)</p> <p>483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.</p>		<p>orders were entered for medications that require monitoring.</p> <p>IV. Monitoring: An audit of eMARs for ordered parameters being followed will be conducted by the DON/designee weekly for 4 weeks and monthly for 5 months or until substantial compliance. May continue another 5 months if ongoing concerns are noted. Results will be reviewed during the monthly QAPI Meetings. [Attachment: Medication Parameters CQI Audit Tool & QA Tracking Log]</p>	

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F 0839 SS=D	<p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>Based on observation and interview, the facility failed to ensure a sanitary kitchen related to built up burnt food debris and grease in 2 ovens for 1 of 1 kitchens observed (Main Kitchen). This had the potential to affect 54 residents who received food from the kitchen.</p> <p>Finding includes:</p> <p>The initial kitchen tour was completed on 11/13/23 at 9:07 a.m. The inside of 2 ovens had an accumulation of built up burnt food debris and grease.</p> <p>Interview with Cook 1 on 11/13/23 at 9:18 a.m., indicated the ovens were supposed to be cleaned weekly and dig not appear to be cleaned for "awhile".</p> <p>Interview with the Dietary Manager on 11/17/23 at 11:09 a.m., indicated the ovens should be cleaned at least weekly.</p> <p>3.1-21(i)(3)</p> <p>483.70(f)(1)(2) Staff Qualifications</p>	F 0812	<p>The facility was alleged to be out of compliance by failing to ensure a sanitary kitchen related to built up burnt food debris and grease in 2 ovens for 1 of 1 kitchens observed.</p> <p>I. <u>Specific Corrective Actions:</u> The built up burnt food debris and grease was immediately cleaned from the 2 ovens in the kitchen. Dietary staff were educated regarding cleaning of the oven.</p> <p>II. <u>Identification and correction of others:</u> There are no other ovens used to prepare food.</p> <p>III. <u>Systemic Changes:</u> Dietary staff were immediately educated on infection control related to burnt food debris and grease in the ovens in the kitchen.</p> <p>IV. <u>Monitoring:</u> An audit of the ovens will be conducted by the Dietary Manager/designee weekly for 4 weeks and monthly for 5 months or until substantial compliance. May continue another 6 months if ongoing concerns are noted. Results will be reviewed during the monthly QAPI Meetings. [Attachment: Oven CQI Audit Tool & QA Tracking Log]</p>	01/12/2024
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Bldg. 00	<p>§483.70(f) Staff qualifications.</p> <p>§483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.</p> <p>§483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. Based on interview and record review, the facility failed to ensure a staff member who worked in the facility as a Registered Nurse had an active license. This had the potential to affect all 54 residents who resided in the facility.</p> <p>Finding includes:</p> <p>The employee files were reviewed on 11/17/23 at 9:22 a.m.</p> <p>RN 2 was hired into the facility as a Registered Nurse on 10/18/23. The nurse's license expired on 10/31/23.</p> <p>Interview with the HR Director on 11/17/23 at 10:24 a.m., indicated the last time RN 2 worked in the facility as a Registered Nurse was 11/16/23. The nurse would be taken off the schedule until her license was renewed.</p> <p>3.1-14(s)</p>	F 0839	<p>The community was alleged to be out of compliance by failing to ensure a staff member who worked in the facility as a Registered Nurse had an active license.</p> <p>I. Specific Corrective Actions: The nurse, RN2, was immediately taken off the schedule until her license could be renewed. The nurse was educated to ensure her licensure remained active while working. HR was educated to ensure licensure is all licensed staff is up to date.</p> <p>II. Identification and correction of others: There were no other nurses with expired licenses working in the facility.</p> <p>III. Systemic Changes: HR was educated on tracking licenses for licensed staff. Nursing staff was educated on the maintenance of licensure.</p> <p>IV. Monitoring: An audit of nurse licenses will be completed by the HR Director/designee weekly for 4 weeks, then monthly for at least 5 months or until substantial</p>	01/12/2024

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F 0880 SS=D Bldg. 00	<p>483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or</p>		<p>compliance. The HR Director/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. [Attachment: Nurse License CQI & QA Tracking Log]</p>	

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	<p>infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.</p>			

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	<p>Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented related to a lancet disposed of improperly for a random observation during a blood sugar check. (Resident 107)</p> <p>Finding includes:</p> <p>On 11/16/23 at 11:21 a.m., RN 3 assessed Resident 107's blood sugar levels. RN 3 sterilized her hands and took the glucometer out of the bag. RN 3 applied gloves, cleaned the residents finger, and pricked the finger to obtain the blood sample. The resident's blood sugar was 190. The RN took off her gloves and threw them, including the lancet, into the garbage can in the resident's room. The RN proceeded to walk out of the resident's room into the hallway.</p> <p>Interview with the RN on 11/16/23 at 11:28 a.m., indicated she thought she put the lancet in the sharps container. The surveyor informed the RN that she put the lancet in her gloves and threw it in the trash can in the resident's room. The RN indicated she believed she did put the lancet in the garbage can inside her glove on accident, but she knew the lancet belonged in the sharps container.</p> <p>Interview with Director of Nursing (DON) on 11/16/23 at 3:15 p.m., indicated the lancet should have been placed in the sharps container and not the resident's trash can. The DON provided documentation of an in-service for RN 3 regarding the proper disposal of sharps.</p> <p>3.1-18(a)</p>	F 0880	<p>The community was alleged to be out of compliance by failing to ensure infection control guidelines were in place and implemented related to a lancet disposed of improperly for a random observation during a blood sugar check.</p> <p>Specific Corrective Actions: RN 3 was immediately educated on the proper disposal of the lancet in a sharp's container and the lancet was retrieved and placed in the proper container.</p> <p>II. Identification and correction of others: No other improper disposal of lancets was observed.</p> <p>III. Systemic Changes: All licensed nursing staff will be re-educated on the proper disposal of a lancet.</p> <p>IV. Monitoring: A random observation of blood sugar checks for proper disposal of lancets will be completed by the DON/designee weekly for 4 weeks, then monthly for at least 5 months or until substantial compliance. The DON/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. [Attachment: Lancet CQI & QA Tracking Log]</p>	01/12/2024	

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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey.</p> <p>Survey dates: November 13, 14, 15, 16, 17 and 20, 2023.</p> <p>Facility number: 010823</p> <p>Residential Census: 33</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on 11/28/23.</p>	R 0000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>Oak Grove Christian Retirement Village desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on January 12, 2024. The facility respectfully requests paper compliance. Please accept the attached as our credible allegation of compliance.</p>	
R 0215 Bldg. 00	<p>410 IAC 16.2-5-2(b) Evaluation - Deficiency</p> <p>(b) The preadmission evaluation (interview) shall provide the baseline information for the initial evaluation. Subsequent evaluations shall compare the resident ' s current status to his or her status on admission and shall be used to assure that the care the resident requires is within the range of personal care and supervision provided by a residential care facility.</p> <p>Based on record review and interview, the facility failed to complete a Pre-Admission Evaluation for 1 of 7 residents reviewed. (Resident 8)</p>	R 0215	<p>The community was alleged to be out of compliance by failing to complete a Pre-Admission</p>	01/12/2024

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R 0216 Bldg. 00	<p>Finding includes:</p> <p>Closed record review for Resident 8 was completed on 11/17/23 at 2:36 p.m. Diagnoses included, but were not limited to, hypertension and hypothyroidism. The resident was admitted to the facility on 8/1/23 and discharged on 10/6/23.</p> <p>There was a lack of documentation that a Pre-Admission Evaluation had been completed prior to the resident being admitted to the facility.</p> <p>Interview with the DON and ADON on 11/20/23 at 3:00 p.m., indicated they were unable to provide any further information.</p> <p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living.</p>		<p>Evaluation.</p> <p>Specific Corrective Actions: Resident 8's Admission Evaluation was completed.</p> <p>II. Identification and correction of others: All Residents' records were reviewed to make sure a Pre-Admission Evaluation was present.</p> <p>III. Systemic Changes: Nursing Leadership was educated on the necessity for a Pre-Admission Evaluation.</p> <p>IV. Monitoring: An audit of AL admissions will be completed by Medical Records/designee weekly for 4 weeks, then monthly for at least 5 months or until substantial compliance. Medical Records/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. [Attachment: AL Admissions CQI & QA Tracking Log]</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155667	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/20/2023
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NAME OF PROVIDER OR SUPPLIER OAK GROVE CHRISTIAN RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP COD 221 W DIVISION ST DEMOTTE, IN 46310
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	<p>(3) The resident ' s weight taken on admission and semiannually thereafter.</p> <p>(4) If applicable, the resident ' s ability to self-administer medications.</p> <p>(d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on record review and interview, the facility failed to ensure resident weights were obtained semi-annually for 2 of 7 records reviewed (Residents 5 and 6). The facility also failed to ensure self medication assessments were completed for 1 of 7 records reviewed (Resident 2) and semi-annual evaluations were completed for 2 of 7 records reviewed. (Residents 7 and 8)</p> <p>Findings include:</p> <p>1. Resident 5's record was reviewed on 11/17/23 at 2:40 p.m. Diagnoses included, but were not limited to, Diabetes Mellitus and muscle weakness. The resident was admitted to the facility on 9/15/20.</p> <p>The last recorded weight was 8/31/21.</p> <p>2. Resident 6's record was reviewed on 11/20/23. Diagnoses included, but were not limited to, heart failure, muscle weakness and anemia. The resident was admitted to the facility on 2/9/17.</p> <p>The last recorded weight was 1/13/23.</p> <p>Interview with the Director of Nursing (DON), on 11/20/23 at 1:12 p.m., indicated weights were checked according to Physician's orders.</p> <p>The current "Weight Management Policy" was received from the DON and indicated, "...4. AL (assisted living) residents will be weighed upon admission and semi-annually and: a. Per MD</p>	R 0216	<p>The community was alleged to be out of compliance by failing to obtain resident weights semi-annually, failing to complete self-medication assessments and semi-annual evaluations.</p> <p>Specific Corrective Actions: Residents' 5 and 6 weights were obtained. Resident 2's self-medication assessment was completed, and Residents' 7 and 8 semi-annual evaluations was completed.</p> <p>II. Identification and correction of others: All Residents' records were reviewed to make sure weights, self-medication assessments if applicable, and semi-annual evaluations were completed.</p> <p>III. Systemic Changes: Nursing Leadership was educated on the necessity for completion of weights, self-medication assessments (when applicable) and semi-annual evaluations are done for all residents.</p> <p>IV. Monitoring: An audit of AL weights, self-medication assessments (when applicable) and semi-annual evaluations will be completed by Medical Records/designee weekly</p>	01/12/2024

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	<p>orders or as clinically indicated...." 3. Record review for Resident 2 was completed on 11/17/23 at 1:19 p.m. Diagnoses included, but were not limited to, hypertension and hyperlipidemia. The resident was admitted to the facility on 4/25/23.</p> <p>There was no service plan available for review. A list provided by the facility indicated the resident self-administered medication.</p> <p>The Physician's Order Summary, dated 11/2023, indicated an order for Biofreeze (a topical pain medication) 4% topical gel every 4 hours as needed for pain. May keep at bedside. There was a lack of any orders for the self-administration of the topical medication.</p> <p>There was a lack of any self-administration of medication assessment completed.</p> <p>Interview with the DON and ADON on 11/20/23 at 3:00 p.m., indicated they were unable to provide any further information.</p> <p>4. Closed record review for Resident 7 was completed on 11/20/23 at 10:27 a.m. Diagnoses included, but were not limited to, hypertension and hyperlipidemia. The resident was admitted to the facility on 7/17/23.</p> <p>There was a lack of any admission assessment or semi-annual evaluation completed.</p> <p>Interview with the DON and ADON on 11/20/23 at 3:00 p.m., indicated they were unable to provide any further information.</p> <p>5. Closed record review for Resident 8 was completed on 11/17/23 at 2:36 p.m. Diagnoses included, but were not limited to, hypertension</p>		<p>for 4 weeks, then monthly for at least 5 months or until substantial compliance. Medical Records/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. [Attachment: AL weights, self-medication assessments (when applicable) and semi-annual evaluations CQI & QA Tracking Log]</p>	

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R 0217 Bldg. 00	<p>and hypothyroidism. The resident was admitted to the facility on 8/1/23 and discharged on 10/6/23.</p> <p>There was a lack of any admission assessment or semi-annual evaluation completed.</p> <p>Interview with the DON and ADON on 11/20/23 at 3:00 p.m., indicated they were unable to provide any further information.</p> <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires may change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be</p>			

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	<p>involved in identification and documentation of the services to be provided.</p> <p>Based on record review and interview, the facility failed to ensure the Service Plan was completed and signed by the resident and/or their responsible party for 2 of 7 records reviewed. (Resident 2 and 7)</p> <p>Findings include:</p> <p>1. Record review for Resident 2 was completed on 11/17/23 at 1:19 p.m. Diagnoses included, but were not limited to, hypertension and hyperlipidemia. The resident was admitted to the facility on 4/25/23.</p> <p>There was a lack of documentation any service plan had been completed.</p> <p>Interview with the DON and ADON on 11/20/23 at 3:00 p.m., indicated they were unable to provide any further information.</p> <p>2. Closed record review for Resident 7 was completed on 11/20/23 at 10:27 a.m. Diagnoses included, but were not limited to, hypertension and hyperlipidemia. The resident was admitted to the facility on 7/17/23.</p> <p>A Service Plan was completed on 7/14/23. There was a lack of documentation the service plan had been provided to and signed by the resident.</p> <p>Interview with the DON and ADON on 11/20/23 at 3:00 p.m., indicated they were unable to provide any further information.</p>	R 0217	<p>The community was alleged to be out of compliance by failing to ensure that the Service Plan was completed and signed by the resident and/or their responsible party.</p> <p>Specific Corrective Actions: Signatures were obtained by resident 2 and 7 or their responsible party on their Service Plan.</p> <p>II. Identification and correction of others: All Residents' records were reviewed to make sure Service Plans have been signed by the resident and/or their responsible party.</p> <p>III. Systemic Changes: Nursing Leadership was educated on the necessity for signatures by the resident and/or their responsible party.</p> <p>IV. Monitoring: An audit of AL Service Plans will be completed by Medical Records/designee weekly for 4 weeks, then monthly for at least 5 months or until substantial compliance. Medical Records/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. [Attachment: AL Service Plan CQI & QA Tracking Log]</p>	01/12/2024

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R 0273 Bldg. 00	<p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure a sanitary kitchen related to built up burnt food debris and grease in 2 ovens for 1 of 1 kitchens observed (Main Kitchen). This had the potential to affect 33 residents who received food from the kitchen.</p> <p>Finding includes:</p> <p>The initial kitchen tour was completed on 11/13/23 at 9:07 a.m. The inside of 2 ovens had an accumulation of built up burnt food debris and grease.</p> <p>Interview with Cook 1 on 11/13/23 at 9:18 a.m., indicated the ovens were supposed to be cleaned weekly and did not appear to be cleaned for "awhile".</p> <p>Interview with the Dietary Manager on 11/17/23 at 11:09 a.m., indicated the ovens should be cleaned at least weekly.</p>	R 0273	<p>The community was alleged to be out of compliance by failing to ensure a sanitary kitchen related to built up burnt food debris and grease in 2 ovens.</p> <p>I. Specific Corrective Actions: Both ovens were immediately cleaned to remove the burnt food debris and grease.</p> <p>II. Identification and correction of others: There are 3 ovens in 1 of 1 main kitchens, all ovens were inspected to ensure they were cleaned.</p> <p>III. Systemic Changes: Dietary staff were educated on the necessity of cleaning any oven he/she uses immediately after finishing cooking the dish.</p> <p>IV. Monitoring: An audit of all ovens will be completed by the Dietary Manager/designee weekly for 4 weeks, then monthly for at least 5 months or until substantial compliance. The Dietary Manager/designee will report findings to the QAPI committee monthly for review, recommendations, and tracking. [Attachment: Oven CQI & QA Tracking Log]</p>	01/12/2024
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R 0298 Bldg. 00	<p>410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days.</p> <p>Based on record review and interview, the facility failed to ensure Pharmacy reviews were completed every 60 days for 3 of 5 residents reviewed whose medication was managed by the facility. (Residents 3, 2 and 8)</p> <p>Findings include:</p> <p>1. Resident 3's record was reviewed on 11/17/23 at 2:40 p.m. Diagnoses included, but were not limited to, Diabetes Mellitus and muscle weakness. The resident was admitted to the facility on 9/15/20.</p> <p>The Consultant Pharmacy Medication Regimen Reviews were provided for 6/19/23 and 8/18/23. There were no additional reviews available.</p> <p>Interview with the DON and ADON on 11/20/23 at 3:00 p.m., indicated they had a call out to the Pharmacist but were unable to provide any further information at this time.2. Record review for Resident 2 was completed on 11/17/23 at 1:19 p.m.</p>	R 0298	<p>The community was alleged to be out of compliance by failing to complete a Pharmacy review every 60 days.</p> <p>Specific Corrective Actions: Residents 3, 2 and 8's Pharmacy reviews were completed.</p> <p>II. Identification and correction of others: All Residents' records were reviewed to ensure that their Pharmacy reviews were completed at least every 60 days.</p> <p>III. Systemic Changes: Nursing Leadership was educated on the necessity for Pharmacy reviews every 60 days.</p> <p>IV. Monitoring: An audit of AL Pharmacy reviews will be completed by Medical Records/designee weekly for 4</p>	01/12/2024
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R 0349 Bldg. 00	<p>Diagnoses included, but were not limited to, hypertension and hyperlipidemia. The resident was admitted to the facility on 4/25/23.</p> <p>The Consultant Pharmacy Medication Regimen Reviews were provided for 6/19/23 and 8/18/23. There was a lack of documentation any pharmacy review had been completed in October 2023.</p> <p>Interview with the DON and ADON on 11/20/23 at 3:00 p.m., indicated they had a call out to the Pharmacist but were unable to provide any further information at this time.</p> <p>3. Closed record review for Resident 8 was completed on 11/17/23 at 2:36 p.m. Diagnoses included, but were not limited to, hypertension and hypothyroidism. The resident was admitted to the facility on 8/1/23 and discharged on 10/6/23.</p> <p>The Consultant Pharmacy Medication Regimen Review was provided for 7/2023, when the resident resided in the healthcare area of the facility.</p> <p>There was a lack of documentation any pharmacy reviews had been completed while the resident resided in the assisted living area of the facility.</p> <p>Interview with the DON and ADON on 11/20/23 at 3:00 p.m., indicated they had a call out to the Pharmacist but were unable to provide any further information at this time.</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that</p>		<p>weeks, then monthly for at least 5 months or until substantial compliance. Medical Records/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. [Attachment: AL Pharmacy Review CQI & QA Tracking Log]</p>	

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	<p>responsibility. The records must be as follows:</p> <ol style="list-style-type: none"> (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. <p>Based on record review and interview, the facility failed to ensure each resident's record was complete and accurate related to no Physician's orders for medications in the the clinical record for 2 of 7 records reviewed. (Residents 6 and 5)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Resident 6's record was reviewed on 11/20/23. Diagnoses included, but were not limited to, heart failure, muscle weakness and anemia. <p>Current Physician's Orders included "resident may self administer medications." There were no orders for medications in the resident's record.</p> <p>On 11/20/23 at 1:40 p.m., the Medical Records Coordinator provided a list of medications dated 5/28/21. She indicated that was the most current list she had and the medication list should be updated if there was a change.</p> <p>Interview with the Director of Nursing (DON), on 11/20/23 at 1:12 p.m., indicated the resident self administered her medications. She provided a list of medications, dated 1/13/23, and indicated that was the most current list she had. 2. Record review for Resident 5 was completed on 11/11/23 at 10:20 a.m. Diagnoses included but were not limited to, hypertension and anemia.</p> <p>The November 2023 Physician's Order Summary (POS) indicated the resident may self administer their own medications.</p>	R 0349	<p>The community was alleged to be out of compliance by failing to ensure that each resident's record was complete and accurate related to no Physician's orders for medications in the clinical record.</p> <p>Specific Corrective Actions: Resident 6 and 5's records had Physician orders added for their medications.</p> <p>II. Identification and correction of others: All Residents' records were reviewed to ensure Physician orders were present for medications.</p> <p>III. Systemic Changes: Nursing Leadership was educated on the necessity for Physician orders for medications.</p> <p>IV. Monitoring: An audit of AL Physician Orders for medications will be completed by Medical Records/designee weekly for 4 weeks, then monthly for at least 5 months or until substantial compliance. Medical Records/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. [Attachment: AL Physician</p>	01/12/2024
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-039

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	<p>The POS did not include what medications the resident was administering.</p> <p>There was a lack of documentation to indicate what medications the resident was prescribed and was administering.</p> <p>Interview with Medical Records on 11/20/23 at 1:39 p.m., indicated she could not provide documentation the resident had a medication list updated since 9/15/20. The resident was currently taking a medication that was not on the list from 9/15/20.</p>		Orders for Medications CQI & QA Tracking Log]		