

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155471	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/07/2023
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NAME OF PROVIDER OR SUPPLIER FOUR SEASONS RETIREMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 1901 TAYLOR RD COLUMBUS, IN 47203
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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: February 1, 2, 3, 6, and 7, 2023</p> <p>Facility number: 000543 Provider number: 155471</p> <p>Census Bed Type: SNF: 15 NCC: 30 Residential: 119 Total: 164</p> <p>Census Payor Type: Medicare: 15 Other: 30 Total: 45</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on February 9, 2023.</p>	F 0000	<p>Four Seasons Retirement Center is dedicated to providing quality care in a safe environment. This Plan of Correction constitutes the written compliance for the deficiency cited. However, submission of this Plan of Correction shall not constitute an admission, or an agreement that the alleged deficiencies made are accurate. This Plan of Correction is submitted to meet the requirements established by State and Federal law. The Mission of Four Seasons Retirement Center is to enhance the quality of life for older adults within a secure environment which supports their needs, values, interest, and independence while encouraging personal and spiritual development.</p> <p>*Four Seasons requests that compliance with Federal and State rules be determined through paper review.</p>	
F 0689 SS=D Bldg. 00	<p>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</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rebecca Stenner	Executive Director, HFA	03/06/2023

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>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on interview and record review, the facility failed to properly secure a resident's wheelchair during transfer resulting in a fall for 1 of 2 residents reviewed for accidents. (Resident 5)</p> <p>Findings include:</p> <p>During an interview on 02/02/23 at 1:50 P.M., Resident 5's family member indicated he was in the resident's room when she fell a few days ago. A staff member was assisting the resident out of her wheelchair and they forgot to lock the wheelchair brakes. The resident fell to the ground. The resident was wearing a gait belt and the aide stood in front of her, took a hold of the gait belt from the middle of the resident and tried to pull her up from the floor by herself. That didn't work, so the aide went and got help. Another aide came in and the two aides assisted the resident up from the floor and onto the bed. The family member was concerned, because the resident was recovering from a broken back, but she didn't suffer any injuries from the fall.</p> <p>The resident's clinical record was reviewed on 02/07/23 at 1:23 P.M. An Admission MDS (Minimum Data Set) assessment, dated 12/08/22, indicated the resident was moderately cognitively impaired. The resident's primary medical condition was a wedge compression fracture, first lumbar vertebra. The additional diagnoses included, but were not limited to, diabetes, hypertension, non-Alzheimer's dementia, and low back pain.</p> <p>The resident's physical therapy orders, dated 01/11/23, indicated the resident may complete</p>	F 0689	<p>Four Seasons Retirement Center is dedicated to providing quality care in a safe environment. This Plan of Correction constitutes the written compliance for the deficiency cited. However, submission of this Plan of Correction shall not constitute an admission, or an agreement that the alleged deficiencies made are accurate. This Plan of Correction is submitted to meet the requirements established by State and Federal law. The Mission of Four Seasons Retirement Center is to enhance the quality of life for older adults within a secure environment which supports their needs, values, interest, and independence while encouraging personal and spiritual development.</p> <p>*Four Seasons requests that compliance with Federal and State rules be determined through paper review.</p> <p>F-689 Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) On 1/31/2023, prior to the Survey, Resident 5 was being assisted out of her wheelchair by a staff member, a nurse aide-in-training, or a Basic Nurse Aide (BNA 4), to</p>	02/24/2023

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	<p>functional transfers with nursing staff using an up-right rollator (rolling walker) with minimal staff assistance.</p> <p>A Progress Note, dated 1/31/2023 at 1:00 P.M., indicated the nurse entered the room and the resident was sitting on the side of the bed being assisted by an aide. The aide reported the resident had been lowered to the floor while being transferred and was not injured. The resident was alert, in good spirits, and wearing a gait belt. The resident denied pain and no injuries were observed.</p> <p>A Progress Note, dated 2/1/2023 at 9:15 A.M., indicated the Interdisciplinary Team met to discuss the fall on 1/31/2023. The resident's wheelchair was not locked when the transfer occurred. The resident was lowered to the floor by staff and was assessed by nursing with no injuries or complaints. The staff member was re-educated.</p> <p>During a telephone interview on 02/07/23 at 9:47 A.M., BNA (Basic Nurse Aide) 4 indicated on the day of the incident, the resident was in her wheelchair and wanted to lay down in bed. She placed the resident's walker in front of the resident and placed a gait belt on the resident. She forgot to lock the wheelchair, and as the resident began to rise, she placed her hands on the wheelchair to push herself up. The wheelchair rolled back. The aide had a hold of the resident, so she lowered her to the ground. Another aide assisted her in getting the resident off the floor and onto the bed.</p> <p>The current facility policy, with a revision date of April 2018, and titled "FALLS, MANAGEMENT AND PREVENTION OF", was provided by the Director of Nursing on 02/07/23, at 12:47 P.M. The</p>		<p>transfer to her walker, and to her bed. During the transfer, Resident 5 was rising from the wheelchair and pushing down on the arms of the chair when the wheelchair moved due to not being properly locked. BNA 4 was assisting the transfer, with a gait belt, and as Resident 5 was losing balance, BNA 4 decided to lower Resident 5 to the floor, for safety. A second aide was called, and Resident 5 was safely transferred to the bed. Resident 5 was immediately assessed by licensed nursing personnel and was found to have no complaints or injuries. No injury occurred.</p> <p>Four Seasons has Certified Nursing Assistant (CNA) training that occurs on site, and BNA 4 was a CNA trainee. At the conclusion of their education and training program, these employees are tested and certified as CNAs. BNA 4 was immediately counseled (on 1/31/2023) by senior staff after the incident occurred.</p> <p>This was an isolated incident; all nursing personnel are aware that wheelchairs are to be locked when making any transfer with a resident. Over the following shifts and days, Four Seasons Supervisors performed random checks with nursing staff to ensure that the appropriate policy and procedures were being followed (Attachment A). All staff</p>	

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	<p>policy indicated, "...It is the responsibility of all staff to...providing a safe environment for residents...identify risk factors for falls and to act upon those risk factors by implementing appropriate, individualized fall prevention..."</p> <p>3.1-45(a)(2)</p>		<p>monitored performed return demonstrations correctly. Written education was provided to BNA 4. A Relias in-service was assigned to all staff providing care to residents for safe transfers. On-going education will occur at monthly staff meetings and in-service trainings.</p> <p>Plan of Correction:</p> <p>Q1: What corrective action(s) will be accomplished for the resident found to have been affected by the deficient practice? A: BNA 4 was immediately re-educated on 1/31/2023 regarding locking wheelchairs before any transfer. Relias in-service training was assigned and completed on 2/21/2023 by BNA 4 (Attachments B and C), and in addition a skills validation checklist was administered. (Attachment D)</p> <p>Q2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. A: Any resident who utilizes a wheelchair has the potential to be affected by this deficient practice. Although this was an isolated incident, as an extra precaution, a Relias in-service was assigned to all staff (Attachment C) providing care to residents for safe transfers</p>	

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			<p>for the month of February. On-going education will occur at monthly staff meetings/in-services going forward.</p> <p>Q3: Actions taken/systems put into place to reduce the risk of future occurrence include: A: Nursing supervisors or designees will perform random monitoring of staff transferring a resident out of or to a wheelchair weekly for the first quarter, monthly for the next quarter, then quarterly for the next two quarters to ensure that facility policy and procedure are followed. If at any time it is deemed necessary, if staff are not consistently (100%) following policy and procedures, then monitoring will be increased.</p> <p>Q4: How the corrective action(s) will be monitored to ensure the practice will not recur? A: Results of monitoring performed by the Nursing Supervisors or designees will be incorporated into a report and will be reported on at the Quarterly QAPI meetings for up to one year if needed. Continuing reporting of results will be based on how long the visual audits are needed. The criteria for continuing the corrective actions will be results that show less than 100% compliance with facility policy and procedures.</p> <p>Q5: By what date will the</p>	

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F 0755 SS=D Bldg. 00	<p>483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p>		<p>systemic changes for each deficiency will be completed? A: Re-education for BNA 4 was completed on 1/31/2023. (Attachment A) Additional education was completed by BNA 4 on 2/21/2023. (Attachment B) All systemic changes will be initiated by 2/24/23, and completed within the projected time frames above.</p>	

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	<p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Based on observation and interview, the facility failed to administer medications appropriately for 1 of 9 residents reviewed for medication administration. (Resident 6)</p> <p>Findings include:</p> <p>During an observation and interview of medication administration on 02/03/23 at 8:57 A.M., RN 3 prepared the following medications for Resident 6 by placing them in a medication cup:</p> <ul style="list-style-type: none"> - Aspirin 81 mg (milligrams), 1 tablet - buspirone 15 mg, 1 tablet - Cetirizine 10 mg, 1 tablet - Lasix 20 mg, 1 tablet - Daliresp 500 micrograms, 1 tablet, and <p>At approximately 8:59 A.M., RN 3 took the cup of medications and a glass of water into Resident 6's room. She handed the medication cup to the resident. The resident tipped the medication cup into her mouth. The resident sat the medication cup on her breakfast tray. The medication cup still contained one pill. The nurse gave the resident her water glass and the resident swallowed the medications she had in her mouth. The resident administered 1 puff of her inhaler and rinsed her mouth. The nurse was leaving the resident's room when she was stopped by the surveyor and alerted that there was still a pill in the medication</p>	F 0755	<p>Four Seasons Retirement Center is dedicated to providing quality care in a safe environment. This Plan of Correction constitutes the written compliance for the deficiency cited. However, submission of this Plan of Correction shall not constitute an admission, or an agreement that the alleged deficiencies made are accurate. This Plan of Correction is submitted to meet the requirements established by State and Federal law. The Mission of Four Seasons Retirement Center is to enhance the quality of life for older adults within a secure environment which supports their needs, values, interest, and independence while encouraging personal and spiritual development.</p> <p>*Four Seasons requests that compliance with Federal and State rules be determined through paper review.</p> <p>F-755 Pharmacy Services/Procedures/Pharmacist/Records</p>	02/24/2023

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	<p>cup. The kitchen staff were in the vicinity picking up breakfast trays. The nurse went back to the resident and administered the pill. RN 3 indicated the resident would not have received the pill if she had not been alerted.</p> <p>The current facility policy titled, "Medication Administration", with a revised date of 2/12/2019, was provided by the DON (Director of Nursing) on 02/07/23 at 2:47 P.M. The policy indicated, "...Observe resident consumption of medication..."</p> <p>The current facility policy titled, "Medication Administration-General Guidelines" with an effective date of January 2007, was provided by Medical Records on 02/07/23 at 1:36 P.M. The policy indicated, "...The resident is always observed after administration to ensure that the dose was completely ingested..."</p> <p>3.1-25(b)</p>		<p>CFR(s) 483.45(a)(b)(1)-(3) On 2/3/2023 Staff Member Registered Nurse 3 (RN 3) was observed administering medication to Resident 6. RN 3 gave Resident 6 her medication in a pill cup (5 tablets in total) and watched Resident 6 tip the cup into her mouth and take medications. Resident 6 then placed the medication cup on her meal tray. RN 3 was leaving Resident 6's room when stopped by surveyor and notified that there was still a pill left in the medication cup. At that time RN 3 then promptly administered the one remaining tablet to Resident 6. RN 3 reported on the incident to the Director of Nursing, and was immediately counseled and re-educated on proper medication administration policies, procedures, and practices, on 2/3/2023.</p> <p>Plan of Correction:</p> <p>1: What corrective action(s) will be accomplished for the resident found to have been affected by the deficient practice? A: RN 3 was immediately re-educated on 2/3/2023 regarding steps to take to ensure that a resident has consumed all medications in a medication cup when administering. (Attachment E)</p>	

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			<p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions (s) will be taken. A: All Residents who receive medication have the potential to be affected by the deficient practice. Although this was an isolated incident, all Licensed and Qualified staff who administer medications were re-educated on proper Medication Administration on 2/22/2023 during a mandatory in-service. (Attachment F) On-going Medication Administration education will occur at monthly staff meetings and in-services for the next calendar year.</p> <p>3: Actions taken/systems put into place to reduce the risk of future occurrence include: A: Nursing supervisors or their designees will perform random medication administration observations and audits weekly for the first quarter, monthly for the next quarter, then quarterly for the next two quarters, to ensure that facility policy and procedure are followed. If at any time it is deemed necessary, monitoring will be increased to prior higher levels.</p> <p>4: How the corrective action(s) will be monitored to ensure the practice will not recur?</p>	

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F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. Based on observation, interview, and record	F 0770	A: Results of monitoring performed by the Nursing Supervisors or designees will be incorporated into regular reports and will be reported on and discussed at the Quarterly QAPI meetings for up to one year if needed. Results reporting will be based on how long the visual audits are needed. The criteria for continuation of the visual audits will any results that indicate less than 100% compliance with the facility's policies and procedures. 5: By what date will the systemic changes for each deficiency be completed? A: Re-education for all Licensed and Qualified Staff who administer medications was completed on 2/22/2023. (Attachments F and G) All systemic changes will be initiated by 2/24/23, and completed within the projected time frames above.	02/24/2023

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	<p>review, the facility failed to follow physician orders related to laboratory services for 1 of 9 residents reviewed. (Resident 65)</p> <p>Findings include:</p> <p>During an observation on 02/06/23 at 9:50 A.M., Resident 65 was sitting in a chair in her room. The call light was in reach and had no concerns.</p> <p>The clinical record for Resident 65 was reviewed on 02/06/23 at 1:37 P.M. An Admission MDS (Minimum Data Set) assessment, dated 01/18/23, indicated the resident was moderately cognitively impaired. The active diagnoses included, but were not limited to, fractures, anemia, hypertension, renal insufficiency, UTI (Urinary Tract Infection) in the last 30 days, hyponatremia, thyroid disorder, and malnutrition.</p> <p>A current physician's order, dated 02/02/23, indicated the resident was to have a recheck of a CBC (Complete Blood Count) and CMP (Comprehensive Metabolic Panel) on 02/06/23.</p> <p>The clinical record lacked indication that the laboratory services were completed on 02/06/23.</p> <p>During an interview on 02/07/23 at 10:25 A.M., RN 3 indicated the resident was admitted to the facility following a fracture. The resident had some subcutaneous fluids for a day last week for an elevated BUN and creatine. When a physician would order labs, the nurse would input them into the clinical record and then input them into the laboratory company web site for when they needed to be completed. The laboratory company came to the facility everyday between 3:00 A.M. and 5:00 A.M.</p>		<p>is dedicated to providing quality care in a safe environment. This Plan of Correction constitutes the written compliance for the deficiency cited. However, submission of this Plan of Correction shall not constitute an admission, or an agreement that the alleged deficiencies made are accurate. This Plan of Correction is submitted to meet the requirements established by State and Federal law. The Mission of Four Seasons Retirement Center is to enhance the quality of life for older adults within a secure environment which supports their needs, values, interest, and independence while encouraging personal and spiritual development.</p> <p>*Four Seasons requests that compliance with Federal and State rules be determined through paper review.</p> <p>F-770 Laboratory Services CFR(s): 483.50(a)(1)(i) Laboratory Services were ordered on Resident 65 to be completed on 2/6/2023. These lab orders were entered into the facility electronic medical record (EMR) system as a physician's order as appropriate. At the same time, the laboratory order should have also been entered into the facility "Med Lab System" to alert the laboratory services vendor that the</p>	

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	<p>During an interview on 02/07/23 at 1:05 P.M., the DON (Director of Nursing) indicated the residents labs were due on the 6th and didn't get completed and should have.</p> <p>During an interview on 02/07/23 at 2:21 P.M., Medical Records indicated the resident's labs for the CBC and CMP were ordered in 02/03/23 and had never been inputted into the laboratory companies system to be completed.</p> <p>The current facility policy titled, "SCHEDULING AND TRACKING LABS POLICY" with a revised date of 06/21/2019, was provided by Admissions Coordinator on 02/07/23 at 2:09 P.M. The policy indicated, "...Laboratory orders will be entered into PCC on the computer...The Laboratory requisition in the Med Lab computer program must be completed by the nurse taking off the order..."</p> <p>3.1-25(b)</p>		<p>laboratory technician had orders for Resident 65 on 2/6/2023. However, the laboratory order was not entered into the Med Lab System resulting in the laboratory service not being informed that a lab draw would be needed for Resident 65.</p> <p>Plan of Correction:</p> <p>1: What corrective action(s) will be accomplished for the resident found to have been affected by the deficient practice? A: Resident 65 was sent to the hospital to be evaluated. A mandatory education/in-service for all Licensed Nursing Staff Members occurred on 2/22/2023. (Attachments F and H)</p> <p>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. A: All residents have the potential to be affected by this deficient practice. Although this was an isolated incident a mandatory education/in-service occurred on 2/22/2023 for Licensed Nursing Staff Members. (Attachment F) On-going education will occur at monthly staff meetings/in-services.</p> <p>3: Actions taken/systems put into place to reduce the risk of future</p>	

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			<p>occurrence include:</p> <p>A: Medical Records or designees will complete daily audits on all orders to review if any laboratory orders were acquired. If orders for any laboratory services are present then Medical Records or designee will ensure that the orders were also entered into the Med Lab System and place on the individual residents Treatment Administration Record for the date that the laboratory service is to occur. These audits will If at any time it is deemed necessary monitoring will be increased. (Attachment I)</p> <p>4: How the corrective action(s) will be monitored to ensure the practice will not recur? A: Results of completed audits performed by Medical Records or designee will be incorporated into a report and will be reported as a Performance Improvement Project (PIP) at the Quarterly QAPI meetings for up to one year if needed. The criteria for discontinuation of the audits will be 100% compliance with facility policies and procedures consistently over a period of 6 months.</p> <p>5: By what date will the systemic changes for each deficiency be completed? A: A mandatory education/in-service occurred on</p>	

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F 0776 SS=D Bldg. 00	<p>483.50(b)(1)(i)(ii) Radiology/Other Diagnostic Services §483.50(b) Radiology and other diagnostic services.</p> <p>§483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>(i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter.</p> <p>(ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.</p> <p>Based on observation, interview, and record review, the facility failed to follow physician orders for a STAT chest X-ray in a timely manner for 2 of 9 residents reviewed. (Residents 65 and 5)</p> <p>Findings include:</p> <p>1. During an observation on 02/06/23 at 9:50 A.M., Resident 65 was sitting in a chair in her room.</p> <p>During an interview on 02/07/23 at 9:34 A.M., the scheduler indicated Resident 65 was being sent to the hospital.</p>	F 0776	<p>2/22/2023 for Licensed Nursing Staff Members. (Attachment G) All systemic changes will be initiated by 2/24/23, and completed within the projected time frames above.</p> <p>Four Seasons Retirement Center is dedicated to providing quality care in a safe environment. This Plan of Correction constitutes the written compliance for the deficiency cited. However, submission of this Plan of Correction shall not constitute an admission, or an agreement that the alleged deficiencies made are accurate. This Plan of Correction is submitted to meet the requirements established by State</p>	02/24/2023

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	<p>The clinical record for Resident 65 was reviewed on 02/06/23 at 1:37 P.M. An Admission MDS (Minimum Data Set) assessment, dated 01/18/23, indicated the resident was moderately cognitively impaired. The active diagnoses included, but were not limited to, fractures, anemia, hypertension, renal insufficiency, UTI (Urinary Tract Infection) in the last 30 days, hyponatremia, thyroid disorder, and malnutrition.</p> <p>A Skilled Evaluation Progress Note, dated 02/06/23 at 4:33 P.M., indicated the resident was having 2+ pitting edema in her bilateral lower extremities that was a new onset. The resident had wheezing in the lungs of her left and right posterior upper lobes on auscultation. A cough was present that was moist, loose, and productive, with a moderate amount of secretions. The resident had been seen by the NP (Nurse Practitioner) with new orders for a STAT (immediately) chest x-ray, ProBNP (B-Type Natriuretic Peptide), and a CMP (Comprehensive Metabolic Panel).</p> <p>A Radiology Order, dated 02/06/23 at 4:28 P.M., indicated the resident was to have a STAT chest x-ray.</p> <p>The clinical record lacked indication that the chest x-ray had been completed before the resident was sent to the local emergency room on 02/07/23 or documentation that the physician had been notified that the chest x-ray was not able to be completed.</p> <p>2. Resident 5's clinical record was reviewed on 02/07/23 at 1:23 P.M. An Admission MDS assessment, dated 12/08/22, indicated the resident was moderately cognitively impaired. The resident's primary medical condition was a wedge</p>		<p>and Federal law. The Mission of Four Seasons Retirement Center is to enhance the quality of life for older adults within a secure environment which supports their needs, values, interest, and independence while encouraging personal and spiritual development.</p> <p>*Four Seasons requests that compliance with Federal and State rules be determined through paper review.</p> <p>F-776 Radiology/Other Diagnostic Services CFR(s): 483.50(b)(1)(i)(ii) Radiology Services for STAT chest X-rays were ordered for both Resident 5 and Resident 65, to be completed on 2/6/2023. The radiology services vendor that Four Seasons utilizes did not respond to the indicated and ordered STAT request on the orders. Resident 65 was sent to the Emergency Department for evaluation on the morning of February 7, 2023. Resident 5 had their X-ray completed on 2/7/2023 at approximately 11:00 am. The physician for both Resident 5 and Resident 65 was notified that the ordered STAT chest X-rays would not be completed until the next day due to the radiology services case load at the time on 2/6/2023. The physician for both</p>	

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	<p>compression fracture, first lumbar vertebra. The additional diagnoses included, but were not limited to, diabetes, hypertension, non-Alzheimer's dementia, and low back pain.</p> <p>A Progress Note, dated 02/06/23 at 6:39 P.M., indicated the resident had been seen by the NP regarding a persistent cough and wheezing. A new physician's order was received for a chest x-ray.</p> <p>A handwritten physician's order, dated 02/06/23, indicated a STAT chest x-ray was to be obtained. The order was signed by the NP, and initialed as "noted" by the nurse.</p> <p>A Radiology Order confirmation document indicated the facility ordered a chest x-ray on 02/06/23 at 4:31 P.M. The priority was listed as "STAT".</p> <p>On 02/07/23 at 2:00 P.M., the resident was observed in bed in her room. The resident indicated she had a chest x-ray around 11:00 A.M. that morning.</p> <p>During an interview on 02/07/23 at 10:44 A.M., the DON (Director of Nursing) indicated that she believed the STAT chest x-rays were not completed because the x-ray company was short staffed.</p> <p>During an interview on 02/07/23 at 1:05 P.M., the DON indicated a night shift nurse had spoken with the x-ray company on the night of 02/06/23 and had indicated they would not be into the building until 02/07/23. The nurse should have documented that she contacted the physician.</p> <p>During an interview on 02/07/23 at 1:46 P.M., RN 3</p>		<p>Resident 5 and Resident 65 informed staff that it was fine to wait until the next day, until 2/7/23. Nursing staff, however, failed to make that notation in each resident's EMR, so it was not in the EMR for the Surveyors to review.</p> <p>Plan of Correction:</p> <p>1. What corrective action(s) will be accomplished for the resident found to have been affected by the deficient practice? A: Resident 65 was sent to the hospital to be evaluated. Resident 5 had the chest X-ray completed on 2/7/2023 at approximately 11:00 am. A mandatory education/in-service occurred on 2/22/2023 for all Licensed Nursing Staff Members. (Attachment F)</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. A: All residents have the potential to be affected by this deficient practice. A mandatory education/in-service occurred on 2/22/2023 for Licensed Nursing Staff Members. (Attachment F) On-going education will occur at monthly staff meetings/in-services for up to one calendar year, if needed, based on results of audits. The criteria for</p>		

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	<p>indicated a STAT chest x-ray should be completed within 4 to 5 hours of getting the order.</p> <p>During an interview on 02/07/23 at 2:25 P.M., RN 3 indicated if the x-ray company was not able to come within the 4-to-5-hour window for a STAT x-ray, she would reassess the resident, call the Nurse Practitioner and see what she would want to do. She would have documented in the progress note the discussion with the x-ray company, and discussion with the Nurse Practitioner. She would also update the family as needed.</p> <p>The current facility policy, titled "Laboratory Services and Reporting", and dated 08/22/22, was provided by the DON on 02/07/23 at 4:03 P.M. The policy indicated, "...The facility must provide or obtain laboratory services when ordered..."</p> <p>The current facility policy, titled "PHYSICIAN and FAMILY NOTIFICATION POLICY", and dated October 1, 2017, was provided by the Admission Coordinator on 02/07/23 at 2:09 P.M. The policy indicated, "...The resident's physician will be notified of the following...all labs..."</p> <p>3.1-49(g)</p>		<p>discontinuing the audits and education will be consistent, 100% compliance with the facility's policies and procedures.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include: A: Medical Records or designees will complete daily audits on all orders to review if any STAT radiology orders were acquired. If orders for any STAT radiology services are present then Medical Records or designee will ensure that the orders were completed in a timely manner or that the nursing staff completed documentation that the physician or designee was notified that there would be a delay. These audits will If at any time it is deemed necessary monitoring will be increased. (Attachment 1)</p> <p>4: How the corrective action(s) will be monitored to ensure the practice will not recur? A: Results of completed audits performed by Medical Records or designee will be incorporated into a report and will be reported as a Performance Improvement Project (PIP) at the Quarterly QAPI meetings for up to one year if needed. The criteria for discontinuing the audits and reporting will be achievement of no discrepancies after 6 months.</p>	

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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: February 1, 2, 3, 6, and 7, 2023</p> <p>Facility number: 000543</p> <p>Residential Census: 119</p> <p>This State Residential Finding is cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on February 9, 2023.</p>	R 0000	<p>5: By what date will the systemic changes for each deficiency be completed? A: A mandatory education/in-service occurred on 2/22/2023 for all Licensed Nursing Staff Members. (Attachment F) All systemic changes will be initiated by 2/24/23, and completed within the projected time frames above.</p> <p>Four Seasons Retirement Center is dedicated to providing quality care in a safe environment. This Plan of Correction constitutes the written compliance for the deficiency cited. However, submission of this Plan of Correction shall not constitute an admission, or an agreement that the alleged deficiencies made are accurate. This Plan of Correction is submitted to meet the requirements established by State and Federal law. The Mission of Four Seasons Retirement Center is to enhance the quality of life for older adults within a secure environment which supports their needs, values, interest, and independence while encouraging personal and spiritual development.</p> <p>*Four Seasons requests that</p>	

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R 0243 Bldg. 00	<p>410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the:</p> <p>(A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment.</p> <p>Based on observation, interview, and record review, the facility failed to follow manufacturer's guidelines for insulin administration for 1 of 5 residents observed during medication administration. (Resident 213)</p> <p>Findings include:</p> <p>Medication administration was observed on 02/02/23 at 10:30 A.M., with LPN (Licensed Practical Nurse) 2. The nurse gathered two insulin pens out of the medication cart for Resident 213. She applied the needles, held the pens sideways, and primed the pens with 2 units each. She turned the knobs of the pens to the prescribed dosages and administered the two insulins. She did not cleanse the tip of the pens with alcohol prior to applying the needles and failed to hold the pens in an upright position when priming.</p> <p>During an interview following the administration of the insulin, LPN 2 indicated insulin pens were primed to expel air, so the resident received the actual dose. The pen should be held with the pen</p>	R 0243	<p>compliance with Federal and State rules be determined through paper review.</p> <p>Four Seasons Retirement Center is dedicated to providing quality care in a safe environment. This Plan of Correction constitutes the written compliance for the deficiency cited. However, submission of this Plan of Correction shall not constitute an admission, or an agreement that the alleged deficiencies made are accurate. This Plan of Correction is submitted to meet the requirements established by State and Federal law. The Mission of Four Seasons Retirement Center is to enhance the quality of life for older adults within a secure environment which supports their needs, values, interest, and independence while encouraging personal and spiritual development.</p> <p>*Four Seasons requests that</p>	02/24/2023
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	<p>pointing upwards when priming the pen.</p> <p>The clinical record for Resident 213 was reviewed on 02/03/23 at 11:38 A.M. The diagnoses included, but were not limited to, diabetes and spinal stenosis.</p> <p>The EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) for February 2023, was provided by Medical Records on 02/07/23 at 2:33 P.M., and included, but was not limited to, the following physician's orders for insulin:</p> <ul style="list-style-type: none"> - Lantus Pen-Injector, inject 8 units subcutaneously one time a day related to type two diabetes, and - Novolog Pen-injector, inject six units subcutaneously one time a day related to type two diabetes, use sliding scale with routine. <p>The Lantus insulin package insert, with a revised date of December 2020, was provided by the Residential Nursing Supervisor on 02/03/23 at 9:35 A.M. The instructions indicated, "...Take off the pen cap...Wipe the Rubber Seal with alcohol...line up the needle with the pen...Performing the safety test ensures that you get an accurate dose by...removing air bubbles...Select a dose of 2 units...Take off the inner needle cap and discard it...Hold the pen with the needle pointing upwards...Tap the insulin reservoir so that any bubbles rise up towards the needle...Press the injection button all the way in. Check if insulin comes out of the needle tip..."</p> <p>The current Novolog package insert, with a revised date of 03/2021, was provided by the Staff Development Coordinator on 02/03/23 at 11:45 A.M. The insert indicated, "Preparing</p>		<p>compliance with Federal and State rules be determined through paper review.</p> <p>R243 410 IAC 16.2-5-4(e)(3) Health Services Deficiency A Surveyor observed LPN 2 improperly administer insulin in the Residential Building when using an Insulin Pen. Four Seasons has policies in place on the proper use of Insulin Pens, and copies of the policies are available in the Residential Building. Existing staff have been educated regarding the proper use of Insulin Pens. As new staff are hired, they are provided with education on how to use Insulin Pens properly. This Plan of Correction will ensure that the deficient practice will not be repeated.</p> <p>Plan of Correction:</p> <p>Q1: What corrective action(s) will be accomplished for the resident found to have been affected by the deficient practice? A: LPN 2, who gave the insulin injection using the Insulin Pen without priming it properly, as witnessed by the state surveyor, was immediately given instruction on the Four Seasons Insulin Pen Policy, and re-educated on the proper procedures and practices. (Attachment 1)</p>	

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	<p>your...pen...Pull off the pen cap...Wipe the rubber stopper with an alcohol swab...Screw the needle tightly onto your...Pen...Before each injection...To avoid injecting air and to ensure proper dosing...Turn the dose selector to select 2 units...Hold your insulin...Pen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge...Keep the needle pointing upwards, press the push-button all the way in...A drop of insulin should appear at the needle tip..."</p> <p>The current Insulin Pen policy, with a revised date of 06/10/21, was provided by the Residential Nursing Supervisor on 02/03/23 at 9:37 A.M. The policy indicated, "...It is the policy of this Four Seasons [sic] to use insulin pens in order to improve the accuracy of insulin doing...Remove the pen cap from the insulin pen...Wipe the rubber seal with an alcohol pad...Screw the pen needle onto the insulin pen...Dial 2 units...With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle..."</p>		<p>Q2: How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) be taken? A: Four Seasons' Clinical Educator worked one-on-one with LPN 2, doing a check off self-demonstration competency checklist. (Attachment 2) LPN 2 passed everything on the checklist and now knows how to prime the insulin pen correctly, and will not be putting other residents at risk. A verbal in-service training was provided by the nurse educator to all Licensed and Qualified staff on the Residential Unit that administer insulin, immediately on the date that the deficient practice occurred, 2/2/2023. (Attachment 3)</p> <p>Q3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? A: An in-service for Licensed and Qualified staff who administer insulin occurred on 2/22/2023. Education was provided on the facility Policy and Procedures, with a return demonstration of the use of an insulin pen. (Attachments 4 and 5)</p> <p>Q4: How will the corrective actions be monitored to ensure the</p>	

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			<p>deficient practice will not recur; For example, what quality assurance program will be put into place? A: Nursing management will monitor the corrective actions with competency checks monthly for 3 months. Results of these checks will be reported on at the Quarterly QAPI Meetings. If additional monitoring is needed, the criteria for which will be less than 100% compliance with facility policies and procedures, then competency checks will continue.</p> <p>Q5: By what date will the systemic changes be completed? A: All systemic changes will be initiated by February 24, 2023, and completed according to the time frames above.</p>	