STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155693	A. BUILDING 00 B. WING	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SILVER OAKS HEALTH CAMPUS	2011 CHAPA STREET COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: April 10, 11, 12, 13, and 14, 2023. Facility number: 002955 Provider number: 155693 AIM number: 200346570 Census Bed Type: SNF/NF: 33 NF: 21 Residential: 32 Total: 86 Census Payor Type: Medicare: 23 Medicaid: 21 Total: 54 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 19, 2023.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey conducted April 14, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of May 01, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure a resident that self-administered medications was appropriately assessed for self-administration for 1 of 5 residents reviewed for medications. (Resident 3)	F 0554	1. Resident #3 was affected by alleged deficient practice. No adverse effects noted. The medications were removed from the resident's room and disposed	05/01/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamela Cole	Executive Director	04/27/2023

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	Findings include: On 04/12/23 at 9:17 A.M., RN 2 was observed at the medication cart a few rooms down from Resident 3's room on the 100 Hall. The RN was actively preparing a resident's medications for administration, and there were several medication cards on top of the cart. Resident 3 was observed in her room on the 100 Hall. The resident was sitting in her chair watching television. A medication cup that contained several unidentified medications was on the resident's overbed table. The nurse was not present. The resident indicated those were her morning medications, the nurse had just left them there for her. The resident picked up the cup and took the medications. During an interview on 04/12/23 at 9:18 A.M., RN 2 indicated the resident did not have an order to self-administer medications. The resident's clinical record was reviewed on 04/12/23 at 2:09 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 03/02/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, anemia, heart failure, non-Alzheimer's dementia, bipolar disorder, and depression. The clinical record lacked a medication self-administration assessment and a physician's order for the resident to self-administer medications. During an interview on 04/13/23 at 3:13 P.M., LPN (Licensed Practical Nurse) 4 indicated she was unaware of any residents that self-administered medications on the 100 Hall. If a resident did self-administer, there would be an assessment that indicated the resident was safe to self-administer,		of. 2. All residents have the potential to be affected. Licensed staff educated on Medication Administration-General Guidelines and Self Administration of Medications policy. 3. As a measure of ongoing compliance, the DHS or designee will audit medication passes during rounding to ensure that medications are administered according to policy. Audit to consist of three residents weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	and an MD order to do so. When administering medications, nurses were supposed to ensure the resident took all the medications in the cup. You wouldn't leave the medications with the resident to take on their own. The current facility policy, titled "Medication Administration-General Guidelines", with a revision date of 11/2018, was provided by the Clinical Support Nurse 5 on 04/12/23 at 4:39 P.M. The policy indicated, "...Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications ..." The current facility policy titled "Guidelines for Self-Administration of Medications", and dated 12/31/22, was provided by the Administrator on 04/13/23 at 11:15 A.M. The policy indicated, "...Residents requesting to self-medicate...shall be assessed...results of the assessment will be presented to the physician for evaluation and an order for self-medication..." 3.1-11(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 0684	1. Residents 263 and 27 affected.	05/01/2023

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	2. The clinical record for Resident 263 was reviewed on 04/12/23 at 10:21 A.M. An Admission MDS assessment, dated 03/31/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, aspiration pneumonia, heart failure, and hypertension. The resident required extensive assistance of two staff members for bed mobility, transfers, dressing, and personal hygiene. A physician's order for Midodrine (a blood pressure medication) 5mg (milligrams) was to be given three times a day at 8:00 A.M., 12:00 P.M., and 4:00 P.M. The medication was to be held for a systolic blood pressure (top number) greater than 180 mmHg (millimeters of mercury) with a start date of 03/29/23. The EMAR/ETER (Electronic Medication Administration Record/Electronic Treatment Administration Record) and Vitals Report for March and April 2023 indicated the resident's blood pressure was documented outside of the medication administration time on the following dates and times in the clinical record: - On 03/29/23 the blood pressure was obtained at 6:36 A.M., and 11:39 P.M., with the medication administered at 8:00 A.M., 12:00 P.M., and 4:00 P.M., - On 03/31/23 no blood pressures were documented, with the medication administered at 8:00 A.M., 12:00 P.M., and 4:00 P.M., - On 04/01/23 no blood pressures were documented, with the medication administered at 9:59 A.M., the 12:00 P.M. dose administered at 5:55 P.M., and the 4:00 P.M. dose administered at 5:55 P.M., - On 04/02/23 the blood pressure was obtained at 1:49 P.M. and 11:28 P.M., with the medication		Resident 263 noted to have blood pressure medications given without documentation of blood pressure. Resident 27 noted to have fall without documentation of neurological assessment. Residents 263 and 27 were assessed with no adverse affected noted. 2. All residents have the potential to be affected. Licensed staff educated on the Medication Administration-General Guidelines and Guidelines for Neurological Checks. 3. As a measure of ongoing compliance, the DHS or designee will perform neuro check and fall assessment audits during morning clinical care meeting: audits will be completed for 3 residents weekly x4 weeks, then every other week x2 months, then monthly x3 months. As a measure of ongoing compliance, the DHS or designee will review medication administration with proper interventions prior to administration on 3 residents weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan	

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	administered at 8:00 A.M., 12:00 P.M., and 5:20 P.M., - On 04/03/23 the blood pressure was obtained at 9:27 A.M., 2:25 P.M., and 6:40 P.M., with the medication administered at 9:13 A.M., 12:00 P.M., and 4:00 P.M., - On 04/04/23 the blood pressure was obtained at 7:14 P.M., with the medication administered at 9:22 A.M., 12:00 P.M., and 4:00 P.M., - On 04/05/23 the blood pressure was obtained at 10:33 A.M., and 10:45 P.M., with the medication administered at 10:37 A.M., 12:00 P.M., and 4:00 P.M., - On 04/06/23 the blood pressure was obtained at 3:14 P.M., with the medication administered at 11:03 A.M., 12:00 P.M., and 4:00 P.M., - On 04/07/23 no blood pressures were documented, with the medication administered at 9:38 A.M., 12:00 P.M., and 4:00 P.M., - On 04/08/23 the blood pressure was obtained at 8:07 A.M., with the medication administered at 8:00 A.M., 1:53 P.M., and 7:35 P.M., - On 04/09/23 the blood pressure was obtained at 1:09 P.M., with the medication administered at 8:00 A.M., 1:06 P.M., and 4:00 P.M., - On 04/10/23 no blood pressures were documented, with the medication administered at 8:00 A.M., 12:00 P.M., and 4:00 P.M., and - On 04/11/23 the blood pressure was obtained at 2:36 P.M., and 6:11 P.M., with the medication administered at 8:00 A.M., 12:00 P.M., and 4:00 P.M. During an interview on 04/14/23 at 10:07 A.M., RN 6 indicated if a resident had parameters in the physician's order, the blood pressure should have been taken before the medication administration and the medication should have been held if the blood pressure was outside of the parameters, if within the parameters the medication would be		will be reviewed and updated as warranted.	

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	administered. If the medication was held then the physician would be notified. Blood pressures were documented in the EMAR and under resident history in vitals. During an interview on 04/14/23 at 10:38 A.M., RN 2 indicated blood pressures should be obtained just prior to medication administration time. The current facility policy titled, "Medication Administration-General Guidelines", with a revised date of 11/18, was provided by the Clinical Support Nurse on 04/12/23 at 4:39 P.M. The policy indicated, "...Medications are administered as prescribed in accordance with good nursing principles and practices...Medications are administered in accordance with written orders of the prescriber..." 3.1-37(a) Based on record review, interview, and observation, the facility failed to complete Neuro Checks (Neurological Evaluations) following a fall and failed to follow physician's orders related obtaining blood pressure values prior to medication administration for 2 of 16 residents reviewed for Quality of Care. (Residents 27 and 263) Findings include: 1. The clinical record for Resident 27 was reviewed on 04/11/23 at 3:02 P.M. A Significant Change MDS (Minimum Data Set) assessment, dated 03/28/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, diabetes, stroke, and dementia. The resident required extensive assistance of two or more staff members for bed mobility, transfers, dressing, and personal hygiene. The resident had			

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	2 or more falls with no injury and one fall with a major injury since the last assessment dated 01/10/23. The Progress Notes were provided by the DON (Director of Nursing) on 04/12/23 at 2:55 P.M., and included, but were not limited to, the following: - A note, dated 02/10/23 at 9:28 P. M., that indicated the resident was found lying on the floor after trying to transfer herself to a recliner in the TV room. (The fall was unwitnessed. The TV room had serveral chairs and a few end tables sitting about.) A Fall Event report, dated 02/10/23 at 7:45 P.M., was provided by the ADON (Assistant Director of Nursing) on 04/11/23 at 3:06 P.M. The report indicated the fall was unwitnessed and Neuro Checks were completed at the following times: - 7:45 P.M., - 8:00 P.M., - 8:15 P.M., and - 8:30 P.M., 45 minutes after the fall. No Neuro Checks were completed at 9:00 P.M., or 9:30 P.M., per the Fall Event guidelines. Neuro Checks did not resume until 10:00 P.M., an hour and a half after the last assessment. During an interview on 04/13/23 at 12:26 P.M., the DON indicated before 03/01/23, vital signs for falls and Neuro Checks were documented in the Fall Event. During an interview on 04/13/23 at 1:50 P.M., RN 2 indicated when a resident fell and they completed Neuro Checks they would assess them every 15 minutes x (times) 4, every 1/2 hour x 4, every hour			

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	x 4, then every eight hours for 72 hours. The Vitals Report for February 2023, was provided by the DON on 04/14/23 at 11:06 A.M. The record indicated the resident's vital signs were obtained at the following times on 02/10/23: - 7:45 P.M., - 8:00 P.M., - 8:15 P.M., and then not until - 10:00 P.M. The "Guidelines for Neurological Checks" policy, with a reviewed date of 12/31/22, was provided by the Administrator on 04/13/23 at 12:08 P.M. The policy indicated, "...Neuro-checks for 24 hours should be completed within the Fall Event Form...Obtain vital signs with each assessment..."			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on record review and interview, the facility failed to prevent, treat, and stage pressure ulcers appropriately for 3 of 6 residents reviewed. (Residents 18, 39, and 16)	F 0686	1. Residents 18, 39 and 16 were affected by alleged deficient practice. Wound care treatment orders were reviewed and updated	05/01/2023

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	Findings include: 1. The clinical record for Resident 18 was reviewed on 04/12/23 at 10:42 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 01/22/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, pneumonia, stroke, and dementia. The resident was at risk for pressure ulcers but had no unhealed pressure ulcers. A Skin Integrity Event record, dated 12/09/22, was provided by Clinical Support Nurse 5 on 04/11/23 at 1:53 P.M. The record indicated the resident had a pressure ulcer to the outside of each calf. The Progress Notes for December 2022 and January 2023, were provided by the Wound Care Nurse on 04/12/23 at 3:27 P.M., and included, but were not limited to, the following: - A note, dated 12/09/22 at 9:53 P.M., that indicated when doing a bed check, the resident was found to have a dime size pressure ulcer on the outside of the left calf that had some necrotic tissue on the inside with redness around it. - An IDT (Interdisciplinary Team) note, dated 12/12/22 at 2:51 P.M., that was recorded as a late entry on 12/14/22 at 3:07 P.M., indicated the resident had a newly acquired pressure ulcer to the left calf that measured 1.4 cm (centimeters) x (by) 0.8 cm. The wound bed was covered in eschar (dry dead tissue). The skin surrounding the wound was pink/normal. Treatment orders were placed to apply Medihoney (a wound healing gel) to the left calf wound and cover with a foam dressing.		as needed. Skin assessments were conducted on all residents with no additional findings. 2. All residents with wounds have the potential to be affected. Nursing staff educated on Guidelines for Weekly Skin Observations and Guidelines for Pressure Prevention. 3. As a measure of ongoing compliance, the DHS or designee will perform random skin sweeps to determine any new skin impairments: Audits will be conducted on 3 residents weekly x4 weeks, then every other week x2 months, then monthly x3 months. As a measure of ongoing compliance, the DHS or designee will review wound care orders on 3 residents weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	- A CAR (Clinically At Risk) IDT note, dated 12/21/22 at 1:01 P.M., indicated the pressure injury to the left calf measured 1.3 cm x 0.6 cm. The wound bed was covered in eschar. Treatment orders were to apply Medihoney to the left calf wound and cover with a foam dressing. New interventions put in place included a new Broda (specialized) wheelchair. - A CAR IDT note, dated 12/27/22 at 11:40 A.M., indicated the pressure injury to the left calf measured 1.3 cm x 0.5 cm. The wound bed was covered in eschar. Treatment orders were to apply Medihoney to the left calf wound and cover with a foam dressing. The EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) for December 2022, and January 2023, were provided by the Wound Care Nurse on 04/12/23 at 3:27 P.M. The records indicated the resident's skin was assessed weekly. On 12/05/22, the resident had no skin impairments. On 12/12/22 the resident had a new skin impairment. Physician's orders included, but were not limited to: - An order, with a start date of 12/14/22, and a discontinued date of 03/26/23, for the left calf wound to cleanse with wound cleanser or normal saline, apply skin prep (a skin toughening agent), and cover with a foam dressing, change every other day. The record lacked a treatment order for Medihoney for the pressure ulcer. The Wound Management Reports were provided by the Wound Care Nurse on 04/12/23 at 3:27 P.M., and included, but was not limited to, the			

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	following: - A report, dated 12/12/22, indicated the resident had an unstageable (covered in slough [a mass of dead tissue] and/or eschar) pressure ulcer to the left calf that was identified on 12/12/22. The wound had no drainage. The wound measured 1.4 cm x 0.8 cm. - A report, dated 12/27/22, indicated the resident had an unstageable pressure ulcer to the left calf, covered in dead tissue, that measured 1.3 cm x 0.5 cm. The wound healed without complications on 01/03/23. During an interview on 04/12/23 at 2:45 P.M., LPN (Licensed Practical Nurse) 8 indicated when a skin condition was identified on a resident, she completed a skin event. They tried to do a root cause analysis. Every morning the management team had a meeting, and they reviewed the nurses charting, skin events, and falls. The wound nurse took over observations, measurements, and treatment recommendations following the initial wound observations. The floor staff followed up on the wounds daily to see how it was progressing. The nurses on the floor changed the dressings. During an interview on 04/12/23 at 2:56 P.M., the Wound Nurse indicated the wounds were caused by the resident's wheelchair. She involved therapy staff in addressing the issue. They placed a cushion on the chair so there would be no pressure on the resident's calves. The wound was on the outside of the calf. The residents were supposed to be looked at every day. The wound should have been identified prior to it being an unstageable pressure ulcer. There was not a wound evaluation completed initially. She relied			

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	on the nurses and the CNAs (Certified Nurse Aides) to come to her when there were skin issues. The Medihoney order should have been on the EMAR/ETAR. 2. During an interview 04/11/23 at 10:34 A.M., Resident 39 indicated she admitted to the facility with a pressure ulcer to her right heel. She went out to the wound clinic every week and the dressing would get changed daily. The clinical record for Resident 39 was reviewed on 04/11/23 at 1:10 P.M. An Admission MDS assessment, dated 02/17/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, anemia, wound infection, malnutrition, peripheral vascular disease, and cellulitis of the right lower limb. The resident had an unstagable pressure ulcer that was present on admission. A physician's order, with a start date of 03/14/23 through 04/03/23, indicated the resident was to have a daily dressing change to the right heel. A Wound Management Report, dated 03/29/23, indicated the resident had an unstagable pressure ulcer to the right ankle. The wound had a moderate amount of serosanguineous (pale red to pink, thin and watery) drainage. There was 80% slough and 20% granulation tissue. The wound measured 2 cm x 1 cm x 0.2 cm. A Wound Management Report, dated 04/07/23, indicated the resident had an unstageable pressure ulcer to the right ankle. The wound had a light amount of exudate. There was 100% slough. The wound measured 2 cm x 1 cm. A physician's order, dated 03/13/23 through 04/03/23, indicated the resident was to have			

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	weekly skin assessments. The March EMAR/ETAR indicated the following: - 03/14/23, the resident had no skin impairments, - 03/21/23, the resident had no impairments, and - 03/28/23, the resident had old impairments. The March 2023 shower sheets indicated the following: - 03/20/23, no skin problems were noted, and - 03/27/23, no skin problems were noted. During an interview on 04/12/23 at 3:08 P.M., RN 7 indicated the resident was admitted to the facility with an injury and pressure ulcer to the right heel. The nurses checked residents' skin twice a week or when the resident complained. The skin could be monitored daily when the aides were assisting residents with getting ready each day. If the resident had a new skin impairment, she would notify the MD and the wound nurse. The new orders would be placed into computer system. During an interview on 04/13/23 at 10:16 A.M., the Wound Nurse indicated the resident was admitted to the facility with a pressure ulcer to her right heel. The resident had poor circulation in the right leg and has had lots of Doppler studies. She had a recent surgery to open the veins on the right side. The resident developed an unstageable pressure ulcer to the right ankle from an orthotic boot she wore. The nursing staff should have assessed the resident skin daily, as she was getting daily dressing changes to the right foot. The staff should have noticed the area to the ankle before it was covered in slough. 3. The clinical record for Resident 16 was reviewed on 04/12/23 at 11:22 A.M. An Admission MDS			

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	assessment, dated 03/27/23, indicated the resident was cognitively intact. The diagnoses, included but were not limited to, fracture of right lower leg, heart failure, renal insufficiency, diabetes, malnutrition, anxiety, and depression. The resident had a one stage 3 (Full-thickness skin loss in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss) and one unstageable pressure ulcer. A Wound Management Report, dated 03/13/23, indicated the resident was admitted with a Stage 2 (Partial-thickness skin loss with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present.) pressure ulcer to the left buttocks that measured 0.6 cm x 0.6 cm. The wound was covered with 100% necrotic (dead) tissue. A Wound Management Report, dated 03/13/23, indicated the resident was admitted with an unstageable pressure ulcer to the right buttocks that measured 2.6 cm x 0.2 cm. An IDT Note, dated 03/13/23 at 8:07 A.M., indicated the resident had a deep tissue injury noted to the upper right buttock on admission that measured 2.6 cm x 0.2 cm. The peri-wound was pink and normal. A stage 3 pressure injury was noted to the left buttock, the wound measured 0.6 cm x 0.6 cm and covered with 100% eschar. The MD and resident were aware. An order was received to cover the wound with			

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	Medihoney and cover with a foam dressing. A Clinical Support Wound Review, dated 03/16/23 at 10:39 A.M., indicated the resident was admitted to the upper right buttock measuring 2.6 cm x 0.2 cm and a Stage 3 pressure injury noted to the left buttock. The wound bed measures 0.6 cm x 0.6 cm covered in eschar, The MD and resident were aware. An order was received to cover the wound with medihoney and cover with a foam dressing. A CAR (Clinical At Risk) IDT Note, dated 03/21/23 at 1:09 P.M., indicated the resident had pressure injuries to the buttocks. A Deep Tissue Injury was noted to the upper right buttock. The area measured 2 cm x 0.2 cm. A Stage 3 pressure injury noted to the left buttock. The area measured 0.4 cm x 0.5 cm and covered with 100% eschar. The MD and resident were aware. An order was received to cover the wound with medihoney and cover with a foam dressing. The clinical record lacked documentation the Medihoney treatment was administered to the wounds on the resident's buttocks. The resident was discharged to the local hospital for an unrelated incident on 03/27/23. The wounds were healed when the resident returned. During an interview on 04/12/23 at 3:18 P.M., RN 7 indicated the resident had been confused recently. The resident was admitted with pressure ulcers to her buttocks that had healed. She had a specialty mattress since admission. During an interview on 04/13/23 at 10:06 A.M., the Wound Nurse indicated the resident was admitted to the facility with pressure ulcers to her buttocks. The wounds have healed. The Stage 3 wound			

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	should have been listed as an unstageable on admission when it was covered with 100% eschar. The ordered Medihoney treatment had never been administered to the resident's wounds and should have. The current facility policy titled, "Guidelines for Weekly Skin Observations", with a review date of 03/16/2022 and provided by the Administrator on 04/13/23 at 11:15 A.M. The policy indicated, "...In addition to the Weekly Observation by the licensed nurse, the nursing assistant shall observe the skin for areas of impairment with bathing and daily dressing and pericare and notify the nurse if an area is identified..." The current facility policy titled, "Guidelines for Pressure Prevention", with a review date of 12/31/2022 and provided by the Administrator on 04/13/23 at 11:15 A.M. The policy indicated, "...To maintain good skin integrity and avoid development of pressure ulcers...Inspect the skin daily during care for signs of breakdown or changes to the skin. Notify the Nurse of changes...Utilize padding for casts and splints. Monitor skin closely when these devices are present..." 3.1-40(a)(1) 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			

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	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, observation, and interview, the facility failed to implement interventions to prevent falls for 1 of 3 residents reviewed for accidents. (Resident 27) Findings include: The clinical record for Resident 27 was reviewed on 04/11/23 at 3:02 P.M. A Significant Change MDS (Minimum Data Set) assessment, dated 03/28/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, diabetes, stroke, and dementia. The resident required extensive assistance of two or more staff members for bed mobility, transfers, dressing, and personal hygiene. The resident had 2 or more falls with no injury and one fall with a major injury since the last assessment dated 01/10/23. An "Event Summary List" was provided by Clinical Support Nurse 5 on 04/11/23 at 1:53 P.M. The list indicated the resident had fallen on the following dates: - 02/10/23 (no fracture), - 03/05/23 (no fracture), - 03/09/23 (no fracture), and - 03/22/23 (with a fracture). The Progress Notes were provided by the DON (Director of Nursing) on 04/12/23 at 2:55 P.M., and included, but were not limited to, the following: - A CAR (Clinically At Risk) note, dated 03/09/23 at 12:56 P.M., indicated the resident had a history of falling. She was severely cognitively impaired.	F 0689	1. Resident 27 was affected by alleged deficient practice. Fall interventions were reviewed and updated as needed. 2. All residents have the potential to be affected. Nursing staff educated on Fall Management Program Guidelines. All residents fall interventions were reviewed and updated as needed. 3. As a measure of ongoing compliance, the DHS or designee will review fall interventions on 3 residents weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	05/01/2023

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	Current Interventions to prevent falls were, "... Brake extenders with bright colored tape..." - A CAR note, dated 03/29/23 at 7:59 A.M., indicated the resident had a history of falling. She was severely cognitively impaired. Current Interventions to prevent falls were, "... Brake extenders with bright colored tape..." The resident had a recent fall on 03/22/23 in which she fell from her wheelchair. The fall resulted in a fracture of her right clavical. During an observation on 04/12/23 at 8:58 A.M., the resident was lying in bed in her room. Her wheelchair was at the bedside. There were no extenders or bright colored tape on her wheelchair brakes. During an observation on 04/12/23 at 10:32 A.M., the resident was lying in bed in her room. Her wheelchair was at the bedside. There were no extenders or bright colored tape on her wheelchair brakes. During an observation on 04/12/23 at 2:02 P.M., the resident was sitting in her wheelchair in the common area across from the nurse's station watching television. There were no extenders or bright colored tape on her wheelchair brakes. During an interview on 04/12/23 at 2:13 P.M., the DON indicated the resident would get up unassisted, even with education, and was unable to retain instruction and education. She was impulsive and had confusion. She was very forgetful. CAR notes for falls were a review of the fall and what interventions were in place, and to ensure the interventions were effective. When a resident fell they generally added an intervention to the Care Plan. She usually looked at the Care			

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	Plan for her CAR Notes. The Care Plan for "Falls" was provided by the DON on 04/13/23 at 1:30 P.M. The Care Plan lacked documentation related to the intervention to add extenders to the resident's wheelchair brakes and cover with bright tape. The current "Fall Management Program Guidelines" policy, with a reviewed date of 03/16/22, was provided by the DON on 04/12/23 at 2:55 P.M. The policy indicated, "...Trilogy health Services...strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures...intensive efforts will be directed toward minimizing or preventing injury...The resident care plan should be updated to reflect any new or change in interventions..." 3.1-35(d)(2)			
F 0691 SS=D Bldg. 00	483.25(f) Colostomy, Urostomy, or Ileostomy Care §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, interview, and record review, the facility failed to obtain physician's orders and appropriately monitor 1 of 1 resident reviewed for colostomy care. (Resident 3) Findings include: On 04/10/23 at 1:35 P.M., Resident 3's ostomy	F 0691	1. Resident 3 was affected by alleged deficient practice. Resident assessed with no adverse events noted. Colostomy orders were reviewed and updated as needed. 2. All like residents have the potential to be affected. Nurses	05/01/2023

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	supplies were observed on a countertop in her room. The resident indicated she has had a colostomy for a long time. The resident's clinical record was reviewed on 04/12/23 at 2:09 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 03/02/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, anemia, heart failure, non-Alzheimer's dementia, bipolar disorder, and diverticulitis. The resident had a colostomy. The clinical record lacked a physician's order for the colostomy or colostomy care. During an interview on 04/13/23 at 9:47 A.M., CNA (Certified Nurse Aide) 3 indicated the resident had a colostomy. CNA staff did not mess with it, the nurse did. During an interview on 04/13/23 at 9:54 A.M., RN 2 indicated the resident did have a colostomy and nursing staff had to provide resident care that included releasing air from the colostomy pouch daily. The resident has had skin problems around the stoma site in the past. They have used anitfungal powder for redness on her skin. There should be a physician's order for the colostomy that included orders to regularly assess and monitor the ostomy site and skin. The current facility policy, titled "Colostomy Ileostomy", dated 12/31/22, was provided by the Administrator on 04/13/23 at 11:18 A.M. The policy indicated, "...information should be recorded in the resident's medical record...date and time the colostomy/ileostomy care was provided...name and title of the individual(s) who provided...care...any breaks in resident's		educated on Colostomy and Ileostomy policy and procedure. 3. As a measure of ongoing compliance, the DHS or designee will review colostomy orders to ensure appropriate order obtained in medical record on 3 residents weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	skin...how the resident tolerated the procedure..." 3.1-47(a)(3)			
F 0695 SS=D Bldg. 00	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. Based on observation, interview, and record review, the facility failed to appropriately manage a resident's respiratory needs related to oxygen use for 1 of 2 residents reviewed for respiratory care. (Resident 3) Findings include: On 04/13/23 at 11:10 A.M., Resident 3 was observed in her room watching television. She indicated she was on 3 liters of oxygen at all times, she had been on that since before admission. The resident's nasal cannula was in place and attached to extension tubing that was attached to an oxygen concentrator that was set to administer 3 liters of oxygen. On 04/12/23 at 3:56 P.M., the resident was observed in her room in her chair. The resident's nasal cannula was in place and attached to a portable oxygen tank hanging from the resident's wheelchair.	F 0695	1. Resident 3 was affected by alleged deficient practice. Resident was assessed with no adverse events noted. Oxygen orders were reviewed and updated as needed. 2. All like residents have the potential to be affected. Nurses educated on Administration of Oxygen policy. All residents with oxygen were reviewed for appropriate orders which were in place. 3. As a measure of ongoing compliance, the DHS or designee will review oxygen orders to ensure proper order placement in medical record, audits will be completed on 3 residents weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the	05/01/2023

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	The resident's clinical record was reviewed on 04/12/23 at 2:09 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 03/02/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, heart failure, non-Alzheimer's dementia, bipolar disorder, COPD (Chronic Obstructive Pulmonary Disease), and pulmonary fibrosis. The assessment did not indicate the resident wore oxygen. The resident's current physician's orders lacked orders for oxygen administration. During an interview on 04/13/23 at 9:47 A.M., CNA (Certified Nurse Aide) 3 indicated the resident did wear oxygen. The aides assisted her with moving her oxygen tubing from the oxygen concentrator to the portable tank and vice versa. During an interview on 04/13/23 at 11:12 A.M., RN 2 indicated the resident had been on 3 liters of oxygen for as long as he has taken care of her. During an interview on 04/14/23 at 9:58 A.M. the Director of Nursing indicated the resident should have had physician's orders for oxygen use. The current facility policy, titled "Administration of Oxygen", dated 12/31/22, was provided by the Administrator on 04/13/23 at 11:18 A.M. The policy indicated, "...Verify physician's order for the procedure..." The current facility policy, titled "Guidelines for Medication Orders", dated 12/31/22, was provided by the Administrator on 04/13/23 at 11:18 A.M. The policy indicated, "...Oxygen orders...When recording oxygen orders specify...rate of flow, route, and rationale..."		DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	3.1-47(a)(6)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending			

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	physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to reevaluate a resident's PRN (as needed) antianxiety medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 22) Findings included: The clinical record for Resident 22 was reviewed on 04/12/23 at 11:18 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 02/13/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, heart failure, hypertension, and anxiety. The Pharmacy Recommendations were provided by Clinical Support Nurse 5 on 04/11/23 at 1:53 P.M., and included the following: - On 03/04/23 at 8:33 A.M., indicated, "...recommend assessing the psychotropic PRN medication, Clorazepate which has been active since 2/8. Federal regulations require that all PRN psychoactives (non-antipsychotics) initially be limited to 14 days of therapy. The order may be extended, by a prescriber, if the following two conditions are met and documented in the chart: 1) Rationale for extending the order beyond 14	F 0758	1. Resident 22 was affected by alleged deficient practice. Resident was assessed with no adverse events noted. Resident was assessed by the nurse practitioner and the medication was continued with warranted indication of use. ~~2.~~ All like residents have the potential to be affected. All like residents have been reviewed and indications of use placed in medical record. 3. As a measure of ongoing compliance, the DHS or designee will review PRN antipsychotic orders to ensure appropriate stop date and/or indications of use are in place. Audits will be completed on 3 residents weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus	05/01/2023

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	155693	A. BUILDING 00 B. WING	04/14/2023

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	days. 2) How long the order is to remain an active order by providing a stop date...", and - On 04/10/23 at 9:08 P.M., indicated, "...Recommend assessing the psychotropic PRN medication, Clorazepate which has been active since 2/8/2023. Federal regulations require that all PRN psychoactives (non-antipsychotics) initially be limited to 14 days of therapy...all PRN psychoactive medications must have a stop date..." The EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) for March 2023, was reviewed on 04/11/23 at 2:00 P.M., and included, but was not limited to, the following physician's orders: - An open-ended order for Clorazepate dipotassium tablet, 3.75 mg (milligrams), one tablet, by mouth three times a day PRN, for anxiety, with a start date of 02/08/23. Prescription Orders for Clorazepate dipotassium tablet, 3.75 mg, one tablet, by mouth three times a day PRN, were provided by the SSD (Social Services Director) on 04/12/22 at 4:18 P.M., and included the following: - An order for Clorazepate dipotassium tablet, 3.75 mg, one tablet, by mouth three times a day PRN, for anxiety, with a start date of 02/08/23, and a discontinued date of 04/12/23 at 8:53 A.M., that the facility was waiting for a physician's signature on, and - An order for Clorazepate dipotassium tablet, 3.75 mg, one tablet, by mouth three times a day PRN,		Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	for anxiety, with a start date of 04/12/23, and an end date of 04/26/23, (a period of 14 days). The clinical record lacked documentation the antianxiety medication had been reviewed after 14 days of use, lacked a rationale for extending the order beyond 14 days, and lacked a stop date until it was discontinued on 04/12/23, and reordered. During an interview on 04/12/23 at 3:47 P.M., the SSD indicated regarding the policy on PRN psychotropic medications they liked to have an end date so the physician could review the medication, see if the resident was using the medication, and decide if it needed to be a routine medication or if another intervention needed to be put into place. The current Psychotropic Medication Usage and Gradual Dose Reductions policy, with a reviewed date of 12/31/22, was provided by the SSD on 04/12/23 at 4:18 P.M. The policy indicated, "...PURPOSE...To ensure every effort is made for residents receiving psychoactive medications to obtain the maximum benefit with minimal unwanted side effects through appropriate use, evaluation and monitoring by the interdisciplinary team...PRN order [sic] for psychotropic drugs are limited to 14 days. Except as provided if the attending physician or prescriber believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order..." 3.1-48(a)(2) 3.1-48(a)(4)			
F 0761 SS=E	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals			

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Bldg. 00	§483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview the facility failed to label and store and medications appropriately for 4 of 5 medication carts reviewed. (200 Hall Medication Cart, 600-1 Medication Cart, 600-2 Medication Cart, and 100 Hall Medication Cart) Findings include: 1. The 200 Hall Medication Cart was observed on 04/10/23 at 10:38 A.M., with LPN (Licensed Practical Nurse) 9 and contained the following:	F 0761	1. No adverse effects noted related to medication being left on top of the cart. No adverse reactions due to medications with no open date. Medications that were not properly stored, labeled or dated were removed from the medication cart and disposed of properly per policy. 2. All residents have the potential to be affected. Nurses educated on Medication Administration-General Guidelines. Medication	05/01/2023

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	- a Humalog insulin vial with no opened date for Resident 102 that was 1/2 full. The Humalog vial had a received date from the pharmacy of 04/05/23. The LPN indicated the insulin pen should have had an opened date written on it, and it was good for 28 days. 2. The 600-1 Medication Cart was observed on 04/10/23 at 10:51 A.M., with LPN 11 and contained the following: - a bottle of Timolol Maleate 0.5% eye drops with no opened date for Resident 254 that was 1/2 full and - a Lispro insulin pen with no opened date for Resident 38 that was 3/4 full. The LPN indicated each bottle should have an opened date written on the bottle. An "Expiration Date Table" was provided by the DON (Director of Nursing) on 04/14/23 at 11:23 A.M. "... Timolol Maleate, 1 month after opening of foil...Lispro pen, 28 days..." 3. The 600-2 Medication Cart was observed on 04/10/23 at 10:54 A.M., with RN 10 and contained the following: - a Humalog insulin vial with no opened date for Resident 16 that was 1/4 full and - a Novolog insulin pen with no name or date that was 1/2 full. The RN indicated the medications in the cart should be labeled with resident names and an opened date.		carts were audited to ensure all medications were properly stored, labeled, and dated with no additional findings. 3. As a measure of ongoing compliance, the DHS or designee will conduct random medication cart audits weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	An "Expiration Date Table" was provided by the DON (Director of Nursing) on 04/14/23 at 11:23 A.M. "...Novolog, 28 days..." The current facility policy titled, "MEDICATION STORAGE IN THE FACILITY" was provided by the Administrator on 04/13/23 at 11:15 A.M. The policy indicated "...Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier..." 4. During an observation on 04/10/23 at 1:42 P.M., an unattended medication cart on the 100 Hall had an unopened clonadine patch on the top of the cart that belonged to Resident 8. RN 2 walked to the cart from the area of the nurses station, retrieved the patch and took it to Resident 8's room. During an interview on 04/13/23 at 2:10 P.M., RN 2 indicated resident medications should absolutely not be left on the top of the medication unattended. The current facility policy, titled "Medication Administration-General Guidelines", with a revision date of 11/2018, was provided by the Clinical Support Nurse 5 on 04/12/23 at 4:39 P.M. The policy indicated, "...During administration of medications, the medication cart is kept closed and locked when out of sight of the facility mediction administration personnel. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by..."			

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	3.1-25(m)			
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 record and interview, the facility failed to follow physician's orders for laboratory work for 3 of 5 residents reviewed for unnecessary medications. (Residents 22, 31, and 253) Findings include: 1. The clinical record for Resident 22 was reviewed on 04/12/23 at 11:18 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 02/13/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, heart failure, hypertension, and anxiety. The Progress Notes for January 2023, were provided by the Administrator on 04/13/23 at 11:15 A.M., and included, but was not limited to, the following: - A note, dated 01/13/23 at 12:19 P.M., indicated the physician visited the resident and she complained of her toes crossing and being stiff at night. A new order was received to draw blood for a BMP (Basic Metabolic Panel) and magnesium levels. - A note, dated 01/21/23 at 6:36 P.M., indicated the	F 0770	1. Residents 22, 31 and 253 were affected by alleged deficient practice. ~~2.~~ All residents have the potential to be affected by this alleged deficient practice. Residents' lab orders reviewed to ensure draws were completed per current orders. Labs identified to be drawn, communicated to the attending physician and interventions added as appropriate. Licensed staff were educated on Synchrony lab process. 3. As a measure of ongoing compliance, the DHS or designee will review lab draw schedule to ensure lab samples are obtained as ordered. Audits will be completed 3x weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until	05/01/2023

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	resident was sent out to the hospital for a change in condition. A "New Laboratory Order", dated 01/13/23 at 11:50 A.M., was provided by the Administrator on 04/13/23 at 11:15 A.M., and indicated the blood draw was scheduled on 01/14/23 at "0:15" The clinical record lacked documentation the labs were drawn for the resident prior to being sent out on 01/21/23. During an interview on 04/12/23 at 9:08 A.M., RN 2 indicated the facility staff drew blood for ordered labs. The lab courier came in every night to pick up lab specimens. The facility had been drawing their own labs for about the last year. During an interview on 04/12/23 at 3:25 P.M., LPN (Licensed Practical Nurse) 8 indicated if a physician ordered labs to be drawn the facility staff would draw them the same day. The staff had to draw them before 10:00 P.M., because the lab courier picked them up between 10:00 P.M. and 1:00 A.M. Lab orders should be placed on the EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record). During an interview on 04/13/23 at 9:58 A.M., the Administrator indicated staff were trained to perform blood draws for ordered labs. The specimens were sent out each night. During an interview on 04/13/23 at 10:52 A.M., the IC (Infection Control) Nurse indicated the labs were not drawn on 01/13/23 or 01/14/23, and they should have been. Staff were trained to perform blood draws for lab work.		campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	2. Resident 31's clinical record was reviewed on 04/13/23 at 11:48 A.M. A Quarterly MDS assessment, dated 01/31/23, indicated the resident had a short-term and long-term memory problem. The diagnoses included, but were not limited to, anemia, diabetes, non-Alzheimer's dementia, and malnutrition. The resident did not experience weight loss and received a therapeutic diet. A Nutrition Progress Note, dated 12/01/22 at 1:36 P.M., indicated the Registered Dietician recommended the facility obtain Vitamin B-12 and Vitamin D lab draws. A Nurse Practitioner's order, dated 12/07/22, indicated a Vitamin D lab draw was to be obtained related to the resident's diagnosis of anemia. A Care Plan, dated 12/08/20, indicated the resident was malnourished or at risk for malnutrition related to diagnoses, inadequate nutrient/energy intakes, and/or metabolic demands. An intervention included, but was not limited to, obtain labs as ordered. The resident's clinical record lacked documentation the Vitamin D level was obtained as ordered. During an interview on 04/13/23 at 9:00 A.M., the DON (Director of Nursing) indicated the facility could not provide documentation that the Vitamin D lab was obtained as ordered. 3. The clinical record for Resident 253 was reviewed on 04/12/23 at 10:42 A.M. An Admission MDS assessment, dated 03/30/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, anemia, thyroid disease, anxiety, depression, and diabetes.			

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	A current physician's order, with a start date of 03/23/23, indicated the resident was to take Synthroid (a medication for thyroid disease) 75 mcg (micrograms), once a day. A Physician's Progress Note, dated 03/24/23 at 9:13 A.M., indicated the resident was to have a TSH (Thyroid-Stimulating Hormone) laboratory level on Monday, 03/27/23. A Care Plan, dated 4/10/23, indicated the resident had a diagnosis of hypothyroidism and was at risk for complications. An intervention included, but was not limited to, obtain labs as ordered. The completed labs for March 2023 were provided by the ADON (Assistant Director of Nursing) on 04/12/23 at 2:26 P.M. The labs lacked a TSH level. During an interview on 04/14/23 at 10:03 A.M., the Corporate Clinical Support Nurse 5 indicated the facility did not have a policy related to obtaining labs in a timely manner. 3.1-49(a)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: April 10, 11, 12, 13, and 14, 2023. Facility number: 002955 Residential Census: 32	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required it is required by the position of Federal and State Law.	

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	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 19, 2023.		The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey conducted April 14, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of May 01, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on record review and interview, the facility failed to follow a physician's orders related to hold parameters for 1 of 7 residents record reviewed. (Resident 356) Findings include: The clinical record for Resident 356 was reviewed on 04/13/23 at 2:47 P.M. The diagnosis included, but was not limited to, hypertension. A physician's order, dated 02/03/23 through 02/21/23, indicated the resident was to take metoprolol tartrate, 50 mg (milligrams), twice a day, for hypertension. The medication was to be held when the systolic blood pressure (top number) was less than 110.	R 0296	1. Resident 356 was affected by alleged deficient practice. No adverse events noted. 2. All residents have the potential to be affected by this alleged deficient practice. Nurses and QMA's educated on the Medication Administration-General Guidelines. 3. As a measure of ongoing compliance, the DHS or designee will review medication administration on 3 residents weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any	05/01/2023

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	A physician's order, dated 02/21/23 through 03/14/23, indicated the resident was to take meoprolol tartrate, 25 mg, twice a day, for hypertension. The medication was to be held when the systolic blood pressure was less than 110. The February 2023 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the resident had received the medication the following dates and times when the systolic blood pressure was less than 110: - 02/05/23 from 6:00 A.M. to 10:00 A.M., the blood pressure was 107/72, - 02/05/23 from 6:00 P.M. to 10:00 P.M., the blood pressure was 94/56, - 02/06/23 from 6:00 A.M. to 10:00 A.M., the blood pressure was 101/62, and - 02/15/23 from 6:00 P.M. to 10:00 P.M., the blood pressure was 108/65. The clinical record lacked documentation that the blood pressure was monitored prior to medication administration on 02/21/23 through 02/28/23. During an interview on 04/14/23 at 10:07 A.M., RN 6 indicated if a resident had parameters in the order for a blood pressure medication the blood pressure should have been taken before the medication administration and the medication should have been held if outside of the parameters. The medication and blood pressure would be documented in the EMAR. The current faciltiy policy titled, "Medication Administration-General Guidelines", with a revised date of 11/18, was provided by the Clinical Cupport Nurse on 04/12/23 at 4:39 P.M. The policy		findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	indicated, "...Medications are administered as prescribed in accordane with good nursing principals and practices...Medications are administered in accordance with written orders of the prescriber..."			