STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155780	A. Building B. Wing	03/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Healthcare Center	7465 Madison Ave Indianapolis, IN 46227

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 44849 Based on interview and record review, the facility failed to ensure an accurate Minimum Data Set (MDS) assessment was completed for for 1 of 21 residents reviewed. An indwelling urinary catheter was not coded on the MDS assessment. (Resident B) Finding includes: The clinical record for Resident B was reviewed on 3/9/22 at 11:22 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder and neurogenic bladder. The Admission MDS assessment, dated 1/1/22, indicated Resident B was cognitively intact and did not have an indwelling urinary catheter. An Initial Admission Evaluation, dated 12/27/21 at 6:26 p.m., indicated Resident B had a 14f (size) indwelling Foley (urinary) catheter that was draining clear urine. A Nurse Practitioner Progress Note, dated 1/13/22 at 2:08 P.M., indicated .Resident B had an indwelling Foley catheter and the catheter had been removed three days prior due to irritation. During an interview on 3/14/22 at 8:47 A.M. The MDS Coordinator indicated she was not aware Resident B had an indwelling urinary catheter because there were no orders entered into the electronic medical record. The indwelling urinary catheter should have been documented on the Admission MDS assessment. On 3/21/22 at 3:20 P.M., the facility was unable to provide a policy regarding MDS assessment accuracy by survey exit. This Federal tag relates to Complaint IN00374538. 3.1-31(d)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 44849 A. Based on interview and record review, the facility failed to ensure a physician order was followed for transferring a resident to the hospital. Two days later the resident was found unresponsive for 1 of 3 residents reviewed for hospital transfers. (Resident B) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on, 1/11/22 at approximately 2:32 p.m., when the facility failed to follow a physician's order to send a resident to the hospital. Two days later the resident was found unresponsive. The Administrator, Director of Nursing, and the Regional Director of Nursing were notified of the Immediate Jeopardy on 3/11/22 at 5:00 p.m. The Immediate Jeopardy was removed on 3/16/22 at 4:05 p.m., but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. B. Based on interview and record review, the facility failed to ensure medication for reversal of low blood sugar was available and given per nursing measures to treat an acute episode of hypoglycemia resulting in hospitalization for 1 of 3 residents reviewed for diabetic care. (Resident C) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 2/22/22 at approximately 8:50 a.m., when the facility failed to provided glucagon as a nursing measure to treat a hypoglycemic episode. The resident was sent emergently to the emergency room . The Administrator, Director of Nursing, and the Regional Director of Nursing were notified of the Immediate Jeopardy on 3/11/22 at 5:00 p.m. The Immediate Jeopardy was removed on 3/16/22 at 4:05 p.m., but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. C. Based on observation, interview, and record review, the facility failed to ensure care was provided to maintain the highest practicable well being for 4 of 21 residents reviewed. Physician's orders were not in place for a resident admitted with surgical wounds and dressings on open wounds were not dated, (Resident J, Resident D, Resident E, Resident F) Findings include: A. The clinical record for Resident B was reviewed on 3/9/22 at 11:22 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder and respiratory failure. The Admission MDS (Minimum Data Set) assessment, dated 1/1/22, indicated Resident B was cognitively intact. A Nurse Practitioner Note, dated 1/11/22 at 2:32 p.m., indicated Resident B was seen for increased confusion and fever. The Physical Therapist reported Resident B had increased confusion and agitation. The resident requested to go to the hospital. An order to send the resident to the emergency room for evaluation was written. A Nurse's progress note, dated 1/13/22 at 3:49 p.m., indicated Resident B was found unresponsive. Resident B's blood pressure was 80/39 mm/Hg (millimeters/Mercury), temperature 101.2 degrees Fahrenheit, pulse 139 beats per minutes, and the blood sugar was 154. Emergency services were called to transport the resident to the emergency room for evaluation. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/9/22 at 3:13 p.m., the Director of Nursing indicated there was no order written to send Resident B to the hospital nor was an order entered into the electronic medical record. The Nurse Practitioner note, dated 1/11/22 at 2:32 p.m., was not actually signed until 1/14/22 at 10:22 a.m., so the staff wouldn't have been aware Resident B needed to be sent to the hospital. During an interview on 3/11/22 at 11:01 a.m., the Nurse Practitioner indicated she had written an order to send Resident B to the Emergency Department and had not reported that to a nurse because it wasn't emergent at that time. The Nurse Practitioner put the order in a mailbox outside the Assistant Director of Nursing's (ADNS) office which was the standard practice used when the Nurse Practitioner wrote new orders for any residents. When the Nurse Practitioner saw him on 1/13/22, she was going to follow up on labs because he was never sent to the hospital as per the 1/11/22 written order. She does not remember Resident B reporting he had refused to go to the Emergency Department nor the staff reporting that Resident B refused to go to the Emergency Department. Resident B should have been sent to the Emergency Department on 1/11/22. During an interview on 3/11/22 at 2:47 p.m., RN (Registered Nurse) 1 indicated she had been working at the facility for several weeks. The Assistant Director of Nursing (ADNS) had been entering the new orders into the electronic medical record and would give a verbal report to the staff to notify them of the new orders. The Nurse Practitioners sometimes entered the orders for themselves, but most of the time it had been the ADNS. During an interview on 3/11/22 at 3:07 p.m., the ADNS indicated she had been entering the new orders for the Nurse Practitioners during the month of January. The Nurse Practitioner's would put the new orders in a mailbox outside her office and then she, the DON, or the Infection Preventionist would enter them into the electronic medical record. They did this because the Nurse Practitioner was not able to sign into the electronic medical record to enter the new orders. She was not aware of an order to send Resident B to the hospital. On 3/11/22 at 2:30 P.M., a Hospital Progress Note, dated 1/13/22, indicated Resident B was admitted with sepsis, respiratory failure, an acute urinary tract infection. On 3/11/22 at 2:30 P.M., a Hospital Discharge Summary, dated 2/8/22, indicated on 1/28/22 Resident B was comfort measures only. Resident B's respirations had ceased. On 3/11/22 at 4:21 p.m., the Administrator provided a copy of a facility policy, titled Physician Orders, dated 8/2010, and indicated this was the current policy used by the facility. A review of the policy indicated .The provider may write the order in the medical record . place orders in electronic medical record . print copy for Physician to sign and place in paper chart unless they are being signed electronically . the nurse that takes the Physician order will be responsible for executing the order or provide for the safe hand-off to the next nurse . contact .outside venders as required to execute the medical order . notify internal staff of changes/updates as appropriate. document contacts in the medical record. B. The clinical record for Resident C was reviewed on 3/11/22 at 12:50 p.m. The diagnoses included, but were not limited to, diabetes mellitus and schizophrenia. The Annual MDS (Minimum Data Set) assessment, dated 12/24/21, indicated Resident C was cognitively intact and had received insulin every day. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Nurse's progress note, dated 2/22/22 at 1:52 p.m. indicated I was informed by the QMA (Qualified Medication Aide) on 700-hallway that [Resident C] was having seizure activities at 0850. I immediately rushed to the room knowing that a QMA was on that hallway. When I got to the room [Resident C] was sitting up in the wheelchair dressed. Both QMA and CNA (Certified Nursing Aide) were in the room. [Resident C] was lethargic but could respond to voices . While observing [Resident C] for seizure activity, I did not see any activity going on. Then I asked the QMA what [Resident C's] blood sugar was. QMA reported that [Resident C's] blood sugar was 70 this morning . when she rechecked the blood sugar, it reads 64. [Resident C's] unresponsiveness continues to worsen. The QMA brought orange juice but [Resident C] was not able to drink. Then I rushed to get glucagon [a prescription medication to treat hypoglycemia] to administer and there is none on the cart or EDK [Emergency Drug Kit] on both sides. Then I called 911. When the ambulance arrived, I reported to them what the situation was and asked for glucagon. During their assessment, [Resident C's] blood sugar went down to 36. [Resident C] was transported to the hospital. The February 2022 MAR (Medication Administration Record) indicated Resident C's blood sugar reading, on 2/22/22 at 7:30 a.m., was 70. During an interview on 3/11/22 at 3:15 p.m., RN (Registered Nurse) 1 indicated she was unable to locate the glucagon for when a resident becomes hypoglycemic. She was unsure where to find the EDK. During an interview on 3/11/22 at 3:30 p.m., LPN (Licensed Practical Nurse) 1 indicated nurses ask each other where to find the glucagon for when a resident's blood sugar declines. LPN 1 was observed to search through the east and west wing medication room refrigerators and was unable to find the glucagon in either refrigerator. During an interview on 3/12/22 at 10:25 a.m., the Director of Nursing indicated the facility did not have standing orders for an emergency reversal medication for hypoglycemia (low blood sugar). A physician's order would be required before the nurse could administer the medication. During an interview on 3/13/22 at 10:00 a.m., UM 1 indicated that if a resident was admitted with insulin orders she would call the physician to see if they would like to add an order for glucagon because a resident's blood sugar could drop with insulin. During an interview on 3/13/22 at 1:54 p.m., the Medical Director indicated that if a nurse would have called and asked for an order for glucagon, he would have given it. On 3/11/22 at 3:00 p.m., the Director of Nursing provided a copy of a facility policy, titled Blood Glucose Point of Care Testing, dated 12/2014, and indicated this was the current policy used by the facility. A review of the policy indicated It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents .Extremely low blood glucose levels (hypoglycemia) may result in confusion, unusual behaviors, coma, and even death if left untreated. C1. During an interview on 3/14/22 at 10:08 A.M., Resident J indicated his surgical wound treatment to his left ankle had not been completed as ordered by the physician when he initially admitted to the facility. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The clinical record for Resident J was reviewed on 3/10/22 at 9:40 A.M. The diagnoses included, but were not limited to, stress fracture of left ankle and fracture of lower left tibia. The Admission MDS (Minimum Data Set) assessment, dated 10/30/21, indicated Resident J was cognitively intact, did have surgical wounds, but did not require surgical wound care. An Initial Admission Evaluation, dated 10/23/21, indicated Skilled services/reason for admission: wound care . skin intact, resident will remain free of skin breakdown .nurse completing this section [the wound nurse]. A hospital discharge summary, dated 10/23/21, indicated collagenase ointment (a prescription ointment used to debride wounds) apply 1 application topically 2 times a day. A Wound Nurse Practitioner Note, dated 10/25/21 at 9:06 A.M., indicated location - left medial ankle .follow surgeon's orders and scheduled follow up appointments-wet to dry dressings daily. A Physician's orders, dated 11/16/21, indicated cleanse left medial foot and lateral ankle with normal saline, apply wet to dry dressing, cover with pad and secure every day shift for wound care with a start date of 11/17/21. The November 2021 TAR (treatment administration record) indicated on 11/17/21 Resident J started receiving the wet to dry dressing to the left foot and ankle that was ordered on 10/25/21. On 3/18/21 at 2:00 P.M., the Activity Director provided a document, titled Resident Council Minutes, dated December 2022. A review of the document indicated concerns with wound care and medication administration were discussed. Residents in attendance for that meeting included, but were not limited to, Resident J, Resident C and Resident F as indicated by the document. During an interview on 3/21/22 at 9:25 A.M., the Wound Nurse indicated she could not explain why the treatment order from 10/25/21 was not entered into the electronic medical record until 11/17/21 because she didn't work for the facility at that time. However, the Initial Admission Evaluation, dated 10/23/21, indicated she completed the skin section of the evaluation. She was able to recall Resident J admitted with an infection in his wounds. On 3/11/22 at 4:21 P.M. The Administrator provided a copy of a facility policy, titled Physician Orders, dated 8/3/2010, and indicated this was the current policy used by the facility. A review of the policy indicated Medical Orders Transcription .the provider may write the order in the medical record .a provider may give a medical order over the phone .verbal orders are accepted but will be input into [the electronic medical record] by the nurse as soon as practicable. The practitioner will need to sign off on these orders . C2. During a random observation on 3/13/22 at 10:00 a.m., Resident D was observed in his room. The resident was lying in his bed. A soiled, undated dressing was noted on his mid-abdomen. The resident was observed to expose the wound. The wound had a moderate amount of thick, dark red, and whitish drainage. During an interview the resident indicated his dressing did not get changed every day. On 3/14/22 at 9:30 a.m., Resident D was observed in his room. An undated dressing was noted on his mid-abdomen. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a wound care observation on 3/15/22 at 10:00 a.m., the Wound Nurse was observed at the resident's bedside. The Wound Nurse removed an undated dressing. During an interview, at that time the Wound Nurse indicated the dressing should be dated at the time the dressing was changed. On 3/15/22 at 10:30 a.m., the clinical record of Resident D was reviewed. The diagnosis included but were not limited to, open wound of abdominal wall. A Quarterly MDS (Minimum Data Set) assessment, dated 2/21/22, indicated Resident D was cognitively intact. A Physician's Order Summary Report, dated March 17, 2022, indicated Cleanse surgical site to mid abdomen with NS [normal saline], pat dry, apply xeroform in wound bed and lastly cover with a bordered gauze Q [every] night shift for surgical wound. A Care Plan, dated 4/30/21 and current through 3/28/22, indicated Resident D was at risk for altered skin integrity related to impaired mobility. The resident had a surgical wound. The interventions included but were not limited to administer treatments as ordered by a medical provider. A Nurse Practitioner note, dated 3/7/22, indicated to encourage nursing staff to change dressings as ordered. A wound evaluation, dated 3/14/22, indicated to change the dressing daily. C3. During an interview on 3/18/22 at 2:30 p.m., Resident E indicated his dressings did not get changed every day as ordered by the physician. On 3/21/22 at 8:30 a.m., the clinical record of Resident E was reviewed. The diagnoses included but were not limited to, acquired absence of right toe and dependence of renal dialysis. The Annual MDS assessment, dated 12/17/21, indicated Resident E was cognitively intact. The physician orders, dated 3/17/22, indicated Right plantar/heel eschar: Cleanse area with wound cleanser or normal saline. Paint the areas with Betadine daily, secure with dry gauze/kerlix daily. During a wound care observation on 3/17/22 at 2:33 p.m., the Wound Nurse was observed completing Resident E's dressing change. The dressing on Resident E's right foot was undated. During an interview at that time, the Wound Nurse indicated the dressing should have been dated. On 3/18/21 at 2:00 P.M., the Activity Director provided a document, titled Resident Council Minutes, dated December 2022. A review of the document indicated concerns with wound care and medication administration were discussed. Residents in attendance for that meeting included, but were not limited to, Resident J, Resident C and Resident F as indicated by the document. C4. During an interview on 3/13/22 at 11:30 a.m., Resident F indicated the areas on his legs were getting worse and sometimes the dressings on this legs do not get changed for days. On 3/15/22 at 2:33 p.m., the clinical record of Resident F was reviewed. The diagnosis included but were not limited to, Type 2 diabetes mellitus with diabetic neuropathy. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Annual MDS assessment, dated 3/12/22, indicated Resident F was cognitively intact. A Physicians Order, with a start date of 12/27/21, indicated to wrap the bilateral lower extremities with kerlix and ace wraps from toes to knees every day for lymphedema. A care plan, undated, indicated Resident F was at risk for further skin breakdown. The interventions included, but were not limited to: evaluate existing wound daily. During a wound care observation on 3/18/22 at 2:00 p.m., the ADON was observed providing wound care. The ADON removed the undated dressing. During an interview at that time, the ADON indicated the dressing should have been dated indicating the date of the previous dressing change. A wound evaluation, dated 3/14/22, indicated to change the dressing daily. On 3/18/22 at 2:15 p.m., a policy/procedure was requested from the ADON for dating the dressing at the time it was changed. On 3/18/21 at 2:00 P.M., the Activity Director provided a document, titled Resident Council Minutes, dated December 2022. A review of the document indicated concerns with wound care and medication administration were discussed. Residents in attendance for that meeting included, but were not limited to, Resident J, Resident C and Resident F as indicated by the document. On 3/21/22 at 4:00 p.m., a policy/procedure for dating dressings was not provided from the facility by the end of the exit date. The Immediate Jeopardy, that began on 1/11/22 and 2/22/22, was removed on 3/16/22 when the facility inserviced the facility staff on following physician's orders and emergency diabetic medications, but the noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because a systemic plan of correction had not been developed and implemented to prevent recurrence. This Federal tag is related to Complaint IN00374538. 3.1-37(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 44849 Based on interview and record review, the facility failed to ensure urinary catheter care was provided for 1 of 2 residents reviewed for catheter care. This resulted in a resident being diagnosed with sepsis and a urinary tract infection. (Resident B) Finding includes: The clinical record for Resident B was reviewed on 3/9/22 at 11:22 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder and neurogenic bladder. The Admission MDS (Minimum Data Set) assessment, dated 1/1/22, indicated Resident B was cognitively intact and did not have an indwelling urinary catheter. An Initial Admission Evaluation, dated 12/27/21 at 6:26 p.m., indicated Resident B had a 14f (size) indwelling Foley catheter that was draining clear urine. A Nurse Practitioner Progress Note, dated 1/11/22 at 2:32 p.m., indicated Resident B was seen for increased confusion and fever. The Physical Therapist reported Resident B had increased confusion and agitation. The resident requested to go to the hospital. An order to send the resident to the emergency room for evaluation was written. A Nurse Practitioner Progress Note, dated 1/13/22 at 2:08 P.M., indicated .Resident B had an indwelling Foley catheter and the catheter had been removed three days prior due to irritation. A Nurse's progress note, dated 1/13/22 at 3:49 p.m., indicated Resident B was found unresponsive. Resident B's blood pressure was 80/39 mm/Hg (millimeters/Mercury), temperature 101.2 degrees Fahrenheit, pulse 139 beats per minutes, and the blood sugar was 154. Emergency services were called to transport the resident to the emergency room for evaluation. The clinical record lacked physician's orders for the care and management of the indwelling urinary catheter. The clinical record lacked a care plan for the indwelling urinary catheter. The clinical record lacked documentation that urinary catheter care had been provided. During an interview on 3/11/22 at 9:45 a.m., the DON indicated Resident B should have had physician's orders and a care plan for the urinary catheter. On 3/11/22 at 2:30 p.m., a Hospital Progress Note, dated 1/13/22, indicated Resident B was admitted with sepsis, respiratory failure, an acute urinary tract infection. On 3/11/22 at 2:30 p.m., a Hospital Discharge Summary, dated 2/8/22, indicated on 1/28/22 Resident B was comfort measures only. Resident B's respirations had ceased. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 3/14/22 at 10:00 a.m., a urinalysis result, dated 1/17/22, indicated the urinalysis that had been collected on 1/13/22 had greater than 100,000 CFU/ML (colony-forming unit per milliliter) of Proteus vulgaris (bacteria) in the urine. On 3/14/22 at 10:30 a.m., the DON provided a copy of a facility policy, titled Catheter Care, dated 10/13/13, and indicated this was the current policy used by the facility. A review of the policy indicated catheter care is performed at least twice daily on residents that have indwelling catheters, for as long as the catheter is in place .the risk of bacteremia (bacteria in the blood) is 3 to 36 times more likely than residents without an indwelling catheter. This Federal tag relates to Complaint IN00374538. 3.1-41(a)(2)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 44849 Based on interview and record review, the facility failed to ensure a physicians orders were obtained for 1 of 21 residents reviewed. Indwelling urinary catheter and oxygen therapy orders were not obtained. (Resident B) Finding includes: The clinical record for Resident B was reviewed on 3/9/22 at 11:22 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder and neurogenic bladder. The Admission MDS (Minimum Data Set) assessment, dated 1/1/22, indicated Resident B was cognitively intact, was receiving oxygen therapy, and did not have an indwelling urinary catheter. An Initial Admission Evaluation, dated 12/27/21 at 6:26 p.m., indicated Resident B had a 14f (size) indwelling Foley catheter that was draining clear urine and was receiving 5 liters per minute of oxygen through a nasal cannula. A Nurse Practitioner Progress Note, dated 1/13/22 at 2:08 p.m., indicated Resident B had an indwelling urinary catheter that had been removed three days prior. The clinical record lacked Physician's orders for the care and management of the urinary catheter and oxygen therapy. During an interview on 3/11/22 at 9:45 A.M., the Director of Nursing indicated Resident B should have had physician's orders for the urinary catheter and oxygen therapy. On 3/11/22 at 4:21 P.M., the Administrator provided a copy of a facility policy, titled Physician Orders, dated 8/3/10, and indicated this was the current policy used by the facility. A review of the policy indicated Medical Orders Transcription .the provider may write the order in the medical record .a provider may give a medical order over the phone .verbal orders are accepted but will be input into [the electronic medical record] by the nurse as soon as practicable. The practitioner will need to sign off on these orders . This Federal tag relates to Complaint IN00374538. 3.1-22(c)(1)

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	155780	A. Building B. Wing	03/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Healthcare Center	7465 Madison Ave Indianapolis, IN 46227

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 44849 Based on observation, interview, and record review, the facility failed to ensure sufficient and competent nursing staff was provided. Treatment orders were not in place, appropriate care for a gtube was not provided, dressings were not dated, PICC line dressings were not changed, catheter care was not provided, medications were left in resident rooms, and antibiotics were given longer than prescribed. (Resident B, Resident Y, Resident E, Resident X, Resident M, Resident F, Resident D, Resident K, Resident J, Resident N) Finding includes: 1. During the survey dates of 3/9/22 through 3/21/22 the following interviews were completed. a. The facility does not have enough staff on evenings and weekends. b. The facility does not have enough staff. It takes an hour for call lights to be answered. 2. During an interview on 3/14/22 at 9:10 a.m. the Director of Nursing indicated the facility does not use competencies, instead the facility uses staff in-services for education. 3. On 3/18/21 at 2:00 P.M., the Activity Director provided a documents, titled Resident Council Minutes. A review of the documents indicated long call light times were discussed at the Resident Council Meetings on 1/31/22 and 2/28/22. During Resident Council Meeting on 3/18/22 at 2:15 p.m., the residents indicated the facility does not have enough staff on third shift. 4. The Facility Assessment Tool, dated 10/1/21, indicated: .average daily census 72 . staffing needs .for direct care needs: 3 or 4 Licensed Practical Nurses (LPN) or Registered Nurses (RN) on day shift, 3 or 4 LPN or RN on evening shift, and 2 LPN or RN on night shift. 5. The as worked nursing schedule, dated 2/23/22 to 3/9/22, indicated: a. On 2/23/22, the facility had 1 Licensed Practical Nurse (LPN) that worked day shift, 1 LPN that worked evening shift, and 1 Registered Nurse (RN) that worked night shift. b. On 2/24/22, the facility had 1 LPN that worked day shift, 2 LPN's that worked evening shift, and 1 LPN that worked night shift. c. On 2/25/22, the facility had 1 LPN that worked day shift, 1 RN that worked evening shift, and 1 RN that worked night shift. d. On 2/26/22, the facility had 1 LPN that worked day shift, 1 LPN that worked evening shift, and 1 LPN that worked night shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0725 Level of Harm - Actual harm Residents Affected - Some	e. On 2/27/22, the facility had 1 LPN that worked day shift, 1 LPN that worked evening shift, and 1 LPN that worked night shift. f. On 2/28/22, the facility had 1 LPN that worked day shift, 2 LPN's that worked evening shift, and 1 RN that worked night shift. g. On 3/1/22, the facility had 2 LPN's that worked day shift, 1 LPN that worked evening shift, and 1 LPN that worked night shift. h. On 3/2/22, the facility had 1 LPN that worked day shift, 1 LPN that worked evening shift, and 1 LPN that worked night shift. i. On 3/3/22, the facility had 1 LPN that worked day shift, 1 LPN and 1 RN that worked evening shift, and 1 RN that worked night shift. j. On 3/4/22, the facility had 2 LPN's that worked day shift, 2 LPN's that worked evening shift, and 1 LPN that worked night shift. k. On 3/5/22, the facility had 1 LPN that worked day shift, 1 LPN and 1 RN that worked evening and night shift. l. On 3/6/22, the facility had 2 LPN's that worked day shift, 1 LPN and 1 RN that worked evening and night shift. m. On 3/7/22, the facility had 1 LPN that worked day shift, 1 LPN and 1 RN that worked evening shift, and 1 RN that worked night shift. n. On 3/8/22, the facility had 1 LPN that worked day shift, 1 LPN that worked evening shift, and 1 LPN that worked night shift. o. On 3/9/22, the facility had 1 LPN that worked day shift, 1 LPN that worked evening shift, and 1 LPN that worked night shift. 6. The lack of sufficient nursing staff resulted surgical dressing changes not being completed. Cross reference F684. 7. The lack of sufficient nursing staff resulted care not being provided for a feeding tube. Cross reference F693. 8. The lack of sufficient nursing staff resulted PICC line dressings not being changed. Cross reference F694. 9. The lack of sufficient nursing staff resulted nutritional supplements not being provided. Cross reference F692. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	10. The lack of sufficient nursing staff resulted medications being left in a resident room. Cross reference F689. 11. The lack of sufficient nursing staff resulted a resident receiving unnecessary medications. Cross reference F757. 12. The lack of sufficient nursing staff resulted a lack of urinary catheter care. Cross reference F690. This Federal tag relates to Complaint IN00374538. 3.1-17(a)