STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOW CROSSING HEALTH & REHABILITATION CENTER	**3550 CENTRAL AVE COLUMBUS, IN 47203**

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to follow physician's orders related to monitoring heart rate and blood pressure for a resident who received medication for hypertension and failed to develop a Care Plan for a resident who required a leg brace for 2 of 25 residents reviewed. (Residents 30 and 56) Findings include: 1. The clinical record for Resident 30 was reviewed on 03/04/20 at 4:28 P.M. A Significant Change MDS (Minimum Data Set) assessment, dated 01/08/20, indicated the resident was cognitively intact. [DIAGNOSES REDACTED]. The Care Plan for hypertension was provided by the ADON (Assistant Director of Nursing) on 03/05/20 at 9:08 A.M. Interventions included, but were not limited to, .Administer medications as ordered .Monitor blood pressure .[MEDICATION NAME] . The physician's orders and the MAR (Medication Administration Record) for February and March, 2020, were provided by the ADON on 03/05/20 at 9:08 A.M. The MAR indicated the resident had an order, with a start date of 09/30/19, for [MEDICATION NAME] (an antihypertensive medication), 12.5 mg (milligrams), every day for hypertension. An order, dated 02/27/20, indicated, .add HR (Heart Rate) and B/P (Blood Pressure) to [MEDICATION NAME] order . The February 2020 MAR lacked documentation that the HR and B/P had been added to the order on February 28 and 29, 2020. The March 2020 MAR lacked documentation of a HR on 03/01/20, a legible HR and B/P on 03/02/20, and a HR on 03/04/20 and 03/05/20. During an interview on 03/05/20 at 9:06 A.M., the ADON indicated the staff's documentation should be legible. The physician's order for the blood pressure and heart rate values should have been documented on the MAR on February 28, and 29, 2020, as well as documented and legible on March 1, 2, 4, and 5, 2020. The current PHYSICIAN'S ORDERS policy, dated 10/2014, was provided by the Administrator on 03/05/20 at 9:41 A.M. The policy indicated, .Facility nursing personnel will ensure clear, accurate and complete physician's orders .Transcribe new order onto MAR .as indicated. Ensure any follow through is completed . 2. The clinical record for Resident 56 was reviewed on 03/04/20 at 1:11 P.M. An Admission MDS assessment, dated 02/06/20, indicated the resident was cognitively intact. [DIAGNOSES REDACTED]. During an observation on 03/03/20 at 2:42 P.M., the resident was lying in bed. She had a brace on her right leg that started above the knee and extended down to the ankle. A Nurse's Note, dated 01/31/20, indicated the report from the local hospital documented the resident had a right distal fractured femur, with internal fixation. The right lower extremity was in a brace and wrapped with ace wrap to keep it straight. A Orthopedic Visit, dated 02/26/20, indicated the resident had a ROM (Range of Motion) brace set. The resident's complete care plan was reviewed and the resident lacked a care plan to address the resident's leg brace. During an interview on 03/06/20 at 2:27 P.M., the DON indicated the resident had a brace to the right leg. The resident did not have a care plan for the brace and should have. The current facility policy titled Care Plan Development and Review with a revision date of 9/17, was provided by Corporate Clinical Support Nurse on 03/05/20 at 10:00 A.M. The policy indicated, .This facility shall develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment . 3.1-35(a)
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to follow the physicians' orders related to skin treatments and laboratory orders for 2 of 18 residents reviewed. (Residents 25, 35) Findings include: 1. The clinical record for Resident 25 was reviewed on 03/05/20 at 9:28 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 12/14/19, indicated the resident was moderately cognitively impaired. [DIAGNOSES REDACTED]. The resident was at risk for pressure ulcers and had two venous/arterial ulcers. A facility skin assessment, dated 11/06/19, indicated the resident developed a non-pressure ulcer to her left shin that was not present on admission to the facility. The wound measured 1.0 cm (centimeters) x (by) 1.0 cm x 0.3 cm. The wound bed contained yellow slough (dead tissue), and the wound edges were red. The most recent skin assessment, dated 03/03/20, indicated the wound measured 0.9 cm x 0.6 cm x 0.3 cm. The wound bed was pink, but contained a small amount of dead tissue, and the wound edges were pink. During an interview on 03/05/20 at 3:32 P.M., the ADON (Assistant Director of Nursing) indicated the resident developed non-pressure vascular ulcers in the facility several months ago. Nursing staff were administering treatments here, but the wounds were getting worse, so they sent the resident to the wound center. The resident currently had one vascular wound remaining and the wound center administered the treatments. The wound center documentation was provided by the ADON on 03/05/20 at 12:09 P.M. A physician's note, dated 01/21/20, indicated the resident's wounds were cleaning up but not closing properly .brawny (strong) [MEDICAL CONDITION] persists in left leg . The physician indicated they would change the wound treatment and cover the wound with an Unna boot (a type of compression dressing). The wound center orders, dated 01/21/20, indicated the facility nursing staff were to cleanse the wounds with normal saline and apply a collagen wound dressing and gauze wrap on Thursdays and Saturdays. For [MEDICAL CONDITION] control, the facility was to apply an Unna boot and a self-adherent wrap to the left leg on Thursdays and Saturdays. The resident's January and February 2020 treatment records indicated the facility administered the wound treatments as ordered, but never applied an Unna boot to the resident's left leg. Wound physician's orders [REDACTED]. The Unna boot and a self-adherent wrap to the left leg were to be applied for [MEDICAL CONDITION] control. The treatments would be administered by the nurse at the wound center on 02/14/20 due to the facility not doing dressing changes . During an interview on 03/05/20 at 10:31 A.M., the wound center office person indicated the resident started receiving treatment at the wound center on 12/17/19. After each visit to the wound center, the driver and the resident would each receive a copy of the wound center documentation, that included the treatment orders. She also faxed the orders to the facility. The facility staff were able to access the computer program the wound center used so they could review and print the wound center documentation themselves. During an interview on 03/05/20 at 3:46 P.M., the wound center nurse indicated the physician ordered an Unna boot and the resident would continually come in without an Unna boot. When she first called the facility, they (facility staff) acted like they didn't know about the boot. The Unna boot was first ordered on [DATE]. The wound center would apply the wound dressing and the Unna boot and send orders back with the resident to the facility. The resident would come to her next appointment with nothing on, not even a dressing. When she called the facility, the nurses acted like they didn't have the orders. That was why the wound center started administering the treatments for the resident. During an interview on 03/05/20 at 2:32 P.M., the resident indicated she was not sure how long she had the wound

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) on her left leg. She went to the wound clinic for the treatments. The facility applied a treatment to the wound, but they never wrapped her leg. During an interview on 03/06/20 at 11:11 A.M., the Corporate Support Nurse indicated it took a while for the facility to get access to current orders and documentation in the wound center's computer system. The facility had to request the physician's orders [REDACTED]. The clinical record for Resident 35 was reviewed on 03/04/20 at 1:57 P.M. A Quarterly MDS assessment, dated 01/03/20, indicated the resident was severely cognitively impaired. [DIAGNOSES REDACTED]. The current physician's orders [REDACTED]. The labs were to be obtained in February and August. The resident's clinical record lacked the 6 month lab test for February. The resident's current medication orders included, but were not limited to, an open ended physician's orders [REDACTED]. During an interview on 03/04/20 at 11:46 A.M., the Corporate Support Nurse indicated the facility had not obtained the labs that were due in February 2020. The current physician's orders [REDACTED].M. The policy indicated, .Facility nursing personnel will ensure clear, accurate and complete physician's orders [REDACTED].as indicated. Ensure any follow through is completed . 3.1-37(a)

F 0686

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide appropriate pressure ulcer care and prevent new ulcers from developing.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation, interview, and record review, the facility failed to prevent a Stage III, Deep Tissue Injury (DTI), and a Stage II pressure ulcers for 4 of 6 residents reviewed for pressure ulcers. (Resident 34, 56, 33, and 29) Findings include: 1. The clinical record for Resident 34 was reviewed on 03/04/20 at 9:39 A.M. A Significant Change MDS (Minimum Data Set) assessment, dated 01/01/20, indicated the resident was cognitively intact. [DIAGNOSES REDACTED]. The resident was at risk for developing pressure ulcers. An Initial Pressure Ulcer Assessment, dated 02/19/20, indicated the resident had a Stage III (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed) pressure ulcer. The wound measured 2 cm (centimeters) X (by) 3 cm X 0.1 cm, with seriosanguinous (both blood and a clear liquid) drainage, and no tunneling or undermining. The wound bed was yellow with pink irregular edges. An Ongoing Assessment of Pressure Ulcer, dated 02/28/20, indicated the resident had an Unstageable (presents as an ulcer in which depth of tissue damage was not able to be determined due to presence of nonviable tissue) pressure ulcer. The wound measured 0.7 cm X 0.7 cm X 0.2 cm, with seriosanguinous drainage, and no tunneling/undermining. The wound bed was irregular and red. A Pressure Ulcer Risk Care Plan, with a start date of 01/18/19, indicated the resident was at risk for the development of pressure ulcers related to deep vein [MEDICAL CONDITIONS], venous ulcers,[MEDICAL CONDITION]([MEDICAL CONDITION] reflux disease),
general weakness, right [MEDICAL CONDITION] with right hip replacement, [MEDICAL CONDITIONS], and [MEDICAL CONDITION].
Interventions included, but were not limited to, a head to toe skin assessment at least weekly by a licensed nurse, staff to observe skin condition while providing care, notify the nurse of any skin concerns for further assessment and possible physician and resident representative notification, pressure reducing cushion to chair, pressure reducing mattress to bed, encourage and assist resident with turning and repositioning at least every two hours and as tolerated, encourage nutrition and hydration, lotion per order, physical and occupation therapy as ordered. A Shower Sheet, dated 02/17/20, had no indication the resident had any skin issues. The February 2020 Weekly Skin Assessment indicated on 02/18/20, the resident had no skin alterations noted, the skin remained intact. The resident had an order, dated 11/29/19 through 01/31/20, that indicated for to apply skin prep to the right heel daily. During an interview on 03/05/20 at 2:53 P.M., the DON (Director of Nursing) and ADON (Assistant Director of Nursing) indicated they had been watching a spot on the top of the residents right foot that had been contact [MEDICAL CONDITION]. The resident had been getting skin prep to the right heel in January but the order was discontinued because the resident had been getting it too long. The resident had an order to float the heels while in bed and was compliant with staff for floating the heels. The resident had a [MEDICAL CONDITION] in December 2019. The resident was not as mobile as she had been in the past and had needed more assistance. When the wound developed there were orders in place and the resident had requested to go to the wound center. Currently the wound was being addressed at the wound clinic and the facility was not to change the dressings. 2. The clinical record for Resident 56 was reviewed on 03/04/20 at 1:11 P.M. An Admission MDS assessment, dated 02/06/20, indicated the resident was cognitively intact. [DIAGNOSES REDACTED]. During an observation on 03/03/20 at 2:42 P.M., the DON knocked on the residents door and went into the room. She explained to the resident she was there to complete her wound care and measure the wound. She washed her hands and donned gloves. She removed the blankets from the residents feet, removed the pressure relieving devices that included boots, and the Heelz up device. The socks were removed. The right heel had a dark purple area towards the heel. The wound measured 2.8 cm X 2.5 cm. The DON indicated the area started as a DTI, had never opened and was never fluid filled. The resident had a brace on her right leg that started above the knee and extended down to the ankle. An Initial Pressure Ulcer Assessment, dated 02/10/20, indicated the resident had a DTI to the right heel. The wound measured 1 cm X 1 cm X 0.1 cm. The wound was deep purple with irregular pink wound edges. An Ongoing Assessment of Pressure Ulcer, dated 03/03/20, indicated the resident had a DTI to the right heel. The wound measured 2.8 cm X 2.5 cm X <(less than) 0.1 cm. The wound was deep purple with irregular pink wound edges. A Shower Sheet, dated 02/06/20, had no indication the resident had any skin issues. A Pressure ulcer Risk Care Plan, dated 02/07/20, indicated, the resident was at risk for the development of pressure ulcers related to, weakness, limited mobility, knee replacement, pain,depression, diabetes, and incontinence. Interventions included, but were not limited to, a head to toe skin assessment at least weekly by a licensed nurse, staff to observe skin condition while providing care, notify the nurse of any skin concerns for further assessment and possible physician and resident representative notification, pressure reducing cushion to chair, pressure reducing mattress to bed, encourage and assist resident with turning and repositioning at least every two hours and as tolerated, and encourage nutrition and hydration. During an interview on 03/05/20 at 3:03 P.M., the DON indicated the resident had a DTI to the right heel that was found on 02/10/20 when the nurse was completing her weekly skin assessments. The wound had slowly gotten bigger. When the wound started she had initiated the use of a Heelz up device. The wound was bigger the next week so she placed off-loading boots on the resident's feet. The area was slowly healing. The resident was compliant with wearing the boots and elevating her heels. The resident didn't have any orders for interventions for the heels prior to developing the wound.

3. The clinical record for Resident 33 was reviewed on 03/05/20 at 3:11 P.M. A Significant Change MDS assessment, dated 12/25/19, indicated the resident was moderately cognitively impaired. [DIAGNOSES REDACTED]. The resident was at risk for developing pressure ulcers. During an observation on 03/05/20 at 10:36 A.M., RN 2 knocked on the residents door and went into the room. She explained to the resident she was there to provide wound care on her left heel. She washed her hands and donned gloves. She removed the soft boot from the residents left foot. The socks were removed. The left heel had a small open area. The wound edges were irregular and pink. RN 2 indicated the area started as a DTI and opened about a month ago to a Stage III. An INITIAL PRESSURE ULCER ASSESSMENT form, dated 01/09/20, indicated the resident had a DTI on her left heel measuring 6.5 cm x 4.5 cm, with a dark wound bed and pink wound edges. An ONGOING ASSESSMENT OF PRESSURE ULCER form,
dated 01/21/20, indicated the wound had changed to a Stage III measuring 2.5 cm x 3.0 cm and a depth of less than 0.1 cm. The wound bed was red with a serous drainage and irregular pink edges. An ONGOING ASSESSMENT OF PRESSURE ULCER form, dated
03/03/20, indicated the Stage III measured 0.4 cm x 0.5 cm with a depth of less than 0.1 cm. The wound bed was partially intact/partially open with irregular pink edges. A Skin Condition Baseline Care plan, dated 12/18/19, had interventions of Monitoring skin for sign/symptoms of skin breakdown. Resident to be monitored per SWAT (Skin and Weight Assessment Team) for 4 weeks following admission . The Shower Sheet, dated 01/06/20, had no indication the resident had any skin concerns. A Weekly Skin Assessment, dated 01/08/20, indicated the resident had No NEW skin alteration . During an interview on 03/05/20 at 2:42 P.M., the DON indicated skin prep and an off loading boot were started to the left heel on 01/09/20 when the DTI was found.

4. During an interview on 03/03/20 at 9:52 A.M., Resident 29 indicated he was not supposed to be sitting up in his chair for very long, he was supposed to be in bed because he had a wound on his bottom. He was paralyzed from the waist down, and needed total staff assistance for turning in bed. The staff here would do good for a day with turning and repositioning him, then they next day it would be as if the staff weren't even aware that he had a pressure wound. During a wound observation on 03/03/20 at 2:18 P.M., the following was noted: The resident had a wound on his lower right buttock/upper right leg area that measured 7.7 cm X 10 cm, with a depth of less than 0.1 cm. The wound bed was pink, with areas of new tissue present. There was no drainage or foul odor noted, and no signs of infection. The clinical record for the resident was reviewed on 03/05/20 at 2:33 P.M. A Quarterly MDS assessment, dated 12/22/19, indicated the resident was cognitively intact. [DIAGNOSES REDACTED]. The resident required total dependence from staff for bed mobility, transferring, and toileting. The resident required extensive staff assistance for dressing, limited assistance for personal hygiene, supervision for eating, and was independent with locomotion. The resident utilized wheelchair. The resident was at risk for pressure ulcers, had one Stage II pressure ulcer that was not present upon admission, moisture associated skin damage, and an unstageable deep tissue injury that was present upon readmission from the hospital. The resident utilized pressure reducing devices to his bed and chair, nutritional interventions, and pressure ulcer care. A Pressure Ulcer Risk Care Plan with a start date of 11/05/19, indicated the resident was at risk for the development of pressure ulcers related to, [MEDICAL CONDITION], current pressure ulcer, and history of pressure ulcers. Initial interventions, with a start date of 11/05/19, included, but were not limited to, a head to toe skin assessment at least weekly by a licensed nurse, staff to observe skin condition while providing care, notify the nurse of any skin concerns for further assessment and possible physician and resident representative notification, a pressure reducing cushion to chair, a pressure reducing mattress to bed, encourage and assist resident with turning and repositioning at least every two hours and as tolerated, encourage nutrition and hydration, float heels, LAL (Low Air Loss) mattress, skin prep as preventative to bilateral heels and left lateral ankle, offload boots to bilateral lower extremities as ordered. On 01/06/20 an intervention to turn the resident

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) every two hours was added to the Care Plan. A Shower Sheet, dated 01/06/20, had no indication the resident had any skin issues. An Initial Pressure Ulcer Assessment, dated 01/06/20, indicated the resident had a Stage II (Partial thickness loss of dermis presenting as a shallow, open ulcer with a red-pink wound bed without slough) pressure ulcer. The wound measured 8.5 cm X 8.0 cm X less than 0.1 cm, with serous (clear to pale yellow) drainage, and no tunneling or undermining. The wound bed was red and white, with irregular edges. A Non-Adherence Care Plan, with a start date of 12/06/19, indicated the resident was non-adherent with laying down during the day to decrease pressure off his bottom and not turning side to side. Interventions included, but were not limited to, .Educate the resident . On 03/06/20 at 11:47 A.M., the DON provided Nurse's Notes for the resident since admission to the facility. There was no documentation of the resident refusing to turn and reposition, or any non-compliance with interventions documented in the Nurse's Notes. There was no indication staff provided any education regarding non-compliance with interventions for pressure ulcer treatments or the risk of developing pressure ulcers. On 03/06/20 at 9:51 A.M., the Corporate Support Nurse provided ADL (Activities of Daily Living) Records for the resident for November 2019 through March 2020. The document indicated staff were to provide Preventative Skin Care, that included keeping the skin dry, preventing skin to skin contact, and encouraging and/or assisting the resident to turn and reposition every 2 hours, and to float the resident's heels when in bed, as tolerated. Instructions on the form indicated, .Should the resident refuse care, enter initials, circle and address refusal below . Staff documented they provided Preventative Skin Care every shift that the resident was in the facility. There was no indication the resident ever refused care. The current facility policy, titled Skin Management Program, with a most recent revision date of 10/2013, was provided by the Corporate Support Nurse on 03/06/20, at 11:22 A.M. The policy indicated, .The facility will assess/identify the presence of risk factors that may contribute to the development of pressure ulcers and other skin alterations in an effort to prevent skin breakdown and/or further deterioration limited by the individual's recognized pathology and pre-existing co-morbid conditions . 3.1-40(a)(1) 3.1-40(a)(2)
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow appropriate infection control guidelines during medication administration related to respiratory care for a resident with a history of respiratory infections for 1 of 3 residents reviewed for respiratory care. (Resident 21) Findings include: A medication administration for Resident 21 was observed on 03/03/20 at 10:41 A.M. RT (Respiratory Therapist) 3 prepared to administer the resident's Yupelri Nebulizer breathing treatment. RT 3 donned gloves, got her keys out of her pocket to unlock the medication cart, turned pages in a binder containing the MAR/TAR (Medication Administration Record/Treatment Administration Record), used her ink pen to document in the binder, then poured the medication solution into a plastic chamber for the breathing treatment. She carried the chamber into the resident's room, checked the resident's lung sounds, pulse, and oxygen saturation, then wrote on a piece of paper she pulled from her pocket. She gathered the breathing treatment apparatus from a plastic bag that was sitting on a dresser behind the resident's television. She took one chamber off of the breathing treatment mask and replaced it with the one she brought into the room. She indicated the staff used a different chamber for the different medications the resident received. The RT dropped the tubing that lead from the breathing treatment machine on the floor. She picked up the tubing, attached it to the new chamber, turned on the machine, and applied the mask to the resident's face. The RT checked the resident's heart rate and respirations during the treatment and documented notes on the paper she pulled from her pocket. When the treatment was completed, the RT placed the tubing and the mask back in the plastic bag. She listened to the resident's lungs, and checked their pulse. She rinsed the medication chamber with sterile water and placed it back in the plastic bag with the rest of the breathing treatment components. She removed her gloves and washed her hands. During an interview on 03/05/20 at 10:24 A.M., RT 4 indicated the respiratory staff changed the Nebulizer chambers daily. The masks and tubing were changed weekly. They made sure the Nebulizer tubing never touched the floor. A Quarterly MDS assessment, dated 12/14/19, indicated the resident was severely cognitively impaired. [DIAGNOSES REDACTED]. The MAR indicated [REDACTED].M. The record indicated the resident received Yupelri, 175 mcg (micrograms) in a 3 ml (milliliters) solution, via Nebulizer, once a day, at 10:00 A.M., for [MEDICAL CONDITION]. The respiratory related Care Plans were provided by Medical Records on 03/05/20 at 11:55 A.M. A Care Plan, dated 01/27/20, indicated the resident had pneumonia and had received antibiotics that included, but were not limited to, [MEDICATION NAME]. A hospital record was provided by the DON on 03/06/20 at 10:26 A.M. The record indicated the resident was admitted on [DATE], with pneumonia. The current STEPS, INITIAL AND FINAL - PROVISION OF CARE policy, dated 10/2014, was provided by the Administrator on 03/05/20 at 8:48 A.M. The policy indicated, .Purpose: To provide resident with care in a manner that ensures .safety, infection control and comfort . 3.1-47(a)(6)
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to store and label medications appropriately for 1 of 2 medication carts reviewed. (200 Hall front medication cart) Finding includes: A medication cart for the front of the 200 hall was observed on 03/05/20 at 11:15 A.M. with the Administrator and RN 2. Several loose capsules and tablets were observed in the bottom of the drawers in the cart. The following medications were observed: one large blue and white capsule; one large round, white, tablet; one medium sized, cream colored, round tablet; one white, oval, tablet; one half of a round, white, tablet; and one half of a round, brown, tablet. In the drawer was an, opened, [MEDICATION NAME]pen. The pen had no legible open date, resident's name, or dosage instructions on the pen. During an interview on 03/05/20 at 11:27 A.M., RN 2 indicated the insulin pens should have had the resident's name, the date the pen was opened, and the time it was opened. No loose capsules or tablets should be left in the medication drawers or cart. The current DRUG LABELS policy, dated 12/2017, was provided by the Administrator on 03/05/20 at 11:54 A.M. The policy indicated, .Drugs will be labeled .All .labels must state .Resident's name .expiration date .specific directions for use The current MEDICATION EXPIRATION policy, dated 12/2017, was provided by the Administrator on 03/05/20 at 11:54 A.M. The policy indicated, .Multiple dose injections, such as insulin will expire 28 days after opening .Any product whose expiration dated depends on the date opened must be labeled with the date the product was opened . 3.1-25(j) 3.1-25(k)(1) 3.1-25(k)(2) 3.1-25(k)(3) 3.1-25(k)(5) 3.1-25(k)(6) 3.1-25(k)(7)
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** Based on observation, interview and record review, the facility failed to identify unresolved quality deficiencies involving the development of pressure ulcers for 4 of 6 residents reviewed for pressure ulcers, respiratory care related to infection control during breathing treatments for 1 of 3 residents reviewed for respiratory care, and care plans for 2 of 25 residents reviewed. Findings include: On 03/02/20 at 10:35 A.M., the current facility policy, titled Quality Assessment and Assurance/Performance Improvement, with a revision date of 9/17. The policy indicated, .The Quality Assessment and Assurance Committee shall identify quality deficiencies and develop and implement plans of action to correct these quality deficiencies, including monitoring the effect of implemented changes and making needed revisions to the action plans .Monthly meetings shall review specific areas for the previous month as follows: .Pressure Sores (Areas of Stage III , IV or DTI must have an accompanying investigation) . The facility's Quality Assurance Committee did not identify, develop, and implement appropriate measures to correct identified issues or prevent deficiencies as follows: 1. Development of Pressure Ulcers: Four residents at risk for pressure ulcers developed pressure ulcers after admission. Three of the four residents had developed Stage III and DTI pressure ulcers. Cross reference 686 2. Respiratory Care: A severely cognitively impaired resident was observed receiving a breathing treatment by a respiratory therapist. The respiratory therapist failed to follow infection control guidelines. Cross reference 695 3. Care Plans: A cognitively intact resident had an order to monitor vital signs with the administration of a hypertensive medication. The resident's clinical record lacked

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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 0867 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) documentation of vital signs and legible vital signs for the medication, and a cognitively intact resident with a brace lacked a care plan for a brace. Cross reference 656 During an interview on 03/06/20 at 3:26 P.M., the Administrator and Corporate Support Nurse indicated the repeat deficiencies were not something they reviewed in the QAPI meeting in January. The facility had a form they reviewed each month to see how many pressure ulcers they had. If the number increased significantly, then they would develop some sort of QAPI plan. They did not have any audit tools that had continued from the previously cited deficiencies. 3.1-52(b)(2)