STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE ARBORS MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

(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 the Investigation of Complaints IN00404726, IN00404823, IN00405200, IN00405707, IN00405922, and IN00408969. Complaint IN00404726 - Federal/state deficiencies related to the allegations are cited at F585. Complaint IN00404823 - Federal/state deficiencies related to the allegations are cited at F755. Complaint IN00405200 - Federal/state deficiencies related to the allegations are cited at F684. Complaint IN00405707 - Federal/state deficiencies related to the allegations are cited at F804. Complaint IN00405922 - Federal/state deficiencies related to the allegations are cited at F677. Complaint IN00408969 - No deficiencies related to the allegations are cited. Survey dates: May 22, 23, 24, 25, 26, and 30, 2023. Facility number: 000076 Provider number: 155156 AIM number: 100271060 Census Bed Type: SNF/NF: 130 Total: 130 Census Payor Type: Medicare: 19 Medicaid: 98	F 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility respectfully requests a desk review for these alleged deficient practices.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Todd Smith	Executive Director	06/22/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo 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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	Other: 13 Total: 130 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 6/2/23.			
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, record review, and interview, the facility failed to ensure residents had Physician's Orders for medications and an assessment to self-administer their own medications for 1 of 2 residents reviewed for self-administration of medication. (Resident D) Finding includes: On 5/22/23 at 2:18 p.m., a saline nasal mist spray was on Resident D's bedside table. On 5/24/23 at 3:17 p.m., a saline nasal mist spray was on Resident D's bedside table. Resident D's record was reviewed on 5/24/23 at 9:13 a.m. Diagnoses included, but were not limited to, dementia, chronic obstructive pulmonary disease, and high blood pressure. The Annual Minimum Data Set (MDS) assessment, dated 4/26/23, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 1/5/22, indicated a saline nasal spray solution 0.65% (saline), 1 spray	F 0554	**Tag number: F554 – Self Administration of Medications** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident D – Self Administration of Medications Assessment Completed by 6-20-2023** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents with the potential to self-administer medications have the potential to be affected by the alleged deficient practice. The Director of Nursing/designee audited all facility residents and found no other resident has the ability to**	06/30/2023

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	in each nostril every 1 hour as needed for nasal congestion with unsupervised self-administration. There was no documentation of a self-administration assessment completed for the saline nasal spray. Interview with the Director of Nursing on 5/30/23 at 9:27 a.m., indicated a self-administration of medications assessment should have been completed. 3.1-11(a)		**self-administer medications.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to re-educate nursing staff by 6-23-2023 on evaluation/assessment of residents for Self-Administration of Medications.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place. **DON/designee will conduct an audit of all new admissions the next business day post admission to determine resident's ability to self-administer medications. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 6/30/2023	
F 0568 SS=D	483.10(f)(10)(iii) Accounting and Records of Personal Funds			

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Bldg. 00	§483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. Based on record review and interview, the facility failed to ensure quarterly statements were provided for 1 of 1 residents reviewed for personal funds. (Resident D) Finding includes: Interview with Resident D on 5/22/23 at 2:14 p.m., indicated she did not receive quarterly statements for her resident funds account. The personal funds review was completed with the Business Office Manager (BOM) on 5/30/23 at 2:48 p.m. The BOM indicated the facility handled Resident D's funds. She indicated statements were provided quarterly to the resident's Power of Attorney (POA). The BOM also indicated the resident was cognitively intact. A statement for the resident was dated 12/31/22 - 3/31/23. Interview with the previous BOM at that time, indicated the resident's POA received a copy of statement. She also indicated if the resident wanted to know her balance she would tell her.	F 0568	**Tag number: F568 – Accounting and Records of Personal Funds** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident D's Personal Funds Quarterly Statement to be presented to the resident by the Business Office Manager by 6-20-2023.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents with a facility Personal Funds Account have the potential to be affected by the alleged deficient practice. The Business Office Manager audited all residents with**	06/30/2023

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	Interview with the BOM on 5/30/23 at 2:30 p.m., indicated moving forward she would give the resident a copy of her quarterly statement. 3.1-6(g)		**Personal Funds Account to ensure all residents received Quarterly Statements. This audit to be completed by 6-20-2023.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administrator re-educated Business Office Manager (BOM) by 6-20-2023 on ensuring all residents with a facility Personal Funds Account receive Quarterly Statements.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place. **Administrator will conduct a Resident Personal Funds Audit quarterly for 2 quarters to ensure all residents with a facility Personal Funds Account receive Quarterly Statements. The results of these audits will be reviewed in Quality Assurance Meeting quarterly for 6 months or until an average of 90% compliance or greater is achieved on the second quarter audited. The QA Committee will identify any trends or patterns and make recommendations to revise the**	

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			plan of correction as indicated. Date of compliance: 6/30/2023	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in			

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	paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on record review and interview, the facility failed to ensure the Physician was notified of a fall for 1 of 1 residents reviewed for notification of change. (Resident J) Finding includes: Resident J's record was reviewed on 5/26/23 at 10:00 a.m. Diagnoses included, but were not limited to, chronic kidney disease, schizoaffective disorder, and hemiparesis (weakness) following cerebral infarction (stroke) affecting the left non-dominant side. The Quarterly Minimum Data Set (MDS) assessment, dated 5/5/23, indicated the resident was cognitively intact for daily decision making. He required extensive assistance for bed mobility, transfers, dressing, toilet use, and personal hygiene. A Care Plan, revised on 3/20/23, indicated the resident was at risk for falls and injury related to hemiparesis, medications, predisposing diseases,	F 0580	**Tag number: F580 – Notify of Changes** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident J's fall happened in January of 2023 and moving forward all notifications of pertinent changes in condition will be communicated with all resident physicians and/or NPs. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice. All notifications of pertinent**	06/30/2023

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	and non-compliance for transfers. Interventions included, but were not limited to notify the Physician as needed of any changes and continue to remind resident to ask for assistance. A Fall Note, dated 1/31/23 at 4:15 p.m., indicated the resident had an unwitnessed fall by the bathroom door while he was transferring himself from the toilet to the wheelchair. He stated that he fell and hit his head. He refused to allow the staff to assess his vital signs and provide first-aid care. His daughter persuaded the resident to go to the hospital to get evaluated. His pain was 8 out of 10 from hitting his forehead on the floor. There was no documentation the Physician was notified of the fall. Interview with the Assistant Director of Nursing on 5/30/23 at 10:52 a.m., indicated the Physician should have been notified of the fall occurrence. 3.1-5(a)(1)		**changes in condition will be communicated with all resident physicians and/or NPs.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to educate nursing staff by 6-23-2023 on necessary notifications of changes in condition to resident physician/NP.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct a notification of change audit to ensure notifications of changes are reported to physician/NP per regulation. Audits will be completed 5x/week for 4 weeks, 3x/week for 4 weeks then weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the**	

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			plan of correction as indicated. Date of compliance: 6/30/2023	
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact			

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	information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance			

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	decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.			
	Based on record review, and interview, the facility failed to thoroughly investigate and resolve grievances from a resident's family member that were reported to staff for 1 of 1 residents reviewed for grievances. (Resident B) Finding includes: During an interview with Resident B on 5/22/23 at 11:44 a.m., she indicated a couple of months ago, a CNA would make fun of her when she had to use the bathroom all the time. The CNA would say "What are we going to do with you [resident's name]? There must be something wrong with you." She told her son and he reported the incident to the Social Service Director (SSD).	F 0585	**Tag number: F585 - Grievances** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **Resident B's grievance was initiated in January of 2023 and again in March 2023. Social Services followed up with resident with no concerns voiced and evidence of psychosocial distress. Moving forward all grievances/concerns voiced**	06/30/2023

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	The record for Resident B was reviewed on 5/24/23 at 11:00 a.m. Diagnoses included but were not limited to, dementia without behaviors, chronic kidney disease, depressive disorders, bipolar disorder, and acute kidney failure. The Quarterly Minimum Data Set (MDS) assessment, dated 4/27/23, indicated the resident was cognitively intact and needed limited assist with 1 person physical assist for bed mobility and transfers. The resident needed extensive assist with 1 person physical assist for toileting, and needed physical help with bathing with 1 person assist. A Concern/ Compliment form, dated 1/7/23 and taken by the previous Administrator, indicated the resident's son was concerned about his mom getting changed and the way his mom indicated the CNA spoke to her. He indicated if the statements were true, it could be verbal abuse and he wanted an investigation into the matter. The Administrator informed the son ISDH was going to be notified and told him he would be made aware of the follow up that would be completed after the investigation. The steps taken to investigate the complaint were staff, resident, and other resident interviews. The summary of the pertinent findings indicated the incident occurred but not as the resident indicated to the son. The resident indicated the CNA's voice was loud and the resident does have a history of auditory hallucinations. A urinalysis was obtained and the behavioral contract company was contacted to review the resident's medication. The son was notified on 1/11/23 with the results of the investigation.		**from any source will be investigated per company policy and procedure following federal/state guidelines.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice. Moving forward all grievances/concerns voiced from any source will be investigated per company policy and procedure following federal/state guidelines.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administrator/designee to re-educate all facility staff on the facility's grievance process and proper follow-up from the investigating department manager.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into	

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	There were no staff, resident, or other residents interviews attached to the complaint form, they were unavailable for review. There was no other documentation to support the findings from the investigation. A Concern form, dated 1/16/23, indicated the resident's son again reported another CNA was making comments about his mother going to the bathroom all the time. The complaint was taken by the SSD and then given to the previous Assistant Director of Nursing (ADON) for review and investigation. The previous Administrator was also made aware of the complaint on 1/16/23. The summary of pertinent findings indicated there were no staff members who met the description or name during the report time. A urinalysis was completed and the behavioral health consult would be notified for increased auditory hallucinations reported by the resident. The son was made aware of the results of the complaint on 1/23/23. There were no staff, resident, or other residents interviews attached to the complaint form, they were unavailable for review. There was no other documentation to support the findings from the investigation. Interview with the SSD on 5/25/23 at 11:00 a.m., indicated in March 2023, she was approached by the resident's son in the hallway and he had a concern about a CNA and how she was talking to his mom. The son indicated that he and his wife had brought his mom back to the facility the previous evening and his mom had to use the bathroom. A CNA entered the room and poked fun at his mom and he did not think it was appropriate for the CNA to do that and he wanted the facility to step in and do something about it.		place; **Administrator/designee will conduct an audit of the grievance investigations to ensure proper procedures are followed and necessary departmental follow-up is completed. Audits will be completed 5x/week for 4 weeks, 3x/week for 4 weeks then weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 6/30/2023	

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	155156	A. BUILDING 00 B. WING	05/30/2023

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	The CNA informed the son that it was ok and the resident and herself banter back and forth and she meant no harm. The SSD indicated after the conversation with the resident's son, she immediately went and reported it to the previous Administrator. The next day, during the morning meeting, the concern was brought up and the previous Administrator indicated she had called the resident's son and spoke to him and his wife on speaker phone. The wife indicated that her husband provoked the CNA and then there was an argument between the son and the CNA. The resident's son indicated that he did start the argument with the CNA and apologized for that. The previous Administrator informed the staff she had worked it out between the son and his wife. She also informed the staff she had spoken with the CNA as well regarding customer service. The SSD indicated the son never indicated he thought it was verbal abuse or that his mother was threatened by the CNA. There was no concern form completed for the son's March complaint regarding the CNA and his mom. There were no staff, resident, or other residents interviews available for review to ensure a thorough investigation was completed for the concern. There was no other documentation to support the findings from the investigation. Interview with the resident's son on 5/25/23 at 1:40 p.m., indicated he had dropped his mom off on the night of 3/15/23 and his mom had to use the bathroom. He indicated the CNA was poking fun at his mom but he thought it was harassment and confronted the CNA to stop. He indicated there was an verbal altercation between him and the CNA and he did not want the CNA taking care of			

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	his mom anymore. He reported the incident the next morning to the SSD. The son indicated he vaguely remembered having a phone conversation with him, his wife and the previous Administrator following the incident. Interview with the Interim Administrator on 5/25/23 at 1:30 p.m., indicated there was no other investigation regarding the concerns in 1/2023 and 3/2023 that he could find. The revised and current 9/25/17, "Grievances" policy, provided by the Interim Administrator on 5/25/23 at 12:30 p.m., indicated all written grievances shall include steps taken to investigate the grievance, a summary of pertinent findings or conclusions regarding the concern, and corrective action taken by the facility, including measures taken to prevent further potential violations of any resident. This Federal tag relates to Complaint IN00404726. 3.1-7(a)(2)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services			

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	staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to ensure residents' care plans were updated to reflect the resident for 1 of 26 residents whose care plans were reviewed. (Resident 3) Finding includes: On 5/23/23 at 11:18 a.m., Resident 3 was observed sitting in bed and was not wearing a helmet. On 5/24/23 at 10:06 a.m., Resident 3 was observed sitting in bed and was not wearing a helmet. Resident 3's record was reviewed on 5/25/23 at 9:17 a.m. Diagnoses included, but were not limited to, dementia, severe intellectual disabilities, and cognitive communication deficit. The Annual Minimum Data Set (MDS) assessment, dated 5/1/23, indicated the resident was severely cognitively impaired for daily decision making. A Care Plan, revised on 7/19/19, indicated the	F 0657	Tag number: F657 – Care Plan Timing and Revision I.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident #3's care plan to be updated by 6-20-2023.** II.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice. The facility's IDT will perform a 100% overview of residents' care plans for accuracy as follows: 10 residents' care**	06/30/2023

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	resident had an alteration in neurological status related to stroke and history of seizures. Interventions included, but were not limited to, wear helmet at all times, may remove for hygiene. Interview with the Director of Nursing on 5/30/23 at 9:27 a.m., indicated the care plan was not updated to reflect the resident only wearing while she was up in the wheelchair and out of bed. She was not supposed to wear it while she was in bed. 3.1-35(d)(2)(B)		**plans per week until all care plans reviewed.** III.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **MDS Coordinator/designee to re-educate nursing staff and clinical managers on assessing accuracy and updating of resident care plans.** IV.How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **MDS Coordinator/designee will conduct a care plan audit to ensure resident care plans are accurate and up to date. Audits will be completed as follows: 10 residents' care plans/week until all care plans have been reviewed for accuracy and updated. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months.¿ The QA Committee will identify any trends or patterns and make**	

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			recommendations to revise the plan of correction as indicated. Date of compliance: 6/30/2023	
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals			

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	and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. Based on record review and interview, the facility failed to ensure residents received restorative therapy as recommended to maintain their current level of function for 1 of 2 residents reviewed for therapy. (Resident 13) Finding includes: During an interview, on 5/25/23 at 8:30 a.m., Resident 13 indicated staff were not performing any type of range of motion to his lower or upper extremities. The record for Resident 13 was reviewed on 5/23/23 at 2:18 p.m. Diagnoses included, but were not limited to, stroke, hemiplegia, morbid obesity, unsteadiness on feet, and major depressive disorder. The 4/25/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and needed extensive assist with 2 person physical assist for transfers. The resident had an impairment in functional limitation of range of motion for both sides of his upper and lower extremities. The resident was not receiving therapy or restorative therapy during the assessment period. A Care Plan, revised on 1/10/23, indicated the resident had right hemiplegia (paralysis) related to a stroke. An approach was to have therapy evaluate and treat as ordered.	F 0676	I.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Facility does not currently have a Restorative Therapy Program. This was related to a documentation error. Resident #13's documentation has been corrected.** II.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **The facility does not currently have a Restorative Therapy Program.** III.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **The facility Rehabilitation Director will notify clinical IDT of residents that are graduating from therapy services in morning clinical meeting. Residents are then encouraged to attend the Monday-Sunday**	06/30/2023

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	A Resident Functional Ability assessment, dated 4/28/23, indicated the resident did not ambulate due to a medical condition and was dependent on the sit to stand lift for transfers. In the CNA Task section the following tasks were noted: - Passive Range of Motion Program: Perform 20 reps times 2 sets of flexion and extension to right upper and lower extremity. In the last 30 days there was no documentation the passive range of motion was completed on 4/25, 4/27-4/29, 5/7, 5/11, 5/13, 5/14, 5/16, 5/17, 5/19, 5/22, and 5/24/23. - Nursing Rehab/Restorative: Active Range of Motion Program Perform 20 reps times 2 sets of flexion and extension to all extremities. In the last 30 days, there was no documentation the active range of motion was completed on 4/25-4/30, 5/2-5/9, 5/11, 5/13, 5/15, and 5/16-5/24/23. Interview with the Rehab Director on 5/24/23 at 12:05 p.m., indicated the facility has not had a restorative therapy program since prior to the pandemic. Interview with the Director of Nursing on 5/30/23 at 9:15 a.m., indicated they were in the process of getting the restorative program back up and running again, however, as of now, there was no restorative program in the facility. The CNAs would be responsible for ensuring the range of motion was completed. 3.1-38(a)(1)(B)		**exercise activity and report to clinical IDT regarding participation as tolerated.** IV.How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **The facility Rehabilitation Director will notify clinical IDT of residents that are graduating from therapy services in morning clinical meeting. Residents are then encouraged to attend the Monday-Sunday exercise activity and report to clinical IDT regarding participation as tolerated.** Date of compliance: 6/30/2023	
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to			

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	carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to provide ADL (activities of daily living) assistance to dependant residents related to nail care, getting out of bed, removing facial hair for female residents, completing scheduled showers, and hair care for 4 of 5 residents reviewed for ADL care. (Residents F, G, B, and H) Findings include: 1. On 5/22/23 at 2:10 p.m. and 3:30 p.m., Resident F was observed in her room in bed. The resident's fingernails on both hands were long and in need of trimming. On 5/23/23 at 9:25 a.m., 1:55 p.m., and 3:16 p.m., the resident was again observed in bed and her fingernails remained long. On 5/24/23 at 9:23 a.m., 11:10 a.m., and 2:45 p.m., the resident was observed in bed and her fingernails remained long. Interview with the resident's family member on 5/24/23 at 11:10 a.m., indicated she wished the resident would be assisted out of bed. On 5/25/23 at 9:30 a.m., the resident was observed in her room in bed. Her finger nails remained long and in need of trimming. On 5/26/23 at 9:05 a.m., the resident was observed in her room in bed. Her finger nails remained long and in need of trimming.	F 0677	**Tag number: F677 – ADL Care Provided for Dependent Residents** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident F's fingernails were trimmed. Resident G's facial hair was trimmed. Resident B has received a shower 2 X week with her hair washed. Resident H has received a shower 2 X week.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to re-educate nursing staff on performing ADL care to include nail care, showers with per**	06/30/2023

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	The record for Resident F was reviewed on 5/23/23 at 2:11 p.m. Diagnoses included, but were not limited to, hemiplegia (paralysis on one side of the body) following a stroke and vascular dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 3/17/23, indicated the resident was cognitively impaired for daily decision making. The resident required extensive assistance with bed mobility, transfers, and personal hygiene. The current Care Plan indicated the resident had an ADL self-care performance deficit and needed assistance with toileting, eating, bed mobility, and transfers. Interventions included, but were not limited to, check nail length and trim and clean on bath day and as necessary. A current Care Plan, indicated the resident had limited physical mobility related to immobility. Interventions included, but were not limited to, resident to be up in broda chair. The resident was to receive a bath on Wednesdays and Saturdays. The resident received a bed bath on 5/3, 5/6, 5/10, 5/13, 5/17, and 5/24/23. The shower sheet, dated 5/24/23, indicated the resident did not need nail care. The "task" section of the record, indicated the resident was to be up in the broda chair with a roho cushion at least once daily for a maximum of 2-3 hours. Interview with the Director of Nursing on 5/30/23 at 9:36 a.m., indicated the resident's nails should		**resident preference, hair care, and trimming of facial hair per resident preference.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct an ADL audit to ensure ADL care, including nail care, showers, hair washing, and trimming of facial hair is being rendered per residents POC. Audits will be completed for 2 residents per Unit (Total of 8 residents) 5x/week for 4 weeks, 3x/week for 4 weeks then weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 6/30/2023	

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	have been trimmed. The Assistant Director of Nursing indicated at that time, there was no reason why the resident should not have been assisted out of bed. 2. On 5/23/23 at 10:19 a.m., 1:59 p.m., and 3:16 p.m., Resident G was observed with facial hair on her chin. Interview with the resident at 10:19 a.m., indicated she did not like having facial hair. The record for Resident G was reviewed on 5/23/23 at 3:04 p.m. Diagnoses included, but were not limited to, Lupus, bipolar disorder, and schizophrenia. The Admission Minimum Data Set (MDS) assessment, dated 4/24/23, indicated the resident was cognitively impaired for daily decision making and she required extensive assistance with personal hygiene. A Care Plan, dated 4/25/23, indicated the resident had an ADL self-care performance deficit related to limited mobility, chronic obstructive pulmonary disease (COPD), Lupus, and weakness. Interventions included, but were not limited to, the resident required limited-extensive assistance of 1-2 staff for bathing and she required staff assistance for personal hygiene. The resident's bathing days were Monday and Thursday evenings. The resident had received a shower on 5/4, 5/15, and 5/18/23. The resident had received a bed bath on 5/1 and 5/11/23. Interview with the Director of Nursing on 5/30/23 at 9:36 a.m., indicated the resident's facial hair should have been removed.3. During an interview on 5/22/23 at 11:52 a.m., Resident B indicated she did not get a shower at least 2 times a week and			

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	has not had her hair washed in a long time. The record for Resident B was reviewed on 5/24/23 at 11:00 a.m. Diagnoses included but were not limited to, dementia without behaviors, chronic kidney disease, depressive disorders, bipolar disorder, and acute kidney failure. The Quarterly Minimum Data Set (MDS) assessment, dated 4/27/23, indicated the resident was cognitively intact and needed limited assist with 1 person physical assist for bed mobility and transfers. The resident needed extensive assist with 1 person physical assist for toileting, and needed physical help with bathing with 1 person assist. A Care Plan, revised on 9/27/22, indicated the resident had an ADL self care performance deficit and required extensive assistance with 1 to 2 staff assist for bathing/showering. The resident was supposed to receive a shower every Monday and Thursday. Shower sheets indicated the resident did not receive a shower on 5/18 and 5/23/23. There was no documentation the resident's hair was washed. Interview with the Director of Nursing on 5/30/23 at 9:15 a.m., indicated showers were to be completed at least 2 times a week. 4. Interview with Resident H on 5/23/23 at 11:01 a.m., indicated she was not getting help to get showered or bathed two times weekly. Resident H's record was reviewed on 5/24/23 at 2:17 p.m. Diagnoses included, but were not limited to type 2 diabetes mellitus, high blood pressure, and chronic kidney disease.			

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	The Quarterly Minimum Data Set (MDS) assessment, dated 4/27/23, indicated the resident was cognitively intact for daily decision making. She required extensive assistance for bed mobility, transfer, dressing, toilet use, and personal hygiene. A Care Plan, revised on 12/2/22, indicated the resident had an ADL self-care deficit. Interventions included, but were not limited to, bathing/showering: the resident required extensive to total assist with 1-2 staff members. The Bathing/Shower sheets provided by the Assistant Director of Nursing (ADON) on 5/30/23 at 9:35 a.m., indicated the resident received a bed bath or shower on the following dates: 3/17, 3/24, 3/28, 4/4, 4/11, 4/14, 4/25, 5/2, 5/5, and 5/6/23. Interview with the ADON on 5/20/23 at 9:37 a.m., indicated she was unable to locate more shower sheets and was aware the resident did not receive twice weekly showers or baths. This Federal tag relates to Complaint IN00405922. 3.1-38(a)(2)(B) 3.1-38(b)(2) 3.1-38(b)(3) 3.1-38(a)(3)(E)			
F 0684 SS=E 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			

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	155156	A. BUILDING 00 B. WING	05/30/2023

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	treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure abrasions and areas of bruising were assessed and monitored for 4 of 6 residents reviewed for skin conditions non-pressure related. The facility also failed to ensure neurological checks were initiated following a fall for 2 of 6 residents reviewed for falls and immobility devices were monitored for 1 of 3 residents reviewed for positioning. (Residents M, G, H, J, L and K) Findings include: 1. On 5/23/23 at 9:51 a.m., 2:00 p.m., and 3:16 p.m., Resident M was observed with an abrasion to his outer right eye. The abrasion was also observed on 5/24 at 10:34 a.m., 11:38 a.m., and 2:46 p.m., 5/25 at 9:33 a.m. and 2:50 p.m., and 5/26/23 at 9:03 a.m. The record for Resident M was reviewed on 5/24/23 at 10:38 a.m. Diagnoses included, but were not limited to, alcoholic liver disease, malnutrition, and lack of coordination. The Quarterly Minimum Data Set (MDS) assessment, dated 4/25/23, indicated the resident was moderately impaired for daily decision making and required limited assistance with bed mobility and transfers. A Care Plan, dated 2/6/23, indicated the resident had a potential for falls related to narcotic analgesic use, psychotropic medication use, and weakness. Interventions included, but were not	F 0684	**Tag number: F684 – Quality of Care** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident M is no longer a resident of the facility. Resident G's care plan related to her right forearm bruising to be updated by 6-20-2023. Resident H received a physician order for her immobilizer and care plan to such updated by 6-20-2023. Resident J's care plan related to a fall to be updated by 6-20-2023. Resident L's care plan related to bruising to the right forearm to be updated by 6-20-2023. Resident K's care plan related to bruising of lower right arm to be updated by 6-20-2023.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice. Moving forward all residents with**	06/30/2023

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	limited to, encourage to use call light for assistance as needed. There was no Care Plan related to the abrasion. Nurses' Notes, dated 5/20/23 at 1:30 a.m., indicated the resident was found in the bathroom face down. The resident was assessed and a laceration was noted to the right eyebrow and upper lip. A bruise was noted under the right eye. A scant amount of blood was noted to the right eyebrow and upper lip. The area was cleansed and left open to air. There were no measurements related to the bruising and lacerations and there was no documentation of an ongoing assessment. The Weekly Skin assessment, dated 5/23/23, indicated the resident had no areas of skin impairment. The Neurological Check flowsheet, dated 5/20/23, indicated there was no documentation of neurological checks initially and every 15 minutes times 4 and every 30 minutes times 4. Documentation was started at 4 hours after the fall. Interview with the Director of Nursing on 5/30/23 at 9:36 a.m., indicated follow up documentation related to the resident's facial injuries should have been completed and neuro checks should have been initiated in a more timely manner. 2. On 5/22/23 at 2:41 p.m., Resident G was observed with a fading bruise to her right forearm. On 5/23/23 at 10:20 a.m. and 1:59 p.m., the bruising remained to the right forearm.		**witnessed/unwitnessed falls and bruising will have monitoring in place and physician orders obtained as necessary. In addition, all unwitnessed falls to have neurological checks completed per policy and procedure.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to re-educate nursing staff on protocols for witnessed/unwitnessed falls, neurological checks, monitoring of bruising utilizing Skin Condition Assessment and Monitoring Pressure and Non-Pressure policy and procedure.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct an accident and incident audit to ensure compliance in monitoring. Audits will be completed 5x/week for 4 weeks, 3x/week for 4 weeks then weekly. The results of these audits will be reviewed in Quality**	

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	The record for Resident G was reviewed on 5/23/23 at 3:04 p.m. Diagnoses included, but were not limited to, Lupus, bipolar disorder, and schizophrenia. The Admission Minimum Data Set (MDS) assessment, dated 4/24/23, indicated the resident was cognitively impaired for daily decision making and she required extensive assistance with bed mobility and transfers. There was no Care Plan related to bruising. A Physician's Order, dated 4/24/23, indicated the resident was to have a weekly skin assessment on Monday evenings. The Weekly Skin assessment, dated 5/22/23 at 9:22 p.m., indicated the resident had an existing area of skin impairment to her feet. There was no documentation related to the bruise on her right forearm. Interview with the Director of Nursing on 5/30/23 at 9:36 a.m., indicated documentation should have been completed related to the bruising. 3. On 5/23/23 at 12:04 p.m., Resident H was observed in bed with an immobilizer in place to the left shoulder. The resident indicated she needed assistance to put on the immobilizer and take it off. On 5/24/23 at 3:12 p.m., the resident was observed in her wheelchair. She indicated she had just returned from dialysis and had her immobilizer device in place, but it was causing her a lot of pain. On 5/25/23 2:54 p.m., the resident was observed in		**Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 6/30/2023	

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	bed with the immobilizer in place. The resident was crying out indicating the immobilizer was causing her a lot of pain. Resident H's record was reviewed on 5/24/23 at 2:17 p.m. Diagnoses included, but were not limited to, chronic kidney disease, anxiety disorder, and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 4/27/23, indicated the resident was cognitively intact for daily decision making. She required extensive assistance for bed mobility, transfer, dressing, toilet use, and personal hygiene. There were no orders for an immobility device. There was no documentation related to monitoring of the immobility device. Interview with the Director of Nursing on 5/30/23 at 9:32 a.m., indicated she had spoken with the therapy department and they had placed the device back on the resident recently, however they were going to re-evaluate and put monitoring in place for the device. 4. Resident J's record was reviewed on 5/26/23 at 10:00 a.m. Diagnoses included, but were not limited to, hemiparesis (weakness) following a stroke affecting the left non-dominant side, chronic kidney disease, and chronic obstructive pulmonary disease. A Quarterly Minimum Data Set (MDS) assessment, dated 5/5/23, indicated the resident was cognitively intact for daily decision making. He required extensive assistance for bed mobility, transfers, dressing, toilet use, and personal			

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	hygiene. A Care Plan, revised on 2/18/23, indicated the resident had an ADL self-care performance deficit and required assistance with toileting, eating, transfers, and bed mobility. A Care Plan, revised on 3/20/23, indicated the resident was at risk for fall and/or injury related to stroke with one-sided weakness, high fall risk medications, predisposing diseases, and non-compliance with transfers. A Fall - Initial Occurrence Note, dated 1/25/23 at 3:00 a.m., indicated the resident had an unwitnessed fall after he slid to his knees while attempting to transfer himself to his wheelchair. The corresponding Neuro Checks, dated 1/25/23, were incomplete. A Fall - Initial Occurrence Note, dated 1/27/23 at 5:00 a.m., indicated the resident had an unwitnessed fall. He was observed on his back beside his bed. The corresponding Neuro Checks, dated 1/27/23, were incomplete. A Fall - Initial Occurrence Note, dated 3/19/23 at 6:00 a.m., indicated the resident had an unwitnessed fall while transferring himself to his wheelchair. The corresponding Neuro checks, dated 3/19/23, were still in progress. A Fall - Initial Occurrence Note, dated 5/2/23 at 12:30 a.m., indicated the resident had an unwitnessed fall while transferring himself to his			

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	wheelchair. The corresponding Neuro Checks, dated 5/2/23, were still in progress. Interview with the Director of Nursing on 5/30/23 at 9:27 a.m., indicated she was unable to locate complete Neuro Checks for the unwitnessed falls. 5. On 5/23/23 at 11:00 a.m., Resident L was observed in his room with a fading bruise to the right forearm. The record for Resident L was reviewed on 5/24/23 at 11:00 a.m. An Admission Minimum Data Set (MDS) assessment, dated 4/14/23, indicated the resident was cognitively intact. A Physician's Order, dated 4/12/23, indicated to monitor bruising to the left antecubital (inner elbow) every shift until resolved. There was no Physician's Order or documentation related to monitoring any bruising on the right arm. A Physician's Order, dated 4/12/23, indicated Brilinta Oral Tablet 90 mg (milligrams), give 1 tablet by mouth every 12 hours for blood thinner. The company's medication website, www.Brilinta.com, indicated the side effects included risk of bleeding/ severe bleeding and shortness of breath. A Weekly skin assessment, dated 5/22/23, indicated no new skin issues. Interview with LPN 1 on 5/25/23 at 12:08 p.m.,			

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	indicated she could not find any documentation on the right forearm bruise for the resident. She would notify the wound nurse to reassess the resident. Interview on 5/25/23 at 12:19 p.m. with the Director of Nursing (DON), indicated she just performed a skin assessment on the resident yesterday and she didn't see anything on the right forearm. She would take the wound nurse with her to reassess the resident Follow up interview with the DON on 5/25/23, indicated the resident indicated he didn't bump his arm and doesn't know how it got there. 6. On 5/23/23 at 9:15 a.m., a fading dark black/purple discoloration was observed on Resident K's lower right arm. The record for Resident K was reviewed on 5/23/23 at 2:15 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus without complications, difficulty in walking and lack of coordination. The Quarterly Minimum Data Set (MDS) assessment, dated 5/19/23, indicated the resident had cognitive impairment. The resident needed extensive assistance with 1 person physical assist for bed mobility and transfers. The Weekly Skin Observation sheets, dated 5/10/23, 5/17/23, and 5/24/23, indicated the resident's skin was intact and there was no documentation of bruising. Interview with LPN 3 on 5/23/23 at 3:00 p.m., indicated the resident arrived to the facility from the hospital with the discoloration. The nurse indicated the discoloration was being monitored.			

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	Interview with LPN 2 on 5/25/23 at 2:12 p.m., indicated she was not aware of the bruising on the resident's lower right arm and she would chart the bruise. Interview with the Director of Nursing on 5/25/23 at 2:23 p.m., indicated she would print a copy of the company's skin condition and monitoring policy. The current and revised policy, titled, "Skin Condition Assessment and Monitoring Pressure and Non-Pressure", dated 1/17/18, was provided by the Director of Nursing on at 5/25/23 at 3:15 p.m. The policy indicated non- pressure skin conditions (bruises/contusions, abrasions, lacerations, rash, etc.) will be assessed for healing progress and signs of complications of infection weekly. Residents identified would have a weekly skin assessment by a licensed nurse. This Federal tag relates to Complaint IN00405200. 3.1-37(a)			
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			

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	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 ensure residents with pressure ulcers received the necessary treatment and services to promote healing, related to treatments not completed as ordered for 1 of 3 residents reviewed for pressure ulcers. (Resident 55) Finding includes: Resident 55's record was reviewed on 5/23/23 at 2:21 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, and high blood pressure. The Annual Minimum Data Set (MDS) assessment, dated 3/14/23, indicated the resident was severely cognitively impaired. She required extensive assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. She had one stage 4 pressure ulcer that was present upon admission or reentry. A Physician's Order, dated 4/18/23, indicated Anasept antimicrobial external gel 0.057% apply to coccyx topically once a day. Cleanse with normal saline, pat dry, apply Anasept and collagen powder to wound bed and cover with a dry dressing. The May 2023 Treatment Administration Record (TAR) indicated the Anasept treatment to the coccyx was not completed as ordered on 5/6, 5/11, 5/18, and 5/20/23. Interview with the Director of Nursing on 5/30/23 at 9:27 a.m., indicated she could not find	F 0686	**Tag number: F686 – Treatment/Svcs to Prevent/Heal Pressure Ulcer** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident #55's TAR to be fully audited for compliance by 6-23-2023.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents with pressure areas have the potential to be affected by the alleged deficient practice. DON/designee to perform a 100% audit of TAR for residents with pressure areas to ensure compliance of treatments.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to re-educate nursing staff on treatment of pressure areas and documentation in the TAR.**	06/30/2023

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	documentation of the treatment being completed on those days. 3.1-40(a)(2)		IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct a Pressure Area audit to ensure compliance as follows:** **Audits will be completed 5x/week for 8 weeks, then 3 X week weekly.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 6/30/2023	
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 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			

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	Based on observation, record review, and interview, the facility failed to ensure fall interventions were in place for residents with a history of falls related to a floor mattress for 1 of 6 residents reviewed for falls. (Resident 55) Finding includes: On 5/25/23 at 9:22 a.m., on 5/25/23 at 9:53 a.m., and on 5/26/23 at 9:00 a.m., Resident 55 was observed in bed. There was no fall mat in place next to the bed. Resident 55's record was reviewed on 5/23/23 at 2:21 p.m. Diagnoses included, but were not limited to, history of falling, dementia, and Alzheimer's disease. The Annual Minimum Data Set (MDS) assessment, dated 3/14/23, indicated the resident was severely cognitively impaired for daily decision making. She required extensive assistance for bed mobility, transfer, dressing, toilet use, and personal hygiene. A Fall Initial Occurrence Note, dated 5/4/23 at 5:00 p.m., indicated the resident had an unwitnessed fall near the foot of the bed. Neuro checks were initiated and a new intervention of placing a fall mat next to the bedside was initiated. Interview with the Director of Nursing on 5/30/23 at 9:27 a.m., indicated she had placed the fall mat next to the bed as it was sitting out in the hall. The resident should have had the fall mat in place next to bedside anytime she was in the bed. 3.1-45(a)(2)	F 0689	**Tag number: F689 – Free of Accident Hazards/Supervision/Devices** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident #55 has a preventative fall mat in place next to bed** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents with fall interventions have the potential to be affected by the alleged deficient practice. DON/designee to complete a 100% fall intervention audit by 6-30-2023** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to re-educate nursing staff on ensuring fall interventions are in place as preventative measures.** IV. How the corrective action(s) will be monitored to	06/30/2023

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			ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct a fall intervention audit as follows: Audits will be completed on 10 residents at risk for falls 3x/week for 8 weeks, then weekly.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 6/30/2023	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;			

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	155156	A. BUILDING 00 B. WING	05/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE ARBORS MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

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	§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and interview, the facility failed to ensure residents with a history of weight loss were assisted with meals, received the correct diet, food consumptions were completed and the consumption of nutritional supplements was documented for 1 of 1 residents reviewed for nutrition. (Resident 16) The facility also failed to ensure the Registered Dietitian (RD) assessed and visited a resident who was receiving dialysis for 1 of 1 residents reviewed for dialysis. (Resident 86) Findings include: 1. On 5/25/23 at 8:52 a.m., Resident 16 was observed in bed with her eyes closed. At that time CNA 2 was standing near the doorway on her phone, getting ready to walk out of the room. The resident's breakfast was served and placed in front of her on the over bed table. The resident remained slumped over with her eyes closed. The resident's coffee and milk were not thickened. The milk was opened and some of it was poured into her coffee. She was served french toast and the ham was chopped into pieces. The french toast was not cut up into pieces for her to eat. At 9:22 a.m., CNA 3 walked into the resident's room and asked her if she was going to eat breakfast. The resident was still in the same position and her breakfast remained untouched. No staff had come back to help her in the 30 minute span. The resident indicated she would like to eat, so the CNA left the room to get help to reposition her. At	F 0692	Tag number: F692 – Nutrition/Hydration Status Maintenance I.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident #16 has assistance with meal consumption – amount and type of meal consistencies reviewed. Resident #86 to have a Registered Dietician (RD) assessment by 6-23-2023.** II.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents with varying meal consistencies and needing RD assessments have the potential to be affected by the alleged deficient practice. Residents receiving dialysis will be identified and have an RD assessment by 6-30-2023.**	06/30/2023

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	9:25 a.m., the CNA came back to the room with help and they lifted her up in bed and raised the head of the bed. At that time, the resident wanted the coffee, however, the CNA questioned the thickness of the coffee and indicated she was not supposed to have unthickened liquids. Interview with CNA 3 at that time, indicated the person who brought the tray into her room should have recognized the milk and coffee were not thickened and should never have left it for her to drink. The record for Resident 16 was reviewed on 5/24/23 at 3:45 a.m. Diagnoses included, but were limited to, stroke, dysphagia, major depressive disorder, weakness, high blood pressure, edema, dementia with behaviors, anxiety, and heart disease. The 3/27/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact and needed extensive assist with a 2 person physical assist for most activities of daily living. The resident weighed 182 pounds and had a significant weight loss. The resident received a mechanically altered and therapeutic diet. A Care Plan, revised on 1/10/23, indicated the resident required a mechanical soft diet related to dysphagia. The approaches were to supervise and set up the resident for meals. A Care Plan, revised on 1/10/23, indicated the resident was at risk for alteration in nutrition status. The approaches were to provide diet as ordered and document intake of each meal. Physician's Orders, dated 2/21/23, indicated		III.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to re-educate nursing staff on understanding different meal consistencies served to the residents by 6-23-2023.** IV.How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct a meal consistency audit on 5 residents to include serving correct meal consistencies and assisting residents needing assistance with eating. Audits will be completed 3x/week for 8 weeks, then weekly. The clinical IDT to review meal/supplement intakes and RD assessments during the weekly At Risk Meeting. RD to be notified of any new dialysis residents for assessments. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months.¿ The QA Committee will identify any trends or**	

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	mechanical soft diet with nectar thick liquids. Physician's Orders, dated 3/10/23, indicated house nutrition supplement three times a day. The resident's weights were as follows: 12/11/22 201 pounds 1/4/23 199 pounds 2/1/23 200 pounds 3/1/23 179 pounds 3/3/23 182 pounds 4/6/23 179 pounds 5/5/23 179 pounds An RD Progress Note, dated 3/10/23 at 11:37 a.m., indicated the resident presented with an unplanned weight loss of 9% times 1 month. RD recommended House Nutritional Supplement three times a day to meet nutritional needs for weight stabilization. An RD Progress Note, dated 5/8/23 at 10:58 a.m., indicated the resident had a 10.3% weight loss times 3 months, however, weight has been stable the last 60 days. The Medication Administration Record (MAR) for the months of 4/2023 and 5/2023 indicated the House Nutritional Supplement was signed out as being administered, however, there was no documentation of how much the resident received or consumed. The Meal Consumption logs for the last 30 days indicated the dinner meal was not documented on 4/25, 4/26, 5/9, 5/11, 5/12, 5/14, 5/18, and 5/20-5/23/23. There were no meals documented on 5/8 and 5/17/23. Interview with the Director of Nursing on 5/25/23		**patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 6/30/2023	

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	at 1:00 p.m., indicated CNA 1 was a newer aide, and she would speak to her. She indicated the resident was to receive thickened liquids and the CNA should have recognized that and set her up for breakfast before walking out of the room. Meal consumptions were to be completed after every meal. Interview with the Nurse Consultant on 5/25/23 at 1:35 p.m., indicated there was no documentation of how much of the house supplement the resident was to receive, nor was there any documentation of how much she consumed. She was unaware of what kind of house supplement the resident was receiving. 2. On 5/25/23 at 8:30 a.m., Resident 86 was sitting in his wheelchair in the activity room. At that time, he was observed eating breakfast. He was served a piece of ham, 2 pieces of french toast, cold cereal, a 4 ounce cranberry juice, and 1/2 pint of 2% milk. The record for Resident 86 was reviewed on 5/23/23 at 3:00 p.m. Diagnoses included, but were not limited to, type 2 diabetes, chronic kidney disease, major depressive disorder, anxiety disorder, vascular dementia, psychosis, and dependence on renal dialysis. The 4/24/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and received dialysis as a resident. The resident had no oral problems, weighed 241 pounds and had no significant weight loss or gain. A Care Plan, revised on 12/3/21, indicated the resident had a nutritional problem related to the need for renal dialysis. The approaches were to			

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	monitor intake and record every meal. Physician's Orders. dated 6/24/22, indicated renal and no added salt regular texture diet. The last 5 months of weights indicated the resident weighed around 241 pounds. The last RD Progress Note was dated 11/30/22, which indicated the resident's weight was 246 pounds which was down 11.9% times 180 days. A slow steady weight loss may be beneficial, as the resident goes to dialysis three times a week. The resident was on a 1500 milliliters fluid restriction that was broken down between dietary and nursing. There were no new labs and his skin was intact. No recommendations at this time, continue plan of care. New labs were collected and drawn on 5/3/23 and 5/22/23. The resident's hemoglobin was low at 7.8 and 7.4 (normal 14-18). The Hematocrit was also low at 25.7 and 25.5 (normal was 42-52). The resident had a low iron count of 38 (normal was 45-164). The labs had not been addressed by the RD for the need of extra supplements. The Meal Consumption log in the last 30 days indicated no meals were documented on 5/1 and 5/14/23. The dinner meal was not documented on 4/26, 4/27, 4/28, 4/29, 5/3, 5/4, 5/6, 5/7, 5/8, 5/10, 5/11, 5/15, 5/20 and 5/22/23. Interview with the Director of Nursing (DON) on 5/30/23 at 9:15 a.m., indicated meal consumptions were to be completed after every meal. Continued Interview with the DON on 5/30/23 at			

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	10:30 a.m., indicated she had spoken to the RD and her last documented entry for the resident was in 11/2022. There were no other notes for review. She indicated there was no facility policy regarding dialysis residents and their nutrition. 3.1-46(a)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review, and interview, the facility failed to ensure gastrostomy tube feedings were infusing at the correct time for 1 of 2 residents reviewed for tube feeding. (Resident F) Finding includes:	F 0693	**Tag number: F693 – Tube Feeding Mgmt/Restore Eating Skills** I. What corrective action(s) will be accomplished for those residents found to have	06/30/2023

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	On 5/23/23 at 1:55 p.m. and 3:16 p.m., Resident F was observed in her room in bed. The resident's tube feeding pump was turned off. On 5/24/23 at 9:23 a.m. and 11:10 a.m., the resident was again observed in bed and her tube feeding pump was turned off. The record for Resident F was reviewed on 5/23/23 at 2:11 p.m. Diagnoses included, but were not limited to, hemiplegia (paralysis on one side of the body) following a stroke, vascular dementia, and dysphagia (difficulty swallowing). The Quarterly Minimum Data Set (MDS) assessment, dated 3/17/23, indicated the resident was cognitively impaired for daily decision making and had received a tube feeding while a resident of the facility. A current Care Plan, indicated the resident required a tube feeding and had an order for a pureed honey consistency meal. Interventions included, but were not limited to, the resident was dependent with tube feeding and water flushes. A Physician's Order, dated 2/25/23, indicated the resident was to receive Osmolite 1.2 tube feeding at 70 milliliters (mls) per hour for 21 hours. Turn on at 9:00 a.m. and off at 6:00 a.m. Interview with the Director of Nursing on 5/30/23 at 9:36 a.m., indicated the resident's tube feeding should have been infusing at the correct time. 3.1-44(a)(2)		been affected by the deficient practice; **Resident F's Gastrostomy tube feedings are infusing at the correct time and had no adverse affects.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents with G-Tubes have the potential to be affected by the alleged deficient practice. All residents with G-Tubes were audited and found to be infusing at the correct rate and time.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to re-educate nursing staff on assessing and monitoring of residents with G-Tube feedings to ensure proper rate and time of infusion.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct a G-Tube audit to**	

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			ensure correct rate and infusion times. Audits will be completed 5x/week for 12 weeks, then weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 6/30/2023	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this			

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	section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation, record review, and interview, the facility failed to ensure the nurse staff posting sign was available for review for the last 18 months as well as accurate documentation of the daily census. This had the potential to affect all residents resideing in the facility. Finding includes: On 5/23/23 at 1:48 p.m. and on 5/24/23 at 8:43 a.m., the daily nurse staffing sign located on a desk by the front door indicated there was no current daily census written on the sign. Interview with the Interim Administrator on 5/24/23 at 3:20 p.m., indicated the census information was not filled in on the sign. At that time, he pulled out a pen and wrote the census number on the sign and put it back on the front table. The daily nurse staffing sheets were requested for	F 0732	**Tag number: F732 – Posted Nurse Staffing Information** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **The facility is correctly posting Nurse Staffing Information.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice. The facility's Staffing Coordinator is utilizing the correct form and**	06/30/2023

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	the weekends in the months of October, November, and December 2022. The daily staffing sheets were unavailable for review. Interview with the Administrator on 5/30/23 at 8:45 a.m., indicated the Nursing Scheduler did not save the daily staffing sheets when she first started back in 9/2022 and did not have the daily nurse staff posting sheets from October-December 2022. The daily nursing staffing sheets available for review for the last 30 days were 5/1, 5/5, 5/7, 5/8, 5/9, 5/15, 5/19, 5/23, 5/24, 5/26, and 5/30/23. The census was only documented on 5/26 and 5/30/23. Interview with the Nursing Scheduler on 5/30/23 at 2:00 p.m., indicated she was never told to save the nurse staffing daily sheets, so she threw them away. She started saving the daily sheets in 1/2023.		**ensuring all areas are completed daily – by 6-20-2023.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administrator/designee to re-educate the Staffing Coordinator by 6-20-2023 Staffing Coordinator on the daily posting of Nurse Staffing Information and to keep said records for 18 months for review.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **Administrator/designee will conduct a Nurse Staffing Information Audit to ensure form is posted daily. Audits will be completed 5x/week for 4 weeks, 3x/week for 4 weeks then weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the**	

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			plan of correction as indicated. Date of compliance: 6/30/2023	
F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			

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	Based on record review and interview, the facility failed to establish and/or maintain a system that accounted for, periodically reconciled, and ensured the disposition of all controlled drugs, related to incomplete and inaccurate documentation of narcotic medications for 4 of 4 residents reviewed for narcotics. (Residents N, O, P, and Q) This had the potential to affect all residents who received narcotic medication. Findings include: On 5/30/23 at 9:01 a.m., an investigation of a narcotic diversion regarding the previous Director of Nursing (DON) was reviewed. The file folder was full of old narcotic sheets of residents who were current and discharged. There was no documentation of interviews, inservices, or what was done as part of the investigation. Interview with the Nurse Consultant on 5/30/23 at 10:00 a.m., indicated she had nothing in writing regarding the investigation and had only interviewed the previous Assistant Director of Nursing (ADON) regarding the allegation. The previous ADON took over the investigation and completed inservices and staff interviews, however, none of that information could be located. A signed statement, created on 5/30/23 by the Nurse Consultant (NC), indicated a complaint was received at the corporate office on March 28, 2023 stating the DON was diverting narcotics. The NC and another nurse consultant conducted the investigation into the matter. The employee's (former DON) office was searched and any narcotics found in the employee's desk drawers were removed. All narcotics and narcotic sheets were counted and all medications were accounted	F 0755	Tag number: F755 – Pharmacy Srvcs/Procedures/Pharmacist/Records I.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Any resident receiving a narcotic mediation will have a controlled drug reconciliation by 6-23-2023.** II.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice. An audit completed by DON/designee of narcotics in the facility revealed no discrepancies in the reconciliation sheets.** III.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to re-educate nursing staff on proper maintaining, accounting for, periodically reconciled, and disposition of all controlled drugs by 6-23-2023.**	06/30/2023

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	155156	A. BUILDING 00 B. WING	05/30/2023

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	for. A whole house count was completed on all medication carts and no discrepancies were noted. Education was provided to all nurses and QMAs regarding proper procedure for narcotic disposal and storage by the ADON. A drug screen was not completed on the former DON due to the employee not showing any signs of impairment, past or present. a. Resident N had a narcotic sheet for Alprazolam 0.25 milligrams (mg) 1 tablet at bed time PRN (as needed) times 14 days, dated 3/2/23. It indicated 34 tablets were received and 27 tablets were left on the punch card and found in the previous DON's drawer. The Medication Administration Record (MAR) indicated the medication was only signed out as being administered on 3/5/23 at 6:43 a.m. and 3/13/23 at 8:39 p.m. The narcotic sheet indicated the medication was signed out on 3/10/23 at 8 p.m., 3/11/23 at 1:30 p.m., 3/16/23 at 8 p.m., and 3/20/23 at 8 p.m. The medication was discontinued on 3/16/23. b. Resident O had a narcotic sheet for Xanax 0.5 mg 1 tablet twice a day for anxiety. On 3/13/23, 10 pills were received. There were 4 tablets left on the punch card that was found in the desk drawer. The medication was discontinued on 3/16/23. The medication was signed out on the narcotic sheet on 3/16/23 at 8:00 p.m., and on the 3/2023 MAR there was an "X" for the p.m., dose because it had been discontinued. c. Resident P had a narcotic sheet for 7 tablets of Oxycodone IR 5 mg, give 1 tablet by mouth every 8 hours PRN for pain, dated 8/2/22. The hospital had sent an E-Script to the pharmacy for the		IV.How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will reconcile narcotics on every Medication Cart 1 X time per week to include MAR documentation for 12 weeks, then weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months.¿ The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 6/30/2023	

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	medication. There were 4 tablets left on the punch card, which were also in the desk drawer. The narcotic sheet indicated 3 tablets had been signed out on 8/25/22 at 5 p.m., 10/18/22 at 12 p.m., and on 11/18/22 (no time). The MARs for 8/2022, 10/2022 and 11/2022, indicated there was no documentation of the medication being administered. The medication had not been transcribed onto the MAR. d. Resident Q had a narcotic sheet, dated 2/7/23, for which 60 tablets of Lorazepam 0.5 mg were received. There were 39 tablets left on the punch card that was found inside the desk drawer. The medication was to be administered two times a day from 2/7/23 to 2/14/23. The narcotic sheet indicated the medication was signed out on 2/15/23 at 9 p.m. A new order was obtained on 2/21/23 for Lorazepam 0.5 mg give 1 tablet by mouth every 12 hours as needed for anxiety. The medication was signed out on the 2/2023 MAR on 2/22/23 at 8:50 a.m. and 2/26/23 at 9:27 a.m. The medication was also signed out on the narcotic sheet but not on the MAR on 2/22 and 2/26/23 at 9 p.m. The 3/2023 MAR indicated the medication was only signed out on 3/1/23 at 6:31 a.m., however the narcotic sheet indicated the medication was signed out on 3/2 and 3/7/23 at 9 p.m. All of the medication found in the previous DON's desk drawer was destroyed on 3/28/23 by 2 witnesses. Interview with the Nurse Consultant on 5/30/23 at			

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	10:25 a.m., indicated she was told not to perform a drug test on the previous DON per the Corporate Human Resource Director. The previous DON was interviewed and indicated the narcotics were in her drawer because she had not found time to destroy them. The Nurse Consultant indicated the narcotics were in an office drawer that was locked and the DON kept her office locked. As far as the investigation, she was only able to find the narcotic sheets in the previous ADON's desk drawer. She could not find any of the investigation the previous ADON had completed as far as staff interviews, inservice regarding promptly destroying the medication. All of the narcotic medications were accounted for when they went through the punch cards and the narcotic sheets. Interview with the Nurse Consultant on 5/30/23 at 3:00 p.m., indicated there were discrepancies of the controlled substance medications being signed out as administered on the MAR and the narcotic count flow sheets for the above mentioned residents. A "Drug/Alcohol-Free Workplace" policy pulled from the Employee Handbook and provided by the Interim Administrator on 5/30/23 at 10:34 a.m., indicated the facility reserved the right to randomly drug test any employee, at any time, or to test any employee at any time in response to a complaint, allegation or investigation which implicates the employee. This Federal tag relates to Complaint IN00404823. 3.1-48(b)(2)			
F 0757 SS=D	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary			

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Bldg. 00	Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure side effects were monitored for anticoagulant and opioid medications, insulin was administered as ordered, and blood pressure medications were not administered outside of the parameters for 1 of 1 residents reviewed for anticoagulant use and 2 of 5 residents reviewed for unnecessary medications. (Residents E, 86, and 55) Findings include: 1. Interview with Resident E on 5/23/23 at 10:51 a.m., indicated he got a bloody nose from his Xarelto (blood thinner) on occasion and there were times he wouldn't take his pill.	F 0757	**Tag number: F757 – Drug Regimen is Free from Unnecessary Drugs** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident E has been offered his anticoagulant medication. Resident #86 has been given his insulin as ordered. Resident #55 has monitoring in place for opioid side affects.**	06/30/2023

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	The record for Resident E was reviewed on 5/25/23 at 9:38 a.m. Diagnoses included, but were not limited to, history of pulmonary embolism, anemia, long term use of anticoagulants, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 4/24/23, indicated the resident was cognitively intact and he was receiving an anticoagulant. A Care Plan, reviewed on 4/20/23, indicated the resident was receiving anticoagulant therapy related to the history of a deep vein thrombosis (DVT). Interventions included, but were not limited to, administer anticoagulant medication as ordered by the Physician. Monitor for side effects and effectiveness every shift. The May 2023 Physician's Order Summary (POS), indicated the resident was to receive Xarelto 10 milligrams (mg) daily and to monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, shortness of breath, and nose bleeds. Document "Y" if side effects occur and "N" for no side effects. The April 2023 Medication Administration Record (MAR), indicated side effects were monitored each shift 4/7 through 4/30/23, however, the monitoring was signed out with a check mark rather than a "Y" or "N". The May 2023 MAR also had check marks for side effect monitoring every shift rather than a "Y" or "N".		II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **Residents taking anticoagulants, insulin, and opioids have the potential to be affected by the alleged deficient practice. Residents on these medications have been audited to ensure they are taking said medications and are being monitored by 6-23-2023.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to re-educate nursing staff on said medications and the monitoring of said medications by 6-23-2023.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct a medication audit of residents with said medications to ensure compliance in receiving medications. Audits will be completed 3x/week for 8 weeks, then weekly. The**	

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	Interview with the Nurse Practitioner on 5/26/23 at 10:34 a.m., indicated the resident had not voiced concerns to her about his Xarelto and he made no comments to her about having bloody noses. Interview with the Director of Nursing on 5/30/23 at 9:36 a.m., indicated the side effect monitoring for the Xarelto should have been filled in with a "Y" or "N" instead of a check mark to determine if the resident was having any side effects. 2. During an interview on 5/23/23 at 10:26 a.m., Resident 86 indicated he did not receive his insulin on dialysis days and sometimes he did not receive his insulin at the scheduled times when he was in the facility. The record for Resident 86 was reviewed on 5/23/23 at 3:00 p.m. Diagnoses included, but were not limited to, type 2 diabetes, chronic kidney disease, major depressive disorder, anxiety disorder, vascular dementia, psychosis, and dependence on renal dialysis. The 4/24/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and received dialysis as a resident. The resident had no oral problems, weighed 241 pounds and had no significant weight loss or gain. In the last 7 days, he received an insulin injection. A Care Plan, revised on 9/30/21, indicated the resident had diabetes and was dependent on insulin. Physician's Orders, dated 6/24/22, indicated Insulin Detemir Solution 100 units/milliliter (ml). Inject 14 units subcutaneously at bedtime. The insulin was to be administered 8 p.m. Insulin Aspart Flexpen Solution Pen-injector 100 units/ml.		**results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 6/30/2023	

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	Inject 8 units subcutaneously with meals at 8 a.m., 12 p.m., and 5 p.m. Renvela Tablet 800 milligrams (mg), give 3 tablets by mouth with meals for chronic kidney disease. The medication was to be administered at 8 a.m., 12 p.m., and 5 p.m. Physician's Orders, dated 12/27/22, indicated Clonidine HCl Tablet 0.1 mg. Give 1 tablet by mouth two times a day related to high blood pressure. Hold if blood pressure was less than 120/80. The 4/2023 Medication Administration Record (MAR) indicated the Insulin Detemir was not signed as being administered on 4/25/23. The Insulin Aspart was not signed out as being administered on 4/7/23 at 8 a.m. The 12 p.m., dose was coded with a "9" (meaning see nurses' notes) on 4/24, 4/26, and 4/28/23. On 4/7, 4/12, 4/14, and 4/17/23 at 12 p.m., the insulin was coded with a "3" (meaning absent from home) and on 4/19/23 the insulin was coded with a "5" (meaning hold). The 12 p.m. dose was blank on 4/10/23, and the 5 p.m. dose was coded with a "5" on 4/24 and was blank on 4/28/23. The Renvela tablet was coded with a "3" for the 12 p.m. dose on 4/7 and 4/12/23. A "9" was coded for the 12 p.m. dose on 4/14, 4/24, 4/26, and 4/28/23, and "5" was coded on 4/19/23. The medication was blank for 12 p.m. dose on 4/10/23. The Clonidine medication was administered on 4/13/23 at 9 a.m. with a blood pressure of 113/68, and on 4/19/23 with a blood pressure of 108/64. The medication was administered at 5 p.m. on 4/12/23 with a blood pressure of 103/72, on 4/19/23 with a blood pressure of 112/64, on 4/22/23 with a blood pressure of 117/75, and on 4/24/23 with a blood pressure of 115/82.			

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	The 5/2023 MAR indicated the Renvela tablet and the Insulin Aspart for the 12 p.m. dose were coded with "3" on 5/1 and 5/3/23, were coded with a "5" on 5/17/23 and were coded with a "9" on 5/5, 5/10, 5/15, 5/19, and 5/22/23. The Clonidine medication was signed out as being administered on 5/11/23 at 9 a.m. with a blood pressure of 107/69, at 5 p.m. on 5/9/23 with a blood pressure of 116/75, and at 5 p.m. on 5/19/23 with a blood pressure of 115/73. The 5/2023 MAR indicated the Insulin Aspart was not administered timely at least 1 hour before and 1 hour after the following scheduled times: 8 a.m. dose: - 5/12/23 at 6:57 p.m. - 5/25/23 at 9:49 a.m. 12 p.m. dose: - 5/12/23 at 6:58 p.m. 5 p.m. dose: - 5/8/23 at 9:33 p.m. - 5/9/23 at 6:21 p.m. - 5/12/23 at 7:39 p.m. - 5/14/23 at 6:52 p.m. - 5/17/23 at 6:56 p.m. - 5/18/23 at 9 p.m. - 5/22/23 at 8:48 p.m. - 5/26/23 at 9:34 p.m. - 5/27/23 at 7:23 p.m. Interview with the Director of Nursing on 5/30/23 at 9:15 a.m., indicated the Physician's Orders were clarified and administration times were changed to allow for dialysis. The Insulin Aspart was not signed out as being administered on time.3. Resident 55's record was reviewed on 5/23/23 at 2:21 p.m. Diagnoses included, but were not limited to, dementia, high blood pressure, and cerebral ischemia (inadequate blood flow to the brain).			

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	The Annual Minimum Data Set (MDS) assessment, dated 3/14/23, indicated the resident was severely cognitively impaired for daily decision making. She received antipsychotic, anti-anxiety, antidepressant, anticoagulant, and opioid medications. A Physician's Order, dated 11/17/22, indicated tramadol (an opioid pain medication) 50 milligrams (mg), 1 tablet by mouth every six hours. The record lacked documentation of monitoring for opioid side effects. Interview with the Director of Nursing on 5/30/23 at 9:27 a.m., indicated they should have been monitoring for side effects with an opioid medication. 3.1-48(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			

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	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 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 ensure ongoing monitoring of psychotropic medications for efficacy and adverse consequences was completed for 1 of 5 residents reviewed for unnecessary medications. (Resident B) Finding includes:	F 0758	**Tag number: F758 – Free from Unnecessary Psychotropic Meds/PRN Use** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	06/30/2023

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	The record for Resident B was reviewed on 5/24/23 at 11:00 a.m. Diagnoses included but were not limited to, dementia without behaviors, chronic kidney disease, depressive disorders, bipolar disorder, and acute kidney failure. The Quarterly Minimum Data Set (MDS) assessment, dated 4/27/23, indicated the resident was cognitively intact and needed limited assist with 1 person physical assist for bed mobility and transfers. In the last 7 days, the resident received an antipsychotic medication 7 times that were administered on a routine basis. A Care Plan, revised on 9/30/22, indicated the resident used antipsychotic medication. The approaches were to monitor/document/report any adverse reactions such as an unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. Physician's Orders, dated 8/20/22, indicated Aripiprazole (an antipsychotic medication) 20 milligrams, give 1 tablet by mouth one time a day. There was no documentation an AIMS assessment had been completed since the resident had been admitted in 8/2022. Interview with the Director of Nursing on 5/30/23 at 9:15 a.m., indicated no AIMS assessment had been completed prior to 5/26/23. The revised and current 1/11/18 "AIMS Side		practice; **Resident B has ongoing monitoring of psychotropic medications utilizing the AIMS Side Effect Monitoring** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents prescribed psychotropic mediations have the potential to be affected by the alleged deficient practice. The DON/designee will audit all AIMS assessments to ensure compliance by 6-23-2023.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to re-educate nursing staff on AIMS assessments completion by 6-23-2023.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct an AIMS audit to ensure compliance with completion no less than q 6**	

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	155156	A. BUILDING 00 B. WING	05/30/2023

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	Effect Monitoring" policy, provided by the Interim Administrator on 5/30/23 at 10:00 a.m., indicated an AIMS examination will be performed at the time of the resident's admission or when medications were initially prescribed and will be repeated at intervals of no less than every 6 months. 3.1-48(3)(a)		**months. Audits will be completed 3x/week for 8 weeks, then weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 6/30/2023	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §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			

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	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, interview, and record review, the facility failed to ensure medications were labeled properly for 1 of 5 medication carts observed. (300 Hall Cart 1) Finding includes: On 5/30/23 at 10:31 a.m., Medication Cart 1 on the 300 hall was observed with QMA 1. There was a bottle of 59 ml (milliliters) of liquid Melatonin observed at the bottom of the medication cart. The bottle was only labeled with the type of medication and not any information regarding residents or specific orders. QMA 1 indicated she did not normally work on that cart and had no knowledge of the medication. The QMA removed the medication from the cart and gave it to the nurse. Interview with the Director of Nursing on 5/30/23 at 10:49 a.m., indicated the nursing staff should have discarded any medication that was not completely labeled in the cart. A medication labeling policy was requested and not received. 3.1-25(k)	F 0761	**Tag number: F 761 – Label/Store Drugs and Biologicals** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **The 300 Hall Medication Cart has all medications appropriately labeled with identifiers.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice. All facility Medication Carts to be audited for compliance by 6-23-2023 ensuring all medications appropriately labeled with identifiers.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to**	06/30/2023

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			re-educate nursing staff on ensuring all medications and biologics are labeled appropriately with identifiers by 6-23-2023. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct a medication cart audit of all units to ensure all medications are labeled appropriately. Audits will be completed as follows: 3 Medication Carts per wk for 8 weeks, then 3 Medication Carts weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 6/30/2023	
F 0773 SS=D Bldg. 00	483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse			

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	specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. Based on record review and interview, the facility failed to ensure labs were collected as ordered by the Physician for 1 of 1 residents reviewed for dialysis and 1 of 5 residents reviewed for unnecessary medication. (Residents 86 and 55) Findings include: 1. The record for Resident 86 was reviewed on 5/23/23 at 3:00 p.m. Diagnoses included, but were not limited to, type 2 diabetes, chronic kidney disease, major depressive disorder, anxiety disorder, vascular dementia, psychosis, and dependence on renal dialysis. The 4/24/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and received dialysis. The resident had no oral problems, weighed 241 pounds and had no significant weight loss or gain. In the last 7 days, he received an insulin injection. Physician's Orders, dated 5/19/23, indicated to collect a stool specimen for occult blood times 3. Lab results, dated 5/4/23, indicated a stool for occult blood - single specimen was collected and reported on 5/5/23 as being positive. There were no other stool specimens collected since 5/4/23.	F 0773	**Tag number: F773 – Physician Order/Notify of Results** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident's #86 and #55 showed no adverse effects to lack of labs obtained.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents having laboratory tests ordered have the potential to be affected by the alleged deficient practice. The facility DON/designee audited residents with laboratory tests ordered to ensure compliance in obtaining labs and reporting results to physician/NP. This to be completed by 6-30-2023.** III. What measures will be put into place and what	06/30/2023

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	Interview with the Director of Nursing on 5/30/23 at 9:15 a.m., indicated a stool specimen for occult blood had not been collected since 5/4/23. A specimen was just collected on 5/28/23 and they were still waiting for lab to pick it up due to the holiday. 2. Resident 55's record was reviewed on 5/23/23 at 2:21 p.m. Diagnoses included, but were not limited to, dementia, high blood pressure, and cerebral ischemia (inadequate blood flow to the brain). The Annual Minimum Data Set (MDS) assessment, dated 3/14/23, indicated the resident was severely cognitively impaired for daily decision making. A Physician's Order, dated 12/28/22, indicated albumin, complete blood count (CBC), and comprehensive metabolic panel (CMP). A Physician's Order, dated 12/29/22, indicated albumin, complete blood count (CBC), and comprehensive metabolic panel (CMP) blood draw. A Physician's Order, dated 1/3/23, indicated albumin level blood draw. A Physician's Order, dated 1/9/23, indicated white blood cell count (WBC), C-Reactive Protein (CRP), CBC with differential and platelets, and erythrocyte sedimentation rate (ESR) blood draw. A Physician's Order, dated 4/19/23, indicated pre-albumin, albumin, CBC with differential blood draw. A Physician's Order, dated 5/10/23, indicated ESR blood draw.		systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to re-educate by 6-23-2023 nursing staff on obtaining laboratory tests as ordered and reporting results to physician/NP.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct a laboratory audit to ensure compliance in obtaining and reporting results. Audits will be completed 5x/week for 4 weeks, 3x/week for 4 weeks then weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 6/30/2023	

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	A Physician's Order, dated 5/16/23, indicated ESR and CRP blood draw. The record lacked documentation of any of the laboratory results. Interview with the Director of Nursing on 5/30/23 at 9:27 a.m., indicated she was unable to locate the lab results to show the blood draws were completed. 3.1-49(a)			
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, record review, and interview, the facility failed to ensure it provided food that was palatable and served at an appetizing temperature for 2 of 9 residents reviewed for food and 1 of 4 units. (Residents E, L, and the 400 unit) Findings include: 1. Interview with Resident E on 5/23/23 at 10:47 a.m., indicated the food was terrible. He also indicated the seasoning was off and the food was	F 0804	**Tag number: F804 – Nutritive Value/Appear, Palatable/Perfer Temp** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Meal trays passed on the 400 Hall and to Residents E and L have been monitored by the interim Dietary Manager**	06/30/2023

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	cold. The resident ate in his room. The record for Resident E was reviewed on 5/25/23 at 9:38 a.m. Diagnoses included, but were not limited to, history of pulmonary embolism, anemia, long term use of anticoagulants, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 4/24/23, indicated the resident was cognitively intact. 2. During an interview on 5/22/23 at 11:39 a.m., Resident L indicated he bought his own food because the food tasted terrible and was always cold. The resident ate in his room. The Admission Minimum Data Set (MDS) assessment, dated 4/14/23, indicated the resident was cognitively intact and required set up assistance only for eating. A Care Plan, dated 5/22/23, indicated a diagnosis of Diabetes Mellitus insulin dependent with the intervention of a dietary consult for nutritional regimen and ongoing monitoring. 3. On 5/25/23 at 12:25 p.m., the lunch cart was brought to the 400 unit. The lunch cart started in the unit dining area at 12:30 p.m., then moved to the unit hallway for room tray pass. At 12:42 p.m., a test lunch tray was obtained from the serving cart on the 400 unit after all other trays had been passed. The Assistant Dietary Manager (ADM) used a food thermometer to obtain the following food temperatures: country fried steak: 115 degrees mash potatoes: 115 degrees The country fried steak and mashed potatoes were sampled and noted to be luke warm to cold.		**and temperatures of foods within guidelines.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents on the 400 Hall have the potential to be affected by the alleged deficient practice. The interim Dietary Manager is checking meals on the 400 Hall, Residents E and L to ensure compliance with temperatures of foods being within guidelines as served to that Unit and those residents.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Dietary Manager/designee to re-educate dietary staff and the DON/designee to re-educate nursing staff on ensuring resident meals are delivered at the appropriate temperature guidelines as prescribed by the Monitoring Food Temperatures for Meal Service.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will	

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	Interview with the ADM at that time, indicated ideally she would like food to be 135 degrees when served to residents and indicated 115 degrees was too cold. The facility did not have heated serving carts and the serving cart door remained open during the tray pass. A facility policy titled, "Monitoring Food Temperatures for Meal Service" provided by the Dietary Manager as current, indicated, "...Meals that are served on room trays may be periodically checked at the point of service for palatable food temperatures. Food temperatures of hot foods on room trays at the point of service are preferred to be at 120 degrees or greater to promote palatability for the resident..." This Federal tag relates to Complaint IN00405707. 3.1-21(a)(2)		not recur i.e., what quality assurance program will be put into place; **Dietary Manager/designee will conduct a food temperature audit on 12 resident trays per day – 3 resident trays per Unit 100, 200, 300, 400: Audits will be completed 5x/week for 4 weeks, 3x/week for 4 weeks then weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 6/30/2023	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with			

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	applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food was stored under sanitary conditions related to labeling of food, outdated food, and dried spillage in freezers, refrigerators, and microwaves in 4 of 4 pantries throughout the facility. (100, 200, 300, and 400 units) Findings include: 1. On 5/30/23 at 11:38 a.m., a plastic container with a white substance was observed in the refrigerator in the 100 unit pantry. There was no name or date on the container. 2. On 5/30/23 at 11:29 a.m., the microwave in the 200 unit pantry had an accumulation of dried food spillage. There was also an accumulation of a brownish substance on the ceiling. In the refrigerator, there were 4 peanut butter and jelly sandwiches that weren't dated and a package of lunch meat that had expired on 4/22/23. A white styrofoam food container had a resident's name on it, but there was no date. On the top shelf of the refrigerator, two styrofoam plates were stacked on top of each other. The plate contained two grilled hot dogs and there was no name or date. 3. On 5/30/23 at 11:19 a.m., the refrigerator in the 300 unit pantry had an accumulation of dried	F 0812	**Tag number: F812 – Food Procurement, Store/Prepare/Serve-Sanitary** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Container not labeled nor dated was removed from the 100 Unit pantry. Food not labeled nor dated was removed from the 200 Unit panty. Microwave, pantry ceiling cleaned for the 200 Unit pantry. Expired foods removed from the 200 Unit pantry. Refrigerator in the 300 Unit pantry was cleaned and expired food was removed. Foods not dated in the 400 Unit pantry was removed.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged**	06/30/2023

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	liquid spillage in the freezer and on the refrigerator shelf. There was a salad on the top shelf of the refrigerator dated 5/16/23. 4. On 5/30/23 at 11:16 a.m., a tupperware container in the refrigerator in the 400 unit pantry contained left over food. A resident's name was on the container but no date. Interview with the Dietary Food Manager (DFM) on 5/30/23 at 1:21 p.m., indicated the food should have been labeled and dated and the refrigerators and microwaves should have been cleaned. The facility policy titled, "Labeling and Dating Foods" was provided by the DFM on 5/30/23 at 1:34 p.m. The policy indicated, prepared food or opened food items should be discarded when the food item did not have a specific manufacturer expiration date and had been refrigerated for 7 days, the food item was leftover more than 72 hours, and the food item was older than the expiration date. 3.1-21(i)(3)		**deficient practice. The Dietary Manager audited each of the Units' pantries to ensure compliance with labeling, dating and cleanliness by 6-20-2023.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administrator to re-educate Dietary Manager and Dietary Manager to re-educate dietary staff on the process of ensuring all food items are labeled and dated properly; no spillage or dirty microwaves, refrigerators and all pantries to be kept cleaned. Education to be completed by 6-6-2023.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **Dietary Manager/designee will conduct a sanitation and food audit of all pantries of the 100 Hall, 200 Hall, 300 Hall and 400 Hall pantries. Audits will be completed 5x/week for 4 weeks, 3x/week for 4 weeks then weekly. The results of these audits will be reviewed**	

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			in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 6/30/2023	
F 0867 SS=F Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance			

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	indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.			

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	§483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s)			

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	functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. Based on observation, record review, and interview, the facility failed to identify unresolved quality deficiencies, some of which had been cited on previous surveys, and ensure actions were developed and implemented to attempt to correct the deficiencies through the quality assessment and assurance (QAA) process as evidenced by the number of repeated deficiencies cited involving activities of daily living and unnecessary medications. This deficient practice affected 130 of 130 residents residing in the facility. Findings include: Interview with the Interim Administrator and the Nurse Consultant on 5/30/23 at 4:50 p.m., indicated the Quality Assessment and Assurance (QAA) Committee met at least quarterly and the committee consisted of the Medical Director, the Administrator, the DON, the ADON, Infection Control Nurse, the Minimum Data Set (MDS) Nurse, the Food Sanitation Supervisor, the Pharmacist, and Maintenance. The Department Heads met on a monthly basis.	F 0867	**Tag number: F867 – QAPI/QAA Improvement Activities** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Moving forward all QAPI/QAA audits and plans for improvement will be audited by the facility Nurse Consultant/designee.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice. Administrator reviewed QAPI plan and all POCs for the Survey Cycle that started on May 30, 2023 with all**	06/30/2023

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	The Quality Assurance and Performance Improvement (QAPI) plan requested at the Entrance Conference was provided during the survey by the Interim Administrator. The plan was a general outline of how to set up a QAPI committee and what the committee should do. The QAPI plan was a data driven, proactive approach for improving the quality of life, care and services in long term care. The activities of QAPI involved members at all levels of the organization to identify opportunities for improvement, address gaps in systems or processes, develop and implement and improvement or corrective plan and continuous monitoring of interventions. The following deficiencies were cited on this survey at an isolated or pattern scope with potential for more than minimal harm and had been cited previously: a. F677 ADL Care Provided for Dependent Residents was previously cited on Complaint surveys dated 3/16/23, 2/15/23, 12/16/22 and 9/29/22 and on the Annual with Complaints survey on 4/21/22. b. F757 Unnecessary Medications was previously cited on Complaint surveys dated 3/16/23, 2/15/23, 12/16/22 and 9/29/22 and on the Annual with Complaints survey on 4/21/22. There was no evidence the facility had identified, developed, or implemented action plans and/or continued to monitor any corrective actions taken when these deficiencies were cited previously. Interview with the Interim Administrator 5/30/23 at 4:50 p.m., indicated shower sheets were supposed to be collected in the daily stand up meeting,		**department managers by 6-20-2023.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administrator to re-educate QAPI team/department managers on the QAPI process and audit tools for the Survey Cycle that started on May 30, 2023 by 6-23-2023.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **Administrator/Nurse Consultant/designee will conduct an audit of all POC audits for this survey cycle as follows: QA minutes will be reviewed monthly and signed off by Regional/corporate staff for 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	however, he had noticed in the last 60 days this was not being done and he had not developed a new QAPI plan. The Medication Records were being reviewed monthly, so medications missed and not administered timely was not being caught. He was unaware of what audits were being done from the previous complaint surveys. 3.1-52(b)(2)		Date of compliance: 6/30/2023	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:			

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

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	its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented related to lack of documentation for tracking and trending infections during the review of the facility infection control process and a lancet disposed of improperly for a random observation during a blood sugar check. (Resident 47) Findings include: 1. The Infection Control binder was reviewed on 5/30/23 at 1:00 p.m. The logs included infections for the month of May 2023. Each resident and the infection type were listed with the location in the facility, the type of infection, cultures/testing, antibiotic, and whether it met McGeer's criteria for a true infection. There were no previous months in the binder for tracking and trending of infections. Interview with the Infection Preventionist on 5/30/23 at 2:45 p.m., indicated she had been working on the infection control logs and antibiotic stewardship logs since she started in the position as the Infection Preventionist, however the records prior to her starting in the position were unable to be located. A Policy titled, "Infection Surveillance, Tracking, and QA Reporting," indicated "Infection Tracking includes but is not limited to: - Completing Infection Tracking Log for all residents with an infection and/or treated with antibiotics - Review documentation of clinical signs and symptoms to determine if McGeer's criteria for	F 0880	**Tag number: F880 – Infection Prevention & Control** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Nurse who improperly disposed of a lancet was re-educated for proper disposal of lancets. The facility's IP Nurse is putting together the binder for tracking and trending of infections.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice. The facility's IP Nurse is putting together the binder for tracking and trending of infections.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to re-educate IP Nurse on the necessary tracking and trending of infections in the facility. DON/designee to**	06/30/2023

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	infection were met and antibiotic use is appropriate - Monitor for trends by unit/location, clusters of same infection types/organisms, outbreaks, employee illness" 2. On 5/24/23 at 11:00 a.m., LPN 1 was observed preparing to check a resident's blood sugar. She removed a glucometer, lancet, alcohol swabs, and the test strips from the medication cart. She performed hand hygiene and donned gloves and proceeded to walk into the resident's room and check his blood sugar. Once the procedure was completed, she put the used lancet in the trash can in the resident's room, removed her gloves, performed hand hygiene and cleaned the glucometer. Interview with LPN 1 on 5/24/23 at 11:15 a.m., indicated she should have placed the used lancet into the sharps container. Interview with the Director of Nursing on 5/24/23 at 3:45 p.m., indicated LPN 1 should have placed the used lancet in the sharp's container, not the trash can. A policy, titled, "Medical Waste Disposal," and received as current on 5/24/23 at 4:21 p.m. from the DON, indicated, " ... 3. Type 1 waste, SHARPS ONLY, shall be placed in a non- porous hazardous waste container marked with the universal biohazard symbol. When full, the container will be securely sealed, labeled and removed from the Medication Room and placed in biohazardous waste container in the Soiled Utility Room...." 3.1-18(b)		**re-educate nurses on the proper disposal of sharps and items potentially containing blood borne pathogens.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct an audit of the binder for tracking and trending of infections. DON/designee to observe nurse completing 5 glucose monitoring checks to ensure proper disposal of lancet. Audits will be completed 5x/week for 4 weeks, 3x/week for 4 weeks then weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 6/30/2023	
F 0921 SS=E	483.90(i) Safe/Functional/Sanitary/Comfortable Environ			

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Bldg. 00	§483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a sanitary and safe environment related to marred walls and doors, holes in walls, dirty tube feeding pumps, and over-bed tables on 3 of 4 units observed. (200, 300, and 400 units) Findings include: During the Environmental Tour with the Maintenance and Housekeeping Directors on 5/30/23 at 1:41 p.m., the following was observed: 1. 200 Unit The wall behind bed "A" in Room 208 was gouged and marred. There was also a large hole in the wall behind the bed. Two residents resided in this room. 2. 300 Unit The wall next to the door of Room 302 was gouged and marred. One resident resided in the room. 3. 400 Unit a. The bathroom walls in Room 427 were gouged and marred. The bathroom door was also scratched along the edge. One resident resided in this room. b. The heat register and the bathroom door frame in Room 439 were scratched and marred. The tube feeding pump next to bed "B" had an accumulation of dried spillage at the base. The	F 0921	**Tag number: F921 – Safe/Functional/Sanitary/Comfortable Environment** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **The following has been completed: 200 Unit – Wall was repaired for Room 208. 300 Unit – Wall was repaired for Room 302. 400 Unit – Wall and bathroom door repaired for Room 427; Heat register and door frame repaired for Room 439. Dried spillage cleaned for Tube Feeding Pump in Room 439 was cleaned. Overbed table replaced for Room 439B.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director/Housekeeping Supervisor performed a 100% audit of the facility regarding any needs for wall repair,**	06/30/2023

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	over-bed table next to bed "B" had an accumulation of rust build up at the base and the plastic trim was peeling away from the table. Two residents resided in this room and one used the bathroom. Interview with the Maintenance Supervisor at the time, indicated all of the above were in need of repair. 3.1-19(f)		**cleaning of tube feeding spillage, and overall condition of each room.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administrator to re-educate Maintenance Director/Housekeeping Supervisor on ensuring Comfortable environment for all residents to include wall repairs, painting, cleanliness.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **Maintenance director/designee will audit 5 resident rooms and 5 common areas weekly for any necessary repairs. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 6/30/2023	

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F 9999 Bldg. 00	3.1-14 PERSONNEL (q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (4) Past employment, experience, and education if applicable. (5) Professional licensure, certification, or registration number or dining assistant certificate or letter of completion if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility and to the specific job skills. (s) Professional staff must be licensed, certified, or registered in accordance with applicable state laws or rules. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. This rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure each new employee had a signed job description as well as job specific orientation. The facility also failed to ensure every new hire had a completed physical exam and pre-employment screening, including criminal background check and references for 4 of 5 new employees reviewed hired in the last 120 days. Findings include: The Employee files were reviewed on 5/30/23 at 3:30 p.m.	F 9999	**Tag number: F9999 – Personnel** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Housekeeper 1, RN 1, Dietary Aide 1, Laundry Aide 1 had their employee files updated. HR Director has received an updated CNA Certificate for CNA 1.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All employees have the potential to be affected by the alleged deficient practice. The HR Director is performing a 100% Employee File audit for compliance to be completed by 6-30-2023.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administrator to re-educate HR Director on needed Employee File documentation. Education completed on 6-15-2023.**	06/30/2023

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APERION CARE ARBORS MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

(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
	a. Housekeeper 1, hired on 5/9/23, had no criminal background check or references. There was no completed physical exam signed by a Physician. There was no job description or job specific orientation in her file. b. RN 1, hired on 4/27/23, had no references, no job description or job specific orientation in her file. c. Dietary Aide 1, hired on 4/18/23, had no completed physical exam signed by a Physician. There was no job description or job specific orientation in her file. d. Laundry Aide 1, hired on 4/19/23, had no completed physical exam signed by a Physician, no references, no job description or job specific orientation in her file. Interview with the Human Resources Director on 5/30/23 at 4:35 p.m., indicated she provided whatever she could find and was aware there was a lot missing from the employee files. e. CNA 1 was hired on 7/18/12 and had a CNA certificate on file which expired on 3/15/23. The last day worked was 5/29/23. Interview with the Human Resources Director on 5/30/23 at 5:50 p.m., indicated she was unaware CNA 1 had an expired certificate. She indicated her date of hire was in 7/2012. She was just made aware the certificate had expired and CNA 1 had been removed from the schedule going forward. CNA 1 had just worked the day prior (5/29/23) and had been on the schedule since March.		IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **HR Director will conduct an Employee File audit as follows: Audits will be completed as follows: All new hire employee files to be audited weekly for 6 months and have 10 employee files corrected and completed each week until 100% compliant. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 6/30/2023	