STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 00 B. WING	12/20/2023

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaints IN00420140, IN00423323, IN00423640. This visit included a State Residential Licensure Survey. Complaint IN00420140 - No deficiencies related to the allegations are cited. Complaint IN00423323 - No deficiencies related to the allegations are cited. Complaint IN00423640 - Federal/State deficiencies related to the allegations are cited at F757. Survey dates: December 13, 14,15, 18, 19, and 20, 2023 Facility number: 000125 Provider number: 155220 AIM number: 100266740 Census Bed Type: SNF/NF: 113 Residential: 35 Total: 148 Census Payor Type: Medicare: 14 Medicaid: 80 Other: 19 Total: 113 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/28/23.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy Maurice	Administrator	01/11/2024

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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F 0623 SS=A Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is			

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	required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill			

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	Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on record review and interview, the facility failed to ensure the resident's Responsible Party was notified in writing related to a transfer to the hospital for 1 of 2 residents reviewed for hospitalization. (Resident 27) Finding includes: The record for Resident 27 was reviewed on 12/18/23 at 10:10 p.m.. Diagnoses included, but were not limited to, stroke, COPD, type 2 diabetes, cardiac pacemaker, seizures, and high blood pressure. The resident was admitted to the hospital on 9/14/23. The Significant Change Minimum Data Set (MDS) assessment, dated 10/4/23, indicated the resident	F 0623	**The facility respectfully requests a desk review.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Facility notice of transfer discharge including the bed hold policies were mailed to the responsible parties for Resident 27. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents that are transferred or	01/17/2024

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	was severely cognitively impaired for decision making and received oxygen as a resident. A Nurses' Note, dated 9/14/23, at 11:37 a.m., indicated the resident's blood sugar was 38, blood pressure was 87/54, pulse was 70 and her oxygen saturation was 76%. Oxygen was applied via a rebreather mask and Physician was notified who gave new orders to send the resident to the hospital. A Nurses' Note, dated 9/14/23 at 12:15 p.m., indicated the resident's Power of Attorney was notified of the change of condition. There was no documentation the resident's Responsible Party was notified in writing of the transfer to the hospital. During an interview on 12/19/23 at 8:50 a.m., the Administrator indicated they give the transfer paperwork to the resident or EMS as they were leaving for the hospital. 3.1-12(a)(6)(A)(iii)		discharged have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The Facility Medical Records Coordinator was educated to mail (Via USPS) a copy of the notice of discharge including the Bed hold policy to the resident's responsible party within 72 hours of the resident's transfer and upload proof into the resident's medical record. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Administrator/Designee will audit all hospital discharges weekly for 4 months to ensure the notice of transfer discharge including bed hold policy is provided to residents' responsible parties upon transfer/discharge. The results of the aforementioned audit will be reviewed by the QAPI committee monthly for no less than 4 mos to ensure continued compliance. If the results fall below 95% the audits will continue.	

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F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other			

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	appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on record review and interview, the facility failed to initiate Care Plans related to psychotropic medications for 1 of 26 residents whose Care Plans were reviewed. (Resident 80) Finding includes: The record for Resident 80 was reviewed on 12/15/23 at 10:55 a.m. Diagnoses included, but were not limited to, metabolic encephalopathy, cellulitis of the left lower limb, vascular dementia, dementia with behaviors, high blood pressure, non-psychotic mental disorder, and Alzheimer's disease. The Quarterly Minimum Data Set (MDS) assessment, dated 10/3/23, indicated the resident was not cognitively intact and was receiving an antipsychotic, antianxiety, antidepressant, and diuretic medication. Physician's Orders, dated 5/25/23, indicated Lorazepam (an anti-anxiety medication) 0.5 milligrams (mg), 1 tablet by mouth two times a day. Physician's Orders, dated 9/28/23, indicated Sertraline (an antidepressant medication) 50 mg, give 1 tablet by mouth daily. There was no Care Plan for the Sertraline or the	F 0656	**The facility respectfully requests a desk review.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 80's plan of care has been updated. **How will facility identify other residents who have the potential to be affected by the same alleged deficient practice?** All residents with orders for psychotropic medications have the potential to be affected by the same deficient practice. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** MDS staff/ and Licensed Nurses were educated on ensuring that care plans are in place for residents with orders for psychotropic medications including anti-anxiety or antidepressant medications. **What quality assurance plans**	01/17/2024

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	Lorazepam medications. During an interview on 12/19/23 at 12:30 p.m., Nurse Consultant 1 indicated there were no Care Plans developed for the above mentioned medications. 3.1-35(a)		**will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** DON/ designee will audit 5 residents who have order for psychotropic medication weekly for 4 months to ensure care plans are in place. The results of the aforementioned audit will be reviewed by the QAPI Committee monthly for no less than 4 months to ensure continued compliance. If the results of these audits fall below 95% the audit will continue	
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 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			

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	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 care plan meetings were completed quarterly and/or included the resident, responsible party, and IDT (interdisciplinary team) members as required for 2 of 3 residents reviewed for care planning. (Residents 72 and 20) Findings include: 1. During an interview on 12/13/23 at 10:21 a.m., Resident 72 indicated he had not been invited or attended any care plan conferences for a while. Resident 72's record was reviewed on 12/15/23 at 10:27 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, chronic kidney disease, and heart failure. The Quarterly Minimum Data Set assessment, dated 9/3/23, indicated the resident was cognitively intact. There was a lack of documentation any care plan meetings had been completed. During an interview on 12/15/23 at 11:20 a.m., the Social Service Director indicated she was new to the facility and would see if she could find any care conference documentation. On 12/15/23 at 12:51 p.m., the Administrator provided a care conference report from the	F 0657	**The facility respectfully requests a desk review.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** A care conference was scheduled for resident 72 and residents family plans to attend via telephone. Resident 20 is no longer at the facility. No corrective actions can be made. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by this alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Social Service and the Care Plan IDT team members were re-educated on: Ensuring care plan meetings are	01/17/2024

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	facility's previous charting system. The last care conference meeting was documented as 3/7/23. She was unable to provide any further information. 2. During an interview on 12/14/23 at 10:15 a.m., Resident 20's daughter indicated she used to be invited to the resident's care conferences, but had not received a call recently. Resident 20's record was reviewed on 12/14/23 at 2:44 p.m. Diagnoses included, but were not limited to, dementia, malnutrition (poor nutrition) , anxiety, hypertension (high blood pressure), chronic obstructive pulmonary disease (restrictive airway disease). The Quarterly Minimum Data Set (MDS) assessment, dated 10/19/23, indicated the resident was severely impaired for daily decision making. The resident had no impairment of upper and lower extremities and used a wheelchair. The Care Conference Report, dated 12/15/23 at 10:40 a.m., indicated a care conference was conducted with the resident at the bedside on 1/25/23, and 4/25/23. A Social Service Progress Note, dated 10/19/23, indicated a care plan meeting was held with the Interdisciplinary Team (IDT). There was no documentation the resident's daughter had been invited and/or attended the care conference. There was no annual care plan meeting documented for July 2023. During an interview with the Social Service Director (SSD) on 12/15/23 at 10:09 a.m., she		completed quarterly and include the resident, responsible party and IDT team members. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Administrator/Designee will review MDS schedule on a monthly basis to ensure residents, and responsible parties are invited to participate. The results of the aforementioned audits will be reviewed with the QAPI committee on a monthly basis to ensure continued compliance. If the results of this audit falls below the 95% threshold, the audits will continue.	

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	indicated there was no documentation the resident's daughter had been invited and/or attended the care conference. 3.1-35(d)(2)(B)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to 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 ensure dependent residents received assistance with activities of daily living (ADL's) related to nail care and the removal of facial hair for 3 of 9 residents reviewed for ADL's. (Residents 88, B, and 20) Findings include: 1. On 12/13/23 at 10:44 a.m., Resident 88 was observed sitting in a wheelchair in the memory care dining room. At that time, there was a large amount of facial hair observed on her face, chin and neck areas. On 12/14/23 at 9:45 a.m. and 1:50 p.m., on 12/15/23 at 8:08 a.m. and 12:50 p.m., and on 12/18/23 at 9:35 a.m. and 11:45 a.m., the resident was observed sitting in her wheelchair in the memory care dining room. At those times, she had a large amount of facial hair on her chin, face, and neck areas. The record for Resident 88 was reviewed on 12/15/23 at 1:07 p.m. Diagnoses included, but were not limited to, dementia, high blood pressure, anxiety, major depressive disorder, and psychotic disorder with delusions.	F 0677	The facility respectfully requests a desk review. Resident B's –nails have been cleaned, trimmed and filed. Resident 88 – facial hair has been shaved. Resident 20 –nails have been cleaned, trimmed and filed. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All dependent residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were reeducated on providing residents with assistance with all ADLs per resident's plan of care including ensuring nails are cleaned, trimmed and filed and	01/17/2024

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	The Admission Minimum Data Set (MDS) assessment, dated 10/5/23, indicated the resident was not cognitively intact. The State Optional MDS assessment, dated 10/5/23, indicated the resident needed extensive assist with her ADL's. A Care Plan, revised on 11/21/23, indicated the resident required assistance with ADL's including bathing. The approaches were to assist with personal hygiene including dressing and grooming as needed. During an interview on 12/19/23 at 8:50 a.m., Nurse Consultant 1 indicated the resident should have had her facial hair removed in a more timely manner. 2. During an interview on 12/13/23 at 10:59 a.m., Resident B indicated their fingernails were long and dirty and in need of cleaning and trimming. At that time, their fingernails were observed to be long and dirty. On 12/14/23 at 10:13 a.m. and 1:50 p.m., on 12/15/23 at 8:10 a.m. and 1:50 p.m., and on 12/18/23 at 9:35 a.m., the resident was observed with long and dirty fingernails. The record for Resident B was reviewed on 12/18/23 at 11:05 a.m. Diagnoses included, but were not limited to, disorder of the brain, heart failure, convulsions, high blood pressure, repeated falls, dementia, and major depressive disorder. The 10/20/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was		shaving of facial hair is completed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Nurse managers will randomly observe 10 residents weekly for 4 months with a focus on dependent residents' to ensure ADL assistance is provided including ensuring nails are cleaned, trimmed and filed and shaving of facial hair. The results of the aforementioned audits will be reviewed by the QAPI Committee on a monthly basis for no less than 4 months to ensure continued compliance. If the threshold falls below 95 % the audit will continue.	

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	moderately impaired for decision making. The 10/20/23 State Optional MDS assessment, indicated the resident needed extensive assist with ADL's. A Care Plan, revised on 11/26/23, indicated the resident required assistance with ADL's including bathing. The approaches were to assist with personal hygiene including dressing and grooming as needed. During an interview on 12/19/23 at 9:00 a.m., the Director of Nursing indicated the resident's nails should have been cleaned and trimmed as needed.3. On 12/14/23 at 2:14 p.m., Resident 20 was observed with long, uneven, and sharp fingernails. There was dried blood on her hands, fingers, and nail beds. The resident indicated that she was "painting her nails" and that was why her hands were red. On 12/14/23 at 2:18 p.m., a nurse's aide was observed entering the resident's room to provide care. On 12/14/23 at 3:16 p.m., the resident was observed with hands and nails covered with dried blood. The resident's nails were sharp and uneven and she was observed scratching her skin. The nurses aide was notified. Resident 20's record was reviewed on 12/14/23 at 2:44 p.m. Diagnoses included, but were not limited to, dementia, malnutrition (poor nutrition), anxiety, hypertension (high blood pressure), chronic obstructive pulmonary disease (restrictive airway disease). The Quarterly Minimum Data Set (MDS)			

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	assessment, dated 10/19/23, indicated the resident was severely impaired for daily decision making. The resident had no impairment of upper and lower extremities and used a wheelchair. A Care Plan, dated 9/19/23, indicated the resident had a self care deficit with ADLs including bed mobility, eating, transfers, bathing and toileting. Interventions included, but were not limited to, assist with bed mobility, oral care, eating, transfers, personal hygiene, toileting, and dressing/grooming as needed. During an interview on 12/19/23 at 9:08 a.m., the East Unit Manager indicated the resident's nails should've been trimmed. 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure treatments were obtained for non pressure ulcers, and bruises and sutures were assessed and monitored for 3 of 3 residents reviewed for skin conditions, and residents were assessed and monitored after falls for 1 of 3 residents reviewed for accidents. (Residents 51, 80 and 53)	F 0684	The facility respectfully requests a desk review. Resident 51-Was assessed by the treatment nurse, he MD and family were notified, and new orders were received. Resident 80- Received clarification orders for the bruises and	01/17/2024

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	Findings include: 1. During an interview on 12/13/23 at 1:50 p.m., Resident 51 indicated he had 2 sores on his butt and they hurt really bad. They were putting something over them to cover them up but that was over a month ago and they have not done anything since then. At 2:03 p.m., CNA 3 was asked to remove the resident's brief and roll him onto his side so his buttocks could be viewed. The CNA removed his brief and rolled him over and at that time there were was a large reddened area on his sacrum with 2 open areas on the left buttock. The CNA cleaned the resident and removed peri cream from the drawer and put it all over the red area. The resident's legs were very dry with scaly skin. The record for Resident 51 was reviewed on 12/14/23 at 2:50 p.m. Diagnoses included, but were not include, Parkinson's disease, heart failure, atrial fibrillation, anemia, high blood pressure, and heart disease. The 9/7/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and needed extensive assist with 1 person physical assist for bed mobility and was totally dependent on staff for transfers and bathing. A Care Plan, (no date) indicated the resident had impaired skin integrity, Moisture Associated Skin Dermatitis (MASD) to the sacrum related to incontinence of bowel and bladder. A Wound Observation Report, dated 10/8/23, indicated the MASD to the sacrum had healed. A Weekly Skin Assessment, dated 12/14/23,		compression stockings. Resident 53- orders were updated, sutures were removed, and area is healed. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nursing staff was re-educated on ensuring treatments are obtained and bruises and sutures are assessed and monitored. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Nurse Managers/designee will observe 5 residents and their records weekly for 4 months to ensure treatments are obtained and bruises and sutures are assessed and monitored. The results of the aforementioned audits will be reviewed by the QAPI Committee on a monthly basis for no less than 4 months to ensure continued compliance. If the threshold falls below 95% the	

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	indicated the resident had no skin impairments. A Skin/Wound Note, dated 12/14/23 at 2:24 p.m., indicated a CNA had reported the resident had complaints of pain to his bottom. The area was assessed and a small area of MASD was observed. Physician's Orders, dated 12/14/23 at 2:22 p.m., indicated cleanse the sacrum with normal saline, pat dry, and apply to skin prep and cover with a hydrocolloid bandage every 3 days. During an interview on 12/15/23 at 2:15 p.m., the Wound Nurse indicated she was made aware of the open area from the CNA yesterday. She was informed the MASD was observed on 12/13/23 by a CNA and the surveyor. She was not made aware of the area until 12/14/23. During an interview on 12/19/23 at 8:50 a.m., Nurse Consultant 1 indicated the CNA should have informed the nurse when the open area was first observed. 2. On 12/13/23 at 11:09 a.m., Resident 80 was observed with faded yellow bruise above her right eye. At that time she was observed with no ace wraps to either leg. On 12/14/23 at 9:45 a.m., the resident had no ace wraps to either leg. On 12/15/23 at 8:10 a.m., 12:48 a.m., and 2:06 p.m., the resident had an ace wrap to the right leg. She was not wearing any compression socks. On 12/18/23 at 9:40 a.m. and 11:30 a.m., the resident was wearing an ace wrap to the right leg, there was nothing on the left leg. At those times, the resident was wearing a short sleeve shirt and		audits will continue.	

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	there was a faded red/yellow bruise observed to her upper left arm. The record for Resident 80 was reviewed on 12/15/23 at 10:55 a.m. Diagnoses included, but were not limited to, metabolic encephalopathy, cellulitis of the left lower limb, vascular dementia, dementia with behaviors, high blood pressure, non-psychotic mental disorder, and Alzheimer's disease. The Quarterly Minimum Data Set (MDS) assessment, dated 10/3/23, indicated the resident was not cognitively intact and was receiving an antipsychotic, antianxiety, antidepressant, and diuretic medication. A Care Plan, revised on 12/4/23, indicated the resident had an actual fall. A Care Plan, revised on 11/21/23, indicated the resident was at risk for complications due to arterial/ischemic ulcer of the bilateral lower extremities. The approaches indicated the resident needed the following protective devices: (compression stockings, ace wraps or tubi grips) to bilateral lower extremities. A Weekly Skin Observation, dated 12/8/23, indicated the resident had bilateral lower leg edema. Physician's Orders, dated 7/17/23, indicated left and right lower extremities. Apply 6" ace bandages from below the knee to the base of the toes daily. A Physician's Order, dated 12/14/23, indicated apply compression socks in the morning to bilateral lower extremities.			

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	A Nurses' Note, dated 12/2/23 at 4:13 a.m., indicated the resident was observed face down in the activity room. There were 2 bumps on her face, ice packs were applied. A Nurses' Note, dated 12/5/23 at 4:59 p.m., indicated the resident was noted with bruising to the right eyebrow that was green in color and bruising to the left upper arm. There was no other documentation of the bruising to the right eye or the left upper arm. Fall Follow Up Assessments were completed on 2/3/23 at 9:12 a.m. and 5:37 p.m., on 12/4/23 at 5:42 a.m., on 12/5/23 at 1:25 p.m., on 12/6/23 at 12:23 p.m., on 12/7/23 at 9:03 p.m., and on 12/8/23 at 8:46 a.m. The assessments were not completed every shift for 72 hours. During an interview on 12/19/23 at 8:30 a.m., Nurse Consultant 1 indicated the facility had identified the problem of not following up after a resident fell. A PIP (Performance Improvement Project), dated 11/7/23, indicated fall follow up assessments were not being completed. There was to be a daily review of fall documentation in point click care by the DON she was to use the fall review audit form. During an interview on 12/19/23 at 12:05 p.m., Nurse Consultant 1 indicated there was no follow up assessment regarding the bruises to the right eye and left arm. Fall follow up assessments were still not being done as there were no audits for the fall. The ace wraps and/or compression stockings should have been on as ordered by the Physician.			

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	During an interview on 12/19/23 at 1:30 p.m., the Director of Nursing indicated the bruise to the resident's right eye was now healed, however, there was still a large faded yellow and red bruise to her left upper arm. There was no assessment or follow up regarding the bruise to the arm. 3. On 12/14/23 at 1:58 p.m., Resident 53 was observed lying in bed with her eyes closed. She had 2 sutures intact to the right temple area of her head. On 12/18/23 at 11:16 a.m., Resident 53 was observed lying in bed with her eyes closed. She had 2 sutures intact to the right temple area of her head. Record review for Resident 53 was completed on 12/15/23 at 11:58 a.m. Diagnoses included, but were not limited to, vascular dementia, hypertension, and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 10/25/23, indicated the resident was cognitively impaired and required staff assistance with ADLs (activities of daily living). A Progress Note, dated 12/8/23 at 6:55 a.m., indicated the resident was found on the floor in her room. She had a laceration to her right brow area. The resident was sent to the Emergency Room for evaluation. A Progress Note, dated 12/9/23 at 7:15 p.m., indicated the resident had returned from the hospital. She had 2 sutures in place to her right forehead. A Physician's Order, dated 12/10/23, indicated to monitor the sutures to the right forehead each shift. A separate Physician's Order, dated			

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	12/10/23, indicated to cleanse the right forehead with normal saline, pat dry, apply betadine, and leave open to air daily. The Medication Administration Record (MAR) and Treatment Administration Records (TAR), dated 12/2023, lacked any documentation the sutures had been monitored each shift or the betadine treatment had been completed daily. During an interview on 12/18/23 at 3:21 p.m., the Director of Nursing indicated she had informed the Wound Nurse to make sure the orders would appear on the TAR. No further information was provided. 3.1-37(a)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on record review and interview, the facility failed to ensure residents with impaired vision received the necessary services for 1 of 2 residents reviewed for vision. (Resident 72) Finding includes:	F 0685	**The facility respectfully requests a desk review. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	01/17/2024

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	During an interview on 12/13/23 at 10:25 a.m., Resident 72 indicated he had glasses, but had not seen the eye doctor for a while. He needed to see a specialist for his right eye as he was going blind in that eye. Resident 72's record was reviewed on 12/15/23 at 10:27 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, chronic kidney disease, and heart failure. The Quarterly Minimum Data Set assessment, dated 9/3/23, indicated the resident was cognitively intact. His vision was listed as adequate with no corrective lenses. A Physician's Order, dated 4/20/23, indicated the resident may receive services of eye care physician, audiologist, dentist, and podiatrist. Eye Care Consult Notes, dated 5/16/23 and 8/8/23, indicated the resident had been scheduled to be treated those days but was not as he was unavailable due to being at dialysis. There was a lack of documentation the facility had attempted to make any other arrangements for the resident to receive eye care services. During an interview on 12/15/23 at 11:20 a.m., the Social Service Director indicated she was new to the facility and would see if she could find any documentation. No further information was provided. 3.1-39(a)(1)		**practice;** Resident 72has an appointment with the optometrist. A review of residents with standing appointments was completed and no like circumstances were identified. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents requiring vision services have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Social Service was educated on communicating the date of optometry visits with nursing to allow time to adjust/reschedule other appointments such as dialysis to prevent overlapping/missed appointments. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Administrator/designee will audit prior to optometry visits weekly for four months to ensure residents with standing appointments such as dialysis, have sessions	

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			re-scheduled to ensure optometry visits aren't missed or off-site optometry appointment is made. The results of the aforementioned audits will be reviewed by the QAPI committee monthly for no less than 4 months to ensure continued compliance. If the threshold falls below 95% the audits will continue.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure each resident received the necessary treatment and services to promote healing for pressure ulcers related to completing treatments as ordered for 1 of 2 residents reviewed for pressure ulcers. (Resident 216) Finding includes:	F 0686	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 216 has been receiving his treatments per orders. **How will facility identify other residents who have the potential to be affected by the**	01/17/2024

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	On 12/14/23 at 1:59 p.m., Resident 216 was observed lying in bed with eyes closed. Soft boots were in place to both feet. Record review for Resident 216 was completed on 12/14/23 at 9:17 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and cerebral infarction. The resident was admitted to the facility on 12/8/23. Wound Rounds, dated 12/11/23, indicated the resident was admitted with a deep tissue injury to the left heel and a fluid filled blister to the left plantar foot. The Physician's Order Summary, dated 12/2023, indicated an order to cleanse the left heel with normal saline or wound cleanser, apply skin prep, and leave open to air daily. A separate order indicated to cleanse the left plantar foot with normal saline or wound cleaner, pat dry, apply skin prep, and leave open to air daily. The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 12/2023, indicated the left heel treatment had not been signed off as completed on 12/11/23, 12/12/23, and 12/13/23. During an interview on 12/18/23 at 3:21 p.m., the Director of Nursing indicated she had informed the Wound Nurse about the blanks on the TAR. No further information was provided. 3.1-40(a)(2)		**same alleged deficient practice?** The deficient practice has the potential to affect all facility residents with orders for treatments. **What corrective measures will the facility take or will alter to ensure that the problem will not recur.** Licensed nursing staff were educated on ensuring wound treatments are signed out as completed upon completion of the treatment. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** The Director of Nursing /designee will audit 10 residents' charts with orders for wound treatments weekly for 4 months to ensure wound treatments are signed out as completed upon completion of the treatment. The results of the aforementioned audits will be reviewed by the QAPI committee monthly for no less than 4 months to ensure continued compliance. If the results fall below 95% the audits will continue.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents.			

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	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. Based on observation, record review, and interview, the facility failed to ensure a resident with a history of falls was wearing the proper footwear to prevent further falls and/or injury for 1 of 3 residents reviewed for accidents. (Resident D) Finding includes: On 12/13/23 at 11:00 a.m., Resident D was observed in bed wearing plain socks to both feet. At that time, there was a floor mat beside the bed and the other side of the bed was against the wall. On 12/14/23 at 9:46 a.m., the resident was observed in bed and attempting to get out with their legs hanging over the side of the bed. The resident was wearing plain socks to both feet with no non-skids. On 12/14/23 at 3:11 p.m., on 12/15/23 at 8:10 a.m. and 1:30 p.m., and on 12/18/23 at 9:36 a.m. and 11:45 a.m., the resident was observed in bed wearing plain sock with no non-skids to both feet. The record for Resident D was reviewed on 12/15/23 at 9:15 a.m. Diagnoses included, but were not limited to, malnutrition, weakness, psychotic disorder, alcohol dependence, high blood pressure, dementia, and adult failure to thrive. The State Optional Minimum Data Set (MDS) assessment, dated 10/2/23, indicated the resident	F 0689	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident D has appropriate footwear in place. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents who have falls have the potential to be affected by the same alleged deficient practice. Rounds have been completed to ensure residents at risk for falls have non-skid socks or appropriate footwear. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were in-serviced on the fall prevention program policy and ensuring residents have proper fitting shoes and/or footwear is non-skid. **How the corrective action(s) will be monitored to ensure the**	01/17/2024

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(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
	was not cognitively intact and was an extensive assist with a 1 person physical assist for bed mobility and transfers. The resident displayed physical and verbal behaviors 1 to 3 days during the reference period. A Care Plan, revised on 11/26/23, indicated the resident preferred to lower self to the floor and crawl on the floor within the unit. A Care Plan, revised on 11/23/23, indicated the resident was at risk for falls. The approaches were to follow the facility fall protocol. A Nurses' Note, dated 11/9/23 at 12:00 p.m., indicated the resident was observed walking away from their wheelchair in the hallway. At that time, the resident's legs weakened, causing the resident to grab the handrails and fall to the floor. A Nurses' Note, dated 11/16/23 at 9:50 a.m., indicated the resident was observed standing in front of the wheelchair. The resident started to ambulate and then lowered self to the floor. During an interview on 12/19/23 at 12:35 p.m., Nurse Consultant 1 indicated she had spoken to the Unit Manager and the resident was wearing non-skid socks today. The current 9/1/20 "Fall Prevention Program" policy provided by Nurse Consultant 1 on 12/19/23 at 12:05 p.m., indicated foot wear will be monitored to ensure the resident has proper fitting shoes and/or footwear was non-skid. 3.1-45(a)(2)		**deficient practice will not recur, i.e., what quality assurance programs will be put into place;** The DON /designee will audit 10 residents weekly for 4 months to ensure the fall prevention program is followed and residents have proper fitting shoes and/or footwear is non-skid. **The results of the aforementioned audit will be reviewed by the QAPI committee monthly for no less than 4 months to ensure continued compliance. If the results fall below 95% the audits will continue.**	

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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; §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 record review and interview, the facility failed to ensure the Registered Dietitian's (RD) recommendations were acted upon in a timely manner for a resident with a history of weight loss for 1 of 2 residents reviewed for nutrition. (Resident 52) Finding includes: The record for Resident 52 was reviewed on 12/14/23 at 2:03 p.m. Diagnoses included, but were not limited to, congestive heart failure, repeated falls, restlessness and agitation, high blood pressure, atrial fibrillation, and dementia with behaviors.	F 0692	**The facility respectfully requests a desk review. corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 52 received a visit by the Registered Dietician. No new recommendations were received. Dietary recommendations have been reviewed to ensure timely follow. No like concerns were identified. **How the facility will identify other residents having the**	01/17/2024

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	The Annual Minimum Data Set (MDS) assessment, dated 11/14/23, indicated the resident was not cognitively intact. The resident had complaints or difficulty swallowing and weighed 116 pounds. He received a mechanically altered diet and had no significant weight loss during the assessment period. A Care Plan, revised on 11/6/23, indicated the resident was at risk for impaired nutritional status due to a mechanically altered diet and a history of weight loss. The resident's current weight on 12/7/23 was 114 pounds. The resident weighed 117 pounds on 8/2/23 and 111 pounds on 9/6/23, which was a significant weight loss greater than 5% in one month. An RD Note, dated 9/7/23 at 8:49 p.m., indicated the resident was receiving Hospice care and a pureed diet. The resident's weight was 111 pounds on 9/6/23 which presented a 5.8% weight loss over the last 30 days. Although not desirable, but anticipate further decline in nutritional status due to disease process. Recommend 120 milliliters (ml) of a high calorie supplement twice a day. Physician's Orders, dated 9/14/23, indicated a 4 ounce house supplement two times a day for weight loss prevention. During an interview on 12/19/23 at 11:30 a.m., Nurse Consultant 1 indicated the recommendations were to be done in a timely manner. The current and undated "Medical Nutrition Therapy Recommendations" policy, provided by Nurse Consultant 1 on 12/19/23 at 11:30 a.m.,		**potential to be affected by the same deficient practice and what corrective action will be taken;** All residents with dietary recommendations have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Licensed Nurses were reeducated on completing dietary recommendations in a timely manner. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will randomly audit 5 residents' dietary recommendations weekly for 4 months to ensure dietary recommendations are completed timely. The results of the aforementioned audit will be reviewed by the QAPI committee for no less than 4 mos to ensure continued compliance. If the threshold falls below 95%, the audits will continue.	

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	indicated the facility clinical designee will follow through on these recommendations in a timely manner. Recommendations that were more urgent will be handled and returned within 72 hours or less. 3.1-46(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure oxygen was on and set at the correct flow rate, and tracheostomy care was completed as ordered by the Physician for 4 of 4 residents reviewed for respiratory care. (Residents 27, 6, 17, and 4) Findings include: 1. On 12/13/23 at 1:41 p.m., Resident 27 was observed in bed. At that time, her oxygen tubing was laying the bed next to her. The oxygen concentrator in the room was set at 2.5 liters per minute. On 12/14/23 at 9:37 a.m. and 1:49 p.m., the resident was observed in bed and the oxygen tubing was in both nares and the flow rate was set at 2.5 liters per minute.	F 0695	**The facility respectfully requests a desk review.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 27 has been receiving her oxygen as ordered. Resident 6 received a new nasal cannula, and her plan of care was updated. Resident 17 Oxygen order and plan of care have been updated. Resident 4 did not have any ill effects from the trach care received. Resident 4 is receiving his trach care per physician orders.	01/17/2024

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	On 12/15/23 at 8:05 a.m., the resident was observed in bed and the oxygen tubing was laying in the bed and not in her nares. On 12/15/23 at 12:49 p.m. and 2:20 p.m., the resident was in bed and her oxygen was not in her nares and was turned off. On 12/18/23 at 9:30 a.m., the resident was observed in bed and her oxygen was in both nares with the concentrator set at 2.5 liters per minute. The record for Resident 27 was reviewed on 12/18/23 at 10:10 p.m.. Diagnoses included, but were not limited to, stroke, COPD, type 2 diabetes, cardiac pacemaker, seizures, and high blood pressure. The resident was admitted to the hospital on 9/14/23. The Significant Change Minimum Data Set (MDS) assessment, dated 10/4/23, indicated the resident was severely cognitively impaired for decision making and received oxygen as a resident. A Care Plan, revised on 11/5/23, indicated the resident had COPD and required oxygen. The approaches were to have the oxygen set at 2 liters per minute. Physician's Orders, dated 9/28/23, indicated oxygen at 2 liters per minute via nasal cannula continuously for shortness of breath. During an interview on 12/19/23 at 8:50 a.m., Nurse Consultant 1 indicated the oxygen was to be set at 2 liters per minute and Care Plan indicating the resident removed her oxygen was written on		**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents requiring oxygen and tracheostomy care have the potential to be affected by the same alleged deficient practice. Observation of all Residents with oxygen has been completed to ensure concentrators are set at proper liter flow in accordance with physician orders. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were re-educated on: Tracheotomy care provided as per physician orders. Oxygen administered at the correct liter flow rate and nasal cannulas to be in place. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Nurse managers/ designee will audit 10 residents with orders for tracheostomy care and/or oxygen weekly for 4 months to ensure tracheostomy care is provided and oxygen is administered as ordered.	

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	12/15/23. 2. On 12/13/23 at 2:02 p.m., on 12/14/23 at 11:39 a.m., and on 12/15/23 at 9:03 a.m., Resident 6 was observed in bed. At those times, the resident was not observed wearing oxygen per nasal cannula. The oxygen was on and the flow rate was on at 3 liters. The tubing was observed on the floor, under the bed, or on the side of the resident. The record for Resident 6 was reviewed on 12/19/22 at 11:29 a.m. Diagnoses included, but were not limited to, anemia, hypertension (high blood pressure) atrial fibrillation (abnormal heart rhythm), heart failure, wound infection, stroke, hemiplegia (paralysis on one side of the body), depression, dysphagia (difficulty swallowing). The Significant Change Minimum Data Set (MDS) assessment, dated 11/20/23, indicated the resident was not cognitively intact. The resident had upper extremity impairment on one side and her lower extremity had impairment on both sides. The resident had an unhealed pressure ulcer and was at risk for pressure ulcers. The Care Plan, dated 11/15/23, indicated the resident used oxygen therapy due to respiratory illness. The approaches were to provide oxygen therapy per nasal cannula and monitor for signs of respiratory distress. Physician's Orders, dated 11/7/23, indicated to administer oxygen at 3 liters via nasal cannula continuously every shift. Physician's Orders, dated 11/8/23, indicated the resident received contracted hospice services every shift. During an interview on 12/19/23 at 3:52 p.m., Nurse Consultant 1 indicated she had no		The results of the aforementioned audit will be reviewed by the QAPI Committee monthly for no less than 4 months to ensure continued compliance. If the threshold falls below 95% the audits will continue.	

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	additional information to provide. 3. On 12/18/23 at 10:40 a.m., Resident 17 was sitting in her wheelchair watching tv. The resident was short of breath while talking. She was observed wearing oxygen via nasal cannula and the flow rate was on 4 liters. On 12/18/23 at 12:05 p.m., the resident was observed asleep in her wheelchair. She was wearing oxygen via nasal cannula at 4 liters. On 12/19/23 at 9:00 a.m., the resident was observed asleep in her bed. She was wearing oxygen via nasal cannula and the flow rate was set to 4 liters. The record for Resident 17 was reviewed on 12/17/22 at 10:02 a.m. Diagnoses included, but were not limited to, hypertension (high blood pressure), dementia, anxiety, depression, respiratory failure, difficulty walking, and atrial fibrillation (abnormal heart rhythm). The Quarterly Minimum Data Set (MDS) assessment, dated 9/9/23, indicated the resident was cognitively intact for daily decision making. The Care Plan, dated 12/3/23, indicated the resident required oxygen therapy due to respiratory illness. The interventions were to provide oxygen therapy per nasal cannula and administer medication as ordered. A Physician's Order, dated 11/29/23, indicated to administer oxygen via nasal cannula at 1 liter every evening and night shift. The current Medication Administration Record (MAR), indicated the order for oxygen to be			

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	administered at 1 liter at evening and night was signed out daily from 11/29/2023-12/18/2023. During an interview on 12/19/23 at 9:08 a.m., the East Unit Manager indicated the resident should've had orders for increased oxygen use. She would notify the physician after assessing the resident. 4. On 12/13/23 at 2:16 p.m. Resident 4 was observed wearing oxygen over his tracheostomy (trach). Oxygen flow rate was on at 9 liters. At the time the resident indicated that staff provided all trach care, but they do not do it everyday. On 12/14/23 at 2:04 p.m. the resident was observed lying in bed watching his laptop. The resident's oxygen mask was covering the tracheostomy (trach) at 9 liters. The resident was short of breath while talking and had visible thick mucus in and around his trach. The resident indicated he had not been suctioned yet that day and that staff does not suction him every day. He had requested for the trach ties to be changed yesterday and they had not been changed yet. On 12/15/23 at 8:58 a.m., Resident 4 was observed sitting in bed watching his computer. He was breathing better and he remained on 9 liters of oxygen via trach mask. He indicated he was not suctioned on 12/14/23 and trach care was not offered or provided. On 12/15/23 at 1:20 p.m., Resident 4 was observed in bed with an oxygen mask over his tracheostomy (trach). At that time, RN 1 was observed performing tracheostomy care. The RN used hand sanitizer and donned clean gloves to both hands. She opened the suction kit, the tracheostomy cleaning kit, and the tracheostomy			

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	tie kit on the resident's bedside dresser. After she prepped the kits, she removed her gloves and applied hand sanitizer. She turned on the suction machine and then donned sterile gloves. At that time, RN 1 begun to suction the resident with her clean hand and the catheter became quickly occluded to due to thick secretions. The nurse then used her clean hand and reached behind her to open a box of single use normal saline vials. She opened the vial with both hands and suctioned the resident again. The catheter remained occluded after using more saline and a tube cleaner to help remove mucus secretions. The RN removed her gloves, applied hand sanitizer, prepped a trach new suction kit, and donned sterile gloves. She began to suction the resident a third time and was able to clear secretions before the catheter became clogged again. She removed her sterile gloves, applied hand sanitizer, donned clean gloves, and changed the tracheostomy ties. During an interview at the time with RN 1, she indicated her right hand was her clean hand and her left hand was her dirty hand, and she realized she shouldn't have opened the saline box with her right hand. Suction and trach care was ordered daily and prn (as needed) for the resident. The record for Resident 4 was reviewed on 12/15/22 at 1:58 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (restrictive airway disease), hypertension (high blood pressure), heart failure, renal insufficiency , neurogenic bladder, diabetes, depression, chronic respiratory failure with hypoxia, cellulitis of left and right leg , and tracheostomy. The Quarterly Minimum Data Set (MDS)			

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	assessment, dated 9/21/23, indicated the resident was cognitively intact for daily decision making. The resident was independent with eating and oral hygiene, dependant with toileting, showering and bathing, and upper/lower body dressing and frequently incontinent of bowel and bladder. A Care Plan, dated 12/8/23, indicated the resident required assistance with ADLs including bed mobility, eating, transfers, bathing and toileting due to congestive heart failure and chronic respiratory failure. Interventions included, but were not limited to, assist with bed mobility, oral care, eating, transfers, personal hygiene, toileting, and dressing/grooming as needed. A Care Plan, dated 12/8/23, indicated the resident required oxygen therapy via tracheostomy related to respiratory illness. Interventions included, but were not limited to, change tracheostomy tubing and mask, oxygen via tracheostomy, and administer medications as ordered by physician. A Physician's Order, dated 12/10/23, indicated to provide daily tracheotomy care and change trach ties daily and as needed (PRN) every day shift. A Physician's Order, dated 12/10/23, indicated to provide tracheotomy care and suctioning daily and as needed (PRN) every day shift. A Physician's Order, dated 7/17/23, indicated to provide tracheotomy care and suctioning daily and as needed (PRN) every day shift. Order was discontinued on 12/8/23. A Physician's Order, dated 12/11/23, indicated to administer oxygen at 9 liters to humidified trach collar every shift.			

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	The MARs indicated daily tracheostomy care and suctioning was not signed out for the months of July, August, September, and October 2023. The December 2023 Medication Administration Record (MAR), indicated daily tracheostomy care and suctioning was signed out as provided for from 12/1/23 -12/18/23. Tracheostomy tie changes were not documented in the MAR from 12/9/23-12/18/23. A Policy titled Tracheostomy Care, dated 9/1/20, indicated ..."10. Turn on suction machine. Put on sterile gloves. Connect sterile catheter to suction tubing keeping one gloved hand and suction catheter sterile..." During an interview on 12/18/23 at 9:08 a.m., the East Unit Manager indicated the order to change trach ties daily and prn was not transferred over to the medication administration record (MAR) and therefore was not documented from 12/9/23-12/18/23. During an interview on 12/19/23 at 9:15 a.m., Nurse Consultant 1 indicated the facility just hired a respiratory therapist last Monday. The resident was supposed to be suctioned as ordered by the physician. 3.1-47(a)(4) 3.1-47(a)(5) 3.1-47(a)(6)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable			

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	physical, mental, and psychosocial well-being. Based on record review and interview, the facility failed to provide care according to the Care Plan to prevent injury for a resident with dementia and who was combative with care for 1 of 2 residents reviewed for dementia care. (Resident 52) Finding includes: The record for Resident 52 was reviewed on 12/14/23 at 2:03 p.m. Diagnoses included, but were not limited to, congestive heart failure, repeated falls, restlessness and agitation, high blood pressure, atrial fibrillation, and dementia with behaviors. The Annual Minimum Data Set (MDS) assessment, dated 11/14/23, indicated the resident was not cognitively intact. The resident had complaints or difficulty swallowing and weighed 116 pounds. He received a mechanically altered diet and had no significant weight loss during the assessment period. A Care Plan, revised on 10/23/23, indicated the resident became combative with staff when given care, as evidenced by swinging arms and hitting staff. The approaches were to educate the resident of the necessity of care, ensure the resident was safe, provide emotional support regarding the behavior, utilize diversion techniques as needed, and reorient the resident to person, place and time. A Care Plan, revised on 12/3/23, indicated the resident had impaired cognitive function or impaired thought processes related to dementia. The approaches were to keep the resident's routine consistent and try to provide consistent	F 0744	The facility respectfully requests a desk review. Resident 52 care plan has been updated to include resident specific interventions for combativeness with care. An in-service related to the care of Resident 52 has been completed for direct care staff. An assessment has been completed and resident was found to be at baseline. A review of allegations of abuse has been completed, no like concerns were identified. Nursing/Social Service has been educated to ensure that during a reportable event related to treatment or care of a resident a full assessment of a resident must be completed and documented in the medical record. Additionally, social service must provide supportive visits to ensure no negative psycho-social outcome because of the interaction has occurred. The Administrator/designee will audit the medical record after any concerns related to resident treatment to ensure the care plan is resident specific, the incident is documented in the medical record, an appropriate assessment is completed and that social service provides supportive visits as needed. The results of this audit will be brought to the QAPI	01/17/2024

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	care givers as much as possible in order to decrease confusion. An allegation of abuse, reported to the Administrator on 10/19/23 at 5:01 a.m., indicated the nurse on the midnight shift made the administrator aware she heard a CNA being rude to a resident. The follow up report on 10/25/23 indicated, upon speaking to staff, the resident was combative with staff during care and they described the manner in which he will hit the arm of the caregiver repeatedly. According to staff present on the unit, the resident was slapping the CNA's arms during care and the CNA told the resident "no, no, no, don't fight." She did raise her voice in an appropriate manner. Staff interviews from the facility investigation indicated the RN heard the resident yelling from his room at the nurses' station. She entered the room and observed the resident and the CNA yelling. The resident spoke Spanish and the CNA was saying "no, no, no." The resident was being aggressive while she was providing care so the nurse intervened and counseled the CNA. At that time, the CNA was not receptive and yelled back at the nurse. Another LPN heard the altercation and indicated "he fights a lot during care with his good arm." She heard the CNA telling the resident not to fight and she was not yelling at him nor was she hurting him. The CNA providing morning care indicated the resident fights when care was provided. She leaned over and told the resident not to fight as he was slapping her arm. She held his other hand so she could see his face. There was no documentation of any of these behaviors in Nursing Progress Notes on 10/19/23 and there was no documentation of any progress notes from Social Service regarding the resident's		committee on a monthly basis for no less than 4 mos to ensure continued compliance.	

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	well being. There were no other interventions or strategies for providing care in the clinical record. A Nurse Practitioner (NP) Behavioral Progress Note, dated 10/19/23, indicated there was no report of agitation, aggression, psychosis or any documentation of the incident that happened earlier that day. During an interview on 12/19/23 at 8:46 a.m., the Administrator indicated the resident was always combative with care by hitting the CNAs and on that particular day during morning care, the nurse heard commotion in the room. She entered the room and told the CNA she had to leave because of the way she was talking to the resident and then the CNA became argumentative with the nurse. Another LPN informed her the resident fought all the time during care and the CNA did nothing wrong. There was no documentation of an assessment of the resident after the incident or any documentation of the incident in the record. She indicated the CNA should have left the room and came back later to see if she could provide the care. 3.1-37(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary 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			

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	§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 medications were managed appropriately related to missed medications, the timing of medications, and no indication for the use of Morphine Sulfate for 2 of 5 residents reviewed for unnecessary medications (Residents D and B). Findings include: 1. The record for Resident D was reviewed on 12/15/23 at 9:15 a.m. Diagnoses included, but were not limited to, malnutrition, weakness, psychotic disorder, alcohol dependence, high blood pressure, dementia, and adult failure to thrive. The State Optional Minimum Data Set (MDS) assessment, dated 10/2/23 indicated the resident was not cognitively intact and was an extensive assist with a 1 person assist for bed mobility and transfers. The resident displayed physical and verbal behaviors 1 to 3 days during the reference period.	F 0757	**The facility respectfully requests a desk review.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident D's Morphine was discontinued. Resident B's Medication orders and plan of care were reviewed and updated. Resident B is receiving he medications per physician orders. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents with medication orders have the potential to be affected by the same alleged deficient practice.	01/17/2024

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	The 10/2/23 Quarterly MDS assessment indicated the resident received an antidepressant medication. The resident received hospice services as of 12/1/23. Physician's Orders, dated 12/6/23, indicated Morphine Sulfate concentrate solution 20 mg/ml, give 0.5 ml orally every 1 hour as needed for shortness of breath. The Controlled Drug Receipt/Record/Disposition Form indicated the facility received 16 syringes of the pre-poured Morphine. The medication was signed out as being administered on 12/7 at 12 a.m. and 12/7 at 9 a.m. There was no documentation on the 12/2023 MAR the medication was signed out as given and there was no documentation the resident had shortness of breath prior to the administration of the Morphine. During an interview on 12/19/23 at 8:50 a.m., Nurse Consultant 1 indicated nursing staff were to sign the medication out on the MAR after administration and there were was no indication for the use of the Morphine Sulfate when is was administered to the resident. 2. During a phone interview on 12/14/23 at 11:06 a.m., Resident B's family indicated the resident had a seizure and was hospitalized last week. They were unsure the resident was receiving the anticonvulsant medication at all. The record for Resident B was reviewed on 12/18/23 at 11:05 a.m. Diagnoses included, but were not limited to, disorder of the brain, heart		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Nurses were educated on: Administering medications as per physician orders. Administering medications at recommended times such as Levothyroxine with other medications that can decrease absorption. Ensuring medications are administered per indication for use and the indication is documented on the EMAR. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will audit the medial records for 10 residents receiving medications weekly for 4 months to ensure medications are administered as per orders, administered at the recommended times, and the indication for use is documented on the EMAR. The results of the aforementioned audit will be reviewed by the QAPI committee on a monthly basis for no less than 4 mos. If the results fall below 95% the audits will continue.	

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	failure, convulsions, high blood pressure, hypothyroidism, dementia, and major depressive disorder. The resident was admitted on 7/13/23. The 10/20/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for decision making. There was no Care Plan for seizures. A Nurses' Note, dated 12/8/23 at 5:53 a.m., indicated the resident was observed with tremors to both arms and legs. The resident's vital signs were abnormal and the Physician was notified and gave orders to send the resident to hospital for further evaluation. The resident was hospitalized on 12/8/23 due to seizure activity. Hospital Notes, dated 12/8/23, indicated the resident's Keppra level was less than 2 at 7:37 a.m.. At that time, 1000 milligrams (mg) of Keppra was administered per IV and at 3:57 p.m., the level was 22.4. On 12/9/23 a TSH (thyroid stimulating hormone) blood test was collected and indicated a level of 23.04 (a high value indicating hypothyroidism). A TSH blood test collected on 7/18/23 indicated a value of 1.969 (normal was .550-4.780). Physician's Orders, dated 7/13/23, indicated Levothyroxine (thyroid medication) Sodium tablet 150 micrograms (mcg), give 1 tablet a day. The scheduled time was for 9:00 a.m. Physician's Orders, dated 7/13/23, indicated Ferosul tablet 325 milligrams (mg), give 1 tablet by mouth two times a day. The scheduled times were			

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	9:00 a.m., and 9:00 p.m. Physician's Orders, dated 7/14/23, indicated Caltrate 600+D Plus Minerals 600-800 mg (Calcium Carbonate-Vitamin D with Minerals), give 1 tablet by mouth one time a day. The scheduled time was for 9:00 a.m. Physician's Orders, dated 7/29/23, indicated Levetiracetam tablet 750 mg (Keppra, an anticonvulsant medication), give 1 tablet by mouth every morning and at bedtime for seizures. Physician's Orders, dated 8/17/23, indicated Centrum Silver oral tablet (Multiple Vitamins with Minerals), give 1 tablet by mouth one time a day. The scheduled time was for 9:00 a.m. Physician's Orders, dated 12/10/23, indicated Levetiracetam tablet 1000 mg, give 1 tablet by mouth every morning and at bedtime for seizures. The 8/2023, 9/2023, 10/2023, 11/2023 and 12/1-12/7 Medication Administration Records (MAR) indicated the Levothyroxine was signed out as being administered at 9:00 a.m. with the iron, calcium and multi-vitamin medication. On 12/18/23 at 2:00 p.m., the medication cart was observed. At that time, LPN 1 removed 2 cards of the Levetiracetam 1000 mg medication. There were 11 pills missing from the card since 12/10/23. The 12/2023 MAR indicated the first dose of the Levetiracetam was signed out as being administered on 12/10 at 10 p.m. From 12/11-12/18 at 9 a.m., the 1000 mg of the medication had been signed out as being administered two times a day, therefore 16 pills should have been removed from the card rather than 11 pills.			

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	During a telephone interview on 12/18/23 at 1:38 p.m., the Pharmacist from the facility's pharmacy indicated they received an order on 7/29/23 for Keppra 750 mg twice a day and it had been filled and sent to the facility on 7/29, 8/22, 10/4, 10/28, and the last one filled was 11/25/23. The Pharmacist indicated they received a new order on 12/10/23 and it was filled that day for 1000 mg twice a day. During an interview on 12/18/23 at 2:30 p.m., the Director of Nursing (DON) indicated she had no medication disposition record from the nursing staff who removed the Keppra 750 mg from the medication cart and placed it in the pile of medications to be sent back to pharmacy. The resident only received 11 doses of the medication from 12/10-12/18/23 at 9:00 a.m. She was unsure if the resident received the correct dose of the Keppra on 12/10/23 at 9:00 p.m., as it might not have been received yet from the pharmacy. During an interview on 12/19/23 at 9:00 a.m., the DON indicated it was the facility's policy to complete a medication disposition form when sending medications back to the pharmacy for destruction or credit. The website https://www.mayoclinic.org/diseases-conditions/hypothyroidism/diagnosis-treatment, indicated some medicines, supplements and even some foods may affect your body's ability to absorb levothyroxine. Also, tell your provider if you take other medicines, especially Iron supplements or multivitamins that contain iron, Aluminum hydroxide, which is found in some antacids. and Calcium supplements.			

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	The current 10/27/14 "Returning Medications to Pharmacy" policy, provided by the DON as current on 12/18/23 at 3:21 p.m., indicated for each medication returned, an entry was made on the drug disposition form. The entry included the date, medication name, strength, quantity, and prescription number. This citation relates to Complaint IN00423640. 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 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;			

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	§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 non-pharmacological interventions were attempted first before the administration of an anti-anxiety medication and the medication was documented on the Medication Administration Record (MAR) for 1 of 5 residents reviewed for unnecessary medications. (Resident D) Finding includes: The record for Resident D was reviewed on 12/15/23 at 9:15 a.m. Diagnoses included, but were not limited to, malnutrition, weakness, psychotic disorder, alcohol dependence, high blood pressure, dementia, and adult failure to thrive. The State Optional Minimum Data Set (MDS)	F 0758	**The facility respectfully requests a desk review.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident D Lorazepam order has been updated. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents with orders for psychotropic medications have the potential to be affected by the	01/17/2024

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	assessment, dated 10/2/23, indicated the resident was not cognitively intact and was an extensive assist with a 1 person assist for bed mobility and transfers. The resident displayed physical and verbal behaviors 1 to 3 days during the reference period. The 10/2/23 Quarterly MDS assessment indicated the resident received an antidepressant medication. The resident received hospice services as of 12/1/23. Physician's Orders, dated 12/6/23, indicated Lorazepam concentrate 2 milligrams (mg)/milliliters (ml) give 0.5 ml by mouth every 2 hours as needed for anxiety. The Controlled Drug Receipt/Record/Disposition Form indicated the facility received 16 syringes of the pre-poured Lorazepam. The medication was signed out as being administered on 12/7/23 at 12 a.m., 12/7 at 8 p.m., 12/9 at 9 a.m., 12/10 at 9 a.m., 12/13 at 10 a.m., and 12/14 at 9 a.m. There was no documentation on the 12/2023 MAR the medication was signed out and there was no documentation of any non-pharmacological interventions tried first before the administration of the Lorazepam. During an interview on 12/18/23 at 2 p.m., LPN 1 indicated she had administered the Lorazepam last week and did not sign the medication out on the MAR. She gave him the Ativan because he was crawling on the floor and seemed agitated. She did not provide any non-pharmacological interventions prior to the administration.		same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Licensed Nurses and Q.M.A.'s were reeducated on ensuring three non-pharmacological interventions are documented prior to the administration of a PRN psychoactive medication. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will audit 5 residents with orders for PRN psychotropics weekly for four months, to ensure that three non-pharmacological interventions are documented prior to the administration of a PRN psychotropic medication and that the medication is signed out on the medication administration record. The results of the aforementioned audit will be reviewed by the QAPI committee monthly for no less than 4 months to ensure continued compliance. If the results fall below 95% the audits will continue.	

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	During an interview on 12/19/23 at 8:50 a.m., Nurse Consultant 1 indicated nursing staff were to sign the medication out on the MAR after administration and there were no non-pharmacological interventions completed before administering the as needed Lorazepam. 3.1-48(a)(4)			
F 0880 SS=D 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: (i) A system of surveillance designed to			

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	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 its IPCP and update their program, as			

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	necessary. Based on observations, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented related to isolation precautions for 1 of 1 resident reviewed for antibiotic use. (Resident 59) Finding includes: During an interview on 12/14/23 at 10:42 a.m., Resident 59 indicated she had a wound to her abdomen that recently became infected, and she was just started on an antibiotic. She was unsure if she was on any type of isolation precautions. There was no isolation signage posted on her door nor any PPE (personal protective equipment) bin outside her room. On 12/14/23 at 2:04 p.m., the resident was lying in bed with her eyes closed. There was no isolation signage posted on her door nor any PPE bin outside her room. On 12/18/23 at 11:20 a.m., the resident was lying in bed watching television. There was no isolation signage posted on her door nor any PPE bin outside her room. On 12/18/23 at 11:53 a.m., staff delivered the resident's lunch tray to her. They did not don PPE prior to entering the room. There was no isolation signage posted on her door nor any PPE bin outside her room. Record review for Resident 59 was completed on 12/18/23 at 10:10 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, congestive heart failure, and hyperlipidemia. The Quarterly Minimum Data Set (MDS)	F 0880	**The facility respectfully requests a desk review.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 59 was placed in contact isolation and was seen by the Infectious Disease Nurse Practitioner. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. An observation of residents with orders for isolation precautions was completed to ensure the doors were labeled properly and that isolation carts were in place. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Facility staff were re-educated on infection control guidelines and the implementation of them. Ensuring isolation set up is provided in the resident's rooms as warranted. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	01/17/2024

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	155220	A. BUILDING 00 B. WING	12/20/2023

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	assessment, dated 10/12/23, indicated the resident was cognitively intact. Abdominal Wound Culture Results, dated 12/6/23 and reported 12/10/23, indicated moderate gram-positive cocci (a type of bacteria) and many methicillin resistant staphylococcus aureus (MRSA). A Progress Note, dated 12/12/23, indicated the resident had been seen by the wound care Physician that morning. The wound culture showed MRSA and the resident was started on linezold (an antibiotic) 600 mg (milligrams) twice a day for four weeks. The red IPC (infection prevention and control) isolation tab at the top of the resident's chart indicated, "onset date-12/12/23, infection status-confirmed, isolation precautions-contact, isolation start date- 12/12/23, expected end date-1/10/24, PPE requirements-gloves and gown, route of transmission-direct contact." During an interview on 12/18/23 at 3:21 p.m., the Director of Nursing (DON) indicated the resident was to be on contact isolation. She had placed a PPE bin outside the resident's room. No further information was provided. 3.1-18(b)		**recur, i.e., what quality assurance programs will be put into place;** Unit managers /designee will audit 5 residents' charts weekly for 4 months to ensure isolation set up is provided in the resident's rooms as warranted. The results of the aforementioned audits will be reviewed by the QAPI Committee on a monthly basis for no less than 4 months to ensure continued compliance. If the results fall below 95% the audits will continue.	
F 9999 Bldg. 00	3.1-14 PERSONNEL (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall	F 9999	The facility respectfully requests a desk review. RA 1 health screen, TB test and	01/17/2024

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	include, but not be limited to, the following: (1) Residents' rights. (q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (7) Documentation of orientation to the facility and to the specific job skills. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure newly hired employees received a		job specific orientation have been completed. RA 2 health screen, TB test and job specific orientation have been completed. Activity Aide 1 physical exam has been completed. LPN 2 annual TB screening Resident rights and dementia training have been completed. Housekeeper 1 annual resident rights and dementia training have been completed. QMA 1 Dementia training, and TB screen have been completed. C.N.A. 1 annual resident rights and dementia have been completed. Dietary aide 2 annual dementia training has been completed. uA review of all current employees has been completed. Any like concerns identified have been rectified. HRD has been educated on the pre-hire requirements related to job specific orientation, health screens, TB tests annual requirements for TB screens, initial training requirements on abuse and neglect, resident rights and dementia as well as ongoing training on said topics. The administrator or designee will audit all new hires and 5 random employees per month to ensure requirements related to job specific orientation, health screenings, TB tests and training is completed for all new hires and	

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	job specific orientation, a physical exam, and a TB screen. The facility also failed to ensure employees received annual resident rights and dementia training for 8 of 10 employee records reviewed. (Resident Assistant 1, Resident Assistant 2, Activity Aide 1, LPN 1, Housekeeper 1, QMA 1, CNA 1, and Dietary Aide 1) Findings include: The employee files were reviewed on 12/19/23 at 1:00 p.m. 1. The following newly hired employees lacked documentation of a physical exam, a TB screen, and a job specific orientation. a. Resident Assistant 1, hired on 8/30/23, lacked documentation of a physical exam, TB screen and job specific orientation. b. Resident Assistant 2, hired on 8/16/23, lacked documentation of a physical exam, TB screen and job specific orientation. c. Activity Aide 1, hired on 8/30/23, lacked documentation of a physical exam. 2. The following employees lacked documentation of annual resident rights and dementia training and a TB screen. a. LPN 2, hired on 2/10/19, lacked documentation of an annual TB screen, resident rights and dementia training. b. Housekeeper 1, hired on 3/1/12, lacked documentation of annual resident rights and dementia training.		annually thereafter. The results of this audit will be reviewed monthly for 4 months by the QAPI committee to ensure continued compliance. If the results fail to meet the threshold of 95% the audits will continue.	

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	c. QMA 1, hired on 12/29/09, lacked documentation of annual dementia training and a TB screen. d. CNA 1, hired on 4/21/04, lacked documentation of annual resident rights and dementia training. e. Dietary Aide 2, hired on 8/2/06, lacked documentation of annual dementia training. During an interview on 12/19/23 at 3:00 p.m., the Human Resource Director indicated the files lacked documentation of annual resident rights and dementia training, as well as job specific orientation, TB screens, and physical exams.			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Complaints IN00420140, IN00423323, and IN00423640. Complaint IN00420140 - No deficiencies related to the allegations are cited. Complaint IN00423323 - No deficiencies related to the allegations are cited. Complaint IN00423640 - Federal/State deficiencies related to the allegations are cited at F757. Survey dates: December 13, 14, 15, 18, 19, and 20, 2023 Facility number: 000125 Residential Census: 35	R 0000		

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	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 12/28/23.			
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor.			

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	(C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure annual resident rights and dementia trainings were completed for 3 of 5 employee files reviewed. (CNA 2, QMA 2, and LPN 3) Finding includes: The employee files were reviewed on 12/19/23 at 1:00 p.m. The following employees lacked documentation of annual resident rights and dementia training. a. CNA 2, hired on 6/7/15, lacked documentation of annual dementia training. b. QMA 2, hired on 1/18/16, lacked documentation of annual dementia training. c. LPN 3, hired on 11/28/16, lacked documentation of annual resident rights and dementia training. During an interview on 12/19/23 at 3:00 p.m., the Human Resource Director indicated the files lacked documentation of annual resident rights and dementia training.	R 0120	The facility respectfully requests a desk review. CNA 2, QMA 2, and LPN 3 have completed their annual resident rights and dementia training. A review of all current employees has been completed. Any like concerns identified have been rectified. HRD has been educated on the requirements for annual dementia and abuse training. The administrator or designee will be responsible for assigning required training on abuse and dementia and ensuring it is completed annually during the month of hire. The results of this audit will be brought to the QAPI committee monthly for no less than 4 months to ensure continued compliance. If the results fall below 95% the audits will continue.	01/17/2024
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction			

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	can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.			
	Based on record review and interview, the facility failed to ensure the health screen was signed by a licensed nurse for 2 of 5 employee files reviewed. (LPN 4 and Dietary Aide 3)	R 0121	The facility respectfully requests a desk review. LPN 4 completed a health screen that was signed by a nurse. Dietary Aide 3 completed a health	01/17/2024

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	Finding includes: The employee files were reviewed on 12/19/23 at 1:00 p.m. The following employees lacked documentation of signed health screen. a. LPN 4, hired on 11/28/23, lacked a signed health screen. b. Dietary Aide 3, hired on 11/14/23, lacked a signed health screen. During an interview on 12/19/23 at 3:00 p.m., the Human Resource Director indicated the health screens were not signed.		screen that was signed by a nurse. HRD has been educated on the requirements for health screening to be completed and signed appropriately. The Administrator or designee will be responsible for auditing all new hires monthly to ensure the health screens are signed and completed prior to the start of work. The results of this audit will be brought to the QAPI committee for no less than 4 months to ensure continued compliance. If the results fall below 95% the audits will continue.	