STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00423199, IN00422758, IN00425349, and IN00425821. Complaint IN00423199 - No deficiencies are cited related to this allegation. Complaint IN00422758 - No deficiencies are cited related to this allegation. Complaint IN00425349 - No deficiencies are cited related to this allegation. Complaint IN00425821 - No deficiencies are cited related to this allegation. Survey dates: January 4, 5, 8, 9, 10, 11, and 12, 2024 Facility number: 000032 Provider number: 155077 AIM number: 100273330 Census Bed Type: SNF/NF: 98 Total: 98 Census Payor Type: Medicare: 0 Medicaid: 94 Other: 4 Total: 98 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 25, 2024.	F 0000	=”” p=””>F000 INITIAL COMMENTS Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey conducted January 11, 2024. Please accept this Plan of Correction as the provider’s credible allegation of compliance as of February 19, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kellie Dickerson	RN, DNS	02/10/2024

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 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other			

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	residents in the facility. Based on observation, interview, and record review, the facility failed to ensure residents from the Wellness unit had the opportunity to attend each Resident Council meeting for 40 of 97 residents who resided on the Secured Wellness unit, and the facility failed to ensure Resident Council requests/suggestions were responded to and/or addressed for 3 of 12 months reviewed. Findings include: On 1/9/24 at 11:00 a.m., the Activity Director provided a copy of the Resident Council Minutes for review. A Resident Council Meeting was held on 7/27/23 for the general population of A and B halls. No residents from the Wellness unit were in attendance. There were no additional minutes or documentation that a Resident Council meeting had been conducted for the Wellness Unit for the month of July. There was no documentation or evidence that a Resident Council meeting had been conducted for the general population A and B halls, or the Wellness Unit for the months of August and September. Instead, there was a typed memo, dated 10/27/23, written by the Social Service Director (SSD) which indicated, the previous Resident Council minutes could not be located after the former Activity Director left. A Resident Council Meeting was held on 10/12/23 for the Wellness Unit. Seven residents were present. Old business was noted, "unknown." New business included, but was not limited to: a. request for Popcorn at night b. requested an additional morning smoke break	F 0565	p="" paraid="1302781414" paraeid="{92c23789-d387-49bb-bedc-717e5c7d86c4}{122}">F565 – Resident/Family Group and Response “Based on observation, interview, and record review, the facility failed to ensure residents from the Wellness unit had the opportunity to attend each Resident Council meeting for 40 of 97 residents who resided on the Secured Wellness unit, and the facility failed to ensure Resident Council requests/suggestions were responded to and/or addressed for 3 of 12 months reviewed.” 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident council meeting was held on Wellness unit at the time of survey Resident council requests were addressed by IDT Wellness unit resident council president was elected October, November and December resident council minutes were reviewed and responses to requests were addressed and recorded All wheelchairs in facility were audited for cleanliness and cleaned as appropriate Activity room was opened for resident use 2 other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. A	02/19/2024

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	for 9:30 a.m. c. requested that wheelchairs needed to be cleaned. A Resident Council Meeting was held on 11/15/23 for the Wellness Unit. Ten residents were present. Old business was discussed, but the only area of response was that the wheelchairs still needed to be cleaned, and the heater in D18 had been repaired. The minutes lacked a response to requests for popcorn and an additional smoke break. New business included, but was not limited to: a. wheelchairs that needed to be cleaned b. the automatic door opener to the courtyard was broken. A Resident Council Meeting was held on 12/28/23 for the general population of A and B halls. No residents form the Wellness unit were in attendance. There were no additional minutes or documentation that a Resident Council meeting had been conducted for the Wellness Unit for the month of December. During an interview on 1/9/24 at 2:32 p.m., Cooperate Consultant 4 and the Director of Nursing (DON) indicated there was no facility policy or procedure related to Resident Council. The facility should follow federal and state regulations. On 1/10/24 at 11:40 a.m., a Resident Council Meeting was held on the Wellness Unit and 5 residents were present. The residents indicated they used to meet once every month, but it had been a couple months where there had not been a meeting. They did not know why the meetings were missed. The residents indicated the thing they wanted most was to be able to go back on		resident council meeting for the residents residing on the Wellness unit will be held every in addition to the general population resident council meeting. director will include questions related to resident activity preferences monthly in resident council meetings. Activity calendars on every unit and provided to individual residents to ensure notification of activity offerings. p="" paraid="1417573191" paraeid="{1afc2e0d-60e5-43fd-836f-46865e6e341f}{2}">3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Director of Activities and Social Services Director were educated on resident council program requirements and appropriate follow-up Director of Activities and Social Services Director were educated on 1/15/2024 by Executive Director Education included: State Operations Manual Appendix PP pages 32-34 Resident Concern / Grievance Policy Activities Program Policy 4: How be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? Executive Director or Designee will audit resident council grievances for appropriate follow-up and resolution once per month, within five days following	

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	outings. They never got to leave the unit and did not have anything else to do. They also requested that food from different restaurants to be considered instead of always ordering Chinese food. They suggested Mexican food and sub sandwiches. Mostly all they got to do was smoke, play Bingo and card games. Although they knew the weather was too cold at that time, the residents all agreed that access to the outdoor courtyard had been restricted for a very long time, and they wished they could go outside when they wanted, and the weather permitted. The residents also indicated they wanted the popcorn machine back. It had been gone for a while, but they missed having fresh popcorn with movies and the bags of popcorn that got popped were often burnt. The residents indicated they wished they could have access to the big Activity Room and wanted things like a ping-pong table, a tabletop computer for internet browsing, magazines of interest, "snack-parties" like hot dogs and chips, popcorn and movie on the new nice big screen TV or "make-your-own-sandwich." Throughout the survey period the main Activity Room on the connector hall of C and D halls, was locked and inaccessible to the residents. On 1/11/24 at 10:25 a.m., the following wheelchairs were observed in need of cleaning and repair. a. Resident 56's wheelchair was dirty with dust, dirt and debris. The padded arm rests were tattered and in poor repair. The chair wheels were loose and when pushed the chair rocked from side to side. The pressure reducing cushion to the seat of the chair was tattered, stained, and ripped. b. Resident 55's wheelchair was observed with only one foot pedal attached. There was a long black strap tied in between the frame, and Resident 55 indicated he tied the strap on to rest		resident council meeting x 6 months. Any identified concerns will be promptly addressed with the responsible individual(s). Audit results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance. p="" paraid="1417573191" paraeid="{1afc2e0d-60e5-43fd-836f-46865e6e341f}{2}"> 5. Date of completion: 02/19/2024	

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	his other foot when he needed. There were no padded arms rests, and the frame was dirty with dirt, dust and debris. c. Resident 3's wheelchair frame was dirty with dust, dirt and debris. d. Resident 13's wheelchair frame was dirty with dust, dirt and debris and the padded arms rests were in poor repair, crack and ripped. During an interview on 1/11/24 at 12:24 p.m., the Executive Director (ED) indicated, there was a room with a wheelchair washing machine, but it had been primarily used for storage. It was unclear if the washing machine worked, or if it had just not been used because of all the other items being stored in the room. The ED indicated night shift staff were supposed to help with routine wheelchair cleaning during their shifts. During an interview on 1/11/24 at 11:10 a.m., the Activity Director (AD) indicated she was new to the Activity Department, but not new to the building as she used to be the Housekeeping Supervisor. During her transition into the AD position, she still functioned as the central supply coordinator for the whole building and was training the new HK Supervisor. In the meantime, the Social Service Director (SSD) had helped her with Resident Council Meetings and programming. When asked about the residents' ability to access the outdoor courtyard, the AD indicated the main activity room on the secured unit was always locked because unsupervised access to the courtyard was considered a safety hazard. The AD indicated the main activity room would be an essential area for the Wellness Unit because it provided more space and room for more activities. At that time, the activity calendar was the same for both the Wellness Unit and the general population, but it was her wish and goal			

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	to implement more specialized programming for the Wellness Unit for the future. During an interview on 1/11/24 at 11:15 a.m., the SSD indicated she helped fill in for the Activity Department when the former director left. She attempted to conduct the meetings and realized when looking at the minutes, a couple months had been missed for the Wellness Unit. Moving forward, it was the goal to hold two meetings, one for A and B halls, and a separate meeting for the Wellness Unit. The SSD indicated, in general, the resident's repeated concerns were requests to start going back on outings, which there was not foreseeable solution at that time due to safety risks and the facility only had one bus which was used for medical transportation appointments. The second issue was that most residents on the Wellness Unit wanted an extra morning smoke break because they liked to get up and have a smoke with their morning coffee but a decision about adding a smoke break had not been made yet. Finally, the SSD indicated the concern related to cleaning residents' wheelchairs was ongoing. During an interview on 1/9/24 at 11:05 a.m., the ED indicated what he preferred to call the secured "Wellness Unit," had been an inherited "Behavioral Health Unit," before he started at the facility. At that time, the ED and other executive staff were in the process of assessing and transitioning the "Wellness Unit," away from admissions/programming for behavioral health and were working towards the goal of turning the unit into a secured Memory Care unit. The ED indicated, during the transition, the facility was still responsible for appropriate services and programming for the residents who resided on the unit. It was a work in progress and many of the resident's behaviors were challenging. When			

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	asked about the above Resident Council Requests, the ED indicated the issues would be evaluated from a safety standpoint to make a plan moving forward. On 1/11/24 at 12:37 p.m., the DON provided a copy of current facility policy titled, "Resident Concern/Grievance," dated 8/2022. The policy indicated, "Purpose: to provide a process for handling, tracking and resolving customer concerns to provide excellence in customer service ... the facility will provide an open customer friendly atmosphere for residents and their families and representatives to voice concerns and problems with the assurance that their concerns will be heard and acted upon ...." On 1/11/24 at 12:37 p.m., the DON provided a copy of current facility policy titled, "Activity Program," dated 8/2022. The policy indicated, "Activity programs are designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident ... Our activity program consists of individual, small group and large group activities that are designed to meet the needs and interests of each resident. Activity program include activities that promote: self-esteem, comfort, pleasure, education, creativity, success and independence ... Individualized and group activities are provided that: reflect the schedules, choices and rights of the residents, are offered at hours convenient to the residents, including evenings, holidays and weekends, reflect the cultural and religious interests, hobbies, life experiences and personal preference of the resident, appeal to men and women as well as those of various age groups residing in the facility and incorporate family, visitor and resident ideas of desired appropriate activities ...."			

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	3.1-3(g) 3.1-3(l)			
F 0577 SS=E Bldg. 00	483.10(g)(10)(11) Right to Survey Results/Advocate Agency Info §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. Based on observation, interview, and record review, the facility failed to ensure Residents on the Wellness Unit had access and ability to review the most recent state survey results which had the potential to effect 40 of 97 residents who resided on the secured Wellness Unit.	F 0577	p="" paraid="898315327" paraeid="{1afc2e0d-60e5-43fd-836f-46865e6e341f}{111}">F577 - Right to Survey Results/Advocate Agency Info “Based on observation, interview, and record review, the facility failed to ensure	02/19/2024

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	Findings include: On 1/4/24 at 10:14 a.m., during an initial observation of the secured Wellness Unit, an available copy of the most recent state survey findings was not able to be located. On 1/5/24 at 1:25 p.m., a copy of the most recent state survey findings was not able to be located on the secured Wellness unit. During an interview on 1/8/24 at 10:43 a.m., the Activity Assistant indicated she did not know if a copy of the state survey results were available on the Wellness Unit, but a copy was at the reception desk. On 1/8/24 at 11:12 a.m., a copy of the most recent state survey findings was not able to be located on the secured Wellness unit. During an interview on 1/8/24 at 2:30 p.m., The Assistant Director of Nursing (ADON) indicated residents from the Wellness Unit could not leave unit without staff assistance and supervision. Throughout the remainder of the survey period, a copy of the most recent state survey findings was not able to be located on the secured Wellness unit. On 1/10/24 at 11:40 a.m., a Resident Council meeting was held in the Wellness Unit and Residents 28, 37, 48, 62 and 84 were present. The residents all indicated, they did not know they were able to read the survey results because no one told them, and they did not know where to find the results. During an interview on 1/11/24 at 12:37 p.m., the		Residents on the Wellness Unit had access and ability to review the most recent state survey results which had the potential to effect 40 of 97 residents who resided on the secured Wellness Unit." 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A binder containing the most recent state survey results was posted on the Wellness Unit for resident access at the time of survey. 2 other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. ul="" role="list" A binder containing the most recent state survey results was posted on the Wellness Unit for resident access at the time of survey. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Executive Director was educated on state survey results posting requirements. The Executive Director was educated on 1/15/24 by Corporate Clinical Support. Education included: State Operations Manual Appendix PP pages 49 Indiana Health Facilities Rules- Resident Rights 4: How be monitored to ensure the deficient practice will	

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	Executive Director (ED) indicated the state survey results had previously been available on the Wellness Unit but was misplaced in an office behind the nurse's station during recent renovations. The binder of survey results had not been replaced upon the completion of the renovations, and since it had been brought to his attention, he would update the binder and replace it for the resident's access on the Wellness Unit. The ED indicated there was no policy related to required postings, but the facility followed the state and federal regulations. 3.1-3(b)(1)		not recur i.e., what quality assurance program will be put into place? ED or designee will audit survey binders to ensure accessibility to all residents and most recent state survey result inclusion three times per week x 4 weeks, then once per week x 4 weeks, then once every other week x 4 weeks, then once per month x 3 months. Any identified concerns will be promptly addressed with the responsible individual(s). Audit results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance. ul="" role="list" 5. Date of completion: 02/19/2024	
F 0584 SS=E Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.			

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	(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview, and record review, the facility failed to maintain a clean, comfortable, and homelike environment for residents who resided on the secured Wellness Unit which had the potential to effect 40 of 97 residents who resided on the secured Wellness Unit. Findings include: Upon initial entrance to the facility on 1/4/24 at 9:40 a.m., evidence of underway construction was noted throughout the A and B hallways. Some floors had been replaced, walls were patching and appeared to be prepped for new paint and	F 0584	p="" paraid="1492526355" paraeid="{87f3a6ce-53a2-4508-8253-6561e6bb8310}{25}">F584 - Safe/Clean/Comfortable/Homelike Environment “Based on observation, interview, and record review, the facility failed to maintain a clean, comfortable, and homelike environment for residents who resided on the secured Wellness Unit which had the potential to effect 40 of 97 residents who resided on the secured Wellness Unit.” 1: What corrective action(s) will be	02/19/2024

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	constructions signs were hung. There was a general odor of "old carpet" and musty airs, but no pungent or foul-smelling odors were noted. Upon initial entrance onto the secured Wellness Unit on 1/4/24 at 10:14 a.m., an immediate and strong odor of urine permeated throughout the unit. The smell was strongest near the end of the Long D-Hall, near the only common area which served as a lounge, activity nook, and dining room. During an interview on 1/4/24 at 10:17 a.m., an Activity Assistant conducted a morning activity with 5 residents. She read from the Daily chronicle and offered coffee. The smell of urine overpowered the smell of coffee and snacks. When asked about the odor, the Activity Assistant indicated there was one resident in particular that would use the bathroom anywhere, and the smell came from his room. During an interview on 1/4/24 at 10:30 a.m., Qualified Medication Aide (QMA) 27 indicated there was always a smell on the unit because the residents had behaviors of peeing anywhere and did not always use the bathroom or did not always flush their toilets. Sometimes the toilets or sinks leaked and that also made the bathrooms smell. During an interview on 1/4/24 at 10:35 a.m., Certified Nursing Aide (CNA) 28 indicated she was a newer employee, but since she started, she had mostly worked on the A and B halls. When she filled in on the Wellness Unit, she noticed the smell was always worse and always there. The residents were on the unit because of their behaviors though, so there was not much they could do.		accomplished for those residents found to have been affected by the deficient practice? Environmental and cleanliness concerns as cited were addressed for all affected residents on the Wellness Unit Resident 3 was provided alternative means to conduct private telephone calls, facility reviewed clock to ensure safety and clock was returned to resident at the time of survey Resident 56 and resident 13 were provided with televisions in the resident rooms ul="" role="list" Resident 68’s bathroom was addressed to ensure resident had access to running water 2 other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. Water fountains removed from wellness unit. Wheelchairs, headboards and bed rails for all residents on unit were audited for necessary repairs and cleanliness. Identified concerns related to cleanliness were promptly addressed. Parts for identified necessary repairs were ordered and will be installed upon receipt. No resident rooms are currently wired to provide landline telephone therefore residents were provided alternative means to conduct private telephone calls Any identified odors were promptly addressed All resident rooms on the Wellness	

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	On 1/4/24 at 10:58 a.m., several residents were lined up at the courtyard door and waited to go outside for a smoke break. A steel-wired wrapped in vinyl security cable and/or bike lock chain was observed wrapped around the door handle. There were no seats available for the residents to use as they waited. Some residents used their rollator walker seats and Resident 57 sat himself on the floor. On 1/4/24 at 11:00 a.m., the Activity Assistant came with a rolling cart of locked smoking materials. She assisted Resident 57 off the floor and used a key to unlock the cable from the door. The Activity Assistant indicated the handicapped button for the door no longer worked and the door lock mechanism was broken, so they used the cable to secure the door shut. The Activity Assistant indicated the only times residents were allowed outside was during the smoke breaks, and she did not know why they could not come and go as they pleased since there was a 6-foot-tall wooden privacy which fenced in the courtyard. During the initial tour and observation of the Wellness Unit on 1/4/24, residents were observed to use the chorded phone at the nurse's station to make all their calls. When asked why they used a public access phone, QMA 27 indicated the phone in the resident's rooms were not working at that time due to renovation and not all residents had a cell phone. During an interview on 1/4/24 at 1:56 p.m., Resident 3 indicated her phone did not work. She was observed in her room seated in her wheelchair. She pointed to a long white, lose chord in the corner of her room on the floor. It was a landline for a phone and the phone on her		Unit were audited for blinds. Parts for any identified concerns were ordered and will be installed upon receipt. All resident bathrooms on the Wellness Unit were audited for leaks and functionality. Parts for any identified concerns were ordered and will be installed upon receipt. Residents who wish to sit while awaiting to exit for smoke break are offered a chair in which to sit Wellness Unit was audited for any additional environmental and cleanliness concerns. Identified concerns were addressed promptly. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance director, maintenance assistant and housekeeping supervisor staff were educated on cleaning, maintenance and homelike environment - Education was provided to the maintenance director, maintenance assistant and housekeeping supervisor on 1/15/24 by the Executive Director Education was provided to the housekeeping staff on 1/16/24 by the housekeeping supervisor Education provided: Secure Unit Program Policy ul="" role="list" Homelike Environment Policy 4: How be monitored to ensure the deficient practice will not recur	

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	over-bed table was unplugged. Resident 3 indicated she wished someone would come and fix the phone and she wanted her clock back. Resident 3 indicated someone took her clock because it had a glass face, and it could be used to cut someone. On 1/5/24 at 1:59 p.m., the Wellness Unit was visited. Odors of urine and body odor permeated the hallways and at that time, several residents returned inside from a smoke break, so the smell of cigarette smoke was noted as well. On 18/24 at 2:14 p.m., Resident 62 complained that she had no hot water in her bathroom and there were no blinds or curtains in her window for privacy. Upon observation and after she ran her sink water for an excess of 3 minutes, no hot water was available. There were no blinds on her window, and she had to pull the hanging privacy curtain in front of the window. On 1/8/24 at 2:18 p.m., Resident 68's bathroom was observed. Neither of his faucets turned hot or cold water on, so that no running water was available in his room. He indicated he had been told to walk up to the shower room if he needed water. The rubber/vinyl baseboard was observed to have been peeled full off the wall and laid loosely on the floor. Resident 68 indicated they were supposed to get his bathroom fixed but had not come back to do it. Resident 68 did not have a roommate and on the empty wall of the other side of the room, there was a red/pink stain that looked like wax had been splashed and dried on the wall. There was also a large area of the bare floor, which was sticky, discolored and appeared to be a dried spill of some kind. On 1/8/24 at 2:20 p.m., Resident 66's restroom was		i.e., what quality assurance program will be put into place? The housekeeping supervisor will complete visual observation rounds on the Wellness Unit at least 5 times weekly, at varied times, for 4 weeks to ensure cleanliness of the Wellness unit, including hallways, resident rooms and resident bathrooms. Thereafter, housekeeping supervisor will complete visual observation rounds at least 5 times per month at varied times for 2 months, then complete visual observation rounds at least 2 times per month at varied times for 3 months. Any identified concerns will be promptly addressed with the responsible individual(s). Audit results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance. ul="" role="list" The maintenance supervisor will complete visual environmental observation rounds on the Wellness Unit at least 5 times weekly, at varied times, for 4 weeks, including hallways, resident rooms and resident bathrooms. Thereafter, maintenance supervisor will complete visual observation rounds at least 5 times per month at varied times for 2 months, then complete visual observation rounds at least 2 times per month at varied times for 3 months. Any	

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	observed. There was an overpowering and intolerable odor of urine. There was a soiled brief on the floor and his toilet bowl water was dark yellow. On 1/8/24 at 2:53 p.m., a game of Bingo was observed. It took place in the lounge/activity/dining nook on the back of Long-D hallway. There was not enough room for the 12-15 gathered residents, so three residents watched. When asked why they could not play games with staff supervision in the main activity lounge, the Activity Assistant indicated the door to the outside courtyard was broken. On 1/10/24 at 8:53 a.m., the water fountain (which was out of service) located on the end of the connector hall between D and C wings was observed. The front metal panel had been removed and rested unsecured on the floor in front of a resident's room. There were towels which had been taped to the water fountain to cover the inner working of the unit. In front of the locked main Activity Room door, there was a rolling cart with an ice chest. The ice chest leaked profusely from the back plug, so that the cart was draped and padded with towels and sat on a heap of wet towel on the floor. During an interview on 1/10/24 at 8:55 a.m., CNA 28 indicated, the cart must have started to leak the night before, it was like that when she got in. She indicated the nursing staff did not do anything about it because it was the Housekeeping departments responsibility to clean up spills. Throughout the survey period, the newly renovated main Activity Room in the connector hallway was observed locked and inaccessible to the residents.		identified concerns will be promptly addressed with the responsible individual(s). Audit results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance. ul="" role="list" 5. Date of completion: 02/19/2024	

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	During a final observation walk-through of the wellness unit on 1/11/24 the following was noted/observed: a. upon entrance, the overwhelming odor of urine and body odor remained. b., Resident 58's headboard of the bed, was broke, laid lose and lopsided and wobbled with moved. c. in room D6, the bathroom sink appeared to be falling away from the wall. The sealing and caulking were severely cracked and crumbled. d. Resident 56 had been without a TV in the room throughout the survey period, and Resident 56 complained that he would like it to be put back since he did not like to do any of the activities. His bathroom was noted to have an intolerable odor of urine and the toilet bowl was observed to be saturated dark yellow/orange almost red colored urine. e. room D15's bathroom was observed. The toilet water ran but had not been flushed. The Resident indicated it always ran and leaked. The vinyl baseboard had been completed removed and old orange glue and other unidentified debris were noted along the wall where the cover had been. f. room D14 was noted to have an intolerable and very pungent odor of urine. A housekeeper was in the room at the time with a mop and indicated, the Resident would pee on the floor. She mopped the floor but neglected to mop under the bed. Although she was using soapy water, no smell of disinfectant or cleaning solution was noted. g. room D12's bathroom was observed. There was an uncovered bathtub which was observed to have a very large dried dark stain. The Housekeeping Supervisor (HKS) entered D12 and when asked about the stain in the tub, he indicated he did not know what it was, but would need a stronger cleaning agent to get it up. He indicated bathrooms should be cleaned daily and			

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	as needed. He did not know why the stain had not been cleaned sooner. h. room D17 was observed. There were crumbs of food at the baseboard of her room which had attracted ants. There was a pot of dead and dried out flowers, which when disturbed, several gnats were observed to fly from it. i. room C23 remained with no running water available in the bathroom, and the lose/removed vinyl baseboard remained on the floor. The red stain remained on the wall, and it did not appear that his floor had been mopped. j. Resident 35's bed was observed. The headboard was completely detached and merely laid against the wall behind his bed. k. Resident 13's fitted bedsheet was tattered and had several small holes all over it. The siderails of the bed were wobbly and needed to be wiped clean and there was a layer of built-up debris and unidentified food crumbs stuck to the rail. Resident 13 did not have a TV. During an interview on 1/9/24 at 11:05 a.m., the Executive Director (ED) indicated what he preferred to call the secured "Wellness Unit," had been an inherited "Behavioral Health Unit," before he started at the facility. At that time, the ED and other executive staff were in the process of assessing and transitioning the "Wellness Unit," away from admissions/programming for behavioral health and were working towards the goal of turning the unit into a secured Memory Care unit. The ED indicated, during the transition, the facility was still responsible for appropriate services and programming for the residents who resided on the unit. It was a work in progress and many of the resident's behaviors were challenging. During an interview on 1/11/24 at 2:27 p.m., the			

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	above observations were shared with the ED. The ED reiterated how the slow but purposeful transition from "Behavioral Health Unit" to a secured memory care unit was a work in progress. The ED and his staff had many ideas and goals for the unit moving forward, and in the meantime, especially during the construction and renovations, some things had not been fixed yet. On 1/11/24 at 11:00 a.m., the Director of Nursing (DON), provided a copy of current facility policy titled, "Homelike environment," dated 8/2022. The policy indicated, "Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Staff shall provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include ... clean, sanitary and orderly environment ... inviting color and décor ... clean bed and bath linens in food condition ... pleasant neutral scents ... The facility staff and management shall minimize, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting. These characteristics include ... institutional odors ...." On 1/9/24 at 11:15 a.m., the ED provided a copy of current facility policy titled, "Secured Unit Program," dated 6/2023. The policy indicated, "Envive Healthcare is committed to providing secured unit services with consistent and therapeutic interventions designed to help individuals acquire the skills necessary to function with as much self-determination as possible in the least restrictive environment.			

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	Therapeutic programming and treatment are effective if it is accessible to the people who need it most ...." 3.1-19(f)(5)			
F 0623 SS=D 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)			

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	(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 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			

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	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 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 a notice of transfer/discharge was sent with residents when they left the facility for 2 of 7 residents reviewed for discharges (Resident 99 and 47). Findings include: 1. On 1/10/24 at 2:56 p.m., a comprehensive record review was completed for Resident 99. He had the following diagnoses which included but were not limited to unspecified psychosis, essential hypertension, gastro-esophageal reflux disease,	F 0623	p="" paraid="396370395" paraeid="{ca4f409b-97c2-47a9-88d2-dfc744adcf78}{142}">F623 - Notice Requirements Before Transfer/Discharge “Based on record review and interview, the facility failed to ensure a notice of transfer/discharge was sent with residents when they left the facility for 2 of 7 residents reviewed for discharges (Resident 99 and 47).” 1: What corrective action(s) will be accomplished for those	02/19/2024

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	chronic kidney disease, benign prostatic hypertrophy, and schizoaffective disorder. Resident 99 was discharged from the facility on 11/18/24. His record indicated he passed away. On 1/11/24 at 2:10 p.m., the DON indicated they did not send any notices with Resident 99 because he went out emergently and passed away at the hospital. On 1/11/24 at 2:50 p.m., the SSD (Social Service Director) indicated she was made aware the nursing staff did not send a notice of transfer/discharge with the residents.2. On 1/9/23 at 2:03 p.m., Resident 47's record was reviewed. He was admitted on 7/15/23. His diagnoses included, but were not limited to, chronic kidney disease, occlusion (partial blockage) and stenosis (narrowing) of bilateral (both) carotid arteries (supply blood and oxygen to the brain), and Moyamoya disease (rare vascular disease of the brain with the main arteries that supply blood to the brain become narrowed and blocked). On 7/21/23 at 2:03 p.m., Resident 47 was found to have slurred speech, confused, and altered level of consciousness. He was unable to follow commands. The nurse notified the Director of Nursing Services (DNS), the physician, and his family. Per the physician order, 911 was called and the resident was sent via ambulance to a local hospital. On 12/5/23 at 11:21 p.m., a nursing note indicated the resident's family called the facility at 8:30 p.m. and requested the resident's blood pressure (BP) be checked. It was 161/ 95. His 9:00 p.m.,		residents found to have been affected by the deficient practice? The listed citation referencing Resident 99, who remains a current resident at facility, is rather in reference to Resident 103, who no longer resides at the facility. Therefore, no further corrective action could be taken for this resident. The listed citation referencing Resident 47 is rather in reference to Resident 49. Resident 49's medical record was reviewed with no negative outcome identified. 2 other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. The medical records of all residents who were discharged or transferred within the previous were audited for transfer/discharge documentation with no negative outcomes identified. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? SSD, licensed nurses and QMAs were educated on transfer/discharge documentation requirements. ul="" role="list" SSD, licensed nurses and QMAs were educated on 1/26/24 by the DNS and ADNS Education included: Transfer/Discharge and Bed Hold Discharge	

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	medications were administered at this time. At 9:20 p.m., he requested to go to the emergency room because he had pain on the left side of his head and was not feeling well. NP 20 was notified at 9:30 p.m., and an order was given to send him to the ER for evaluation. The nurse called 911 at 9:40 p.m. He left the facility at 9:55 p.m. The DNS and family were notified. On 1/11/24 at 2:49 p.m., the DNS indicated the facility did not have any discharge documentation for when Resident 47 went to the hospital on 7/21/23 and 12/5/23. A current policy titled, "Emergency Discharge," dated 5/2022, was provided by the DNS on 1/12/24 at 10:45 a.m. A review of the policy indicated, " ...to make an emergency transfer or discharge to the hospital ...Send completed copy of Nursing Home Transfer and Discharge Form ...Transfer and Discharge From [sic] and Bedhold [sic] Form, when appropriate, will be attached to the Patient Transfer Form ...." 3.1-12(a)(9)(A) 3.1-12(a)(9)(B) 3.1-12(a)(9)(C) 3.1-12(a)(9)(D) 3.1-12(a)(9)(E) 3.1-12(a)(9)(F)		Policy Emergency Discharge Policy State Form 49669 State Form 49831 4: How be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? SSD or designee will conduct a random audit of the medical record of 5 residents per week who have been transferred or discharged from the facility to ensure notice of transfer/discharge documentation has been completed and sent with resident. These audits will be conducted weekly x 4 weeks, thereafter, 3 resident's medical records per week will be audited x 4 weeks, then one resident's medical record weekly x 4 weeks, then 1 resident's medical record biweekly x 3 months. Any identified concerns will be promptly addressed with the responsible individual(s). Audit results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance. ul="" role="list" 5. Date of completion: 02/19/2024	
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic			

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	leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on record review and interview, the facility failed to send a bed-hold with residents when they left the facility for 2 of 7 residents reviewed bed-hold (Resident 99 and 47). Findings include: 1. On 1/10/24 at 2:56 p.m., a comprehensive record review was completed for Resident 99. He had the following diagnoses which included but were not limited to unspecified psychosis, essential hypertension, gastro-esophageal reflux disease, chronic kidney disease, benign prostatic hypertrophy, and schizoaffective disorder. Resident 99 was discharged from the facility on	F 0625	p="" paraid="1089837399" paraeid="{4e065f5a-e150-439f-a371-58cead2b9463}{112}">F625 - Notice of Bed Hold Policy Before/Upon "Based on record review and interview, the facility failed to send a bed-hold with residents when they left the facility for 2 of 7 residents reviewed bed-hold (Resident 99 and 47)." 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The listed citation referencing Resident 99, who remains a current resident at	02/19/2024

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	11/18/24. His record indicated he passed away. On 1/11/24 at 2:10 p.m., the DON indicated they did not send a bed-hold with Resident 99 because he went out emergently and passed away at the hospital. On 1/11/24 at 2:50 p.m., the SSD (Social Service Director) indicated she was made aware the nursing staff did not send a bed-hold with the residents.2. On 1/9/23 at 2:03 p.m., Resident 47's record was reviewed. He was admitted on 7/15/23. His diagnoses included, but were not limited to, chronic kidney disease, occlusion (partial blockage) and stenosis (narrowing) of bilateral (both) carotid arteries (supply blood and oxygen to the brain), and Moyamoya disease (rare vascular disease of the brain with the main arteries that supply blood to the brain become narrowed and blocked). On 7/21/23 at 2:03 p.m., Resident 47 was found to have slurred speech, confused, and altered level of consciousness. He was unable to follow commands. The nurse notified the Director of Nursing Services (DNS), the physician, and his family. Per the physician order, 911 was called and the resident was sent via ambulance to a local hospital. On 12/5/23 at 11:21 p.m., a nursing note indicated the resident's family called the facility at 8:30 p.m. and requested the resident's blood pressure (BP) be checked. It was 161/ 95. His 9:00 p.m., medications were administered at this time. At 9:20 p.m., he requested to go to the emergency room because he had pain on the left side of his head and was not feeling good. NP 20 was notified at 9:30 p.m., and an order was given to send him to		facility, is rather in reference to Resident 103, who no longer resides at the facility. Therefore, no further corrective action could be taken for this resident. The listed citation referencing Resident 47 is rather in reference to Resident 49. Resident 49's medical record was reviewed with no negative outcome identified. 2 other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. ul="" role="list" The medical records of all residents who were discharged or transferred within the previous were audited for bed-hold policy with no negative outcomes identified. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? SSD, licensed nurses and QMAs were educated on bed-hold policy notification requirements. SSD, licensed nurses and QMAs were educated on 1/26/24 by the DNS and ADNS Education included: Transfer/Discharge and Bed Hold Bed-hold Policy Discharge Policy Emergency Discharge Policy 4: How be monitored to ensure the deficient practice will not recur i.e., what quality	

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	the ER for evaluation. The nurse called 911 at 9:40 p.m. He left the facility at 9:55 p.m. The DNS and family were notified. On 1/11/24 at 2:49 p.m., the DNS indicated the facility did not have any discharge documentation for when Resident 47 went to the hospital on 7/21/23 and 12/5/23. A current policy, titled, "Emergency Discharge," dated 5/2022, was provided by the DNS on 1/12/24 at 10:45 a.m. A review of the policy indicated, " ...to make an emergency transfer or discharge to the hospital ...Send completed copy of Nursing Home Transfer and Discharge Form ...Transfer and Discharge From [sic] and Bedhold [sic] Form, when appropriate, will be attached to the Patient Transfer Form ...." 3.1-12(a)(9)(A) 3.1-12(a)(9)(B) 3.1-12(a)(27)(A)		assurance program will be put into place? SSD or designee will conduct a random audit of the medical record of 5 residents per week who have been transferred or discharged from the facility to ensure bed-hold policy has been sent with resident. These audits will be conducted weekly x 4 weeks, thereafter, 3 resident's medical records per week will be audited x 4 weeks, then one resident's medical record weekly x 4 weeks, then 1 resident's medical record biweekly x 3 months. Any identified concerns will be promptly addressed with the responsible individual(s). Audit results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance. 5. Date of completion: 02/19/2024	
F 0641 SS=B Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessment was accurately coded for Preadmission Screening and Resident Review (PASRR) for 4 of 4 residents reviewed for accuracy of MDS assessments (Resident 100, 13, 22, and 82). Findings include: 1. On 1/5/24 at 11:46 a.m., Resident 100's record	F 0641	F641 – Accuracy of Assessments "Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessment was accurately coded for Preadmission Screening and Resident Review (PASRR) for 4 of 4 residents reviewed for accuracy of MDS assessments (Resident 100, 13, 22, and 82)." 1:	02/19/2024

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	was reviewed. She was admitted 8/7/23. Her diagnoses included, but were not limited to, unspecified psychosis (severe mental condition with thought and emotion are so affected that contact is lost wit external reality), anxiety disorder, and PTSD (post-traumatic stress disorder) (persistent mental and emotional stress occurring as a result of injury or severe psychological shock). A care plan, dated 1/4/24, indicated Resident 100 had a serious mental illness, without specialized services, and was followed by a local psychiatric service. A care plan, dated 8/14/23, indicated Resident 100 had a diagnosis of unspecified psychosis. An intervention indicated to observe and report symptoms of hallucinations, delusion, change in sleep pattern, irritability, and mood fluctuations. On 1/9/23 at 2:33 p.m., her admission MDS assessment, dated 8/14/23, was reviewed. It indicated she did not have a PASRR and did not have a serious mental illness or related condition. On 1/9/24 at 3:31 p.m., the MDS Coordinator (MDSC) provided the corrected MDS assessment, dated 8/14/23, that indicated Resident 100 had a PASRR assessment. On 1/10/24 at 11:11 a.m., the MDSC indicated he would review a resident's chart to get accurate information for the MDS assessments. On 1/15/24 at 11:38 a.m., the Director of Nursing Services (DNS) indicate the facility followed the RAI (Resident Assessment Instrument) manual. She provided a document titled, "A1500:		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ul="" role="list" Resident 100's most recent comprehensive MDS assessment was audited for accuracy of MDS items A1500 through A1550 and modified as appropriate to reflect accurate information Resident 13's most recent comprehensive MDS assessment was audited for accuracy of MDS items A1500 through A1550 and modified as appropriate to reflect accurate information Resident 22's most recent comprehensive MDS assessment was audited for accuracy of MDS items A1500 through A1550 and modified as appropriate to reflect accurate information The listed citation referencing Resident 82 is rather in reference to Resident 85. Resident 85's most recent comprehensive MDS assessment was audited for accuracy of MDS items A1500 through A1550 and modified as appropriate to reflect accurate information 2 other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - The most recent comprehensive MDS assessments for all residents were audited for accuracy of MDS items A1500 through A1550 with modifications	

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	Preadmission Screening and Resident Review (PASRR)," dated 10/2023. It indicated, " ...Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness ...." 2. a. On 1/4/24 at 12:57 p.m., Resident 13's medical record was reviewed. She was a long-term care resident with diagnoses which include, but were not limited to, schizophrenia, anxiety and major depressive disorder. She had a Pre-Admission Screen and Resident Review (PASRR) Level II, dated 10/7/20, which indicated she had a serious mental health illness which should be coded on Section A of her most recent comprehensive Minimum Data Set (MDS) assessment. Resident 13's most recent MDS was an Annual assessment dated 2/17/23. Section A was not coded accurately to reflect the Level II determination for her mental health illness. 3. On 1/11/24 at 11:00 a.m., Resident 22's medical record was reviewed. She was a long-term care resident with diagnoses which include, but were not limited to, bipolar disorder, schizoaffective disorder, psychotic disturbance and mood disorder. She had a PASRR Level II, dated 9/8/22, which indicated she had a serious mental health illness which should be coded on Section A of her most recent comprehensive Minimum Data Set (MDS) assessment. Resident 22's most recent MDS was an annual assessment dated 4/4/23. Section A was not		completed as appropriate to reflect accurate information. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The MDS Coordinator was educated on accurate coding of MDS items A1500 through A1550 MDS Coordinator was educated on 1/15/24 by Corporate Assessment Support Education included: CMS's RAI Version 3.0 Manual Pages A-30 through A-34 4: How be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? DNS or designee will audit all comprehensive MDS assessments completed each week, for accuracy of MDS items A1500 through A1550, x 4 weeks, then 3 comprehensive MDS assessments per week x 4 weeks, then 1 comprehensive MDS assessment per week x 4 weeks, then 1 comprehensive MDS assessment per month x 3 months. Any identified concerns will be promptly addressed with the responsible individual(s). Audit results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance. ul="" role="list" 5. Date of completion: 02/19/2024	

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	coded accurately to reflect the Level II determination for her mental health illness. During an interview on 1/11/24 at 11:15 a.m., the MDS Coordinator (MDSC) indicated, Resident 13's and 22's annual assessments should be amended to accurately reflect the Level II determinations. 4. On 1/9/23 at 11:02 a.m., a comprehensive record review was completed for Resident 82. She had the following diagnoses which included but were not limited to essential hypertension, bipolar disorder, aphasia (difficulty speaking), psychotic disorder, and gastro-esophageal reflux disease. Based on Resident 82's diagnoses she required a level II. A level II was completed but was not coded on resident's annual MDS (Minimum Data Set) dated 9/4/23. She had a care plan dated 7/26/23 indicating she required a level II. On 1/11/24 at 2:15 p.m., the MDS Coordinator indicated he was aware Resident 82's MDS was not coded correctly and corrected the MDS. During an interview with the MDS Coordinator on 1/12/24 at 11:30 a.m., he indicated he followed the RAI (Resident Assessment Instrument) for accuracy of assessments.			
F 0644 SS=A Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and			

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	effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on observation, interview, and record review, the facility failed to ensure a new Level of Care screen was submitted for a resident for 1 of 5 residents reviewed for Resident Assessments (Resident 56). Findings include: On 1/4/24 at 10:15 a.m., Resident 56 was initially observed. He laid in his bed, he was alert, oriented, and receptive to questions. When asked why he lived at the facility he indicated, "because I'm a crazy F---." He laughed at his joke with good nature. On 1/11/23 at 11:30 a.m., Resident 56's medical record was reviewed. He was a long-term care resident with diagnoses which included, but were not limited to a psychotic disorder, hallucinations and dementia with severe agitation. A Pre-Admission Screen and Resident Review (PASRR) Level I, dated 2/1/23, indicated a Level II was not required because there were no serious	F 0644	=”” span=””>F644- Coordination of PASARR and Assessments “Based on observation, interview, and record review, the facility failed to ensure a new Level of Care screen was submitted for a resident for 1 of 5 residents reviewed for Resident Assessments (Resident 56).” 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 56’s medical record was and a new Level of Care (LOC) screening was submitted for a review of his potential needs and/or requirements related to his new diagnoses. 2 other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents who have received new mental health diagnoses have the potential to be affected by the	02/19/2024

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	mental health diagnoses to consider. Resident 56's diagnosis of a psychotic disorder was added to his record on 2/23/22. The diagnosis of hallucinations was added on 8/15/23. In May of 2022, Resident 56 had been started on Quetiapine (an antipsychotic medication), with an indication for use related to his psychotic disorder with delusions. The record lacked documentation that a new Level of Care (LOC) screen had been submitted for a review of his potential needs and/or requirements related to his new diagnoses. During an interview on 1/11/23 at 11:45 a.m., the Minimum Data Set Coordinator (MDSC) indicated, it was most likely that a new LOC had not been submitted since his diagnoses was acquired too close to the determination date of the level I. However due to his diagnoses and having been started on an antipsychotic medication, an updated LOC screen should have been submitted.		alleged deficiency An audit of all residents with mental health diagnoses was conducted to ensure a current and accurate Level of Care was submitted with no negative outcomes identified. The SSD was educated on the PASARR Level of Care and requirements to submit a new Level of Care screening when a resident receives a new mental health diagnosis. SSD was educated on 1/15/24 by the Executive Director 4: How be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? SSD or will conduct a random audit of the medical record of 5 residents per week to ensure a current and accurate Level of Care Screening has been completed. These audits will be conducted weekly x 4 weeks, thereafter, 3 resident's medical records per week will be audited x 4 weeks, then one resident's medical record weekly x 4 weeks, then 1 resident's medical record biweekly x 3 months. Any identified concerns will be promptly addressed with the responsible individual(s). Audit results will be discussed monthly in and adjustments will be made as needed to ensure on-going compliance. 5. Date of completion: 02/19/2024	

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F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observations, interview and record review, the facility failed to prevent the potential for accidents by implementing new fall interventions for a resident with a history of falls, (Resident 56) for 1 of 3 residents reviewed for fall, the facility failed to ensure the only shower room for the secured Wellness Unit was free from standing water and lose items on the floor for 40 of 97 residents who resided on the unit, the facility failed to ensure medications were not stored in a resident's room for 2 of 2 random observations (Resident 100), and failed to ensure residents who required supervision while smoking were supervised in appropriate and designated smoking areas and failed to ensure residents who smoked had a current smoking assessment for 3 of 7 residents reviewed for smoking (Residents 10, 14, and 71). Findings include: 1. On 1/10/24 at 9:08 a.m., Resident 56 was observed at the nurse's station. He was seated in his wheelchair but, had slid down and appeared more reclined than seated upright. There was no bright colored tape to his wheelchair brake handles.	F 0689	F 689 – Free of Accident Hazards/Supervision/Devices p="" paraid="1070174130" paraeid="{34368fb3-2ef6-4fb6-be61-681441aa791a}{58}">“Based on observations, interview and record review, the facility failed to prevent the potential for accidents by implementing new fall interventions for a resident with a history of falls, (Resident 56) for 1 of 3 residents reviewed for fall, the facility failed to ensure the only shower room for the secured Wellness Unit was free from standing water and lose items on the floor for 40 of 97 residents who resided on the unit, the facility failed to ensure medications were not stored in a resident's room for 2 of 2 random observations (Resident 100), and failed to ensure residents who required supervision while smoking were supervised in appropriate and designated smoking areas and failed to ensure residents who smoked had a current smoking	02/19/2024

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	On 1/11/24 at 11:30 a.m., Resident 56's medical record was reviewed. He was a long-term care resident with diagnoses which included but were not limited to, unspecified dementia. A nursing progress note, dated, 9/12/23 at 10:11 p.m., indicated, Resident 56 had been found lying on the floor next to his bed and wheelchair. He stated he was trying to self-transfer from bed to wheelchair forgot to lock the brakes on his wheelchair and slipped. No apparent injuries were sustained, and vital signs were within normal limited. The record lacked documentation the physician had been notified. An Interdisciplinary team (IDT) progress note dated 9/13/23 at 10:04 a.m., reviewed Resident 56's fall from the previous evening. The new intervention placed was to put high visibility tape to his wheelchair brakes. The Nurse Practitioner (NP) conducted a routine visit on 9/14/23 7:13 p.m., however the NP entered a late progress note for the visit on 10/10/23 at 7:13 p.m., which was 26 days after the visit. The NP note lacked documentation that Resident 56's fall from 9/12/23 had been reviewed. Resident 56 had a comprehensive care plan dated 10/20/23 which was revised to include the new intervention of high visibility tape to his breaks, but it was not observed in place throughout the survey period. 2. On 1/11/24 at 10:40 a.m., the shower room for the Wellness Unit was observed. There was standing water in front of the sink, in the middle of the shower room, and smaller puddles around the		assessment for 3 of 7 residents reviewed for smoking (Residents 10, 14, and 71).” 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The listed citation referencing Resident 56 is rather in reference to Resident 58. Resident 58’s medical record was reviewed by DNS. DNS confirmed presence of NP note for fall follow-up in chart dated 9/12/23. In addition, IDT review note dated 9/13/24 verifies prompt NP and family notification. High visibility tape was added to c brakes. All fall interventions for were reviewed and verified in place by DNS. Unit Shower Room was mopped at the time of survey with all standing water removed. Loose tubing was removed from the shower room. medications were found anywhere in the resident room. DNS verified NP notification of missed Eliquis dose with NP. NP note dated 1/4/24 states: “Writer notified by QMA that patient refused Eliquis. Patient educated on the risks of refusal of her Eliquis. Patient verbalized understanding.” Residents 10 had a new smoking assessment completed on 1/15/24. Resident requires supervision and does not sign self out of facility. also noted with accurate smoking assessment for 11/27/23 in chart. Resident 14 had a new	

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	foot of the toilet. There was a long white rubber tubing that laid lose and cured on the floor in between the shower tiles and bathroom floor. During an interview on 1/11/24 at 10:45 a.m., the Housekeeping Supervisor (HKS) observed the shower room and indicated staff should mop up standing water so that residents do not slip in the puddles. When asked about the rubber tubing, the HKS indicated it had been installed as an attempt to help keep water from spreading to the bathroom floor from the shower since the drain would often clog or drained too slow. The tubing had been cut in half because staff found they were unable to get wheelchairs over the bump it created. The HKS indicated it should be pulled out and not left curled on the floor, so residents did not trip on the tubing. The HKS indicated since the C wing was closed, and there were more Residents on the D hall, it was the only shower available for the unit and a high traffic area. On 1/11/24 at 2:00 p.m., the Director of Nursing (DON) provided a copy of current facility policy titled, "Fall Program Guidelines," dated 12/2022. The policy indicated, "to screen all residents to identify possible risk factors that could place a resident at risks for falls, evaluate those risks, implement interventions to reduce risk and monitor the interventions for effectiveness ... should a resident have a fall the attending physician or medical director in the absence of the attending physician and the responsible party should be notified ...."3. On 1/4/24 at 11:56 a.m., Resident 100 was observed to be absent from her room. Her door was wide open. Two medication cups were observed in her room. They were on her over-the-bed table. One medication cup had a pill in it, later to be identified as Eliquis (anti-coagulant).		smoking assessment completed on 1/15/24. On the new assessment, documentation reflects that the resident does not require supervision for smoking. Of note, resident signs himself out LOA from facility for all unsupervised smoking. LOA sign out includes a Release of Responsibility for Leave of Absence stating “I, the undersigned, hereby accept complete responsibility for the resident while on leave of absence from this facility and absolve the management of this facility, its personnel and the attending physician of responsibility for any deterioration in condition or accident that may occur while the resident is on leave of absence. If the resident is on portable oxygen, I understand I must check with the nursing staff to ensure the portable oxygen tank is full prior to leaving the facility. My signature denotes the same.” Resident had signed himself out of facility at time of IDOH observation. Resident 71 had a new smoking assessment completed on 1/18/24. On the new assessment, documentation reflects that the resident smokes. Of note, resident signs herself out LOA from facility for all unsupervised smoking. LOA sign out includes a Release of Responsibility for Leave of Absence stating “I, the undersigned, hereby accept	

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	On 1/4/24 at 11:59 a.m., Qualified Medication Aide (QMA) and Certified Nursing Aide (CNA) 8 entered Resident 100's empty room and moved the medication cup with the pill in it so he could put down her lunch tray. He indicated medications should not be left in the resident's room. He left the medication in her room and exited. On 1/4/24 at 12:45 p.m., a white pill was observed on the floor, near the trash can, of Resident 100's room. Resident 100 indicated that was not good. The pill was identified as Tylenol. Resident 100 indicated she did take Tylenol, but did not know if she took it today or not. On 1/4/24 at 1:09 p.m., QMA 10 indicated she did not provide Eliquis or Tylenol to Resident 100 today. She indicated Resident 100 did not want to take Eliquis at this time due to a uterine cancer diagnosis with active uterine bleeding. On 1/5/24 at 11:46 a.m., Resident 100's record was reviewed. She was admitted 8/7/23. Her diagnoses included, but were not limited to, unspecified psychosis (severe mental condition with thought and emotion are so affected that contact is lost wit external reality), anxiety disorder, and PTSD (post-traumatic stress disorder) (persistent mental and emotional stress occurring as a result of injury or severe psychological shock). A care plan, dated 1/4/24, indicated Resident 100 had a serious mental illness, without specialized services, and was followed by a local psychiatric service. A care plan, dated 8/14/23, indicated Resident 100		complete responsibility for the resident while on leave of absence from this facility and absolve the management of this facility, its personnel and the attending physician of responsibility for any deterioration in condition or accident that may occur while the resident is on leave of absence. If the resident is on portable oxygen, I understand I must check with the nursing staff to ensure the portable oxygen tank is full prior to leaving the facility. My signature denotes the same." Resident was returning from LOA on IDOH observation. 2 other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. Fall care plan interventions for all residents with a history of falls were audited with corresponding validation to ensure all fall interventions were in place. All shower rooms were audited for standing water and other potential safety hazards. All residents have the potential to be affected by the alleged deficiency r/t unattended medications in resident rooms All resident rooms were audited for unattended medications in room with any identified concerns promptly addressed All residents who smoke tobacco products had a new smoking assessment completed with care plans reviewed and updated as	

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	had a diagnosis of unspecified psychosis. An intervention indicated to observe and report symptoms of hallucinations, delusion, change in sleep pattern, irritability, and mood fluctuations. A care plan, dated 11/18//23, indicated she was on anti-coagulant therapy related to atrial fibrillation (rapid flutter of the heart) and history of stroke (interruption of blood flow in the brain). An intervention indicated to administer the anti-coagulant medication as ordered by the physician. A care plan, dated 8/14/23, indicate she had impaired cognitive function. An intervention indicated to administer the medication as ordered and to assist the resident with making safe decisions. A care plan, dated 8/7/23, indicated she was at risk for pain. An intervention indicated to administer the analgesic as ordered. Her physician orders indicated to provide apixaban (Eliquis) anti-coagulant medication 5 mg, twice a day and acetaminophen (Tylenol), two 325 mg tablets, four times a day as needed. On 1/5/24 at 10:20 a.m., the Executive Director (ED) indicated medication should not be left in the resident rooms unless they have a self-administration assessment. On 1/5/24 at 10:21 a.m., the Director of Nursing Services (DNS) indicated Resident 100 did not have a self-administration assessment for Eliquis or Tylenol. On 1/9/24 at 10:10 a.m., the DNS indicated the first QMA (QMA/CNA 8) who delivered Resident		necessary. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ul="" role="list" Clinical staff were educated on fall interventions and verification of placement of those interventions Licensed nurses and QMAs were educated on bedside storage of medication Licensed nurses were educated on smoking assessment completion and accuracy Maintenance and housekeeping supervisors were educated on shower room safety standards Clinical staff including CNAs, QMAs and licensed nurses were educated on 1/26/24 by DNS and ADNS Maintenance and housekeeping supervisors were educated on 1/15/24 by the Executive Director Education Includes: Fall Interventions Fall Program Guidelines Policy Pharmacy Manual PCU028 - Bedside Storage of Medications Smoking Policy Shower Room Safety Standards 4: How be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? DNS or designee will conduct random visual observation audits of at least 5 residents weekly x 2 weeks, to ensure fall prevention interventions are in place, then random visual	

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	100's lunch tray should have removed the Eliquis from her room. A current policy, titled, "Medication Storage in the Facility," with no date, was provided by the Corporation Consultant (CC), on 1/10/24 at 12:01 p.m. A review of the policy indicated, " ...Only licensed nurses, the Consultant Pharmacist, and those lawfully authorized to administer medication (e.g. medication aides) are allowed unsupervised access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access ...."4A. On 1/9/23 at 3:03 p.m., Resident 10's record was reviewed. He had the following diagnoses which included but was not limited to hypothyroidism, vitamin D deficiency, nicotine dependence, major depression disorder, generalized anxiety disorder, unspecified mood disorder, hypertension, heart failure and hypertension. Resident 10's last smoking assessment was completed on 10/4/22. The DON was informed and completed a new smoking assessment on 1/5/24 indicating he required supervision with smoking. Resident 10 had a care plan dated 3/31/22 indicating he desired to use tobacco products. 4B. During an observation on 1/5/24 at 10:45 a.m., Resident 14 was outside smoking a cigarette. He was sitting on a curb and lighting a second cigarette with the first one still burning. During an observation on 1/10/24 Resident 14 was observed coming in from the A hall exit door with no supervision from smoking. On 1/10/24 at 12:40 p.m., a comprehensive record		observation audits of at least 3 residents weekly x 2 weeks, then random visual observation audits of at least 2 residents once per week x 4 weeks, then random visual observation audits of at least 2 residents biweekly x 4 weeks, then random visual observation audits of at least 1 resident once per month x 3 months. Any identified concerns will be promptly addressed with the responsible individual(s). Audit results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance. ul="" role="list" DNS or designee will conduct random visual observation audits of at least 5 resident rooms weekly x 4 weeks for unsecured medications, then random visual observation audits of at least 3 resident rooms weekly x 4 weeks, then random visual observation audits of at least 2 resident rooms weekly x 4 weeks, then random visual observation audits of at least 1 resident room monthly x 3 months. Any identified concerns will be promptly addressed with the responsible individual(s). Audit results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance. ul="" role="list" DNS or will audit all new admissions, for accurate smoking assessments, as well as	

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	review was completed for Resident 14. He had the following diagnoses which included but were not limited to viral hepatitis B, alcohol abuse, major depressive-like episodes, schizoaffective disorder bipolar type, anxiety, and mood disorders. Resident 14' s smoking assessment, dated 11/28/, indicated he required supervision with smoking. 4C. On 1/10/24 at 9:19 a.m., Resident 71 was observed returning from outside the A hall entrance. She indicated she did not have any staff with her while smoking. On 1/10/24 at 11:48 a.m., a comprehensive record review was completed. She had the following diagnoses which included but were not limited to schizophrenia, constipation, and essential hypertension. She had a smoking assessment, dated 12/1/23 which indicated she did not smoke. A policy titled; "Smoking Policy" was provided by the DON (Director of Nursing) on 1/5/23 at 11:54 a.m. It indicated, " ...Supervision of residents who smoke on the facility grounds will be supervised. Each resident who smokes must have a smoking assessment completed upon admission, quarterly, and with significant change in condition by Social Services or designee ...." 3.1-45(a)		all smoking residents once per month x 6 months to ensure accurate smoking assessments. Any identified concerns will be promptly addressed with the responsible individual(s). Audit results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance. ul="" role="list" Maintenance director or designee will conduct random visual observation audits of all shower rooms, to ensure no standing water or other safety hazards are present, five times per week x 2 weeks, then three times per week x 2 weeks, then once per week x 4 weeks, then once bi-weekly x 4 weeks, then once per month x 3 months. Any identified concerns will be promptly addressed with the responsible individual(s). Audit results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance. ul="" role="list" 5. Date of completion: 02/19/2024	
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			

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	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 maintain residents Ideal Body Weight (IDW) who had no desire to lose weight for 1 of 5 residents reviewed for weight loss and gain (Resident 14), and failed to montior weight as ordered for 2 of 5 residents reviewed for weight loss and gain (Residents 14 and 16). Findings include: 1. On 1/10/24 at 12:40 p.m., a comprehensive record review was completed for Resident 14. He had the following diagnoses which included but were not limited to viral hepatitis B, alcohol abuse, major depressive-like episodes, schizoaffective disorder bipolar type, anxiety, and mood disorders. The resident's medical record lacked assessments from the RD (Registered Dietician). Resident was not weighed as ordered during the month of 11/23.	F 0692	p="" paraid="1036608570" paraeid="{57e0f5ec-9f56-467e-aa5a-2131eaca0a5c}{200}">F692 – Nutrition/Hydration Status Maintenance “Based on record review and interview, the facility failed to maintain residents Ideal Body Weight (IDW) who had no desire to lose weight for 1 of 5 residents reviewed for weight loss and gain (Resident 14 failed to monitor weight as ordered for 2 of 5 residents reviewed for weight loss and gain (Residents 14 and 16)." 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 14’s weight was obtained on 1/8/24. The resident was reviewed by NP and dietician. Resident was not placed	02/19/2024

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	Resident 14's weights were as follows: 6/11/23: 160.0 7/8/23: 158.0 8/1/23: 155.3 9/8/23: 151.3 10/20/23: 146.0 10/23/23: 149.0 12/8/23: 138.0 Resident had an overall weight loss of 7.38% in 30 days and 13.7% in 180 days. Resident 14 consumed a regular diet. He had a care plan that indicated he had a nutritional problem related to increased protein needs related to COPD (chronic obstructive pulmonary disease) and that his weight would be maintained at 140 pounds. The NP (Nurse Practitioner) was made aware of the weight loss on 1/8/24. The NP indicated to continue his diet as ordered. 2. On 1/4/24 at 2:12 p.m., a comprehensive record review was completed for Resident 16. He had the following diagnoses which included but were not limited to anemia, vitamin D deficiency, hyperlipidemia, alcohol abuse, sleep disorder, constipation, and repeated falls. Resident 16 had an order for weekly weights. He was missing weights from 11/10/23 through 1/4/24. He had the following weights: 9/26/23: 116.5 10/2/23: 118.5 10/7/23: 118.5		on Clinically at Risk (CAR) monitoring d/t weight remaining stable x 4 weeks. Per NP and RD, the resident's current plan of care remains appropriate. Resident 16's weight was obtained on 1/16/24. The resident was reviewed by NP and dietician, with frequency of obtaining weights clarified. Per NP and RD, the resident's current plan of care remains appropriate, and the resident's weight remains stable. 2 other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. The facility completed an audit to identify residents with significant weight changes. RD will review the identified and make recommendations, as needed. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Clinical staff were educated on and nutrition. DNS and ADNS were educated on CAR program. Clinical staff were educated on 1/26/24 by DNS and ADNS DNS and ADNS were educated on 1/15/24 by the Executive Director Education included: Weights/Nutrition Clinica lly Program (CAR) p="" paraid="78091103" paraeid="{d6a5b6dd-442e-4b8f-9eb f-708067b30fb0}{111}">4: How be	

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	11/10/23: 156.0 RD recommended a re-weight on 11/15/23. This was not addressed. Resident 16 had a care plan indicating he had nutritional problems related to increased protein needs related to COPD. The goal was for resident to have a gradual weight gain of 1 to 2 pounds per month. On 1/11/24 at 11:00 a.m., the Corporate Consultant indicated she would look for additional documentation to support the residents were followed for their weights. No further documentation was provided. A policy titled, "Clinically at Risk," dated 5/2023 was provided the VP of Clinical Services on 1/10/24 at 10:42 a.m. It indicated, " ...Criteria for residents who will be followed by the CAR (Clinically at Risk) team: Residents who have experienced a significant weight change. Significant weight change is defined as a variance of 5% in 30 days, 7.5% in 90 days and 10% in 180 days. Resident is to be discussed in CAR meeting until weight is stabilized for 4 weeks or weight loss is determined to be unavoidable/expected due to the resident's diagnosis and/or medical condition per physician progress note. If terminal condition or end of life, the palliative care form should be completed by the attending MD ....". 3.1-46		monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? DNS or will review weekly weights and the documentation relative to weights for completion, accuracy, and appropriate interventions once per week x 4 weeks, then twice per month x 5 months. Additionally, monthly weights and the documentation relative to weights will be reviewed twice per month x 6 months. Any identified concerns will be promptly addressed with the responsible individual(s). Audit results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance. p="" paraid="78091103" paraeid="{d6a5b6dd-442e-4b8f-9ebf-708067b30fb0}{111}"> 5. Date of completion: 02/19/2024	
F 0711 SS=E Bldg. 00	483.30(b)(1)-(3) Physician Visits - Review Care/Notes/Order §483.30(b) Physician Visits The physician must-			

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	§483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. Based on record review and interview, the facility failed to ensure timely charting and documentation was completed by the Nurse Practitioner (NP) who functioned as an authoritative designee under the Medical Director (MD) for routine and acute needs of the residents. This deficient practice had the potential to effeect 4 of 20 residents whose medical records were reviewed, (Residents 36, 51, 56, and 47). Findings include: 1. Throughout the survey period, Resident 36 was observed laying in his bed. He was selected for review due to a chronic wound on his stomach which became infected and required a wound vac. On 1/9/24 at 10:43 a.m., a preventative treatment was conducted by Registered Nurse (RN) 12 with no concern for technique noted. During the treatment observation, RN 12 indicated at one point the wound had been infected and the consideration for palliative care was suggested, but it had since healed, and he was doing great. Resident 36 was a long-term care resident with diagnoses which included, but were not limited to, necrotizing fasciitis, history of cancer of the large	F 0711	p="" paraid="325019469" paraeid="{d6a5b6dd-442e-4b8f-9ebf-708067b30fb0}{161}">F711 – Physician Visits- Review Care/Notes/Order “Based on record review and interview, the facility failed to ensure timely charting and documentation was completed by the Nurse Practitioner (NP) who functioned as an authoritative designee under the Medical Director (MD) for routine and acute needs of the residents. This deficient practice had the potential to effect 4 of 20 residents whose medical records were reviewed, (Residents 36, 51, 56, and 47).” 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 36 chart was audited for timing of NP/MD notes. No adverse effects noted from delayed notes. Resident 51 chart was audited for timing of NP/MD notes. No adverse effects noted	02/19/2024

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	155077	A. BUILDING 00 B. WING	01/11/2024

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	intestine and dementia. On 1/10/24 at 8:41 a.m., Resident 36's NP routine and acute visit progress notes were reviewed for timeliness of documentation. Several notes were entered late which included but were not limited to the following examples: a. On 1/23/23 at 12:36 p.m., the NP was asked to see Resident 36 for an acute visit due to an unidentified object in his abdominal wound. "Resident has an unidentified object sticking out of his umbilical area. Patient has some drainage from the area," and he was referred to a gastrointestinal (GI) surgeon. The note was entered late on 2/16/23 at 12:37 p.m., a month after the visit. b. On 1/24/23at 12:37 p.m., the NP entered a note which indicated, "Facility nurse reported difficulty getting ultrasound scheduled due to questioning of proper imaging type. Discussed with floor nurse and [Infection Preventionist (IP) nurse] today about having primary care NP evaluate patient and gather her opinion on preferred imaging for evaluation. I don't believe an x-ray would be helpful. If ultrasound not able to be completed, I would consider at CT scan for eval and referral to general surgeon. Or possibly just refer to surgeon first and let them order what imaging they feel is appropriate. Whatever the primary care team believes is best," but the note was not entered until 2/16/23 at 12:37 p.m., a month after the visit. c. On 10/3/23 at 10:55 p.m., the NP was asked to see Resident 36 due to complaints of diarrhea, and the plan was to "follow up with patient tomorrow regarding diarrhea."		from delayed notes. Resident 56 chart was audited for timing of NP/MD notes. No adverse effects noted from delayed notes. Resident 47 chart was audited for timing of NP/MD notes. No adverse effects noted from delayed notes. 2 other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - All residents have the potential to be affected by the alleged deficient practice. No adverse effects noted to residents from delayed notes. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Nurse practitioners educated on documentation expectations and how to remain compliant with CMS regulations Nurse Practitioners were educated on 1/25/24 by the DNS Education includes: ul="" role="list" State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities (Pages 457-460) 4: How be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? DNS or designee will audit the medical records of at least 5 residents, for timely MD/NP documentation, weekly x 4 weeks,	

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	d. On 10/4/23 at 7:54 p.m., the NP followed up as noted above. Resident 36 was still having diarrhea and the plan was to provide him with Nutrisource (a fiber supplement) for 5 days and Loperamide (an anti-diarrheal) for diarrhea and follow up with the patient in a week. The note was not entered until 11/4/2023 7:54 p.m., a month after the visit. 2. Throughout the survey period, Resident 51 was observed laying in her bed most of the time, with the exceptional occasion she was seated in her wheelchair in the frame of her door for medication administration times. She was automatically selected a medication regimen review, and recent rehospitalizations. Resident 51 was a long-term care resident with diagnoses which included, but were not limited to, hallucinations, delusions and unspecified psychosis. On 1/10/24 at 8:41 a.m., Resident 51's NP routine and acute visit progress notes were reviewed for timeliness of documentation. Several notes were entered late which included but were not limited to the following: a. On 8/14/23 at 3:33 p.m., the NP was asked to visit Resident 51 for complaints of left knee pain. "She is being seen in her room, she is lying in her bed where she is most of the time ... The patient reports that she rolled over in bed 'last week' and her knee 'popped' and she has been having pain since that time. She reports that she has been having pain for a week or so. The NP placed an order to obtain an x-ray." An NP note, dated 8/16/23 at 7:52 a.m., indicated, "Left knee x-ray is still pending. Will follow up next week. Nursing is aware." The note was		then the medical records of at least 3 residents weekly x 4 weeks, then the medical records of at least 2 residents weekly x 4 weeks, then the medical records of at least 1 resident monthly x 3 months. Any identified concerns will be promptly addressed with the responsible individual(s). Audit results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance. ul="" role="list" 5. Date of completion: 02/19/2024	

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	created 8/25/23 at 7:53 a.m. An NP note, dated 8/17/23 at 7:18 p.m., indicated, "Memo X-ray is not resulted [sic] Writer will follow up when x-ray of knee resulted [sic]." The note was created 9/10/23 at 7:19 p.m. An NP note, dated 8/26/23 at 7:30 p.m., indicated, "Memo X-ray is not resulted [sic] Writer will follow up when x-ray of knee resulted [sic]." The note was created 9/16/23 at 7:31 p.m. The results were available on 8/28/23 and did not reveal any acute injury. 3. On 1/10/24 at 9:08 a.m., Resident 56 was observed at the nurse's station. He was seated in his wheelchair but, had slid down and appeared more reclined than seated upright. There was no bright colored tape to his wheelchair brake handles. Her was selected for review related to falls and falls with injuries. He was a long-term care resident with diagnoses which included but were not limited to, unspecified dementia. On 1/11/24 at 11:30 a.m., Resident 56's NP routine and acute visit progress notes were reviewed for timeliness of documentation. Several notes were entered late which included but were not limited to the following: a. An NP note, dated 6/12/23 at 3:56 p.m., indicated Resident 56 was being seen for a follow-up to a fall. He had a witnessed fall of this resident observed by staff member outside in smoking area. Resident was standing up to pull his shirt down, lost balance and fell on ground. Resident 56 reported left knee pain and it was			

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	swollen and tender to touch. The plan was to follow up in a week to monitor swelling. The note was created 7/9/2023 3:57 p.m., 27 days after the visit. b. The follow up visit was not conducted until 6/20/23 at 10:07 p.m.. the knee was no longer swollen and he reported feeling much better. The note was created 7/25/23 at 10:07 p.m., 35 days after the visit. c. Resident 56 was seen for a routine visit on 8/16/23 at 2:54 p.m., but the note was note created until 9/10/23 at 2:55 p.m., 25 days after the visit. d. On 10/16/23 at 12:55 p.m., the NP was asked to see Resident 56 due to altered mental status. He complained of left hip pain which may have been contributed to a previous fall. The NP ordered an X-ray. The note was created 12/7/23 at 12:56 p.m., which was 52 days after the visit. A nursing progress note, dated 10/16/23 at 10:07 p.m., indicated the x-ray results have been received a revealed a hip fracture. An order was obtained and he was sent to the hospital for evaluation and treatment. He returned to the facility on 10/20/23 with no surgical intervention required. An NP note, dated 10/17/23 at 9:06 a.m., indicated "...[Resident 56] is seen laying in bed," although he had been transferred to the hospital the evening before and had not returned yet. The note was created 12/7/23 at 9:06 a.m., 51 days after the visit. 5. On 1/9/24 at 2:59 p.m., Resident 47's chart was reviewed. He was admitted on 7/15/23. His progress notes were reviewed for late charting.			

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	a. On 12/18/23 at 2:28 p.m., NP 20 created a progress note, as a late entry, for Resident 47. She indicated the effective date of the note was 12/8/24 at 2:28 p.m. The note was not charted for electronic access until 10 days later. It included, but was not limited to the following notes. It indicated, " ...Writer called per nursing regarding patient's refusal of medications during the evening. Patient will be added to the rounding list on 12/11/2023 ...." b. On 12/18/23 at 2:27 p.m., NP 20 created a progress note, as a late entry, for Resident 47. She indicated the effective date of the note was 12/15/23 at 2:27 p.m. The note was not charted for electronic access until 3 days later. It included, but was not limited to the following notes. It indicated, " ...Writer called per nursing. Patient refused all night medications. Patient will be added to the rounding list for 12/18/2023 ....." c. On 12/29/23 at 3:46 p.m., NP 20 created a progress note, as a late entry, for Resident 47. She indicated the effective date of the note was 12/4/24 at 3:46 p.m. The note was not charted for electronic access until 25 days later. It included, but was not limited to the following notes. It indicated Resident 47 was being seen today to follow-up to complaint of a headache. He reported that his headache started this morning on the bridge of his nose and had been hurting all morning. He denied any fever, chills, falls, trauma or hematomas (bruising) noted. He denied any lightheadedness or dizziness. He reported that he was smoking this morning and his headache started shortly after. His blood pressure during this visit was 112/55. He did not seem to be in any acute distress during this visit. Contributing factors include smoking tobacco. Smoking			

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	cessation education completed. Occlusion (blockage or closure of a blood vessel) and stenosis (narrowing of a blood vessel) of bilateral (both sides) carotid arteries (two main blood vessels carrying blood to the brain) started 11/15/22. Moyamoya disease (rare condition in which the blood vessels that supply blood to the brain become narrowed) started 11/15/22. Hemiplegia (paralysis effecting one side of the body) following cerebral infarction (stroke) affecting left non-dominant side, started 11/15/22. Resident 47 was examined and seen by NP 20 and discussed with nursing. Chart reviewed and evaluated. Acute (sudden onset) headache. Nursing to administer hydrocodone (narcotics analgesic) for headache and to continue to monitor for lightheadedness, dizziness and blood pressures. To control BP (blood pressure) and adhere with antihypertensive medications (reduces high blood pressure), lisinopril (treats high blood pressure), and metoprolol (treats high blood pressure). d. On 12/30/23 at 12:40 p.m., NP 20 created a progress note, as a late entry, for Resident 47. She indicated the effective date of the note was 12/11/23 at 12:40 p.m. The note was not charted for electronic access until 19 days later. It included, but was not limited to the following notes. It indicated, " ...He had chronic, but stable spastic hemiplegia (paralysis) affecting his left non-dominant side. He was using appropriate assistive devices. He had a history of cerebral infarction (stroke), depressive disorder that was managed by psychiatric nursing NP. The facility staff should monitor for headaches, jaw pain, vision loss, fever or fatigue. The resident should continue with diclofenac and hydrocodone. The staff should continue to monitor for changes.			

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	e. On 1/2/24 at 8:35 a.m., Nurse Practitioner (NP) 20 created a progress note, as a late entry, for Resident 47. She indicated the effective date of the note was 12/18/23 at 8:35 a.m. for refusal of medication that happened on 12/15/23. The note was not charted for electronic access until 18 days later. It included, but was not limited to the following notes. It indicated Resident 47 was being seen today per nursing request for refusal of medications on 12/15/2023. Nursing reports he did not take his medications but had been taking his medications since that time. When asked why he did not take his medications, patient reported, He didn't know. He had been counseled on the risks of not adhering to his medication regimen and had expressed an understanding of these risks. His medications were reviewed for potential risks associated with non-compliance with medications. His chart was reviewed for blood pressure levels over the weekend. His blood pressures were WNL (within normal limits). plan was to control BP and adhere with antihypertensive medications. f. On 1/4/24 at 12:15 p.m., the Director of Nursing Services (DNS) created a progress note, as a late entry, for Resident 47. She indicated the effective date of the note was 12/29/23 at 12:15 p.m. The note was not charted for electronic access until 6 days later. It included, but was not limited to the following notes. It indicated, The family reported the resident received the wrong medication on multiple occasions. The medication was a pink oval with G and 678 identifiers. This writer looked up the medication and identified the medication as lacosamide 50 mg (anticonvulsant to treat seizures) which the resident had ordered BID (twice a day). The writer showed the medication card to the family. They agreed that the tablet matched the ones provided to resident. The family			

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	then expressed concerns related to the resident's glucose levels (blood sugar). The writer spoke with NP 20. The resident's last A1C (3 month average of blood sugar levels) was 5.9 per NP 20. There were no current concerns with glucose levels. Daily blood glucose monitoring was ordered to verify glucose levels remain in an acceptable range. A new order to reinitiate Jardiance (lowers blood sugar) related heart failure given and initiated by NP 20. The family was also concerned that resident was taking ferrous sulfate. An order was received to discontinue the ferrous sulfate. The family was satisfied with explanations and left to visit with the resident. On 1/9/24 at 10:18 a.m., the NP indicated the nurses should have been charting that she was contacted per resident issue. She indicated she put her notes on paper and put her electronic notes in later. If it is not something really critical, she had 2 weeks to get electronic notes put in. She indicated it was not a delay in treatment to put her electronic notes in later. She indicated she ended up double charting and she liked it that way. She usually charted when she was talking with the nurses. The most recent notes were from 12/28/23 and her notes were in for yesterday. She indicated if the electronic note was not put in at the time of the exam or evaluation, she would go back to her paper notes and add them if questioned. NP 20 was observed reviewing her multiple pages of paper notes. She indicated she had further pages of paper notes in her bag. After reviewing, she indicated she wrote her notes as "tickler notes." She further indicated she made all her notes in tickler notes. She indicated she knew the residents and she knew what the abbreviated notes meant. Pages of incomplete notes were observed in her paper notes. She indicated the continuity of her notes were in her memory and			

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	everyone used notes. On the day she visited the residents, the notes would not be put in that day and she was a week behind in putting in her electronic notes. On 1/9/24 at 10:35 a.m., the Director of Nursing Services (DNS) indicated NP 20 communicates with her daily with verbal communication and then the DNS would have verbal communicate with the floor staff. She indicated she understood the lack of continuity of care if the NP notes were put in 1-2 weeks late. On 1/9/24 at 10:51 a.m., the Corporate Consultant (CC) indicated with the recent holidays, NP 20 was typically 3 days behind in her electronic charting. She would go back and identify and reference her hand-written documentation. What she was doing was legal. She agreed with the component of lack of nursing notes, and there was an opportunity for the facility to do better. She indicated the NP had 72 hours to get her electronic notes in, not a week or two. On 1/9/24 at 12:26 p.m., the CC indicated she spoke with NP 20, and she was unable to provided documentation of a 2 week windows to add electronic notes for residents under her care. CC indicated NP 20's resident charting may have been going out 4 days without electronic documentation. If she saw a resident on Monday, she would have had electronic documentation in by Friday. It all boiled down to follow-up and nursing documentation, the staff nurse should have provided an electronic note, and the NP was, "falling on the sword." It simply wasn't done and was an opportunity to improve. She indicated they needed to, "tweak" their Quality Assurance and Performance Improvement (QAPI) plan.			

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	The facility provided the F711 Regulations, Intent, and Guidance as there policy. It was provided on 1/10/24 at 12:01 p.m., by the CC. A review of the document indicated, " ...Except where the regulation specifies the task must be completed personally by the physician, the term "attending physician" or "physician: also includes a non-physician practitioner (NPP) involved in the management of the resident's care, to the extent permitted by State law ...Progress notes must be written, signed and dated at each physician visit, which may be done in a physical chart or electronic record, in keeping with facility practices ...." 3.1-22(c)(1) 3.1-22(c)(2) 3.1-22(c)(3)			
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on observation, interview, and record review, the facility failed to ensure a resident received adequate mental health services, interventions and/or therapeutic programming to prevent the potential for a continued resident-to-resident altercations, increasing anxiety and aggressive outburst towards	F 0740	p="" paraid="1325218665" paraeid="{ce807326-ab0c-4c00-aff5-00bb5e81ffbf}{74}">F740 – Behavioral Health Services “Based on observation, interview, and record review, the facility failed to ensure a resident received	02/19/2024

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	residents and staff and failed to provide the opportunity for age-appropriate past time activities and interests for 1 of 1 resident reviewed for behavioral health (Resident 80) Findings include: On 1/4/24 at 12:10 p.m., Resident 80 was initially observed. He appeared to be asleep in his bed and the bedroom lights were off. There was a visitor chair directly in front of his bed and Certified Nursing Aide (CNA) 22 was seated in the chair. During an interview on 1/4/24 at 12:11 p.m., CNA 22 indicated Resident 80 was on 24/7 one-to-one (1:1) safety supervision due to his behaviors towards other residents and staff members. Resident 80 had frequent and unpredictable outbursts of paranoia, anger and aggression. He had a serious mental illness and had just been born that way. He was only 24 years old and was too young to be in a nursing home, but there was no where else for him to go. Mostly he did what typical young people like to do like stay up late, play on his phone, and slept all day. He did not like to participate in group activities and that had become a trigger for behaviors. Sometimes the noise would overstimulate him and he would lash out. Other times, it could be really quiet and be would just stare up at the mirror and that was a sign he might start acting out too. Resident 80 had a guardian who was supposed to be looking for more appropriate placement because there was nothing for him to do. On 1/5/24 at 9:23 a.m., Resident 80 was observed as he paced the halls with a male CNA. Resident 80 held a Smartphone which played rap music. He had a flat affect, appeared to be very young, and did not engage with other passing residents as he		adequate mental health services, interventions and/or therapeutic programming to prevent the potential for a continued resident-to-resident altercations, increasing anxiety and aggressive outburst towards residents and staff and failed to provide the opportunity for age-appropriate past time activities and interests for 1 of 1 resident reviewed for behavioral health (Resident 80)" 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The listed citation referencing Resident 80 is rather in reference to Resident 83. Resident 83 continues to be supervised by 1:1 staff. Resident has been re-evaluated by SSD and AD to identify any potential activities resident would be interested in being involved in, with care plan reviewed and revised, as necessary. Alternate placement in a setting more appropriate for Resident 83 is actively being pursued, with placement pending currently. 2 other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - Residents residing on the Wellness Unit have the potential to be affected by the alleged deficient practice. SSD and AD have conducted reviews of those residents' preferences with care plans reviewed and revised,	

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	paced back and forth from the locked door at the front of the hall, to the locked door at the end of the hall. During an interview on 1/5/24 at 9:19 a.m., Registered Nurse (RN) 12 indicated Resident 80 was much too young to be in a nursing home. It often made him mad that the doors were locked because she believed he must have been homeless before and liked to walk all night long. He did not get a long well with the other residents and had to have a sitter 100% of the time to prevent him from wanting to fight everyone. On 1/8/24 at 10:42 a.m., Resident 80 appeared to be asleep in his bed. CNA 22 sat in the visitor chair and indicated she was his 1:1 sitter for the morning. She had gotten report that he was up late last night, he had become aggravated that he could not go off the unit and he had walked around a lot, so he was tired and she expected him to sleep a while longer. On 1/8/24 at 1:39 p.m., Resident 80 was observed as he paced up and down the hall. CNA 22 walked beside him. She indicated, staff had to stay with him very close, and could not follow at a distance because he had the tendency to flip like a switch, so they had to be close to keep him from getting at other residents. On 1/8/24 at 2:00 p.m., the Social Service Director, (SSD) entered the unit and approached Resident 80. She remarked at how nice he looked after his shower, and asked what he was playing on his phone. Resident 80 did not smile as he turned his phone to show the SSD and he did not give a verbal response. The SSD continued down the hall, and Resident 80 continued up the hall to the locked door.		as necessary, to reflect potential activities would be interested in. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? SSD, AD, and clinical staff were educated relative to adequate mental health services, interventions, and/or therapeutic programming. - Education and training were provided to SSD, AD, and clinical staff on 1/26/24 by the DNS and ADNS. Education provided: Activity Program Policy ul="" role="list" Secured Unit Program Policy 4: How be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? The SSD/Designee will complete visual observation rounds at least 5 times weekly, at varied times, for 4 weeks to validate residents are receiving adequate mental health services, interventions, and/or therapeutic programming, as indicated. Thereafter, SSD/Designee will complete visual observation rounds at least 5 times per month at varied times for 2 months, then complete visual observation rounds at least 2 times per month at varied times for 3 months. Any identified concerns will be promptly addressed with the responsible individual(s). Audit	

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	On 1/8/24 at 2:45 p.m., Resident 80 was observed as he continued to pace up and down the hall. He stopped at the locked door and stood there as if waiting to be let out. The 1:1 CNA indicated he could not leave the unit. Resident 80 turned around and paced back down the hall. On 1/8/24 at 2:53 p.m., 12 residents had gathered in the back lounge/activity/dining room area for a game of Bingo. There was an Activity Assistant, and two nurses. The area was crowded, loud and lively as the gathered resident enjoyed the game. Resident 80 was observed as he continued to pace up and down the hall. With the ongoing activity, it appeared to capture his attention and he lingered at the end of the hall. He approached a resident and his 1:1 aide, stepped in between them. Resident 80 pointed to the chair, and the aide asked the seated resident if Resident 80 could sit down. The seated resident shrugged his shoulders and got up. Resident 80 sat down momentarily but then got back up and continued to walk up and down the hall. During an interview on 1/8/24 at 3:00 p.m., Qualified Medication Aide (QMA) 24 indicated, if there were more than 3-4 residents gathered in the activity lounge it was advised to have a nurse supervise, especially if Resident 80 was awake because he was unpredictable and would lash out at residents or staff. She liked to supervise louder activities "just in case" because it would overstimulate Resident 80. During an interview on 1/9/24 at 11:05 a.m., the Executive Director (ED) indicated, what he preferred to call the secured "Wellness Unit," had been an inherited "behavioral health unit," before he started at the facility. At that time, the ED and		results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance. ul="" role="list" 5. Date of completion: 02/19/2024	

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	other executive staff were in the process of assessing and transitioning the "Wellness Unit," away from admissions/programming for behavioral health and wanted to turn the unit into a secured Memory Care unit. It needed to be a slow and careful transition so that each resident could have/find appropriate placement, whether that meant staying there in the unit, or at the facility but transferred to the general community or transferring to a different facility. The ED indicated, the facility was still required and responsible for appropriate services and programming which they fulfilled through resources such as; regular Nurse Practitioner visits, contracted Psychiatric practitioner visits, an involved Social Service Director, and specialized activity programming. The ED indicated, Resident 80's admission should not have been approved because he was too young for a nursing home and had serious safety risk behaviors, however the decision had not been his, but as they looked for more appropriate placement (which was difficult and ongoing) the facility should do anything they could within their means to satisfy and ensure his health and safety. He required 24/7 1:1 safety supervision after several behavioral outbursts and psychiatric in-patient hospitalizations. Throughout the survey period, the main activity room remained locked and inaccessible to residents. Doors to the fenced in outdoor courtyard and designated smoking areas were locked with wrapped bike locks except for prescheduled smoking breaktimes. There were no "at-will" activities available such as; magazines to browse, books, coloring, card games, computer/internet access etc. The newly renovated hallways had not been redecorated with pictures/art/clocks etc. There were two newly			

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	installed observation mirrors for the nurses' station for visual supervision down the length of each hall. There were no lounge chairs or benches for visitors or residents to sit. During an interview on 1/11/24 at 11:03 a.m., the SSD indicated, there used to be some magazines and other lose paper type activities but much of it had been put up for the renovation and she was not sure where they were now. During an interview on 1/11/24 at 11:10 a.m., the Activity Director (AD) indicated, the activity room on the secured unit always remained locked because the lock on the door to the courtyard was not working so it was considered a safety hazard. It had been broken for a while, and she did not know when it would be fixed. The AD indicated the activity room was an essential area for the behavior unit because it provided more space and room for more activities. At that time, the activity calendar was the same for both the secured unit and the general population, but it was her wish and goal to make more specialized programming for the Wellness Unit. She had not been able to get to it yet since she was newer to her position, still training new housekeeping staff (as she recently transferred from that department) and she also serviced as the facilities supply coordinator. The SSD had been helping her maintain the activity program, but she too was busy with her other required duties as the SSD. On 1/8/24 at 10:40 a.m., Resident 80's medical record was reviewed. He was a twenty-four-year-old long-term care resident with diagnoses which included, but were not limited to, schizophrenia and schizoaffective disorder, depressive type, unspecified psychosis not due to substance abuse and adjustment disorder with			

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	anxiety. He was admitted on 11/9/22 from an extended in-patient psychiatric hospitalization. The corresponding hospital record, dated 7/13/22 ,indicated, " ...presented to the Emergency Department [ED] for altered mental status. History was limited ... patient was seen at a bus stop coming from Chicago with a layover here in Indianapolis going to Danville IL.... " According to the ED note, EMS stated that he was "acting abnormally, difficult to orient, not answering questions correctly or demonstrating linear thought...He did try to elope while in the ED ... during assessment, patient has been saying 'I don't know' or not answering majority of the questions asked. He did state that he is 23 years old, from Danville, IL, and that when he grows up he 'wants to be normal.' When asked to elaborate on what he meant, he said he wants to 'stop seeing things' .... Plan: continue hospitalization for stabilization of symptoms and safety planning ...." After his admission on 11/9/22, he had subsequently been transferred to the hospital on 6 separate occasions for physical aggression. A care plan meeting was held on 11/15/22 at 3:11 p.m., where the SSD and Resident 80's guardian were present. The guardian discussed discharge plans and applying for a Bureau of Developmental Disabilities Services' (BDDS-) waiver but stated it may take up to 22 months. A nursing progress note, dated 12/31/22 at 7:22 p.m., indicated, Resident 80 had become aggressive to staff members, EMT's and policeman. He was unable to be redirected, and the Psych NP did not return the call and message			

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	about his increased behaviors. The in-house NP gave an order to send him to the ED for psychiatric evaluation and treatment. He returned to the facility the following morning. A nursing progress note, dated 1/5/23 at 5:58 p.m., indicated Resident 80 requested a roommate because he was lonely. He was introduced to another resident and they agreed to be roommates. A Psychiatric NP progress note dated 1/13/2023 3:57 p.m., indicated, " ...he disclosed that he often worries, is 'scared,' and he has had difficulty adjusting to living in this facility ...." A nursing progress note, dated 1/14/23 at 1:30 p.m., indicated. Resident 80 was restless and agitated and showed frustration over not being about to go outside to smoke due to the weather and facility policy. He was noted to listen to his music and played with his game, but he was unable to focus on one task for a long time. He continued pacing in the unit back and forth and stated he just wants to take a walk. A nursing progress note, dated 1/15/23 at 12:02 p.m., indicated Resident 80 was noted to have increased anxiety and aggressiveness due to not being able to smoke due to the weather and per facility policy. He was hard to be re-direct and it took multiple attempts and interventions to calm him down. Management aware, NP aware. A nursing progress note, dated, 1/22/23 at 1:00 p.m., indicated Resident 80 had increased agitation and paced back and forth in the unit hallway and started to have physical altercations with staff members and tried to fight other			

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	resident too. When asked why he was acting that way, he stated he had no cigarette to smoke. He was given as needed "agitation medication," given per order and one on one care provided per facility protocol. Administration aware, NP aware. A Psychiatric NP progress note, dated 1/27/23 at 7:27 p.m., indicated, Resident 80 admitted that he was frustrated at times. He asked if someone could call his sister and tell her that he can be discharged. He was encouraged to talk to staff and ask questions. A nursing progress note, dated 1/28/23 at 10:50 a.m., indicated, Resident 80 had multiple physical altercations with other residents and staff members. Redirection was attempted, but he "kept going on fighting." He claimed that some of the other residents took the skin from his face and arm and he wanted it back. He was placed on 15-minute safety checks until he was transferred to an in-patient psychiatric hospital on 1/28/23 at 3:30 p.m. He returned to the facility on 2/10/23. Upon his return, a care plan meeting was held on 2/15/2023 at 11:48 a.m., where the SSD and Resident 80's guardian were present. His guardian stated she will apply for BDDS waiver application but discussed an up to two-year waiting list. A nursing progress note, dated 4/8/23 at 4:30 p.m., indicated, Resident 84 asked for a drink of water, but the QMA told him to wait just a second since she was busy with another resident. As a CNA came back onto the unit, Resident 80 saw her and began to swing at her. The CNA, QMA, and another resident tried to calm him down, but they			

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	had to get a male CNA to redirect him to his room. Although the DON was notified, the progress note lacked documentation the physician had been notified. A nursing progress note, dated 4/11/23 at 4:32 p.m., indicated Resident 84 had increased aggressive behaviors towards other residents and staff members. On 4/11/23 at 5:38 p.m., the Psych NP was notified of his increased behaviors and he was started back on Divalproex, (An anticonvulsant medication that can be used to treat seizures and bipolar disorder). A nursing progress note dated 4/30/23 at 5:05 p.m., indicated Resident 80 was involved in physical contact with another resident. The resident were separated and neither sustained injuries. All parties were notified, and Resident 80 was made to remain within eyesight of staff at all times until further notice. A nursing progress note dated 5/2/23 at 10:50 p.m., indicated Resident 80 had increased physical aggressiveness towards staff members and other residents and he vandalized facility property by breaking a glass window, and threw his personal staff all over his room. He was to remain within eyesight of staff at all times until he could be transferred to the ED that evening. He returned to the facility the following morning on 5/3/23. A re-admission nursing progress note, dated 5/3/23 at 1:15 a.m., indicated, Resident 80 returned and was moved to another room due to aggression towards his roommate and "broken			

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	glass from window still present in room." Housekeeping and maintenance will be notified by day shift nurse. The Nurse contacted a local Psych facility to try and find placement due to his aggressive behavior during the prior shift, but was told he was too young. A SSD progress note, dated 5/3/23 at 9:36 a.m., indicated, Resident 80's guardian consented to a transfer to in-patient psych due to his aggression and behaviors, and he was sent out that day. He returned on 5/17/23. A nursing progress note, dated 6/13/23 at 11:50 p.m., indicated Resident 80 was physically aggressive towards staff members. He ran behind the nurse station, kicked the door and broke the nob, he removed the whiteboard off the wall and threw it on the floor. He took the unit phone and through it on the floor too. He ran towards staff and tried to hit them, but a nurse and another staff member managed to redirect him and took him to his room. He stayed calm and fell asleep before midnight. The progress note lacked documentation the physician had been notified of his physical aggression and outbursts. A nursing progress note, dated 6/14/23 at 10:05 p.m., indicated Resident 80 was physically aggressive with staff members and ran through the nurse's station door and into the office where he swung at a staff member. The nurse was able to intervene and allowed for the staff member to remove themselves from the situation and redirected to him to his room to calm down. The progress note lacked documentation the			

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	physician had been notified of his physical aggression and outbursts. A psychiatric NP progress note, dated 6/15/23 at 7:20 p.m., indicated Resident 80 was being actually for increased aggressive behaviors and request for cognitive testing. "Staff report aggressive behavior at night when patient is bored. He currently does not have a TV, radio, or phone. He does go out to smoke, but that is it." A nursing progress note, dated 6/23/23 at 5:03 a.m., indicated Resident 80 had been up most of the night and paced the hallways. He continued to pace the hallway and was observed to lay down on the floor and stared up into the corner mirrors. While lying on the floor looking at the mirrors he said, "leave me alone just go away and leave me alone." Staff intervened and offered resident snack and a shower. The progress note lacked documentation the physician had been notified of his hallucinations. A nursing progress note, dated 6/24/23 at 6:30 p.m., indicated Resident 80 tried to fight other residents, but staff members were able to redirect him to smoke and go to his room. The progress note lacked documentation the physician was notified of behaviors towards other residents. A nursing progress note, dated 6/24/23 at 9:37 p.m., indicated Resident 80 returned from a smoke break and unprovoked, attacked a staff member. Another staff intervened to stop the attack so the staff member could remove themselves from the situation. When the staff member left, Resident 80 ran up to another staff member and began to hit.			

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	Staff again intervened and redirected him to his room to calm down. The progress note lacked documentation the physician had been notified of his unprovoked attack of two staff members. A nursing progress note, dated 6/25/23 at 1:06 a.m., indicated Resident 80 called 911. Paramedics arrived and while they spoke with Resident 80, the resident expressed he was having anxiety, felt angry and was having a hard time dealing with it. He then expressed he had been feeling suicidal for the past month but had not told anyone. He was transferred to the hospital but returned later the same day. A care plan, dated 11/10/22, indicated he had an intellectual/developmental disability with a goal of meeting his developmental and psychosocial needs through the next review. Interventions included, but were not limited to, community-based services as indicated. The record lacked documentation of outreach to local community services for identification of possible resources/services. A care plan, dated 11/10/22, revised 4/5/23 indicated Resident 80 had a mood problem related to his diagnoses with a goal of having improved mood state through the next review date. Interventions included, but were not limited to, encourage and provide opportunities for exercise/physical activity. Apart from pacing the unit hallways, the record lacked documentation of the implementation of any meaningful form of physical activity/exercise.			

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	A care plan dated 11/11/22 indicated, Resident 80 was dependent on staff for meeting emotional, intellectual, physical and social needs related to his cognitive deficits. Interventions included, but were not limited to, ensure that the activities the resident attends are age-appropriate, provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression and responsibility. The record lacked documentation of a comprehensive, specialized, person-centered and age-appropriate activities/services/materials were available. A care plan, initiated on 11/10/22 and revised 5/15/23, indicated Resident 80 planned to remain in the nursing facility for long-term care. The care plan lacked revision of his discharge wishes to go home and/or his guardian's plan to apply for a BDDS waiver. A care plan, initiated on 7/21/23 and revised 8/23/23, indicated Resident 80 was at risk for ineffective coping due to traumatic history and psychiatric mental illness. "[Resident 80] is intellectually disabled and parents/family have lost communication and involvement per their choice ...." Interventions included, but were not limited to, encourage physical activity and exercise. The care plan lacked revision to include Resident 80's fathers attempt to bring him home and/or reasons why or why not a discharge to his father was not feasible, or revision to include his sister's attempt at outreach to him and/or reasons why or why not a relationship with her would or would not be beneficial.			

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	The record lacked documentation of specialized activities, programming, or services to be provided for residents under the age of 55, especially significantly younger than 65. On 1/11/24 at 12:37 p.m., the DON provided a copy of current facility policy titled, "Activity Program," dated 8/2022. The policy indicated, "Activity programs are designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident ... reflect the cultural and religious interests, hobbies, life experiences and personal preference of the resident, appeal to men and women as well as those of various age groups residing in the facility ...." On 1/9/24 at 11:15 a.m., the ED provided a copy of current facility policy titled, "Secured Unit Program," dated 6/2023. The policy indicated, "Envive Healthcare is committed to providing secured unit services with consistent and therapeutic interventions designed to help individuals acquire the skills necessary to function with as much self-determination as possible in the least restrictive environment. Therapeutic programming and treatment are effective if it is accessible to the people who need it most ... Secured Unit Expectations ... d. There are natural/logical positive and negative consequences for all behaviors and actions. e. Advancement, rehabilitation and self-determination, and eventual successful transition to a less structured environment, are only possible if everyone takes personal responsibility for engaging in treatment ... n. the following are inappropriate and unacceptable behaviors and will result in immediate pass suspension: Smoking in non-designated areas,			

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	stealing and/or any illegal acts, damage to community property, and physical aggression or excessive verbal aggression, refusing medication without conferring with your physician, using non-prescribed drugs and/or alcohol and/or intimidating or harassing other residents or staff ... Staff Expectations: a. Training: Upon orientation, all newly hired staff shall receive abuse preventions, mental health diagnoses, how to use appropriate interventions skills while interacting with residents, managing aggressive behaviors, professional boundaries, Relias and any other training deemed appropriate." The policy lacked revision to include requirements for ongoing staff training and education related to the Wellness Unit and its unique resident population. On 1/9/24 at 11:15 a.m., the ED provided a copy of an educational power-point presentation which had been conducted 6/6/23. The ED indicated it had been the only specialized training provided for staff related to the Wellness Unit's unique residents and design, and he wanted education to be provided at least annually, but was still working on details and getting more training scheduled. The power-point was titled, "Dementia Specific Approaches when Dealing with Behaviors and those of Bipolar/Schizophrenia." The power point was written in narrative voice and summarized general interventions for dementia, bipolar and/or mania with three key elements; 1. Understanding the history and medical records for knowing the best ways to respond to behavior, 2. Communication and 3. Body language..." 3.1-37 3.1-43			

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F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on observation, interview, and record review, the facility failed to ensure insulin was administer correctly by insulin flex pen for 1 of 1 resident observed for insulin administration (Resident 38). Findings include: On 1/12/24 at 9:19 a.m., Resident 38's record was reviewed. He was admitted to on 2/22/19. His diagnoses included, but were not limited to, diabetes mellitus (blood sugar disorder), long term use of insulin (injection medication to control blood sugar levels), and long term use of oral hypoglycemic drugs (low blood sugar medication). His care plan for diabetes mellitus, dated 12/8/23, indicated to provided his diabetes medication as order by his doctor. His care plan for nutritional problems, dated 12/8/23, indicated to administered medications as ordered and to obtain and monitor lab/diagnostic work as ordered. On 1/10/24 at 3:20 p.m., Resident 38's blood test results (labs), dated 1/9/24, were reviewed. His serum glucose level was 158 with a reference range (high and lows of a normal result) of 70-99. His A1C (measured average blood sugar over 3 months) was 9.2%. The lab's reference range indicated 4.0 to 5.6%. His estimated average glucose over the past 3 months was 217 mg/dL	F 0760	p="" paraid="8733816" paraeid="{ce807326-ab0c-4c00-aff5-00bb5e81ffbf}{249}">F760 – Residents are Free of Significant Med Errors “Based on observation, interview, and record review, the facility failed to ensure insulin was administer correctly by insulin flex pen for 1 of 1 resident observed for insulin administration (Resident 38).” 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? NP Resident 38 insulin administration in which pen needle was not primed. Per NP, do not readminister insulin dose. checked glucose as scheduled at dinnertime per NP request. Glucose remained in sliding scale parameters and insulin continued per . 2 other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. Licensed nurses were audited for insulin administration including priming pen needle. 3: 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 educated on insulin	02/19/2024

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	(milligram/deciliter). The reference range was equal to/or less than 114. On 1/10/24 at 12:30 p.m., Registered Nurse (RN) 12 indicated Resident 38's accu-check (device to measure blood sugar) was taken at 12:21 p.m., the results were 189. His physician ordered sliding scale indicated he needed 2 units of insulin. She was indicated he used a Novolog Flex Pen (insulin delivery device) 100 units/mL (milliliter). She was observed to use hand gel and apply disposable gloves. She turned the flex pen to 2 units and administered the insulin. She did not prime the needle with 2 units before the administration of the Novolog. She held the flex pen needle in his abdomen for about 5 seconds. On 1/10/24 at 12: 40 p.m., RN 12 indicated she did not prime the needle with 2 units before trying to administer 2 units. On 1/10/24 at 12:46 p.m., the Director of Nursing Services (DNS) indicated to give the correct dose, the nurse should have added 2 units to the dosage amount required, wasted only 2 units to prime the needle. Then, after confirming the correct amount was on the insulin flex pen, administer the dosage. A current policy, titled, "Subcutaneous Injection Administration," was provided by the Vice President of Clinical Operations (VPCO), on 1/10/23 at 3:01 p.m. A review of the document, indicated insulin injection information was included, but not insulin administration with an insulin flex pen. A current policy, titled, "Resident Rights," with no date, was provided by the VPCO, on 1/12/24 at 9:37 a.m. A review of the policy indicated, " ...The		administration, including priming insulin pen needles Education to licensed nurses on 1/26/24 by ADNS and DNS Education included: Pharmacy Manual PCU043 - Subcutaneous Injection Administration ul="" role="list" Insulin Administration competency Checklist 4: How be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? DNS or designee will audit insulin administrations for at least 5 residents to ensure appropriate administration technique, weekly x 4 weeks, then for at least 3 residents weekly x 4 weeks, then for at least 2 residents weekly x 4 weeks, then for at least 1 resident monthly x 3 months. Any identified concerns will be promptly addressed with the responsible individual(s). Audit results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance. ul="" role="list" 5. Date of completion: 02/19/2024	

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	resident has the right to ...health care consistent with his or her interests, assessments, and plans of care ...." 3.1-48(c)(2)			
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. Based on record review and interview, the facility failed to obtain labs as ordered by the physician for 2 of 2 residents (Residents 14 and 61). Findings include: 1. On 1/10/24 at 12:40 p.m., a comprehensive record review was completed for Resident 14. He had the following diagnoses which included but were not limited to viral hepatitis B, alcohol abuse, major depressive-like episodes, schizoaffective disorder bipolar type, anxiety, and mood disorders. Resident 14 had lab orders for a CBC (complete blood count), CMP (complete metabolic profile), TSH (thyroid stimulating hormone), vitamin B12 level, Hgb A1C (average of blood sugars), iron, and liver panel dated 12/12/23. These labs were not obtained. On 1/8/24 at 1:25 p.m., the DON (Director of Nursing) indicated he refused and provided a	F 0770	p="" paraid="79447403" paraeid="{cadbdd85-b81c-4527-a433-25329d71e315}{195}">F770 – Laboratory Services “Based on record review and interview, the facility failed to obtain labs as ordered by the physician for 2 of 2 residents (Residents 14 and 61).” 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 14’s 12/12/23 lab order reviewed. Per order, labs to be drawn within three days of 1/2/24. NP notified refusal of labs on 1/4/24. Resident labs reordered and completed 1/9/24. NP notified of lab results. Resident 61’s 10/29/23 lab order reviewed. The resident refused labs and NP was notified. No order to attempt redraw at time of order. Resident	02/19/2024

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	progress note from the NP (Nurse Practitioner) dated 1/8/24 indicating he refused and will allow the lab to draw his blood next time. 2. On 1/9/24 at 10:20 a.m., a comprehensive record review was completed for Resident 61. She had the following diagnoses which included but were not limited to Alzheimer's disease, diabetes mellitus type 2, essential hypertension, hyperlipidemia, hypothyroidism, and anxiety. Resident 61 had orders for labs which included a CBC, BMP, A1C, TSH and lipid panel on 10/29/23. On 1/9/24 3:00 p.m., the DON provided a progress note from the NP dated 1/9/24 indicating the resident refused her labs and she was educated via google translate on the purpose of labs and resident continued to refuse. A policy titled, "Laboratory Orders, Timely Draws" dated 10/2014, was provided by the Corporate Consultant on 1/11/24 at 1:52 p.m. It indicated, " ...If not specified "now" or "stat" or in a given time frame (e.g., 14 days), any laboratory blood work ordered to be drawn shall be drawn on the next regularly scheduled facility lab day. 3.1-49(a) 3.1-49(b)		61 will have labs obtained as per NP order in the future. 2 other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents' medical records were audited for the previous 30-day to identify any labs that may not have been obtained, with re-orders acquired and submitted to the laboratory. 3: 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 educated on lab services and completion of labs Education was provided to licensed nurses on 1/26/24 by ADNS and DNS ul="" role="list" Education included: Lab Services 4: How be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? DNS or will conduct a random audit of at least 5 residents per week, for 4 weeks, with lab orders to ensure labs are obtained timely with results reported to the NP and reviewed by the NP timely. Thereafter, a random audit of at least 3 residents per week, for 4 weeks will be conducted to ensure continued compliance, and then random audits of at least 2 residents per week for . Any	

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			identified concerns will be promptly addressed with the responsible individual(s). Audit results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance. ul="" role="list" 5. Date of completion: 02/19/2024	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure the kitchen was maintained under generally clean conditions, food was covered as it sat underneath a dirty blowing air vent, and failed to ensure the dishwashing	F 0812	p="" paraid="1978947881" paraeid="{c3054df4-7f19-43d6-ae02-1441bce4611f}{100}">F812 – Food Procurement, Store/Prepare/Serve-Sanitary “Bas	02/19/2024

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	machine was maintained in a neat and clean fashion for 1 of 1 observation of the kitchen. Findings include: On 1/4/24 at 9:38 a.m., an initial kitchen tour was conducted with the Dietary Manager (DM). Upon entrance to the kitchen at 9:38 a.m., three large pans of uncovered and individually plated pieces of cake, were observed on a preparation table in the middle of the kitchen. There was a large blowing air vent above the food preparation isle and the pans of cake rested on a table directly underneath the vent. The grates of the vent were observed to have a thick layer of built-up debris/dust. At the conclusion of the kitchen tour, around approximately 9:50 a.m., the pans of cake remained uncovered under the dirty blowing vent. The dishwashing machine was observed. The edges/seals of the dishwasher were built up with lime/hard water and appeared textured white and green in color. There was copious amounts of macerated food particles splashed on the surfaces of the machine and on the surface of the disposal motor. The walls behind the dish machine were spotted with food particles and other unidentified discolorations. Dish Washer 21 indicated, the dishwasher was supposed to be wiped clean at the end of each day deep cleaned at least once a month, but sometimes it was hard to get to it with everything else that needed to be done. In between the walk-in refrigerator and freezer, there was a copper metal pipe which leaked and dripped onto an already standing puddle of water. The pipe was disconnected from itself in the middle, and when asked about the leak, the DM indicated, the pipe sometimes became		ed on observation, interview, and record review, the facility failed to ensure the kitchen was maintained under generally clean conditions, food was covered as it sat underneath a dirty blowing air vent, and failed to ensure the dishwashing machine was maintained in a neat and clean fashion for 1 of 1 observation of the kitchen." 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The air vent in the kitchen has been cleaned. The dishwashing machine has been thoroughly cleaned, the walls behind the dish machine have been cleaned. The copper metal pipe has been repaired. No residents were affected by the alleged deficient practice. 2 other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - All residents have the potential to be affected by the alleged deficient practice. Therefore, this plan of correction applies to all residents currently residing in the facility. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ul="" role="list" Dietary and maintenance staff were educated on cleaning and maintenance of the kitchen vents	

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	disconnected in the middle and would leak. Staff had reported it to maintenance, but it had not been repaired yet. The DM did not know where the water came from or if it was fresh water or dirty water. She and her staff tried to keep it mopped up as often as possible. The DM provided a copy of the daily//weekly/monthly kitchen cleaning schedule and indicated the dish machine should be cleaned well at the end of each day, and deep cleaned/de-limed at least once a month. Her kitchen tasks did not include monitoring of the intake/output ceiling vents and maintenance should clean them as needed. 3.1-21(i)(1) 3.1-21(i)(3)		and dishwashing machine, and timely reporting of needed repairs to the maintenance director. Dietary and maintenance staff were educated on 1/16/24 by the Dietary Manager Education included: Food Safety- Kitchen Sanitation Infection Control: Cleaning and Sanitizing Equipment Daily/weekly/monthly kitchen cleaning schedule 4: How be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? Dietary manager or will conduct random kitchen sanitation audits 5 days a week for 2 weeks to ensure the kitchen is maintained under clean conditions. Then three times per week x 2 weeks, then once per week x 4 weeks, then bi-weekly x 4 weeks, then once per month x 3 months. Any identified concerns will be promptly addressed with responsible individual(s). Audit results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance. ul="" role="list" 5. Date of completion: 02/19/2024	
F 0883 SS=E Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure			

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	that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse			

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	immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on observation, interview, and record review, the facility failed to ensure residents received annual influenza and/or pneumococcal vaccinations per their requirements and consent for 5 of 8 residents reviewed for vaccinations (Residents 32, 56, 14, 10, and 35). Findings include: 1. 1/4/24 at 10:58 a.m., Resident 32 was observed as he waited with several peers to go outside and smoke. He was seated in a wheelchair and in conversation with a peer when he began to cough. When asked about his cough, Resident 31 indicated it was mostly from smoking but seemed to have gotten worse since he got pneumonia. On 1/11/24 at 11:52 a.m., Resident 32's medical record was reviewed. He was a 71-year-old, long-term care resident with diagnoses which included, but were not limited to, chronic obstructive pulmonary disease (COPD), major depressive disorder and pneumonia. His immunization history revealed he had received two Pneumonia vaccinations, the PPSV23 on 11/5/2011 and a Prevnar 13 on 9/15/2017.	F 0883	p="" paraid="514314165" paraeid="{b2b917e9-63c2-440a-8ad3-44c1076680c5}{14}">F883 – Influenza and Pneumococcal Immunizations “Based on observation, interview, and record review, the facility failed to ensure residents received annual influenza and/or pneumococcal vaccinations per their requirements and consent for 5 of 8 residents reviewed for vaccinations (Residents 32, 56, 14, 10, and 35).” 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 32 received the Prevnar 20 immunization on 1/11/24 Resident 56’s immunization record was reviewed. Per resident record, resident received Prevnar 13 immunizations on 4/29/16 and 8/13/19. also received PPSV23 Immunization on 2/24/20. Per CDC recommendations, not due for pneumococcal immunization	02/19/2024

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	155077	A. BUILDING 00 B. WING	01/11/2024

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	A late Nurse Practitioner (NP) progress note dated 3/3/23 at 3:40 p.m., (created 3/5/23 at 3:40 p.m.), indicated Resident 32 required an acute visit to be seen for a cough and complaints of fatigue. Resident 31 indicated, "I feel like I have something in my lungs." The NP ordered a chest x-ray. A nursing progress note, dated 3/5/23 at 4:16 p.m., indicated the chest x-ray results had been received and confirmed a diagnosis of pneumonia. The record lacked documentation Resident 32 had declined the pneumococcal vaccine, and/or had received the next scheduled dose as outline per the Centers for Disease Control, (CDC) recommendations, which indicated, "..for people 65 and older who have ...previously received both PCV13 and PPSV23x, and the PPSV23 was received at age 65 years or older: based on shared clinical decision-making, 1 dose of PCV20 at least 5 years after the last pneumococcal vaccine dose ...." On 1/11/24 at 3:50 p.m., the Director of Nursing (DON) provided a copy of Resident 32's immunization record and indicated Resident 31 should have received the next pneumococcal dose in 2023 as it would have been 5 years after his last dose. 2. On 1/11/24 at 11:30 a.m., Resident 56's medical record was reviewed. He was a long-term care resident with diagnoses which included, but were not limited to, hypertensive heart disease, atrial fibrillation and heart failure. The record lacked documentation of consent		until 2/24/25, five years after dose. Resident 14 received the Prevnar 20 immunization on 1/17/24 Resident 10 received the Prevnar 20 immunization on 1/18/24 Resident 35 received the Prevnar 20 immunization on 1/17/24 p="" paraid="842148409" paraeid="{b2b917e9-63c2-440a-8ad3-44c1076680c5}{85}"> 2 other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. An audit was conducted to identify those residents who were due to receive pneumococcal vaccination. Those residents identified as due have had consent obtained and orders received for Prevnar 20 immunization, as appropriate. 3: 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 educated on immunization guidelines DNS, ADNS and Infection Preventionist educated on pneumococcal immunization schedules Licensed nurses were educated on 1/26/24 by the DNS and ADNS DNS, ADNS and Infection Preventionist were educated on 1/15/24 by Corporate Clinical Support Education provided: Influenza, Pneumococcal and COVID-19 Immunizations CDC	

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	and/or declination for up-to-date pneumococcal vaccination. On 1/11/24 at 3:50 p.m., the DON indicated she could not find a declination for the pneumococcal vaccine and provided a copy of Resident 56's immunization record. The record revealed he had only received one dose of the PVC13 on 8/20/2020. The DON indicated, and should have received the next scheduled vaccination per the CDC recommendations which indicate, "...for people 65 and older who have ... previously received only PCV13: 1 dose PCV20 OR 1 dose PPSV23- if PCV20 is selected, administer at least 1 year after the PCV13 dose. If PPSV23 is selected, administer at least 1 year after the last PSCV13 dose ...."3. On 1/10/24 at 12:40 p.m., a comprehensive record review was completed for Resident 14. He had the following diagnoses which included but were not limited to viral hepatitis B, alcohol abuse, major depressive-like episodes, schizoaffective disorder bipolar type, anxiety, and mood disorders. Resident 14's immunization record was reviewed. Resident 14's record lacked a pneumococcal consent to administer an additional dose of the vaccine. He did not receive an additional dose of the vaccination as recommended by the CDC (Centers of Disease Control). 4. On 1/9/24 at 3:03 p.m., a comprehensive record review was completed for Resident 10. He had the following diagnoses which included but were not limited to hypothyroidism, vitamin D deficiency, nicotine dependence, major depressive disorder, mood disorder, generalized anxiety disorder and chronic pain. Resident 10's immunization was reviewed.		Pneumococcal Guidance for Adults 4: How be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? The DNS or Designee will be responsible to audit the charts of 5 residents per week X 4 weeks, then 3 residents per week X 4 weeks, then 2 residents per month X 4 months to ensure residents' vaccinations are , in accordance with current CDC recommendations. Any identified concerns will be promptly addressed with responsible individual(s). Audit results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance. p="" paraid="842148409" paraeid="{b2b917e9-63c2-440a-8ad3-44c1076680c5}{85}"> 5. Date of completion: 02/19/2024	

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	Resident 10 had documentation for a pneumococcal vaccination consent, but it lacked the resident's signature. The vaccination was not administered. Resident had only 1 previous pneumococcal vaccination which was a Prevnar 13. He did not receive an additional dose of the vaccination as recommended by the CDC. 5. On 1/9/24 at 3:07 p.m., a comprehensive record review was completed for Resident 35. He had the following diagnoses which included but were not limited to hyperlipidemia, schizophrenia, major depression, generalized anxiety disorder, sleep disorder, GERD (gastro-esophageal reflux disease), and muscle weakness. Resident 35's immunization was reviewed. Resident 35's record lacked a pneumococcal consent. The last one noted in the medical record was from 2019. Resident 35 had no previous pneumococcal vaccinations recorded. On 1/11/24 at 3:05 p.m., the DON (Director of Nursing) was interviewed. She indicated the facility needed to improve with vaccination of their residents. A policy titled, "Infection Prevention and Control Program," with a date of 8/2022, was provided by the ED (Executive Director) on 1/4/24. It indicated, " ...The community has a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases that: covers all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement, is based on the facility assessment, and follow accepted national standards ...." 3.1-13(a)			