STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155580	A. BUILDING 00 B. WING	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE TOLLESTON PARK	2350 TAFT ST GARY, IN 46404

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00415961. Complaint IN00415961 - Federal/State deficiencies related to the allegations are cited at F921. Survey dates: August 21, 22, 23, 24, and 25, 2023 Facility number: 008505 Provider number: 155580 AIM number: 200064830 Census Bed Type: SNF/NF: 127 Total: 127 Census Payor Type: Medicare: 6 Medicaid: 117 Other: 4 Total: 127 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/1/23.	F 0000	**The facility respectfully requests paper compliance for this survey.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deana Jordan Collins	Regional Nurse Consultant	09/25/2023

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

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	§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to wearing a hospital gown during the day for 1 of 2 residents reviewed for dignity. (Resident 63)	F 0550	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident # 63's care plan was updated to reflect resident's choice to wear a gown	09/22/2023

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	Finding includes: On 8/21/23 at 1:55 p.m., Resident 63 was observed in his room in bed. The resident was awake and wearing a hospital gown. On 8/22/23 at 9:03 a.m. and 2:10 p.m., the resident was observed in his room in bed wearing a hospital gown. On 8/24/23 at 9:15 a.m., 10:07 a.m., 1:35 p.m., and 2:45 p.m., the resident was observed in his room in bed. He was wearing a hospital gown at those times. The record for Resident 63 was reviewed on 8/24/23 at 1:44 p.m. Diagnoses included, but were not limited to, stroke and hemiplegia (muscle weakness on one side of the body). The Annual Minimum Data Set (MDS) assessment, dated 6/23/23, indicated the resident was cognitively impaired for daily decision making and he required extensive assistance with dressing. The resident did not have a care plan or documentation related to any preference of wearing a gown during the day while in bed. Interview with the Director of Nursing on 8/24/23 at 3:00 p.m., indicated the resident preferred a gown while in bed and his care plan needed to be updated. 3.1-3(t)		while in bed. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Social Services/designee will review residents clothing preferences at initial care plan and with the quarterly MDS.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **Social Services/designee will review residents clothing preferences upon admission and with each quarterly MDS. Care plans will be amended as needed.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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

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

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	Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on record review and interview, the facility failed to ensure the resident's Responsible Party was notified in writing related to a transfer to the hospital for 1 of 3 residents reviewed for hospitalization. (Resident 52) Finding includes: The record for Resident 52 was reviewed on 8/24/23 at 11:30 a.m. Diagnoses included, but were not limited, major depressive disorder, high blood pressure, hallucinations, bipolar disorder, dementia, and catatonic disorder. The 7/7/23 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact. A Nurses' Note, dated 7/24/23 at 5:13 p.m.,	F 0623	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 52's Poa was mailed a transfer notification. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Hospital transfers from the last 14 days were audited to ensure the residents responsible party received transfer notifications when appropriate. III. What measures will be put into place and what systemic changes will be made to ensure the	09/22/2023

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	indicated the resident was not looking well during the shift. She was crying, yelling, and placing herself on the floor. The Nurse Practitioner (NP) was notified and gave orders to send the resident to the hospital. The resident was admitted to the hospital with altered mental status. There was no indication the State transfer form was mailed to the resident's responsible party. Interview with the Social Service Director on 8/25/23 at 10:15 a.m., indicated the State transfer form was not mailed to the resident's Responsible Party. 3.1-12(a)(6)(ii) 3.1-12(a)(6)(iii)		deficient practice does not recur; Social Services will be educated on sending a transfer notice to a residents responsible party when a resident is sent to the hospital. ="" b="">IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Administrator/designee will audit hospital transfers to ensure the responsible party was sent a transfer notification. Audits will be completed on 3 hospital transfers a week x 8 weeks, then monthly x 4 months.="" b="">The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0641 SS=D 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 observation, record review, and interview, the facility failed to ensure the Comprehensive Minimum Data Set (MDS) assessments were accurately completed related to hospice care, anticoagulant use, and tracheostomy care for 3 of 30 MDS assessments	F 0641	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **R24, R37 and R60 will have MDS**	09/22/2023

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	reviewed. (Residents 24, 37, and 60) Findings include: 1. The record for Resident 24 was reviewed on 8/22/23 at 1:50 p.m. Diagnoses included, but were not limited to, atherosclerotic heart disease, congestive heart failure, and hypertension. The Quarterly Minimum Data Set (MDS) assessment, dated 6/6/23, indicated the resident was cognitively impaired and he had received an anticoagulant (blood thinner) for 7 days during the assessment reference period. A Physician's Order, dated 10/27/21 and listed as current on the August 2023 Physician's Order Summary (POS), indicated the resident was to receive Plavix (an antiplatelet) 75 milligrams (mg) daily. The resident had no orders for an anticoagulant during the assessment reference period. Interview with the Director of Nursing on 8/24/23 at 3:00 p.m., indicated the resident's MDS had been coded incorrectly related to anticoagulant use. 2. The record for Resident 37 was reviewed on 8/24/23 at 9:34 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance and Alzheimer's disease. The Significant Change Minimum Data Set (MDS) assessment, dated 7/19/23, indicated the resident was moderately impaired for daily decision making and he was not receiving hospice services while a resident of the facility.		**modification made and transmitted** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents with special care needs including Anticoagulants, tracheostomy and hospice care will have MDS reviewed for accuracy all inaccuracies will be modified as indicated**. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **IDT team will be re-educated on the MDS process and accuracy of MDS** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON or Designee will review 5 MDS/week for accuracy and modifications will be made as indicated**. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make	

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	A Physician's Order, dated 7/6/23, indicated the resident was admitted to hospice. Interview with the Director of Nursing on 8/25/23 at 11:00 a.m., indicated hospice should have been coded on the Significant Change MDS assessment. 3. The record for Resident 60 was reviewed on 8/22/23 at 1:57 p.m. Diagnoses included, but were not limited to, anoxic brain damage and chronic obstructive pulmonary disease (COPD). The Significant Change Minimum Data Set (MDS) assessment, dated 5/17/23, indicated the resident was receiving tracheostomy (trach - a surgical airway in the neck/trachea to allow breathing) care while a resident of the facility. A Physician's Order, dated 9/1/22 and listed as current on the August 2023 Physician's Order Summary (POS), indicated the resident's tracheostomy stoma was to be cleansed with normal saline and covered with a dry dressing daily and as needed (PRN). Interview with the MDS Coordinator on 8/25/23 at 9:29 a.m., indicated the resident's trach had been removed and she just had a stoma. The MDS had been coded inaccurately related to tracheostomy care. 3.1-31(i)		recommendations to revise the plan of correction as indicated.	
F 0644 SS=D 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			

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	subpart C of this part to the maximum extent practicable to avoid duplicative testing and 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 record review and interview, the facility failed to ensure a resident with diagnoses of mental illness received a new Level 1 PASARR (Preadmission Screening and Resident Review) for 1 of 1 residents reviewed for PASARR. (Resident 22) Finding includes: The record for Resident 22 was reviewed on 8/24/23 at 10:30 a.m. The resident was admitted to the facility on 11/4/21. Diagnoses included, but were not limited to, bipolar disorder and schizoaffective disorder. The 8/14/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. A Level 1 PASARR, completed on 10/20/2016 (prior to the resident's admission to the facility), indicated a PASARR Level 2 was not required. There was no other Level 1 PASARR completed	F 0644	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #22 had a new Level I completed by the Social Services Director by date of compliance. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents with a mental health diagnosis have the potential to be affected by the alleged deficient practice; The SSD will perform a 100% audit of all residents to determine accurate and up-to-date Level Is are completed and therefore also determine the need for any Level IIs to be completed based on any current and new mental health diagnoses. 100%	09/22/2023

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	after 10/20/16. Interview with the Social Service Director on 8/22/23 at 11:45 a.m., indicated she was not aware the resident had a mental illness diagnosis and she did not have a Level 2 completed. 3.1-16(d)(1)(A)		audit to be completed by the facility SSD by date of compliance. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Administrator/designee to re-educate Social Services on the need to ensure up-to-date and accurate Level Is and Level IIs are completed based on each resident's mental health diagnoses. Education to be completed by date of compliance. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/MDS/designee will conduct an audit of all new admissions 1 X weekly for 6 months to determine accuracy of Level I's for all new admissions. In addition, the SSD will perform an audit every 2 weeks for 6 months to cross reference the facility's psychiatric MD/NP visits to ensure all new diagnoses are monitored and new Level I's are completed timely. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make	

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

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	whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.			
	Based on observation, record review, and interview, the facility failed to complete a Care Plan related to hospice care and oxygen use for 1 of 30 Care Plans reviewed. (Resident 37) Finding includes: On 8/21/23 at 10:40 a.m., Resident 37 was observed in his room. He was wearing oxygen by the way of a nasal cannula. The record for Resident 37 was reviewed on 8/24/23 at 9:34 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance and Alzheimer's disease. The Significant Change Minimum Data Set (MDS) assessment, dated 7/19/23, indicated the resident was moderately impaired for daily decision making and he was not receiving hospice services while a resident of the facility. The resident was also identified as receiving oxygen. A Physician's Order, dated 7/6/23, indicated the resident was admitted to hospice. A Physician's Order, dated 7/7/23, indicated the	F 0656	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #37's care plan was updated to reflect the use of oxygen and hospice services II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Any resident receiving hospice services or on oxygen has the potential to be affected by the alleged deficient practice. ="" b=""> III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; MDS coordinator/designee will conduct a care plan audit to ensure residents care plans are accurate and up to date. Audits will be completed as follows: 8 residents care plans a week until all residents care plans have been	09/22/2023

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	resident was to receive oxygen at 2 liters per nasal cannula continuously. The resident's Care Plan was revised on 7/14/23. He had no Care Plan related to hospice care and oxygen use. Interview with the Director of Nursing on 8/24/23 at 3:00 p.m., indicated the resident should have had a care plan related to hospice and oxygen. 3.1-31(e)		reviewed for accuracy and updated as needed. ="" span=""> IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee will audit the order listing report to ensure any resident placed on hospice services and/or new orders for oxygen usage also has a care plan reflecting the same. Audits will be completed 5x a week x 4week, 2x a week x 4 weeks, weekly x 4 weeks then monthly x 3 months The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;			
	Based on observation, record review, and interview, the facility failed to ensure dependent residents received assistance with ADL's (activities of daily living) related to nail care for 4 of 7 residents reviewed for ADL's. (Residents 63,	F 0677	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents #63, #27, #35, #68 received nail care	09/22/2023

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	27, 35, and 68) Findings include: 1. On 8/21/23 at 1:55 p.m., Resident 63 was observed in his room in bed. His fingernails on both hands were long and in need of trimming. On 8/22/23 at 9:04 a.m. and 2:10 p.m., the resident's fingernails remained long. On 8/23/23 at 7:55 a.m. and 11:04 a.m., the resident's fingernails remained long. On 8/24/23 at 9:15 a.m., 10:07 a.m., 1:35 p.m., and 2:45 p.m., the resident's fingernails remained long and were in need of trimming. The record for Resident 63 was reviewed on 8/24/23 at 1:44 p.m. Diagnoses included, but were not limited to, stroke and hemiplegia (muscle weakness on one side of the body). The Annual Minimum Data Set (MDS) assessment, dated 6/23/23, indicated the resident was cognitively impaired for daily decision making and he required extensive assistance with personal hygiene. Documentation in the "task" section of the resident's record, indicated he had received a shower on 8/17, 8/21, and 8/24/23. Interview with the Director of Nursing on 8/24/23 at 3:00 p.m., indicated the resident's fingernails should have been trimmed at least weekly. 2. During random observations on 8/21/23 at 2:45 p.m., 8/22/23 at 10:30 a.m. and 2:20 p.m., 8/23/23 at 8:30 a.m., and 8/24/23 at 8:40 a.m. and 10:05 a.m., Resident 27 was observed with long dirty		on 8/28 II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Any resident who requires assistance with nail care has the potential to be affected by the alleged deficient practice. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee to educate nursing staff on performing ADL care to include nail care. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee will conduct an ADL audit to ensure nail care is being rendered per residents POC. Audits will be completed for 2 residents per unit (total of 8 residents) 5x week for 4 weeks, 2x week for 4 weeks, weekly x 4 weeks then monthly x 3 months The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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fingernails on both hands.

The record for Resident 27 was reviewed on 8/22/23 at 2:38 p.m. Diagnoses included, but were not limited to, multiple sclerosis, stroke, dementia, and contracture of the right hand.

The 7/27/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact. The resident needed extensive assist with a 2 person physical assist for personal hygiene and was totally dependent on staff for bathing.

A Care Plan, revised on 4/22/22, indicated the resident needed staff assistance for all activities of daily living.

There was no documentation the resident refused personal hygiene care and that her nails were trimmed and cleaned.

Interview with the Director of Nursing on 8/24/23 at 2:00 p.m., indicated the resident's nails were to be cleaned and trimmed.

3. During random observations on 8/21/23 at 10:55 a.m. and 3:02 p.m., 8/22/23 at 9:25 a.m. and 2:20 p.m., 8/23/23 at 8:30 a.m. and 1:43 p.m., and 8/24/23 at 8:40 a.m. and 10:05 a.m., Resident 35 was observed with long and dirty fingernails on both hands.

The record for Resident 35 was reviewed on 8/22/23 at 1:52 p.m. The resident was admitted to the facility on 8/1/23. Diagnoses included, but were not limited to, stroke and high blood pressure.

The Admission Minimum Data Set (MDS)

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assessment, dated 8/8/23, indicated the resident was not cognitively intact. The resident needed extensive assist with 1 person physical assist for personal hygiene.

A Care Plan, dated 8/2/23, indicated the resident had an activities of daily living self care deficit related to a stroke.

There was no documentation the resident refused personal hygiene care and that his nails were trimmed and cleaned.

Interview with the Director of Nursing on 8/24/23 at 2:00 p.m., indicated the resident's nails should have been cleaned and trimmed.

4. During random observations on 8/21/23 at 10:52 a.m. and 3:03 p.m., 8/23/23 at 8:30 a.m., and 8/24/23 at 8:40 a.m. and 10:05 a.m., Resident 68 was observed with long and dirty fingernails on both hands.

The record for Resident 68 was reviewed on 8/22/23 at 2:10 p.m. Diagnoses included, but were not limited to, dementia with mild behavioral disturbance and anxiety, bipolar disorder, stroke, and depressive disorder.

The Modification of the Quarterly Minimum Data Set (MDS) assessment, dated 5/22/23, indicated the resident was not cognitively intact and he was totally dependent with 1 person physical assist for personal hygiene.

A Care Plan, revised on 2/3/22, indicated the resident had an activities of daily living self care deficit related to a stroke.

There was no documentation the resident refused

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	personal hygiene care and that his nails were trimmed and cleaned. Interview with the Director of Nursing on 8/24/23 at 2:00 p.m., indicated the resident's nails were to be cleaned and trimmed. 3.1-38(a)(3)(E)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.			
	Based on observation, record review, and interview, the facility failed to ensure an ongoing activity program was implemented for alert and oriented, cognitively impaired, and dependent residents for 2 of 5 residents reviewed for activities. (Residents 63 and 10) Findings include: 1. On 8/21/23 at 1:55 p.m., Resident 63 was observed in his room in bed. The resident was awake and his television was turned off. On 8/22/23 at 9:04 a.m. and 2:10 p.m., the resident was observed in his room in bed. The resident was awake and his television was turned off.	F 0679	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents #63 and #10 had a new Comprehensive Activity Assessment completed with the collaboration of family as needed. The focus to be on 1:1 activities. The Activity Director to complete by date of compliance II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be	09/22/2023

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	On 8/23/23 at 7:55 a.m., the resident was observed in his room in bed. The resident was awake and his television was turned off. On 8/24/23 at 9:15 a.m., 10:07 a.m., 1:35 p.m., and 2:45 p.m., the resident was observed in his room in bed. The resident was awake and his television was turned off. The record for Resident 63 was reviewed on 8/24/23 at 1:44 p.m. Diagnoses included, but were not limited to, stroke and hemiplegia (muscle weakness on one side of the body). The Annual Minimum Data Set (MDS) assessment, dated 6/23/23, indicated the resident was cognitively impaired for daily decision making and he required extensive assistance with transfers. It was somewhat important for the resident to have things to read, listen to music, and keep up with the news. A Care Plan, dated 6/26/23, indicated the resident had a potential for decreased activity/recreational involvement due to receiving one to one room visits. His interests were watching television in his room. Interventions included, but were not limited to, provide in room activities as requested and needed. The Activity Assessment, dated 6/26/23, indicated the resident's current interests were television, movies, music, and current events. The resident was to receive one-to-one visits three times a week on Monday, Wednesday, and Friday.		affected by the alleged deficient practice. The Activity Director will perform a 100% audit of all residents to determine accurate and up-to-date Activity Assessments – particularly related to 1:1 activities. 100% audit to be completed by the facility Activity Director by date of compliance. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Administrator/designee to re-educate Activity Director and Staff on the need to ensure up-to-date Activity Assessments and participation records of residents in group and 1:1 activities are according to each resident preference. Education to be completed by date of compliance. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Administrator/designee will conduct an audit of group activity participation and 1:1 activity participation 3 X weekly for 4 weeks, 1 X week for 4 week, then monthly x 4 months to ensure participation of residents in activities per resident preference. The results of these audits will be reviewed in Quality Assurance	

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	One to one documentation for August 2023, indicated the resident had only received one, one-to-one visit on 8/16/23, which consisted of sensory stimulation, conversation, and music. Interview with the Activity Director on 8/25/23 at 12:35 p.m., indicated the resident should have received one-to-one visits three times a week and his television should have been turned on. 2. An interview with Resident 10 on 8/21/23 at 12:55 p.m., indicated she would love to go activities, but no one ever comes to get her. She would like to go to church. On 8/22/23 from 9:00 a.m. until 2:20 p.m., the resident remained in her room and did not participate in any group activities. The record for Resident 10 was reviewed on 8/22/23 at 2:25 p.m. Diagnoses included, but were not limited to, stroke, vascular dementia with behaviors, major depressive disorder, and delusional disorder. The 1/13/23 Annual Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact and it was somewhat important to read or to have available newspapers and books, listen to music, keep up with the news, and do her favorite activities. The 8/4/23 Quarterly MDS assessment, indicated the resident was cognitively intact and needed extensive assist with 1 person physical assist for locomotion on and off the unit. A Care Plan, revised on 9/9/19, indicated the resident had the diagnosis of depression. The approaches were for 1 to 1 staff visits as needed		Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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and to encourage socialization and participation in activities of her choice and interest.

A Care Plan, revised on 9/16/19, indicated the resident was dependent on staff for sensory stimulation. The approaches were to provide drop by visits, give the resident verbal reminders of an activity before commencement of the activity, and post an activity schedule in the resident's room.

The last documented Annual Activity Assessment was dated 3/22/22, which indicated the resident's current interests were spiritual programs, current events, television/music and books to read. The information was provided by the resident.

The 8/7/23 Quarterly/Annual Participation Review indicated the resident enjoyed watching television in her own room and her activity participation was stop by visits.

The Activity participation in the last 30 days indicated the resident did not attend worship or church.

The 1 to 1 activity log for 8/2023, indicated the resident was to receive multi-stimulation three times a week. The only documented visit was on 8/16/23 for the entire month.

Interview with Activity Aide 1 on 8/24/23 at 3:30 p.m., indicated the resident had not attended church services. She was unaware if the resident received 1 to 1 visits as another activity aide did those. They had been without an Activity Director "for a minute."

Interview with Activity Aide 2 on 8/24/23 at 3:30 p.m., indicated she did the 1 to 1 visits, however,

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	she was off for some time earlier in the month. Interview with the Activity Director on 8/25/23 at 10:45 a.m., indicated she has had some staffing challenges and just recently hired an activity aide to do 1 to 1 visits. The resident had not participated in church services this month. 3.1-33(a) 3.1-33(b)(8)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			
	Based on observation, record review, and interview, the facility failed to ensure areas of skin discoloration and scabbing were assessed and monitored for 2 of 2 residents reviewed for skin conditions non-pressure related. (Residents 97 and 45) Findings include: 1. On 8/21/23 at 10:45 a.m., Resident 97 was observed with numerous areas of reddish purple discoloration to both of his arms and his right hand. He was wearing a short sleeve shirt at that time. No geri sleeves (a protective layer of fabric that is worn on the arms to prevent skin damage) were in use.	F 0684	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents #97 and #45 had no adverse outcomes related to the alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. A full house skin sweep with be completed by date of compliance to ensure all areas	09/22/2023

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	On 8/22/23 at 9:04 a.m., the discoloration remained to his right arm and his right hand. The resident had a geri sleeve in place to his left arm but not his right. He was wearing a short sleeve shirt. Interview with the resident at that time, indicated he did not know how he got the areas but they wanted him to wear the sleeves on his arms. On 8/23/23 at 7:55 a.m., the resident was in his room in bed. No geri sleeves were in use and he was wearing a short sleeve shirt. The reddish/purple discoloration remained to both of his arms and his right hand. The record for Resident 97 was reviewed on 8/22/23 at 3:13 p.m. Diagnoses included, but were not limited to, congestive heart failure, chronic obstructive pulmonary disease (COPD), and renal dialysis. The Significant Change Minimum Data Set (MDS) assessment, dated 6/22/23, indicated the resident was moderately impaired for daily decision making and he required extensive assistance with bed mobility and limited assistance with transfers. The resident did not have a care plan related to the bruising. A Physician's Order, dated 8/21/23, indicated the resident was to have geri sleeves to his bilateral arms every shift for preventative care. The sleeves could be removed for hygiene purposes. A Weekly Skin assessment, dated 8/15/23, indicated the resident's skin was intact. No areas of bruising were documented. There was no order to monitor the discoloration to		have been identified. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee to educate nursing staff on "Skin Condition Assessment and Monitoring-Pressure and Non-Pressure" to include areas of discoloration and scabbing. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee to conductrandom visual observation rounds three times weekly times 4 weeks, then weekly times 4 weeks, then monthly x 4 months to ensure any areas of discoloration or scabbing have been identified. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

the resident's bilateral arms and hands.

Interview with the Director of Nursing on 8/24/23 at 3:00 p.m., indicated LPN 3 was instructed on 8/21/23 to get an order for geri-sleeves and to complete a skin assessment related to the areas of discoloration.2. On 8/21/23 at 10:33 a.m., Resident 45 was observed with a left swollen foot, scabs were present on the second toe, fourth toe, and inner left ankle. The resident indicated he told the staff he wanted to go to the emergency room.

Resident 45 was sent to the emergency room on 8/21/23.

The record for Resident 45 was reviewed on 8/23/23 at 11:00 a.m. Diagnoses included, but were not limited to, hyperlipidemia, chronic obstructive pulmonary disease, cellulitis of unspecified part of the limb, amputation of left great toe, hypertension, and peripheral vascular disease.

The Quarterly Minimum Data Set (MDS) assessment, dated 8/1/23, indicated the resident required limited assistance with bed mobility, transfers, dressing, eating, toileting, and bathing.

A Care Plan, dated 8/1/23, indicated the resident was on antibiotic therapy related to cellulitis.

A Physician's Order, dated 8/22/23, indicated to monitor the scab to the left ankle every shift, to monitor the scab to the left foot inner, every shift, to monitor the scab to the left foot 4th toe every shift for changes.

Skin Observations, from 8/11/23 through 8/21/23, indicated "not applicable, none of the above observed, or resident not available". There was no

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documentation of swelling to the left foot, scrapes to the second left toe, fourth toe, or inner ankle.

A Discharge Summary, dated 8/21/23, indicated Resident 45 had an amputation of the left great toe, excoriations (raw or irritated skin), on the medial aspect of the left foot, and erythema (redness) of the left foot, the left lower leg, the right lower leg, and the right foot.

Interview with the Director of Nursing (DON) on 8/24/23 at 2:50 p.m., indicated she wanted to go see the foot scabs on the resident's foot for herself, and she would get the assessment from the ER visit the day before.

During a follow up Interview with the DON on 8/25/23 at 8:54 a.m., she provided the hospital assessment of Resident 45's foot and indicated the resident cellulitis is probably why the foot looked scabbed. Skin assessments by staff should have indicated what was seen on the skin.

A facility policy titled, "Skin Condition Assessment & Monitoring - Pressure and Non-Pressure", provided as current by the DON on 8/25/23 at 11:10 a.m., indicated... " Non-pressure skin conditions (bruises/contusions, abrasions, lacerations, rashes, skin tears, surgical wounds, etc,) will be assessed for healing progress and signs of complications or infection weekly". The "Skin Condition Assessment & Monitoring" policy also indicated, ... "A wound assessment will be initiated and documented in the resident chart when pressure and/or other non-pressure skin conditions are identified by licensed nurse".

3.1-37(a)

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	155580	A. BUILDING 00 B. WING	08/25/2023

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on observation, record review, and interview, the facility failed to ensure fall precautions were in place for a resident with a history of falls for 1 of 2 residents reviewed for accidents. (Resident 52) Finding includes: On 8/21/23 at 10:35 a.m., Resident 52 was observed standing in her room reaching towards the over bed table. She was dressed in only a hospital gown and wearing plain gray socks. The socks did not have a non-skid surface. Her gown was falling off of her shoulder and she was unsteady on her feet. She was attempting to walk in the room and was redirected by the surveyor to sit back down on the bed. The resident's breakfast tray, which she had already finished, was on the over bed table. On 8/24/23 at 8:40 a.m., the resident was observed in bed with her eyes closed and dressed in a hospital gown. At 10:05 a.m., she was still in bed and her eyes were closed. The head of the bed was elevated, and her head was leaning to one side. The breakfast tray was placed in front of her on the over bed table.	F 0689	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #52 had no adverse outcomes related to the alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice; DON/designee to complete a 100% fall intervention audit by 9/29/23. **span="">** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;DON/designee to re-educate nursing staff on ensuring fall interventions are in place as preventative measures. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance	09/22/2023

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	The record for Resident 52 was reviewed on 8/24/23 at 11:30 a.m. Diagnoses included, but were not limited, major depressive disorder, high blood pressure, hallucinations, bipolar disorder, dementia, and catatonic disorder. The 7/7/23 Significant Change Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact. The resident was a limited assist with a 2 person physical assist for transfers and for walking in the room. There were no history of falls since the last assessment. A Care Plan, revised on 8/25/23, indicated the resident was at risk for falls. The approaches were to follow the facility's fall protocol and to educate the staff to assist the resident to get up by breakfast. The 6/5/23 Fall Risk Assessment, indicated the resident was a high risk for falls. A Fall-Initial Occurrence Note, dated 6/5/23 at 10:50 a.m., indicated the resident had an unwitnessed fall in her room by the bed. The sheets were off of the bed and under the resident. A Fall IDT Note, dated 6/6/23 at 8:52 a.m., indicated the root cause of the fall was the resident attempted to self transfer herself and she required assistance with transfers. An intervention was included on the Care Plan which was to educate the staff on having the resident up and dressed and in the wheelchair by breakfast. Interview with the Director of Nursing (DON) on 8/24/23 at 2:00 p.m., indicated the resident was supposed to be up and dressed by breakfast and for her safety, to have non-skid socks on her feet.		program will be put into place;DON/designee will conduct a fall intervention audit as follows: Audits will be completed on 10 residents at risk for falls weekly for 8 weeks, then 10 residents monthly x 4 months The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	The current and revised 11/21/17 "Fall Prevention Program" policy, provided by the DON on 8/25/23 at 11:10 a.m., indicated fall/safety interventions may include but were not limited to: footwear would be monitored to ensure the resident had proper fitting shoes and/or footwear was non skid. 3.1-45(a)(2)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.			
	Based on observation, record review, and interview, the facility failed to care for a PICC line (peripherally inserted central catheter, intravenous catheter placed into the peripheral veins of the upper arm) in accordance with professional standards of practice, related to flushing the PICC line for 1 of 1 residents reviewed for intravenous care. (Resident 379) Finding includes: On 8/23/23 at 9:02 a.m., LPN 2 was observed passing medication to Resident 379. He prepared the cefepime (an antibiotic medication) 2 grams. He primed new intravenous (IV) tubing, cleaned the right upper arm PICC access lumen with an alcohol swab, flushed the PICC with 5 milliliters (ml) of normal saline, attached the IV tubing containing the cefepime, and started the IV infusion.	F 0694	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #379s orders were reviewed and revised as appropriate. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Any resident receiving IV medication has the potential to be affected by the alleged deficient practice. Any resident with a PICC line will have their orders reviewed and revised as needed by date of compliance. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	09/22/2023

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	At 9:44 a.m., LPN 2 was observed disconnecting the IV tubing after the medication had completed infusing. He flushed the PICC with 5 ml of normal saline, flushed the PICC with 5 ml of heparin (an anticoagulant), and applied a new cap to the lumen. Resident 379's record was reviewed on 8/23/23 at 9:56 a.m. Diagnoses included, but were not limited to, osteomyelitis, type 2 diabetes mellitus, and hypertension. A Physician's Order, dated 8/19/23, indicated cefepime 2 g (grams) every 12 hours (9 a.m. and 9 p.m.) intravenously for 28 days. A Physician's Order, dated 8/22/23, indicated heparin lock flush 5 ml intravenously every 12 hours (9 a.m. and 9 p.m.). A Physician's Order, dated 8/22/23, indicated saline flush 5 ml intravenously every 12 hours (9 a.m. and 9 p.m.). There were no Physician's Orders to indicate the PICC was to be flushed with saline before and after the administration of the antibiotic medication. The Medication Administration Record (MAR), dated 8/2023, indicated the cefepime had been administered as ordered starting on 8/19/23. There were no documented saline or heparin flushes to the PICC line until 8/22/23. Interview with the Director of Nursing (DON) on 8/23/23 at 2:31 p.m., indicated LPN 2 had administered the medication and flushed the PICC correctly, however, the orders for the flushes had been entered in the computer late and incorrectly. Staff should have flushed the PICC with saline before and after each antibiotic administration,		DON/designee will educate nurses on following physicians orders regarding PICC line care. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee will conduct audits on residents with PICC lines to ensure the nurse is following physicians orders related to flushes. Audits will be conducted on 5 residents a week x 8 weeks, then 5 residents a month x 4 months The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	and then flushed with heparin last. 3.1-47(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.			
	Based on observation, record review, and interview, the facility failed to provide proper respiratory care and services related to oxygen at the correct flow rate for 2 of 2 residents reviewed for oxygen. (Residents 37 and 35) Findings include: 1. On 8/21/23 at 10:40 a.m., Resident 37 was observed with oxygen by the way of a nasal cannula in use. The resident's oxygen concentrator was set at 3 1/2 liters. On 8/22/23 at 9:19 a.m. and 2:10 p.m., the resident was wearing his oxygen per nasal cannula and his oxygen concentrator was set at 3 1/2 liters. On 8/23/23 at 7:55 a.m., the resident was in his room in bed. His oxygen per nasal cannula was in use and the concentrator was set at 4 liters. At 11:05 a.m., the resident was in the main dining room. His oxygen was in use and his portable oxygen tank was set at 4 liters.	F 0695	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #37 and #35 oxygen concentrators are set at the correct liter flow rate. Neither resident has any adverse outcomes related to the alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents who receive oxygen have the potential to be affected by the alleged deficient practice. All residents with oxygen were audited to ensure the settings are at the correct liter flow rate. III. What measures will be put into place and what systemic changes will be made to ensure that the	09/22/2023

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	On 8/24/23 at 9:16 a.m., the resident was in his room in bed sleeping. His oxygen was in use and his concentrator was set at 1 1/2 liters. At 10:27 a.m., the resident was in the main dining room. His oxygen was in use and his portable oxygen tank was set at 4 liters. The record for Resident 37 was reviewed on 8/24/23 at 9:34 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, Alzheimer's disease, congestive heart failure, and chronic obstructive pulmonary disease (COPD). The Significant Change Minimum Data Set (MDS) assessment, dated 7/19/23, indicated the resident was moderately impaired for daily decision making and he was receiving oxygen while a resident of the facility. The resident did not have a Care Plan related to oxygen use. A Physician's Order, dated 7/6/23, indicated the resident could start oxygen at 2 liters per nasal cannula and titrate to 4 liters to maintain oxygen saturations above 90% every 8 hours as needed (PRN) for preventative. A Physician's Order, dated 7/7/23, indicated the resident was to receive oxygen at 2 liters per nasal cannula continuously. Interview with the Director of Nursing on 8/24/23 at 3:00 p.m., indicated the resident's oxygen order needed to be clarified. 2. During random observations on 8/21/23 at 10:55 a.m. and 3:02 p.m., 8/22/23 at 9:25 a.m. and 2:20 p.m., and 8/23/23 at 8:30 a.m., Resident 35 was observed wearing		deficient practice does not recur; DON/designee to educate nursing staff on following physicians orders for the correct oxygen liter flow rate. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee will conduct an oxygen audit to ensure correct liter flow rate. Audits will be conducted on 10 residents a week x 4 weeks then 10 residents a month x 5 months The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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oxygen per a nasal cannula. The flow rate was set at 3.5 liters per minute via the concentrator tank.

On 8/23/23 at 1:43 p.m., the resident was seated in a wheelchair in his room. He was observed wearing his oxygen per nasal cannula and it was connected to a portable tank hanging on the back of his wheelchair. The oxygen tank was set on 2 liters per minute.

On 8/24/23 at 8:40 a.m., the resident was observed sitting on the side of the bed, waiting for breakfast. He was observed with the nasal cannula in his nose and the tubing was connected to the concentrator tank, however, the oxygen was turned off.

On 8/24/23 at 10:05 a.m., the resident was observed lying in bed and he was awake. The oxygen concentrator was turned on and the flow rate was set at 3.5 liters per minute.

The record for Resident 35 was reviewed on 8/22/23 at 1:52 p.m. The resident was admitted to the facility on 8/1/23. Diagnoses included, but were not limited to, stroke, chronic obstructive pulmonary disease (COPD), and high blood pressure.

The Admission Minimum Data Set (MDS) assessment, dated 8/8/23, indicated the resident was not cognitively intact. The resident received oxygen while a resident.

A Care Plan, dated 8/2/23, indicated the resident had COPD.

Physician's Orders, dated 8/2/23, indicated oxygen at 3 liters per nasal cannula.

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	Interview with the Director of Nursing on 8/24/23 at 2:00 p.m., indicated the resident's oxygen was to be at 3 liters per minute. 3.1-47(a)(6)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.			
	Based on record review and interview, the facility failed to monitor a fluid restriction for a resident receiving hemodialysis for 1 of 1 residents reviewed for dialysis. (Resident 46) Finding includes: The record for Resident 46 was reviewed on 8/24/23 at 9:45 a.m. Diagnoses included, but were not limited to, end stage renal disease and dependence on renal dialysis. The 7/26/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and received dialysis while a resident. A Care Plan, revised on 8/1/22, indicated the resident received hemodialysis three times a week. The approaches were to check the perma cath (dialysis access port in the upper chest) site every shift and record and encourage diet as ordered. Physician's Orders, dated 4/26/23, indicated hemodialysis three times a week on Tuesday, Thursday, and Saturday. Provide a renal, no	F 0698	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;Resident II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Any resident on a fluid restriction has the potential to be affected by the cited practice. An audit was completed on any resident on a fluid restriction to ensure their fluid restriction is being monitored as per orders. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;DON/designee to educate nurses on documenting the amount of fluid the resident consumed as per physicians orders.	09/22/2023

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	added salt regular texture diet. Serve double proteins every meal and follow a 1.8 liter fluid restriction with 600 milliliters (ml) every shift. The Treatment and Medication Administration Records (TAR) and (MAR) for 7/2023 and 8/2023, indicated there was no documentation the fluid restriction was monitored by nursing staff. Interview with the Director of Nursing on 8/24/23 at 2:00 p.m., indicated there was no documentation to indicate how the nurses were monitoring the fluid restriction. The current 2017 "Fluid Restriction " policy, provided by the Director of Nursing on 8/25/23 at 11:10 a.m., indicated fluid restrictions were typically ordered in total milliliters allowed per day which then must be divided among nursing, dining services, and activities. The amount allowed at meals was usually indicated on the individual's meal card. Nursing services were recommended to include the amount allocated with medications on the MAR or an other flow sheet. 3.1-37(a)		IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee to conduct an audit on any resident with a fluid restriction to ensure the residents allotted amount is being documented. Audits will be conducted on 5 residents a week for 4 weeks, 2 residents a week for 4 weeks, then 5 residents a month x 4 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and			

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	(iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.			
	Based on record review and interview, the facility failed to ensure there was an adequate indication	F 0758	I. What corrective action(s) will be accomplished for those residents	09/22/2023

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	for the use of a hypnotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 52) Finding includes: The record for Resident 52 was reviewed on 8/24/23 at 11:30 a.m. Diagnoses included, but were not limited, major depressive disorder, hallucinations, bipolar disorder, dementia, and catatonic disorder. The 7/7/23 Significant Change Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact. In the last 7 days, the resident had received an anti-anxiety medication 7 times. There was no Care Plan for a hypnotic medication. Physician's Orders, dated 7/26/23, indicated Temazepam (a hypnotic medication) oral capsule 15 milligrams (mg), give 1 capsule by mouth every day. An After Care Summary from the hospital, dated 7/26/23, indicated to continue the medication of Temazepam 15 mg daily. There was no indication for the use of the hypnotic medication. Interview with the Director of Nursing on 8/25/23 at 11:10 a.m., indicated she had just spoken to the resident's Physician and he discontinued the Temazepam. 3.1-48(a)(4)		found to have been affected by the deficient practice; Resident #52 discharged from the facility on 8/30/23. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents who receive a hypnotic medication has the potential to be affected by the alleged deficient practice. An audit will be completed on any resident who receives a hypnotic medication to ensure they have an indication for use. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee to educate nursing staff on ensuring any resident who receives an order for a hypnotic drug has the indication for use. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee will audit new orders to ensure any hypnotic drug has the indication for use present. Audits will be conducted 5x a week for 4 weeks, 2x week for 4 weeks, weekly x 4 weeks then monthly x 3 months The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or	

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			until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, record review, and interview, the facility failed to ensure a controlled substance was double locked at all times for 1 of 2	F 0761	I. What corrective action(s) will be accomplished for those residents found to have been affected by the	09/22/2023

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	medication rooms observed. (PCU) Finding includes: On 8/22/23 at 1:23 p.m., the PCU Medication Room was observed with LPN 1. Inside the unlocked refrigerator was a black tackle box. The box was not locked. Inside the box was a medication card of dronabinol (Marinol) pills. Interview with LPN 1 at that time, indicated the black box was normally locked. She wasn't sure why it was not locked currently. She would notify the Director of Nursing (DON). Interview with the DON on 8/22/23 at 1:46 p.m., indicated earlier in the day the QMA had notified her the lock on the black box had broken. They had requested a new lock from the pharmacy, and it was coming in tonight. She had asked the Maintenance staff to go to the store and get a lock until the new lock arrived from pharmacy, but they had not gotten to it yet. A facility policy, titled "Medication Storage," indicated, "...12. Controlled substances storage...12.2. After receiving controlled substances and adding to inventory, facility should ensure that schedule II-V controlled substances are immediately placed into a secured storage area (i.e., a safe, self-locked cabinet or locked room, in all cases in accordance with Applicable Law) and double locked (i.e. locked narcotic drawer inside locked medication cart or locked box in locked medication room)..." The U.S. Department of Justice Drug Enforcement Administration Drugs of Abuse Guide, dated 2020, indicated dronabinol was a Schedule III medication.		deficient practice; The medication in the PCU med room was secured as per policy. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. All facility medication rooms will be audited to ensure the proper storage of controlled substances. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee will educate nurses/QMA's on the policy "Medication Storage" to include the proper storage of controlled substances. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee will audit medication rooms to ensure all controlled substances are secured as per policy.Audits will be completed as follows: 3 Medication rooms per wk for 8 weeks, then 3 Medication Rooms monthly 4 months The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90%	

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	3.1-25(m)		compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.			
	Based on observation, record review, and interview, the facility failed to follow the puree recipe for scrambled eggs, sausage, and waffles for the 1 resident who received a pureed diet from the kitchen. (Main Kitchen) Finding includes: On 8/23/23 at 7:41 a.m., Cook 1 was observed preparing the puree breakfast meal. The cook donned clean gloves to both hands and placed 2 scoops of scrambled eggs from the pan into the blender. She blended the mixture until smooth and stirred the contents. She added 1 piece of bread to the egg mixture and blended again. She removed the blender and stirred the eggs and put them in an aluminum pan. She washed the blender and utensils in the 3 compartment sink. She removed 17 sausage links from the steam table and put	F 0804	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Dietary Manager/designee to re-educate dietary staff on following recipes for pureed diets. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Any resident who receives an altered diet have the potential to be affected by the alleged deficient practice. III. What measures will be put into place and what systemic changes will be made to ensure that the	09/22/2023

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	them into the blender and blended them. She added 1/2 cup of prepared chicken broth to the mixture and blended again. The cook removed the blender and stirred the contents and placed them into an aluminum pan. She washed the blender and the utensils in the 3 compartment sink. Cook 1 then removed 3 cooked waffles from the steam table and put them into the blender and blended them together. She walked over to another table and with a knife, cut off an unknown amount of butter and placed it into 2 cups of hot water. She poured a 1/2 cup of the water mixture into the blender and mixed everything together. She removed the blender, stirred the contents, and poured it into a pan. The puree scrambled egg recipe indicated milk was to be used to prepare the eggs. The puree sausage patty recipe indicated a pork or ham base was to be dissolved in water and used as well as toast. The puree waffle recipe indicated syrup and butter were to be added to the waffles. Interview with the Dietary Food Manager on 8/23/23 at 8:40 a.m., indicated the cook did not follow the recipes for the pureed eggs, sausage and waffles. 3.1-21(a)(1)		deficient practice does not recur;Dietary Manager/designee to re-educate dietary staff on following recipes for pureed diets. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Dietary Manager/designee to observe staff preparing pureed food to ensure the recipe is being followed. Audits will be conducted 5x a week x 4 weeks, 2x a week for 4 weeks, then monthly x 4 months . The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0812 SS=F 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			

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	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 and interview, the facility failed to store and serve food under sanitary conditions related to expired food in the reach in cooler, a dirty oven hood, grease build up on the stove, as well as touching food items with a gloved hand and the lack of hand hygiene after glove removal. This had the potential to affect the 125 residents who received their meals from the kitchen. (The Main Kitchen) Findings include: 1. Observation during the initial kitchen tour, on 8/21/23 at 9:15 a.m. with the Dietary Food Manager (DFM), indicated the following: a. There were 3 bowls of pudding, dated 8/16/23, in the reach in cooler. b. The flour scoop was stored directly in the flour. c. The oven hood had a heavy accumulation of dirt and grease noted in all the slats. d. There was a heavy accumulation of grease	F 0812	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Expired food was disposed of. The oven hood was cleaned. The grease build up on the stove was removed. Cook #1 was educated on glove use and hand hygiene. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Dietary manager/designee will educate dietary staff on the policy “Food Storage (Dry, Refrigerated and Frozen). Dietary staff will also	09/22/2023

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	build up on the back splash of the stove. e. The transportation cart that housed the dome lids for the plates was rusted out in many places. Interview with the DFM at that time, indicated all of the above was in need of cleaning. The current 2020 "Food Storage (Dry, Refrigerated, and Frozen)" policy, provided by the DFM on 8/23/23 at 9:42 a.m., indicated discard food that has passed the expiration date. Whipped topping prepared from a mix was to be discarded after 2 to 3 days. 2. On 8/23/23 at 7:41 a.m., Cook 1 was observed preparing the pureed meal. She donned a pair of clean gloves to both hands, however, she did not perform hand hygiene. She added the scrambled eggs to the blender and blended until smooth. She stirred the contents wearing the same gloves and with one of her gloved hands, she picked up a piece of bread and added it to the mixture. After the eggs were finished, wearing the same gloves to both hands, she washed the blender in the 3 compartment sink. She proceeded to puree sausage and waffles wearing the same gloves and she wore them while cleaning the blender in the 3 compartment sink. She removed her gloves and threw them away, however, she did not perform hand hygiene. Cook 1 proceeded to check the temperatures of the food on the steam table with her bare hands. After completing the temperature checks, she donned a pair of clean gloves to both hands to start plating the food for breakfast and did not perform hand hygiene. Interview with the Dietary Food Manager on		be educated on hand hygiene and glove use. A s IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Dietary manager/designee will conduct sanitations audits to ensure compliance. Audits will include glove use and hand hygiene. Audits will be completed 5x a week for 4 weeks, 2x a week for 4 weeks, then monthly x 4 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	8/23/23 at 8:40 a.m., indicated hand hygiene was to be performed after the gloves were removed. The current 2020 "Proper Hand Washing and Glove Use" policy, provided by the DFM on 8/23/23 at 9:42 a.m., indicated hands were to washed before donning gloves and after removing gloves. 3.1-21(i)(3)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable			

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	law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic			

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	services reports as required under §483.50. Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to medication administration and a dialysis access site for 1 of 5 residents reviewed for unnecessary medications and 1 of 1 residents reviewed for dialysis. (Residents 24 and 46) Findings include: 1. The record for Resident 24 was reviewed on 8/22/23 at 1:50 p.m. Diagnoses included, but were not limited to, atherosclerotic heart disease, congestive heart failure, and hypertension. The Quarterly Minimum Data Set (MDS) assessment, dated 6/6/23, indicated the resident was cognitively impaired and he had received an opioid medication during the assessment reference period. A Physician's Order, dated 5/5/23, indicated the resident was to receive Norco (a narcotic pain medication)10-325 milligrams (mg), 1 tablet three times a day for chronic pain. The August 2023 Medication Administration Record (MAR) indicated the resident's Norco was not signed out on the following dates and times: - 8:00 a.m. on 8/5/23 - 2:00 p.m. on 8/1, 8/5, and 8/11/23 - 10:00 p.m. on 8/19, 8/20, 8/21, and 8/22/23 The Norco had been signed out as being given on the controlled medication flowsheet. Interview with the Director of Nursing on 8/25/23 at 1:49 p.m., indicated the medication should have been signed out on the MAR as well as the	F 0842	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents 24 and 46 had no adverse outcomes related to the alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee to educate nursing staff on the policy for signing controlled substances out to include MAR/flow sheet documentation. Nurses will also be educated on the procedure for signing out all treatments/procedures on the TAR after completion.**="" bdon="" designee="" to="" educate="" nursing="" staff="" on="" the="" policy="" for="" signing="" controlled="" substances="" out="" mar="" and="" medication="" flowsheet.="" will="" also="" be="" educated="" all="" procedures="" treatments="" tar="" when="" completed.<="" p="">**	09/22/2023

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narcotic sheet.
2. The record for Resident 46 was reviewed on 8/24/23 at 9:45 a.m. Diagnoses included, but were not limited to, end stage renal disease and dependence on renal dialysis.

The 7/26/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact and received dialysis while a resident.

A Care Plan, revised on 8/1/22, indicated the resident received hemodialysis three times a week. The approaches were to check the perma cath (dialysis access port) site every shift and record and to encourage diet as ordered.

Physician's Orders, dated 4/27/23, indicated hemodialysis three times a week on Tuesday, Thursday, and Saturday. Check the site of the dialysis catheter every shift for drainage and condition of dressing, indicate: N=no drainage dressing intact and Y=see progress note and notify the doctor.

The Treatment Administration Record (TAR) for 8/2023, indicated the documentation for checking the site of the dialysis catheter every shift for drainage and condition of dressing, indicate: N=no drainage dressing intact and Y=see progress note and notify the doctor was inaccurate. A "Y" was documented on the day shift for 8/1, 8/3, 8/4, 8/7-8/13, 8/15, 8/17, and 8/20-8/22/23 and on the evening shift for 8/10, 8/12, 8/13, 8/19, and 8/22/23.

There was no documentation in Nursing Progress Notes regarding any drainage or anything about the catheter site.

="" bdon="" designee="" to="" educate="" nursing="" staff="" on="" the="" policy="" for="" signing="" controlled="" substances="" out="" mar="" and="" medication="" flowsheet.="" will="" also="" be="" educated="" all="" procedures="" treatments="" tar="" when="" completed.<="" p="">="" bdon="" designee="" to="" educate="" nursing="" staff="" on="" the="" policy="" for="" signing="" controlled="" substances="" out="" mar="" and="" medication="" flowsheet.="" will="" also="" be="" educated="" all="" procedures="" treatments="" tar="" when="" completed.="" p="">IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee will audit narcotics flow sheets to include MAR documentation. TAR audits will be completed to ensure all procedures/treatments are signed out on TAR when completed. Audits will be as follows: 8 residents a week x 4 weeks, 4 residents per week 4 weeks, then 4 residents monthly x 4 months.
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	Interview with the Director of Nursing on 8/24/23 at 2:00 p.m., indicated the nurses were incorrectly placing a "Y" instead of a "N" for checking the dialysis catheter site. 3.1-50(a)(2)		**and="" medication="" flowsheet.="" will="" also="" be="" educated="" all="" procedures="" treatments="" tar="" when="" completed.<="" p="">**="" bdon="" designee="" to="" educate="" nursing="" staff="" on="" the="" policy="" for="" signing="" controlled="" substances="" out="" mar="" and="" medication="" flowsheet.="" will="" also="" be="" educated="" all="" procedures="" treatments="" tar="" when="" completed.="" p=""> The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to dirty and stained floor tiles, marred walls, stained privacy curtains, dirty baseboards, and improper storage of wash basins and bed pans for 3 of 3 units. (North, South and PCU)	F 0921	I.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Room 106-walls were repaired, rust stains removed from bathroom floor, bedpan and basin and cleaned stored properly. Room 111-spillage on	09/22/2023

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	155580	A. BUILDING 00 B. WING	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE TOLLESTON PARK	2350 TAFT ST GARY, IN 46404

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	Findings include: During the environmental tour with the Maintenance and Housekeeping Supervisors on 8/25/23 at 1:12 p.m., the following was observed. 1. North Unit a. In Room 106, the room walls and bathroom walls were marred. There were rust stains on the floor around the toilet and there was a yellow bedpan and pink wash basin on the floor under the sink in the bathroom. The bed pan was placed inside the wash basin. There were 2 residents in the room and shared the bathroom. b. In Room 111, the tube feeding pole located next to bed 2 had dried tube feeding spillage on the base. There was also dried tube feeding on the ceiling above the tube feeding pump. The wall behind bed 2 was marred and there was black discoloration on the tile floor under the oxygen concentrator. The bathroom floor was scuffed and dirty. There was rust on the floor tile located around the toilet. Two residents resided in the room and shared the bathroom. c. In Room 112, the bathroom floor was scuffed and dirty looking. The walls in the room were marred. Two residents resided in the room and shared the bathroom. d. In Room 113, the bathroom ceiling vent was dusty. Two residents shared the bathroom. e. In Room 119, the privacy curtain was soiled with dried spillage. There was an accumulation of dirt and food crumb build up along the baseboard throughout the room. The tile floor throughout the room was dirty. The bathroom floor tile was		tube feeding pump cleaned, ceiling cleaned, walls repaired, black discoloration removed, bathroom floor cleaned, rust removed from tile around toilet. Room 112-bathroom floor cleaned; walls repaired. Room 113-bathroom ceiling fan cleaned. Room 119-privacy curtain cleaned, baseboards cleaned, tile floor cleaned, bathroom floor cleaned. Room 120-floor tile cleaned/replaced, walls repaired, bathroom floors cleaned. Wash basin replaced and stored properly; knobs placed on closet doors. Room 121-floors cleaned/repaired, walls marred, floor tiles in bathroom cleaned/repaired. Room 123-wall repaired, walls cleaned, baseboard repaired, bathroom floor /walls cleaned, caulk repaired around bathroom sink. Room 127- tile cleaned, overbed table cleaned, knob replaced on closet door, bathroom tile cleaned/repaired, privacy curtain cleaned. Room 129- privacy curtain cleaned, tile cleaned, bathroom walls repaired, rust removed from cold water knob on sink, baseboards cleaned. Room 205- walls/tile repaired, bathroom tile cleaned. Room 312-walls repaired, bed side stand replaced. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	

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	dirty with a black substance underneath the sink and around the toilet. Two residents resided in the room and shared the bathroom. f. In Room 120, the floor tile throughout the room was stained and dirty. The bathroom floor was dirty and the walls were marred. A wash basin was stored on the floor underneath the bathroom sink. No knobs were present on the closet doors. Two residents resided in this room and shared the bathroom. g. In Room 121, the floors were dirty and stained. The walls were also marred. The floor tile in the bathroom was stained and dirty. Two residents resided in the room and shared the bathroom. h. In Room 123, the wall behind bed 1 was marred. Dried food spillage was observed on the wall next to the side of bed 1. The baseboard was pulling away from the wall beneath the air conditioning/heating unit. The bathroom floor was dirty with a black substance. There was also spillage on the bathroom floors and walls. The caulk was cracked and paint was peeling around the bathroom sink. A dark substance was observed around the base of the toilet. Two residents resided in the room and shared the bathroom. i. In Room 127, the tile floor throughout the room was dirty and stained. The base of the overbed table for bed 2 had a thick accumulation of a black substance. A knob was missing on the closet door. The tile floor throughout the bathroom was dirty and stained. The privacy curtain was stained with dried food spillage. Two residents resided in this room and shared the bathroom. j. In Room 129, the privacy curtain was stained.		action(s) will be taken; The Maintenance Director/Housekeeping Supervisor performed a 100% audit of the facility regarding any needs for wall repair, cleaning of tube feeding spillage, and overall condition of each room. **="" span="">** **="" b="">** **III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Administrator/designee to educate Maintenance Director/Housekeeping Supervisor on ensuring a comfortable environment for all residents to include wall repairs, painting and cleanliness.="" b="">** **="" b="">** **IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Maintenance Director/designee will audit 5 resident rooms and 5 common area weekly for any necessary repairs. Audits will be completed x 6 months.="" b="">** **The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater**	

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	The tile floor in the room was dirty, stained, and had an accumulation of crumbs. The bathroom walls were marred and the floor tile was stained. The cold water knob on the sink had an accumulation of rust build up. There was an accumulation of dirt and debris along the baseboard in the bathroom. Two residents resided in the room and shared the bathroom. 2. South Unit In Room 205, the wall behind bed 1 was marred. The wall next to the side of the bed was also marred. A piece of floor tile was missing in the bathroom. The floor tile in the bathroom was discolored and a urine odor was present. One resident resided in this room. 3. PCU Unit In Room 312, the wall behind bed 1 was marred. A drawer was missing from the bed side stand. Two residents resided in this room. Interview with the Maintenance and Housekeeping Supervisors at that time, indicated all of the above were in need of cleaning and repair. The Housekeeping Supervisor indicated the floor stripper was broken and they were waiting for a new one and it should be delivered by next week. This Federal tag relates to Complaint IN00415961. 3.1-19(f)		**is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
F 9999 Bldg. 00	3.1-14 PERSONNEL	F 9999	. What corrective action(s) will be	09/22/2023

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	(k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure annual resident rights, abuse training, and dementia training was completed for 4 of 5 employee records reviewed. (CNA 1, Activity Aide 3, Housekeeper 1, and QMA 1) Findings include: The employee records were reviewed on 8/25/23 at 1:10 p.m., and indicated the following: a. CNA 1, hired on 9/25/20, had only completed 1 hour of annual dementia training for 2022. b. Activity Aide 3, hired on 5/5/21, had only completed 2 hours of annual dementia training for 2022.		accomplished for those residents found to have been affected by the deficient practice; CAN 1, Activity Aide 3, Housekeeper 1 and QMA 1 will have all training completed by date of compliance II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The HR director will compete a 100% audit on all employees to ensure their annual/new hire training has been completed by date of compliance. III. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur; ="" b="">The HR director will compete a 100% audit on all employees to ensure their annual/new hire training has been completed. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; HR Director will conduct an employee training audit as follows: All new hire employee training to be audited weekly x 6 months and 10 current employee training files completed each week until 100% compliant. ="" b=""> The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90%	

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	c. Housekeeper 1, hired on 12/15/18, did not complete annual training for resident rights, abuse or dementia for 2022. d. QMA 1, hired on 1/5/21, did not complete annual training for resident rights, abuse or dementia for 2022. Interview with the Human Resource Director on 8/25/23 at 1:50 p.m., indicated she was aware the above employees did not complete the required annual training for 2022.		compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	