STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155733	A. BUILDING 00 B. WING	05/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL NURSING HOME	119 N INDIANA AVE CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00379004. Complaint IN00379004 - Substantiated. Federal/State deficiencies related to the allegations are cited at F609 and F610. Survey dates: May 4, 5, 6, 9, and 10, 2022. Facility number: 000360 Provider number: 155733 AIM number: 100290370 Census Bed Type: SNF/NF: 30 Total: 30 Census Payor Type: Medicare: 1 Medicaid: 25 Other: 4 Total: 30 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/12/22.	F 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. Colonial Nursing and Rehab requests that the plan of correction be considered our allegation of compliance effective June 5, 2021 to the annual survey conducted on May 4-10, 2022 and request paper compliance.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents	F 0554	F554 Resident Self Admin Meds-Clinically Appropriate	06/02/2022

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

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

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	had Physician's Orders and an assessment to self administer their own medications for 1 of 5 residents reviewed for unnecessary medications. (Resident 1) Finding includes: On 5/4/22 at 2:45 p.m., Resident 1 was seated on the side of her bed resting her arms on her bedside table. She indicated she was feeling anxious. A bottle of saline nasal spray and a bottle of artificial tears eye drops were observed on the resident's bedside table. An albuterol sulfate inhaler was observed on the resident's nightstand. On 5/5/22 at 11:31 a.m., the resident was lying in bed. A staff member entered the room to check on the resident. The bottle of saline nasal spray and the bottle of artificial tears eye drops remained on the resident's bedside table. The albuterol sulfate inhaler remained on the resident's nightstand. On 5/6/22 at 12:05 p.m., Resident 1 was seated on the side of her bed eating her lunch. The bottle of saline nasal spray and the bottle of artificial tears eye drops remained on the resident's bedside table. The albuterol sulfate inhaler remained on the resident's nightstand. Resident 1's record was reviewed on 5/5/22 at 2:07 p.m. Diagnoses included, but were not limited to, hypertension, anxiety disorder, and COPD (chronic obstructive pulmonary disease). The Quarterly Minimum Data Set (MDS) assessment, dated 4/14/22, indicated the resident was cognitively intact.		***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** *Resident 1 immediately received a self-administration assessment and was determined safe to have the medications at bedside. A physician's order was obtained.* ***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;*** *A facility wide audit was done to determine if any other residents had medications at bedside. All residents with medication at bedside were reviewed to identify that orders and assessments were in place.* ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;*** Nursing employees will be in-serviced on the self-administration policy and procedure which will include obtaining physician orders and assessing for appropriateness of self-administration. Resident's will be monitored and audited to ensure that any resident self-administering medication is appropriate.	

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	The Physician's Order Summary, dated 5/2022, included the following orders: -Artificial Tears solution 1%, instill 1 drop in both eyes four times a day. May keep at bedside and administer per self. -Sodium Chloride solution 0.65% Deep Sea Nose spray, 1 spray to each nostril every hour for dryness. May self-administer. May keep at bedside -Albuterol Sulfate aerosol solution 90 mcg, inhale 2 puffs four times a day. There was lack of a Physician's Order for the self administration of the albuterol inhaler or any self administration assessment to indicate the resident could safely administer her own medications. Interview with the Director of Nursing (DON) on 5/09/22 at 11:45 a.m., indicated a self-administration assessment should have been completed. A Facility policy, titled "Self Administration of Medications," received as current from the DON, indicated "...3. The interdisciplinary team determines the resident's ability to self-administer medications by means of a skill assessment conducted on a quarterly basis. 4. The results of the interdisciplinary team assessment are recorded in the resident's medical record..." 3.1-25(m)		***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** A Performance Improvement Tool has been initiated that randomly checks three (3) residents to ensure that if they are self-administering medication the proper steps have been followed.This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee Weekly for four (4) weeks; then monthly for five (5) months. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. ***By what date the systemic changes will be made;*** *6/2/2022*	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident			

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	self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.			
	Based on record review and interview, the facility failed to assess a resident's personal preferences upon admission for 1 of 1 residents reviewed for choices. (Resident B) Finding includes: Resident B's record was reviewed on 5/5/22 at 1:51 p.m. Diagnoses included, but were not limited to, Alzheimer's dementia, dysphagia and scoliosis. The resident was admitted to the facility on 11/23/21.	F 0561	***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** *Resident B received a preference assessment by the Activity Director while the survey was in progress.* ***How other residents having the potential to be affected by the***	06/02/2022

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	The Quarterly Minimum Data Set assessment, dated 4/11/22, indicated the resident was cognitively intact and needed extensive assistance of staff for bed mobility, transferring and toileting. There was no Personal Preference assessment available for review. Interview with the Activity Director on 5/9/22 at 12:34 p.m., indicated a Personal Preference assessment should have been completed upon admission and annually. She indicated a Personal Preference assessment had not been completed for the resident on admission and she would complete one now. 3.1-3(u)(3)		***same deficient practice will be identified and what corrective action(s) will be taken;*** *All residents have the potential to be effected by the alleged deficient practice. A facility-wide audit was conducted to ensure that all resident preferences had been assessed with no further issues identified.* ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;*** All disciplines that complete resident assessments regarding self-determination received an in-service on assessing preferences and completion of the proper forms in the electronic record. Records will be audited to ensure that preferences are identified. ***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** A Performance Improvement Tool has been initiated that randomly checks three (3) residents to ensure that preference assessments are in place.This Quality Assurance Audit Tool will be completed by the Administrator/Designee Weekly for four (4) weeks; then monthly for five (5) months. In the event any further concerns are identified the issue will be	

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			immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. ***By what date the systemic changes will be made;*** *6/2/2022*	
F 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			

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	Based on record review and interview, the facility failed to report allegations of abuse to the Indiana Department of Health in a timely manner for 2 of 2 residents reviewed for abuse. (Residents B and C) Findings include: 1. During an interview with Resident B on 5/4/22 at 11:05 a.m., she indicated a couple weeks ago she had an incident with CNA 1. She indicated CNA 1 had been very rough with her during evening care and she was afraid of her. She indicated she had told her son about it the following day and it had been reported to the Administrator, but she didn't think anything had been done. Resident B's record was reviewed on 5/5/22 at 1:51 p.m. Diagnoses included, but were not limited to, Alzheimer's dementia, dysphagia and scoliosis. The resident was admitted on 11/23/21. The Quarterly Minimum Data Set (MDS) assessment, dated 4/11/22, indicated the resident was cognitively intact, and required extensive assistance for bed mobility, transfers and toileting. A list of all abuse allegations since January 2022 was requested from the Administrator during the entrance conference on 5/4/22. There were no abuse allegations provided and the Administrator indicated there had not been any. During an interview with the Administrator on 5/4/22 at 12:45 p.m., he indicated there had been no abuse allegations involving the resident. There was a grievance made 4/25/22 involving CNA 1	F 0609	***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** *The Administrator entered the allegations made by Resident B and C into the ISDH portal.* ***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;*** *A facility-wide audit was conducted to ensure that there were no additional violation allegations. No additional allegations were made.* ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;*** Staff received an in-service on policy and procedure of types of violations, reporting violations to the abuse coordinator, and timeframe of reporting allegations. All allegations of violations will be reported to ISDH within the allowable window by the Administrator or Designee. ***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** A Performance Improvement Tool has been initiated that randomly checks three (3) residents to	06/02/2022

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	not assisting the resident with evening care as requested, but he did not feel it was abuse. The Administrator was notified at that time the resident had reported an allegation of abuse during her earlier interview with the Surveyor. Interview with the Administrator on 5/5/22 at 2:35 p.m., indicated he had not initiated an abuse investigation or reported the allegation to the Indiana Department of Health. He indicated he spoke with the resident and she did not say anything about the abuse allegation. 2. Resident C's record was reviewed on 5/5/22 at 12:50 p.m. Diagnoses included, but were not limited to, heart disease, hemiplegia and polyneuropathy. The Quarterly Minimum Data Set assessment, dated 3/30/22, indicated the resident was cognitively intact, and required extensive assistance for bed mobility, transfers and toileting. During an interview with the resident on 5/4/22 at 9:28 a.m., she indicated there had been an incident with a nurse that was no longer employed at the facility. The nurse had been aggressive with her and physically removed medications from the resident's hands. She indicated an unnamed CNA had contacted the Director of Nursing (DON) about the incident. She also indicated the Administrator had spoken with her about it, but she did not know of any outcome. During an interview with the Administrator and DON on 5/4/22 at 12:45 p.m., they indicated they were unaware of any allegations of abuse made by the resident. The Administrator was		ensure that there are no allegations of violations.This Quality Assurance Audit Tool will be completed by the Administrator/Designee Weekly for four (4) weeks; then monthly for five (5) months. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. ***By what date the systemic changes will be made;*** *6/2/2022*	

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	notified at that time the resident had reported an allegation of abuse during her earlier interview with the Surveyor. Interview with the Administrator on 5/5/22 at 2:35 p.m., indicated he had not initiated an abuse investigation or reported the allegation to the Indiana Department of Health. He indicated he spoke with the resident that morning and she did not say anything about an abuse allegation. The document, "Abuse Policy", dated 1/2020, indicated, "...1. An alleged violation of abuse, neglect, exploitation or mistreatment and reasonable suspicion of a crime...will be reported immediately but not later than Two (2) hours if the alleged violation involves abuse...." This Federal tag relates to Complaint IN00379004. 3.1-28(c)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law,			

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	including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to ensure an allegation of abuse was thoroughly investigated for 1 of 2 residents reviewed for abuse. (Resident B) Finding includes: During an interview with Resident B on 5/4/22 at 11:05 a.m., she indicated a couple weeks ago she had an incident with CNA 1. She indicated CNA 1 had been very rough with her during evening care and she was afraid of her. She indicated she had told her son about it the following day and it had been reported to the Administrator, but she didn't think anything had been done. Resident B's record was reviewed on 5/5/22 at 1:51 p.m. Diagnoses included, but were not limited to, Alzheimer's dementia, dysphagia and scoliosis. The resident was admitted on 11/23/21. The Quarterly Minimum Data Set (MDS) assessment, dated 4/11/22, indicated the resident was cognitively intact, and required extensive assistance for bed mobility, transfers and toileting. A list of all abuse allegations since January 2022 was requested from the Administrator during the entrance conference on 5/4/22. There were no abuse allegations provided and the Administrator indicated there had not been any. During an interview with the Administrator on 5/4/22 at 12:45 p.m., he indicated there had been	F 0610	***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** *The Administrator investigated the allegations made by Resident B. Staff, family, and resident were all interviewed and there were no findings that a violation had occurred. The incident had previously been investigated as a grievance as soon as it was reported and not elevated to the level of abuse.* ***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 an allegation of abuse have the potential to be affected. A facility-wide audit of reported allegations was conducted to ensure that a thorough investigation was done. At the time of the audit there were no allegations identified to investigate.* ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;***	06/02/2022

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	no abuse allegations involving the resident. He indicated there was a grievance made 4/25/22 involving CNA 1 not assisting the resident with evening care as requested, but he did not feel it was abuse. The Administrator was notified at that time the resident had reported an allegation of abuse during her earlier interview with the Surveyor. The grievance was provided for review. The Grievance form dated 4/25/22, indicated the Resident's Son had reported the grievance. The resident had indicated CNA 1 had not provided evening care. The form indicated the resident was not afraid of the CNA, and the CNA was not rude to her, just did not provide enough assistance. Human Resources, the Director of Nursing and the Administrator had spoke to the CNA, who indicated she was trying to encourage the resident to do as much as she could for herself. As a corrective action, the aide would no longer be assigned to the resident to avoid potential issues. During a telephone interview with the Resident's Son on 5/5/22 at 2:50 p.m., he indicated about 2 weeks ago his mother had told him the previous night, CNA 1 had come to assist her for bed. At first she would not help her, then began to aggressively remove her shirt and pants. She then stood over her in bed. He indicated his mother was afraid. Interview with LPN 3 on 5/9/22 at 2:00 p.m., indicated on 4/25/22, the resident's son and an unnamed CNA had reported to her the allegation of abuse over the weekend involving CNA 1 and the resident. The resident had told LPN 3 that CNA 1 had been rough with her and she was afraid of her. LPN 3 indicated she had		Staff received an in-service of types of violations, reporting violations to the abuse coordinator, and timeframe of reporting allegations. An investigation into the allegation will be immediately initiated to determine if a violation occurred. An audit will be done to ensure that all investigations are being completed thoroughly. ***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** A Performance Improvement Tool has been initiated that checks for alleged violations to ensure that they have been properly investigated.This Quality Assurance Audit Tool will be completed by the Administrator/Designee Weekly for four (4) weeks; then monthly for five (5) months. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. ***By what date the systemic changes will be made;*** *6/2/2022*	

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	immediately reported the incident to the Administrator. Interview with the Administrator on 5/5/22 at 2:35 p.m., indicated he had not initiated an abuse investigation or reported the allegation to the Indiana Department of Health. He indicated he spoke with the resident and she did not say anything about the abuse allegation to him. The document, "Abuse Policy", dated 1/2020, indicated, "...Investigations- Timely and thorough investigations of all reports and allegations of abuse to include injuries of unknown origin...." This Federal tag relates to Complaint IN00379004. 3.1-28(d)			
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to anticoagulant medication use for 1 of 12 MDS assessments reviewed. (Resident 29) Finding includes: Resident 29's record was reviewed on 5/5/22 at 11:26 a.m. Diagnoses included, but were not limited to, congestive heart failure and Diabetes Mellitus. The resident was admitted to the facility on 1/11/22.	F 0641	A plan of correction is not required for deficiencies at scope and severity of level A. The facility remains responsible to expeditiously correct all deficiencies and to ensure measures are in place to maintain compliance.	06/02/2022

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	The Quarterly MDS assessment, dated 4/13/22, indicated the resident was receiving an anticoagulant medication. The Physician Orders for April and May 2022, did not include an order for anticoagulant. Interview with the MDS nurse on 5/10/22 at 11:21 a.m., indicated the resident was not on an anticoagulant and it was an error, she indicated she would make corrections. 3.1-31(i)			
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, interview and record review, the facility failed to ensure safe water temperatures were maintained for 2 of the 30 rooms observed. This had the potential to affect 3 residents who resided in these rooms. (Rooms 122 & 123) Finding includes: During a random room observation on 5/4/22 at 9:15 a.m., the water temperature in Room 122 felt excessively hot. There was one resident who resided in the room.	F 0689	***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** *The Maintenance Director adjusted the water heater and retook the temperature in 122 and 123. They were at or under the 120-degree Fahrenheit temperature threshold .* ***How other residents having the potential to be affected by the***	06/02/2022

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	During an observation with the Maintenance Director on 5/4/22 at 9:25 a.m., he completed a temperature reading on the hot water in Room 122. The thermometer read 126.8 degrees Fahrenheit. Room 123 was also checked and the hot water temperature was 126.0 degrees Fahrenheit. Two residents resided in the room. During an interview at that time, the Maintenance Director indicated the hot water temperatures were checked in random rooms daily. The water temperatures should have been 120 degrees Fahrenheit or less. He would adjust the boiler immediately. There had not been any injuries or complaints related to the hot water temperatures. The current policy, "Water Temperatures, Safety of", was received from the Maintenance Director on 5/9/22 at 9:45 a.m., indicated, "...Water heaters that service resident room, bathrooms and common areas, and tub/shower areas shall be set to temperatures of no more that the maximum allowable temperature per state and federal regulation......" 3.1-45(a)(1)		***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 faucets in the building including common areas, resident rooms, and restrooms were tested by the Maintenance and found to be at or below 120 degrees Fahrenheit.* ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;*** The Maintenance Director received an in-service on water temperature and proper methods of adjusting the boilers/water heaters. An audit of water temperatures will be conducted throughout the building to ensure that water temperatures are at or below the 120-degree Fahrenheit threshold ***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** A Performance Improvement Tool has been initiated that randomly checks Five (5) areas of the building to ensure that water temps are at or below 120 degrees Fahrenheit.This Quality Assurance Audit Tool will be completed by the Director of Maintenance/Designee weekly times four (4) weeks; then monthly	

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			for five (5) months. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. ***By what date the systemic changes will be made;*** *6/2/2022*	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, record review, and interview, the facility failed to ensure a resident experiencing pain was assessed and treated in a timely manner for 1 of 1 residents reviewed for pain. (Resident 29) Finding includes: On 5/5/22, Resident 29 was observed turning her call light on repeatedly. At 2:00 p.m., the call light was turned on and a staff member entered the room and left a moment later. At 2:05 p.m., the call light was turned on. LPN 2 entered the room and was heard telling the resident the doctor was in the building and she would have to wait for her, then exited the room. At 2:12 p.m., the resident was observed lying in her bed on her right side. She was grimacing and	F 0697	***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** *Resident 29 pain has been assessed and has been controlled with ordered interventions.* ***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 that identify pain have the potential to be affected by the alleged deficient practice. All residents pain levels were assessed to ensure that*	06/02/2022

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	appeared to be in pain. She indicated she was having pain and asked for the nurse right away. LPN 2 had left the floor and the evening Qualified Medication Aide (QMA) had arrived. QMA 1 entered the room and spoke to the resident. She indicated she was having severe pain and needed assistance. The resident's record was reviewed on 5/5/22 at 11:26 a.m. Diagnoses included, but were not limited to, congestive heart failure and Diabetes Mellitus. The resident was admitted to the facility on 1/11/22 The Quarterly MDS assessment, dated 4/13/22, indicated the resident had moderate cognitive deficits and needed extensive assistance for bed mobility and toileting. A Physician's Order, dated 5/4/22, indicated the resident could have Tylenol 650 milligrams (mg) every six hours, as needed, for pain. A Physician's Order, dated 3/30/22, indicated the resident could have Norco (a narcotic pain medication) 5/325 mg every six hours, as needed, for pain. The May 2022 Medication Administration Record indicated Tylenol had been given one time the previous day on 5/4/22. There was not any Norco recorded as being given. A Pain Care Plan, dated 1/19/22, indicated the resident had acute and chronic pain. Interventions included to anticipate need for pain relief and respond immediately to any complaint of pain and to administer medications as ordered. Interview with QMA 1 indicated he was told		*interventions were in place and being administered.* ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;*** Nursing staff received an in-service on monitoring pain and proper interventions in a timely manner. An audit on pain management will be conducted to ensure that interventions are being administered. ***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** A Performance Improvement Tool has been initiated that randomly checks Five (5) residents pain levels to ensure that they are being managed according to physician order.This Quality Assurance Audit Tool will be completed by the Director of Maintenance/Designee weekly for four (4) weeks; then monthly for five (5) months. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. ***By what date the systemic changes will be made;*** *6/2/2022*	

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	during shift change report on 5/5/22 that the resident was having pain related constipation and possible bowel impaction. He indicated she had been given laxatives on the previous shift, and he would give her something for pain. Phone interview with LPN 2 on 5/6/22 at 12:55 p.m., indicated the resident had been complaining of stomach issues the past few days. She had attempted to complete digital disimpaction the previous day. She had notified the Nurse Practitioner the resident was constipated and asked her to visit the resident. She indicated she had not given the resident any pain medication because she was not aware the resident had Tylenol or Norco available. 3.1-37(a)			
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 provide the necessary care and services for a resident who received hemodialysis (treatment to filter wastes and water from your blood) related to not assessing and monitoring the resident's dialysis access site on non-dialysis days for 1 of 1 residents reviewed for dialysis. (Resident 24) Finding includes: Resident 24's record was reviewed on 5/9/22 at	F 0698	***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** *Resident 24 Access site was assessed by the nurse and will be monitored daily.* ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective***	06/02/2022

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	8:35 a.m.. Diagnoses included, but were not limited to, chronic kidney disease, dependence on renal dialysis and diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 2/24/22, indicated the resident was on dialysis. A Physician's Order, dated 10/26/21, indicated "Dialysis - inspect dialysis access site for infection daily: left arm fistula (access site for hemodialysis): access for localized pain, erythema (redness), warmth, edema (swelling) to site, bleeding or abnormal drainage, caps are secure, shortness of breath/generalized edema, and assess for thrill/bruit (techniques to make sure there is a good blood flow through port). The Medication Administration Record, dated 5/2022, lacked documentation of monitoring and assessing the dialysis access site on non-dialysis days: Tuesdays, Thursdays, Saturdays and Sundays. The Nurse Progress Notes lacked any documentation for monitoring and assessing the dialysis access site on non-dialysis days. A Care Plan, revised on 12/23/19, indicated the resident had chronic renal disease. Interventions included, to monitor for signs and symptoms of infection, monitor vital signs and notify the physical of significant abnormalities. A Care Plan, revised on 12/23/19, indicated the resident required hemodialysis related to renal failure. Interventions included to monitor/document/report for any signs and symptoms of infection to the access site: redness, swelling, warmth or drainage.		***action(s) will be taken;*** *All residents with a dialysis access have the potential to be affected by the deficient practice. A facility wide audit was done to determine if there were additional residents with an access site.* ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;*** Nursing Staff received an in-service on monitoring the dialysis access site and documenting it in the electronic record. An audit will be conducted to ensure that the access sites are monitored. ***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** A Performance Improvement Tool has been initiated that randomly checks Two (2) residents in the building for monitoring of their dialysis access site.This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly times four (4) weeks; then monthly for five (5) months. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly.	

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	Interview with the Director of Nursing on 5/9/22 at 2:13 p.m., indicated the order was put in the computer system as a "standard order," and that would not prompt the Nurses to monitor and assess the dialysis site on a daily basis. A Facility policy titled, "Care of a Dialysis Resident, " was provided by the Director of Nursing on 5/9/22 at 2:55 p.m. This current policy indicated: "...Procedure ...10. If the resident has an accessed fistula or graft, the nursing will check the site daily for a bruit and thrill...12. Proper infection control procedures can significantly reduce the risk of infection...the facility will be responsible to monitor the bandaged access site and surrounding area every shift for any signs and symptoms of infection, i.e. drainage, complaints of discomfort to the site or redness surrounding the bandage...." 3.1-37(a)		***By what date the systemic changes will be made;*** *6/2/2022*	
F 0727 SS=C Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the			

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	facility has an average daily occupancy of 60 or fewer residents. Based on record review and interview, the facility failed to ensure there were 8 hours of consecutive RN (Registered Nurse) coverage for 7 out of 21 days reviewed. Findings include: On 5/10/22 at 10:52 a.m., the Nursing Staff Schedules, dated 4/20/22 through 5/10/22 were reviewed. There was no RN scheduled for 4/4/22, 4/8/22, 4/14/22, 4/15/22, 4/28/22, 4/29/22, and 5/8/22. On 5/10/22 at 10:52 a.m., the daily Nursing Staffing Postings, dated 4/20/22 through 5/10/22 were reviewed. There were no RN hours listed for 4/4/22, 4/8/22, 4/14/22, 4/15/22, 4/28/22, 4/29/22, and 5/8/22. Interview with RN 1 on 5/10/22 at 2:01 p.m., indicated she assisted the Director of Nursing with scheduling. There was no RN coverage on the above dates. 3.1-17(b)(3)	F 0727	***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** *The upcoming schedule for the remainder of the week was reviewed to make sure that there was the recommended RN coverage.* ***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 schedule for the remaining weeks was reviewed to ensure the necessary RN coverage. Any open days were staffed with RN coverage.* ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;*** DON and scheduler received an in-service on 8-hour requirement for RN coverage. An audit of the schedule will be done weekly to ensure that RN coverage is in place. ***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** A Performance Improvement Tool has been initiated that will review	06/02/2022

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			the schedule weekly to ensure that there are 8 consecutive hours of RN coverage for 7 days in a row.This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly times 24 weeks. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. ***By what date the systemic changes will be made;*** *6/2/2022*	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 1 of 6 residents observed during medication pass. Two errors were observed during 25 opportunities for errors during medication administration. This resulted in a medication error rate of 8%. (Resident C) Finding includes: On 5/10/22 at 9:45 a.m., LPN 1 was observed during medication pass. She prepared medications for Resident C, which included 11 tablets and eye drops. She administered the	F 0759	***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** *Resident C medications/passes were monitored to ensure that there were no errors* ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;*** *All residents have the potential to be affected by the alleged*	06/02/2022

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	medications and moved on to the next resident. The residents record was reviewed on 5/5/22 at 12:50 p.m. Resident diagnoses included, but were not limited to, type 2 diabetes, polyneuropathy and heart disease. A Physician's Order, dated 3/30/22, indicated to apply Aspercream lidocaine cream 4%, three times daily to left foot and leg for pain. The Medication Administration Record indicated the cream was to be applied at 9:00 a.m., 1:00 p.m., and 5:00 p.m. A Physician's Order, dated 9/1/20, indicated to give isosorbide mononitrate (a cardiac medication used to treat heart pain), 60 milligrams extended release, daily for angina. During medication pass the LPN had not administered the isosorbide mononitrate. There was a Nursing Note that indicated the medication was not available and had been ordered from the pharmacy. The LPN had not applied the Aspercream as ordered and there was no documentation to indicate why. Interview with LPN 1 on 5/9/22 at 10:03 a.m., indicated she did not know if isosorbide mononitrate was available in the emergency drug kit, she had not checked it yet. She also indicated she had not applied the Aspercream because the resident stayed in bed and it could be applied at anytime. The current policy, "Medication Administration General Guidelines," was received from the Director of Nursing on 5/9/22 at 2:03 p.m., indicated, "... b. Ensure medication cart is stocked with all necessary supplies to complete		*deficient practice. Other resident's med passes were monitored to ensure that the medications prescribed were available and passed in the allowable time.* ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;*** *Nursing Staff received an in-service on medication pass policy and procedure, allowable time frames to pass medication, and what to do if a medication was not available. An audit of the med pass will be completed to ensure proper procedure was followed.* ***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** A Performance Improvement Tool has been initiated that randomly checks Five (5) residents med pass to ensure that no errors occur during the pass.This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee one (1) time per week for four (4) weeks; then monthly for five (5) months. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be	

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	medication administration without interruption...." and "...q. Medications are to be administered no sooner than 60 minutes prior and no later than 60 minutes after scheduled time...." 3.1-48(c)(1)		reviewed at the Quality Assurance Meeting at least quarterly. ***By what date the systemic changes will be made;*** *6/2/2022*	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or			

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

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	155733	A. BUILDING 00 B. WING	05/10/2022

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	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to a resident not placed in Transmission Based Precautions (TBP) after a hospitalization for 1 of 3 residents reviewed for COVID-19 infection control. (Resident 20) Finding includes: On 5/10/22 at 10:51 a.m., there was a sign observed on Resident 20's room door. The sign indicated the room was a "Green Zone" and only a mask had to been worn with direct care of the resident. Outside of the room, there was no supply of PPE (Personal Protective Equipment) observed. Two residents resided in this room. Resident 20 was observed lying in bed bed watching TV. Resident 20's record was reviewed on 5/10/22 at 10:00 a.m. Diagnoses included, but were not limited to, cellulitis (a bacterial infection that causes redness, swelling, and pain in the infected area of the skin), dementia, chronic kidney disease and high blood pressure. A Nurse Progress Note, dated 5/4/22 at 3:45 p.m., indicated the resident had been readmitted to the facility from the hospital. Resident 20 had her first and second dose of the COVID-19 vaccine on 1/27/21 and 2/24/21. She had refused the COVID-19 booster, but was eligible to have received the booster. Interview with LPN 6 on 5/10/22 at 10:54 a.m., indicated the resident had just came back from	F 0880	**F880 Infection Prevention and Control** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* *Resident 20 was immediately placed in Transmission Based Precautions and a yellow sign placed on the door.* *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* *A facility wide audit was conducted to ensure that all residents were placed in the proper zone based on their vaccination status. No additional deficiencies were found.* *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur?* *A root cause analysis will be performed by a consultant Infection Preventionist through Q Source. All staff that may enter a resident's room have been in-serviced on proper precautions based on the need for Transmission-based precautions and which zone they should be placed based on vaccination status. The consultant Infection Preventionist will be providing*	06/02/2022

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	the hospital recently and she was unaware of her vaccination status. The sign on the door indicated to only wear a mask. Per the testing logs provided from the Director of Nursing (DON) on 5/10/22, the resident had a COVID-19 rapid test completed on 5/4/22. The result was negative. Interview with DON on 5/10/22 at 1:32 p.m., indicated upon re-admission the resident had not received her COVID-19 booster and was therefore not considered up to date with her COVID-19 vaccinations and she should have been placed in TBP. A yellow stop sign should have been placed on her door to indicate to wear gowns, gloves, N95 mask, and eye protection. The Long-term Care COVID-19 Clinical Guidance, updated on 2/8/22, indicated : "...A resident is not up to date on COVID Vaccination: Unvaccinated or fully vaccinated, but not received a booster as recommended by CDC.... New admissions/re-admissions, if not up to date on COVID-19 vaccination should be observed in TBP, yellow zone for 10 days. COVID-19 vaccination should also be offered. They should be moved to red zone if confirmed positive for COVID -19. They can be released to green zone after 10 days if asymptomatic...." 3.1-18(b)		*additional materials and in-services to be given to staff. This will be contained in the Intervention and improvement plan. An audit of admissions and readmissions will be done to ensure that the residents are in the proper zone.* *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?* *A Performance Improvement Tool has been initiated that monitors admissions and readmission to ensure that the proper transmission-based precautions are followed, if they are needed. The Director of Nursing, or designee, will complete these tools weekly x4 weeks and monthly x5. Any issues identified will be immediately corrected and additional training will immediately occur. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcomes of the tools* *By what date the systemic changes will be completed?* *6/2/2022*	

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F 0912 SS=B Bldg. 00	483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq Ft/Resident §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; Based on observation and interview, the facility failed to provide at least 80 square feet (SQ FT) per resident in multiple resident rooms and 100 SQ FT in single occupancy rooms. This was evidenced in 8 of 30 resident rooms in the facility. (Rooms 101, 104, 111, 201, 202, 204, 206, and 208) Findings include: 1. The floor area of the following single resident room measured: a. Room 111-1 resident, 96.2 SQ FT. NF. 2. The floor areas of the following multiple resident rooms measured: a. Room 101 - 1 resident, 150.3 SQ FT, 75.2 SQ FT per bed. NF. b. Room 104 - 1 resident, 145.0 SQ FT, 72.5 SQ FT per bed. NF. c. Room 201 - 1 resident, 149.0 SQ FT, 74.5 SQ FT per bed. NF. d. Room 202 - 2 beds, 1 resident, 144.0 SQ FT, 72.0 SQ FT per bed. NF. e. Room 204 - 1 resident, 144.0 SQ FT, 72.0 SQ FT per bed. NF. f. Room 206 - 1 resident, 140.9 SQ FT, 70.5 SQ FT per bed. NF. g. Room 208 - No residents, 146.9 SQ FT, 73.4 SQ FT per bed. NF.	F 0912	*What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* ="" span=""> *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* ="" span=""> *What measures will be put into place or what systematic changes the facility will make to ensure the deficient practice does not recur?* /iresidents> *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?* ="" span=""> *By what date the systemic changes will be completed?* *6/2/2022*	06/02/2022

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	The facility rooms with room variances were observed on 5/5/22 at 11:45 a.m. The rooms were observed with the following number of beds: Room 101 - 1 bed Room 104 - 1 bed Room 111 - 1 bed Room 201 - 1 bed Room 202 - 2 beds Room 204 - 1 bed Room 206 - 1 bed Room 208 - 1 bed Interview with the Administrator on 5/4/22 at 8:53 a.m., indicated these were the rooms which had the variance waivers and there had not been any changes from the previous annual survey. 3.1-19(l)(2)			