STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	07/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00376634, IN00376675, IN00377212, IN00378664, IN00383367, and IN00384016. Complaint IN00376634 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00376675 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00377212 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00378664 - Substantiated. Federal/State deficiencies related to the allegations are cited at F805 and F807. Complaint IN00383367 - Substantiated. Federal/State deficiencies related to the allegations are cited at F805. Complaint IN00384016 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: June 27, 28, 29, 30, and July 1 and 5, 2022. Facility number: 000120 Provider number: 155214 AIM number: 100274780 Census Bed Type: SNF/NF: 145	F 0000		

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

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	SNF: 17 NCC: 1 Total: 163 Census Payor Type: Medicare: 19 Medicaid: 100 Other: 44 Total: 163 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 7/8/22.			
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. §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			

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	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 the resident's dignity was maintained related to an uncovered urinary catheter bag for 2 of 5 residents reviewed for dignity. (Residents 143 and 157) Findings include: 1. On 6/27/22 at 10:43 a.m., Resident 143 was observed sitting in a Broda chair (positioning chair) in her room. A urinary catheter bag was hanging on the side of the Broda chair with visible urine in the bag. There was not a covering over the bag. The bag was visible from the doorway. On 6/28/22 at 3:47 p.m., Resident 143 was observed lying in bed. A urinary catheter bag was on the floor next to the bed. The bag had visible urine in it and was not covered. The bag was visible from the doorway.	F 0550	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Regarding residents #143 & #157 the urinary catheter bags were placed/covered with a dignity bag & are no longer visible from the doorway. Family and physicians were notified. Physicians gave no new orders. Residents are in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents with urinary catheter bags have the potential to be affected by this practice.	07/20/2022

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	Record review for Resident 143 was completed on 6/29/22 at 10:38 a.m. Diagnoses included, but were not limited to, neurogenic bladder, stroke, and dementia. The Significant Change Minimum Data Set (MDS) assessment, dated 5/26/22, indicated the resident was cognitively impaired. The resident required an extensive 2+ person assist for bed mobility and toilet use. A total 2+ person assist for transfers. The resident had an indwelling urinary catheter. Interview with Agency LPN 1 on 6/28/22 at 3:51 p.m., indicated the resident's urinary catheter bag should have been covered with a dignity bag. 2. On 6/28/22 at 9:26 a.m., Resident 157 was observed lying in bed. A urinary catheter bag was hanging on the side of the bed. The bag had visible urine in it and was not covered. The bag was visible from the doorway. On 6/28/22 at 3:44 p.m., Resident 157 was observed lying in bed. A urinary catheter bag was attached to a wheelchair next to the bed. The bag had visible urine in it and was not covered. The bag was visible from the doorway. Record review for Resident 157 was completed on 6/29/22 at 4:08 p.m. Diagnoses included, but were not limited to, end stage renal disease, uropathy, and depression. The Quarterly MDS assessment, dated 5/22/22, indicated the resident was cognitively moderately impaired. The resident required an extensive 1 person assist for bed mobility, transfers, and toilet use. The resident had an indwelling urinary catheter.		**The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Nurse Managers/designee audited/observed all the residents who require a urinary catheter to ensure all catheter bags are placed/covered with a dignity bag & are not visible from the doorway. Any deficiencies were corrected at that time. The Director of Nursing/designee re-in-serviced the staff on dignity, proper placement of urinary catheter bags, ensuring urinary catheter bags are placed/covered in a dignity bag & are not visible from the doorway. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** The Unit Manager/designee will observe residents who require a urinary catheter five (5) times per week per unit to ensure their dignity is maintained for six (6) months. The DON/designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	

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	Interview with Agency LPN 1 on 6/28/22 at 3:51 p.m., indicated the resident's urinary catheter bag should have been covered with a dignity bag. A facility policy titled, "Quality of Life - Dignity", and received as current from the facility, indicated, "...11. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents. For example: a. Helping the resident to keep urinary catheter bags covered...." 3.1-3(a)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's			

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	needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to provide documentation of care conferences being held with the resident and facility staff for 1 of 1 residents reviewed for care planning decisions. (Resident L) Finding includes: Interview with Resident L on 6/28/22 at 8:58 a.m., indicated she was not aware of care conferences or meetings. Resident L's record was reviewed on 6/28/22 at 3:47 p.m. Diagnoses included, but were not limited to, diabetes mellitus, irregular heart rhythms and Chronic Obstructive Pulmonary Disease (COPD-disease of the lungs that makes it hard to breathe). The Quarterly Minimum Data Set assessment, dated 6/10/22, indicated the resident was cognitively intact and could answer questions appropriately. The last Care Plan Conference Summary was dated 7/28/21. There was no documentation in her record of a Care Plan Meeting attendance sheet or to indicate that the resident and her representative were invited to the meetings. Interview with Social Services (SS) 1 on 6/29/22 at 10:25 a.m., indicated she had invited the resident's daughter. The daughter does not come, and the resident had attended the meetings.	F 0657	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Regarding resident L the Unit Manager reviewed her plan of care with her & no concerns were voiced. ¿¿¿¿¿ Family was notified. Residents are in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents have the potential to be affected by this practice. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** The MDS Nurse/designee audited care plan invitations to ensure the resident (if applicable) & the Responsible Party were invited to the Care Plan meeting in the past 30 days. Any deficiencies were corrected at that time. The Director of Nursing/designee educated the MDS staff/Social Service Staff regarding care plan meetings & inviting the resident (if applicable) as well as the	07/20/2022

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	SS 1 and the Administrator were unable to locate any further Care Plan Conference Summaries, invitations, or a log of who attended. 3.1-35(d)(2)(B)		Responsible party to the meeting. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** The Director of Nursing/designee will audit care plan meeting invitations weekly to ensure the resident (if applicable) & the Responsible Party has been invited to ensure compliance for six (6) months. The DON/designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.¿¿	
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 residents received the necessary treatment and services related to the monitoring and assessment of skin	F 0684	**The corrective actions that were accomplished for those residents to have been affected by the practice are:**	07/20/2022

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	discolorations for 3 of 4 residents reviewed for non-pressure related skin conditions. (Residents B, H, and J) Findings include: 1. On 6/28/22 at 10:07 a.m., Resident B was observed lying in bed. A dark purple discoloration was observed to the inside of her right wrist. On 6/28/22 at 3:59 p.m., Resident B was observed lying in bed. Dark purple discolorations were observed to her right wrist, right forearm and her left shin. On 6/29/22 at 8:49 a.m., Resident B was observed sitting in a wheelchair by the nurses station. Dark purple discolorations were observed to her right wrist, right forearm and her left shin. Record review for Resident B was completed on 6/30/22 at 9:53 a.m. Diagnoses included, but were not limited to, anemia, hypertension, dementia, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 6/3/22, indicated the resident was cognitively impaired. The resident required and extensive 2+ person assist for bed mobility and toilet use, and total 2+ assist for transfers. A Care Plan, dated 6/17/2020, indicated the resident was at risk for skin breakdown. An intervention included to complete a skin inspection weekly and as needed, and to document and notify MD of abnormal findings. The Weekly Nursing Summary, dated 6/29/22, indicated the resident's skin had no current		The Unit Manager/ designee completed a head-to-toe assessment of resident B, H, & J. Skin assessments were completed on the identified areas. Non-pressure skin evaluations and care plans were also completed on the identified areas. Family and physicians notified. Physician gave no new orders. Residents are in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents have the potential to be affected by this practice. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Unit Managers / designee completed head to toe assessments on all residents to ensure identification and notification of discolorations/skin tears/non-pressure skin areas with any deficiencies corrected at that time. Director of Nursing Services / designee educated nursing staff on the proper procedure to follow regarding identification of a discoloration, skin tear, non-pressure areas when noted, as well as proper notification and monitoring of the area.	

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	issues. Bruising was not checked on the summary. The record lacked any documentation the resident's discolorations had been assessed or monitored. Interview with the Infection Preventionist and the Director of Nursing (DON) on 6/30/22 at 9:25 a.m., indicated they were unaware of the resident's discolorations and would look into it. The staff should have observed the discolorations and assessed them. 2. On 6/27/22 at 10:16 a.m., Resident H was observed lying in bed. There was a purple discoloration to his right forearm. He was not sure how it happened, but indicated it was probably related to some of the medication he took. On 6/29/22 at 10:47 a.m., Resident H was observed lying in bed. The purple discoloration remained to his right forearm. The Nurse and the Physician were in the room speaking to the resident about his eye that was bloodshot. Record review for Resident H was completed on 6/29/22 at 3:12 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, chronic kidney disease, and hypertension. The Quarterly MDS assessment, dated 4/29/22, indicated the resident was cognitively intact. The resident required an extensive 2 + person assist for personal hygiene and totally dependent on staff for bathing. The resident had received anticoagulant (blood thinning) medication. A current Care Plan indicated the resident was taking anticoagulant medication related to atrial		**Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** The Unit Managers / designee will assess five (5) residents per unit per week for six (6) months to ensure discolorations, skin tears, non-pressure areas have been identified and documented per policy. The DON / designee will report audit findings completed by the Unit Manager/designee to the QAPI committee monthly for six (6) months. The QAPI committee will monitor the data presented for any trends and determine if further monitoring / action is necessary for continued compliance.	

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flutter. An intervention included to inspect the skin during care for bruising or increased bruising and notify the nurse of abnormal findings.

The Physician's Order Summary (POS), dated 6/2022, indicated an order for Eliquis (apixaban, a blood thinning medication) 5 mg (milligrams) every 12 hours.

The most recent Weekly Nursing Summary, dated 6/21/22, indicated the resident didn't have any current skin issues. There were no areas of bruising or discoloration documented.

Interview on 6/30/22 at 9:23 a.m. with the Director of Nursing and the Infection Preventionist, indicated they were not aware of any skin discolorations or bruising and would go assess the resident.

3. On 6/27/22 at 10:50 a.m., Resident J was observed lying in bed with her eyes closed. There was a purple discoloration to her right forearm and two circular red areas to her right cheek.

On 6/29/22 at 10:56 a.m., Resident J was observed lying in bed. The two circular red areas remained to her right cheek. Her arms were underneath her blanket and were not visible.

On 6/30/22 at 2:47 p.m., Resident J was observed seated in her wheelchair near the nurse's station. The two circular red areas remained to her right cheek. One of the areas was covered with a band-aid. The purple discoloration remained to her right forearm.

Record review for Resident J was completed on 6/30/22 at 2:21 p.m. Diagnoses included, but were

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	not limited to, hypertension, anxiety disorder, and atrial fibrillation. The Quarterly MDS assessment, dated 5/14/22, indicated the resident was cognitively impaired. The resident required an extensive 2 + person assist for transfers and an assist of one with dressing, personal hygiene and bating. A current Care Plan indicated the resident had impaired skin integrity to the right side of her face. An intervention included to assess and document skin condition and to complete the wound treatment as ordered. The Physician's Order Summary, dated 6/2022, lacked any treatment orders for the resident's right cheek. The most recent Weekly Nursing Summary, dated 6/25/22, indicated the resident did not have any current skin issues. There were no areas of bruising or discolorations documented. Interview on 6/30/22 at 9:23 a.m. with the Director of Nursing and the Infection Preventionist, indicated they were not aware of any skin discolorations or bruising to the resident's forearm. She had had the areas to her cheek for a while, but they were unsure if the area had been documented. A facility policy, titled "Skin Management," indicated, "...7. Any skin alterations noted by direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment, to include but not limited to bruises, open areas, redness, skin tears, blisters, and rashes. a) The licensed nurse is responsible for assessing any and all skin alterations as			

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	reported by the direct caregivers on the shift reported...3. All alterations in skin integrity will be documented in the medical record...b) All newly identified areas after admission will be documented on the weekly pressure/non-pressure evaluation..." This Federal tag relates to Complaints IN00376634 and IN00376675. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure pressure offloading boots were in place as ordered for 1 of 6 residents reviewed for pressure ulcers. (Resident 45) Finding includes: On 6/29/22 at 2:18 p.m., Resident 45 was observed lying in bed watching television. The pressure	F 0686	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Regarding resident #45 the Director of Nursing Services & the Assistant Director of Nursing Services assessed this resident's bilateral heels & applied the offloading boots after completing	07/20/2022

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	offloading boots were not observed in place. Two pressure offloading boots were observed on the window sill. On 6/30/22 at 2:33 p.m., Resident 45 was observed lying in bed watching television. The pressure offloading boots were not observed in place. Two pressure offloading boots were observed on the window sill. On 6/30/22 at 2:35 p.m. wound care was observed for Resident 45 with the Director of Nursing and the Assistant Director of Nursing. The resident had a stage 4 pressure ulcer to his coccyx and a stage 4 pressure ulcer to his left lateral hip. Interview with the Director of Nursing at the time of the observation, indicated the resident should have had the offloading boots on and she would educate the staff. Record review for Resident 45 was completed on 6/29/22 at 10:30 a.m. Diagnoses included, but were not limited to, pressure ulcers, hypertension, and hypothyroidism. The Quarterly Minimum Data Set (MDS) assessment, dated 4/14/22, indicated the resident had 2 stage 4 pressure ulcers. The resident had a current care plan for risk for skin breakdown. The interventions included, preventative skin care as ordered. The Physician's Order Summary, dated 6/2022, indicated an order for heel protectors to bilateral feet while in bed. A facility policy, titled, "Skin Management," indicated, "...8. Residents identified at risk for skin breakdown will have appropriate		this resident's dressing change with the State Surveyor. Family and physicians notified. Physician gave no new orders. Residents are in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents have the potential to be affected by this practice. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Unit Managers/designees observed all residents requiring preventative pressure ulcer interventions to ensure placement. Any deficiencies were corrected at that time. Director of Nursing/designee educated the staff on pressure ulcer preventative management/interventions/placement. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** The Unit Managers/designees will observe five (5) residents per week per unit that require preventative pressure ulcer interventions for six (6) months to ensure compliance.	

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	interventions put into place. a) A care plan will be developed specific to the resident's needs including prevention interventions..." 3.1-40(a)(2)		The DON/designee will report audit findings to the QAPI committee monthly for six (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and interview, the facility failed to ensure a resident maintained acceptable parameters of nutritional status related to meal consumption records not completed and tube feeding not given for a resident who was nutritionally at risk for 1 of 8 residents reviewed for nutrition. (Resident 77)	F 0692	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Resident #77 was assessed by the Registered Dietician. No New orders noted.	07/20/2022

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	Finding includes: On 6/30/22 at 12:46 p.m., Resident 77 was observed lying in bed with her eyes closed. Her lunch tray had already been served and was on the bedside table. None of the puree meal had been consumed. The record for Resident 77 was reviewed on 6/30/22 at 9:58 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, severe protein calorie malnutrition, and adult failure to thrive. The Quarterly Minimum Data Set (MDS) assessment, dated 4/26/22, indicated the resident was cognitively impaired, received a mechanically altered diet, had a feeding tube, and had not had any weight loss. A current Care Plan indicated the resident required a tube feeding related to weight loss. Interventions included, tube feeding and water flushes per Physician orders. A Physician's Order, dated 4/27/22, indicated the resident was to receive a tube feeding bolus of 2 Cal (type of feeding formula) 237 ml (milliliters) three times a day. This order was discontinued on 5/27/22. The Medication Administration Record (MAR), dated 5/2022, indicated the tube feeding administration had not been signed off as given on the following times and dates: 9:00 a.m.-5/8/22, 5/21/22, 5/22/22, 5/23/22, and 5/26/22 1:00 p.m.-5/8/22, 5/16/22, 5/21/22, 5/22/22, 5/23/22, and 5/26/22		Nurse Managers/designee obtained weights of all the current residents if the resident allowed. Family and physicians notified. Physician gave no new orders. Residents are in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents have the potential to be affected by this practice. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** The Registered Dietician/designee completed a whole house review of current resident weights to determine if weight loss occurred & if supplements/fortified foods/enteral orders were necessary. Nurse Managers/designee completed a whole house audit on resident meal consumption records as well as enteral intake records to ensure documentation was completed. The Director of Nursing/designee educated the nursing staff on the weight policy, following physician's orders related to weights, supplements/fortified foods, proper documentation of supplements/fortified food consumption, enteral feeding	

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	A Physician's Order, dated 4/13/22, indicated the resident was to receive a tube feeding bolus of 200 ml four times a day. This order was discontinued on 4/21/22. The Medication Administration Record (MAR), dated 4/2022, indicated the tube feeding administration had not been signed off as given on the following times and dates: 9:00 a.m.-4/15/22 and 4/20/22 1:00 p.m.-4/15/22 and 4/20/22 The Physician's Order Summary, dated 6/2022, indicated an order for a puree diet for pleasure. The food consumption documentation for June 2022, indicated there was no meal intake documented on 6/11, 6/12, 6/13, 6/15, 6/17, 6/22, 6/23, 6/24, 6/26, and 6/28. There were multiple days when intake was only documented for 1 or 2 meals. The resident's weight on 12/4/21 was 100 pounds. The weight on 6/24/22 was 90 pounds, a 10% weight loss from 12/4/21. Interview with the Administrator on 6/30/22 at 3:55 p.m., indicated the resident was being followed for weight loss by the nutrition at risk committee. 3.1-46(a)		documentation & notification of the Registered Dietician when a resident has a change in condition. Nutrition at risk meetings will be held weekly with the IDT to review resident weight loss, change in condition, enteral intake, meal consumption records, & supplements/fortified food intake. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** The Unit Manager/designee will audit resident meal consumption records as well enteral feeding records to ensure completion on the next business day to ensure compliance for six (6) months. The DON/designee will report audit findings to the QAPI committee monthly for six (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	
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			

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	tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure residents received proper treatment and care related to oxygen administration flow rate and nebulizer assessments for 3 of 3 sampled residents reviewed for respiratory care. (Residents 98, K, 130) Findings include: 1. On 6/28/22 at 11:19 a.m., Resident 98 was observed sitting in her wheelchair. Oxygen was in place via nasal cannula. The oxygen concentrator flow rate was set to 3 liters. On 6/30/22 1:13 p.m., Resident 98 was sitting up in bed eating lunch. Oxygen was in place via nasal cannula. The oxygen concentrator flow rate was set to 3.5 liters. Record review for Resident 98 was completed on 7/5/22 at 11:24 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, end stage renal disease, and pleural effusion. The Quarterly Minimum Data Set (MDS) assessment, dated 5/12/22, indicated the resident was cognitively intact and received oxygen. A current Care Plan indicated the resident was at risk for respiratory distress. The interventions included, oxygen as ordered. The Physician's Order Summary, dated 6/8/22, indicated oxygen 2 liters per minute via nasal	F 0695	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Regarding resident #98, & K the oxygen flow rate was set per physician's orders. Resident was assessed. Regarding resident #130 the Physician was made aware of the nebulizer pre/post assessments noted being completed. Resident was assessed. Family and physicians notified. Physician gave no new orders. Residents are in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents with oxygen and nebulizer orders have the potential to be affected by this practice. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Unit Managers/designees observed all residents requiring oxygen therapy to ensure the physician's orders were being	07/20/2022

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	cannula. Interview on 6/30/22 at 3:55 p.m. with the Administrator, indicated she would have staff check on the oxygen rate. A facility policy, titled, "Oxygen Administration," indicated "...10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered in accordance with the physician's orders..."2. On 6/27/22 at 10:26 a.m., Resident K was observed lying flat in her bed. Her oxygen was on and the flow rate was set at 3.5 lpm (liters per minute). On 6/28/22 at 3:20 p.m., Resident K was observed lying flat in her bed. Her oxygen was on and the flow rate was set at 3.5 lpm. Resident K's record was reviewed on 6/29/22 at 10:35 a.m. Diagnoses were included, but not limited to, diabetes mellitus, arthritis and asthma. The current Physician Order Summary indicated oxygen at 3 lpm, continuously per nasal cannula. A current Care Plan, dated 6/1/21, indicated the resident was at risk for respiratory distress related to asthma. Interventions included, but were not limited to, administer medications as ordered, elevate the head of the bed to alleviate shortness of breath caused by lying flat, and administer oxygen as ordered. Interview with LPN 4 on 6/28/22 at 3:20 p.m., indicated her oxygen flow rate should have been set as 3 lpm. 3. Resident 130's record was reviewed on 7/1/22 at		followed. Any deficiencies were corrected at that time. The Unit Managers/designees audited resident records who require nebulizer treatments to ensure pre/post assessment orders were part of the physician's order as well as completion. Any deficiencies corrected at that time. Director of Nursing/designee educated the nursing staff on following physician's orders related to oxygen flow rates as well as pre/post nebulizer assessments. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** The Unit Managers/designee will observe five (5) residents who require oxygen therapy five (5) times per week per unit to ensure the accuracy of the oxygen flow rate for six (6) months. The Unit Manager/designee will audit five (5) resident records who require nebulizer treatments to ensure the pre/post nebulizer assessments were completed five (5) times per week per unit for six (6) months. The DON/designee will report audit findings to the QAPI committee monthly for six (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for	

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	11:24 a.m. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD- a lung disease that makes it difficult to breathe) and heart failure. The current Physician's Order Summary indicated to assess and document her pulse, respiratory rate, lung sounds and oxygen saturation levels before and after a nebulizer treatment (a machine that administers a liquid medication into a mist for the lungs). Administer via a nebulizer, ipratropium-albuterol solution 0.5-2.5 milligrams per 3 milliners orally four times a day and every four hours as needed for cough or shortness of breath. The Treatment Administration Record (TAR) for June 2022 lacked any documentation that she was assessed before and after a scheduled nebulaizer treatment. A current Care Plan, dated 6/1/22, indicated she was at risk for respiratory distress related to COPD. Interventions included, but were not limited to, administer nebulizer treatments as ordered, notify MD of changes in her respiratory status, observe her and report any abnormal breathing patterns to MD: increased rate, decreased rate, periods of apnea, prolonged inhalation, prolonged exhalation, prolonged shallow breathing, prolonged deep breathing, use of accessory muscles, pursed-lip breathing, nasal flaring, observe her for changes in orientation, increased restlessness, anxiety, and air hunger, observe her for signs of respiratory distress : Increased Respirations; Decreased Pulse oximetry; Increased heart rate; Restlessness; Diaphoresis; Headaches; Lethargy; Confusion; Hemoptysis (coughing of blood); Cough; Pleuritic pain (a sharp chest pain when breathing deeply);		continued compliance.	

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	Accessory muscle usage; Skin color changes to blue/grey. Interview with Nurse Consultant 1 on 7/1/22 at 2:34 p.m., indicated the order for pre and post assessments for nebulizer treatment had only been attached to the "as needed" nebulizer treatment order. The TAR should have had a pre and post assessment for all treatments. 3.1-47(a)(6)			
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 interview and record review, the facility failed to ensure a resident experiencing pain was assessed and treated in a timely manner for 1 of 5 residents reviewed for pain. (Resident K) Finding includes: Interview with Resident K on 6/27/22 at 10:27 a.m., indicated she had "excruciating" pain across her back. She was only given Tylenol for the pain, the pain was better when she laid down, and no one had investigated the cause of the pain. Interview with Resident K on 6/29/22 at 9:05 a.m., indicated she had pain in her groin area and the pain was "better" when she laid down. Interview with the resident on 6/20/22 at 3:18 p.m., indicated she had to ask a nurse for the "capsaicin	F 0697	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Regarding resident K the Unit Manager assessed the resident for pain. Assessment within normal limits, no pain noted. Family and physicians notified. Physician gave no new orders. Residents are in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents have the potential to	07/20/2022

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	cream" (a cream used to help relieve neuralgia - shooting or burning pain in the nerves) and the Lidocaine patch did not help very much. Resident K's record was reviewed on 6/29/22 at 10:35 a.m. Diagnoses were included, but not limited to, diabetes mellitus, arthritis and asthma. The Quarterly Minimum Data Set assessment, dated 5/29/22, indicated she was interviewable and cognitively intact. She received scheduled and as needed pain medication. The current Physician's Order Summary indicated to administer acetaminophen (Tylenol) 325 mg (milligrams) 2 tablets, by mouth, every four hours for pain or fever. Apply a Lidocaine (numbing medication) patch to the lower back, topically one time a day for pain. Apply topically capsaicin cream 0.1% to both knees, two times a day for pain. The Treatment Administration Record (TAR) for May 2022, indicated the following days were not documented as administered for scheduled pain medications: - Lidocaine Patch at 6:00 a.m. on 6/26. - capsaicin cream at 7:00 a.m. on 5/2, 5/4, 5/11, 5/12, 5/19, 5/21, 5/25, 5/26, 5/28, 5/29 and 5/31. - capsaicin cream at 4:00 p.m. on 5/2, 5/3, 5/5, 5/10, 5/16, 5/17, 5/19, 5/21, 5/22, 5/24, 5/26, 5/27, 5/30 and 5/31. The TAR for June 2022, indicated the following days were not documented as administered for scheduled pain medications: - Lidocaine Patch at 6:00 a.m. on 6/18. - Lidocaine Patch at 6:00 a.m., the documentation was marked as a "9" (see notes) on 6/2, 6/4, 6/5, 6/6, 6/27, 6/29 and 6/30. The was no		be affected by this practice. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Unit Managers/designees audited resident MARS to ensure medication was administered per order. The Physician was notified of any deficiencies and residents were assessed for pain as applicable. Director of Nursing/designee educated the nursing staff on following physician's orders related medication administration & proper documentation. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** The Unit Managers/designee will audit the resident's MAR on the next business day to ensure medication administration & documentation has been completed for six (6) months. The DON/designee will report audit findings to the QAPI committee monthly for six (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	

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	documentation in the Progress Notes. - capsaicin cream at 7:00 a.m. on 6/1, 6/2, 6/4, 6/6, 6/7, 6/8, 6/18 and 6/29. - capsaicin cream at 4:00 p.m. on 6/2, 6/4, 6/5, 6/7, 6/8, 6/14, 6/14, 6/16, 6/18, 6/19, 6/21, 6/22, 6/23, 6/24 and 6/30. The Medication Administration Record for June 2022, indicated the acetaminophen was only administered twice in the month of June, when the resident had asked for the pain medication. A Care Plan, dated 3/9/22, indicated the resident was at risk for pain due to arthritis, depression, gout (inflammatory disease), retention of urine and diabetic polyneuropathy (a type of nerve damage that can occur with diabetes and for some people symptoms can be painful and debilitating). Interventions included, but were not limited to, administer medications as ordered, notify the MD of unrelieved or worsening pain, observe for side effects of pain medication - constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls., report occurrences to the physician, observe for symptoms of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow), vocalizations (grunting, moans, yelling out, silence), mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion);, eyes (wide open/narrow slits/shut, glazed, tearing, no focus), her farcical expressions (sad, crying, worried, scared, clenched teeth, grimacing) , her body (tense, rigid, rocking, curled up, thrashing), offer non pharmacological interventions such as position change, relaxation, quiet environment, back rub, and diversional activity. Interview with Unit Manger 3 on 6/30/22 at 3:20			

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	p.m., indicated she did not know why there was not any documentation on the TAR for the pain medications given as ordered. Any notes from the TARs should have been in the Progress Notes. A policy titled, "Administering Medications," was provided by the Administrator on 7/1/22 at 11:47 a.m. This current policy indicated,"Policy Statement: Medications are administered in a safe and timely manner, and as prescribed...Policy Interpretation and Implementation:...4. Medications are administered in accordance with prescribe orders, including any required time frame...21. If the drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. 22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones...." 3.1-37(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or			

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	§483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure medications were documented and administered per the Physician's Orders and not given outside the physician ordered parameters for 3 of 5 residents reviewed for unnecessary medications. (Residents 110, 123 and 129) Findings include: 1. Resident 110's record was reviewed on 6/20/22 at 12:50 p.m. Diagnoses included, but were not limited to, diabetes mellitus, dementia, and multiple sclerosis (MS-a disabling disease of the brain and spinal cord). A Physician's Order, dated 8/3/21-5/30/22, indicated to administer an injection of glatiramer acetate solution (used to treat relapsing forms of multiple sclerosis) 20 mg/ml (milligrams/milliliter) one time a day. A Physician's Order, dated 2/14/22-6/24/22, indicated to administer an injection of Lantus (insulin) solution 15 units every twelve hours and to hold the medication if the blood sugar level was below 110. A Physician's Order, dated 3/18/22-5/16/22,	F 0757	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Regarding residents #110, #123, & #129 the Unit Manager made the Physician aware of the medications not being administered per order or given outside the physician's ordered parameters. Family and physicians notified. Physician gave no new orders. Residents are in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents have the potential to be affected by this practice. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** The Unit Managers/designees audited resident MARS to ensure	07/20/2022

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	155214	A. BUILDING 00 B. WING	07/05/2022

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	indicated to administer an injection of Novolog (insulin) solution per the sliding scale: if 151-200; 2 units, 201-250; 4 units, 251-300; 6 units, 301-400; 8 units three times a day for diabetes. Administer within fifteen minutes of eating. A Physician's Order, dated 5/16/22, indicated to administer an injection of Novolog solution per the sliding scale: if 151-200; 2 units, 201-250; 4 units, 251-300; 6 units, 301-400; 8 units , and over 400 notify the MD, three times a day for diabetes. Administer within fifteen minutes of eating. The May 2022 Medication Administration Record (MAR) indicated the following: - glatiramer acetate solution was not documented as given at 6:00 a.m. on 5/4, 5/10, 5/11, 5/13, 5/14, 5/18, 5/19, 5/24, 5/25, 5/27, 5/29, 5/30. - Lantus injection of 15 units and blood sugar levels were not documented at 6:00 a.m. on 5/4, 5/10, 5/11, 5/13, 5/14, 5/18, 5/19, 5/24. 5/25, 5/27, 5/29, 5/30 and 5/31. - Lantus injection of 15 units and blood sugar levels were not documented at 6:00 p.m. on 5/9. - Lantus injections were not held per the physician ordered parameters of "hold if the blood sugar level was below 110." It was documented as given at 6:00 a.m. for the following days and blood sugar (b.s.) levels: - 5/5; b.s. was 66 - 5/9; b.s. was 99 - 5/12; b.s. was 104 - 5/21; b.s. was 90 - Lantus injections were not held per the physician ordered parameters of "hold if the blood sugar level was below 110." It was documented as given on 5/22 at 6:00 p.m., with a blood sugar level of 109. - Novolog injection per the sliding scale, the dosage and the blood sugar levels were not		medications were documented and administrated per the physician's orders as well as not given outside the physician ordered parameters. The Physician was notified of any deficiencies. ¿Director of Nursing/designee educated the licensed nursing staff/QMAS on following physician's orders related medication administration, proper documentation, & not giving medication outside the physician's ordered parameters. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** The Unit Managers/designee will audit the resident's MAR on the next business day to ensure physician's orders were followed for medication administration, proper documentation, & not giving medication outside the physician's ordered parameters or six (6) months. The DON/designee will report audit findings to the QAPI committee monthly for six (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	

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	documented on the following times and days: - 6:00 a.m.: 5/4, 5/10, 5/11, 5/13, 5/14. - 4:00 p.m. on 5/9. - Novolog injection per the sliding scale, the dosage and the blood sugar levels were not documented on the following times and days: - 6:00 a.m.: 5/18, 5/19, 5/24, 5/25, 5/27, 5/29, 5/30. - 11:00 a.m. on 5/29. A Physician's Order, dated 2/14/22-6/24/22, indicated to administer an injection, under the skin of Lantus (insulin) solution 15 units every twelve hours and to hold the medication if the blood sugar level was below 110. A "Communication with Physician Note", dated 6/24/22, indicated new orders to increase Lantus to 20 units every twelve hours and add Aspart (Novolog) 8 units injected under the skin three times a day due to his blood sugars levels had been ranging 300-500 the past few days. Continue the Novolog the sliding scale as previously ordered. A Physician's Order, dated 6/24/22, indicated to administer an injection of Lantus (insulin) solution 20 units every twelve hours due to excessively high blood sugars. The June 2022 MAR indicated the following: - Lantus injection of 15 units and blood sugar levels were not documented at 6:00 a.m. on 6/1, 6/4, 6/7, 6/8, 6/13, 6/15, 6/16, 6/19, and 6/22. - Lantus injection of 15 units and blood sugar levels were not documented at 6:00 p.m. on 6/3, and 6/12. - Lantus injection of 20 units at 6:00 a.m., was not documented as given on 6/27 and 6/28. - Novolog injection per the sliding scale, the dosage and the blood sugar levels were not			

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	documented at 12:00 p.m. on 6/19 and 6/25. - Novolog injection per the sliding scale, on 6/12 at 5:00 p.m., the blood sugar level was 237. There lacked documentation that 4 units of Novolog should have been administered per the sliding scale at 5:00 p.m. - Novolog injection per the sliding scale, on 6/19 at 11:00 a.m., the blood sugar level was 267. There lacked documentation that 6 units of Novolog should have been administered per the sliding scale at 12:00 p.m. - Novolog injection per the sliding scale, on 6/25 at 11:00 a.m., the blood sugar level was 227. There lacked documentation that 4 units of Novolog should have been administered per the sliding scale at 12:00 p.m. A Care Plan, undated, indicated he was at risk for pain due to multiple sclerosis. Interventions included, but were not limited to, administer medication as ordered. A Care Plan, undated, indicated he had been at risk for complications related to medical conditions, medications and treatments due to diagnoses of diabetes/metabolic disorder. Interventions included, but were not limited to, medications and treatments per physicians orders, observe for adverse side effects of complications related to medical diagnosis, vital signs and physical assessment as ordered/indicated. A Care Plan, dated 5/19/22, indicated he presented with potential for nutritional risk related to absence of an insulin pump, he refuses to eat most meals and downgrade to a mechanical soft diet. Interventions included, but were not limited to, fortified items/supplements/extra portions per order, and perform laboratory/diagnostic work as ordered.			

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	Interview with Unit Manager 3 on 7/1/22 at 11:58 a.m., indicated she did not know why there was not any documentation on the MARs or in the Progress Notes. The MAR's should have been signed by the nurse as medication given, refused, or not given and why, for each medication and each ordered time. 2. Resident 123's record was reviewed on 6/29/22 at 11:47 a.m. Diagnoses were included, but not limited to, non-traumatic brain dysfunction, dementia with behavioral disturbances psychotic disorder, diabetes mellitus with polyneuropathy (a type of nerve damage), depression, high blood pressure, and thyroid disorder. The Significant Change Minimum Data Set assessment, dated 5/23/22, indicated she was cognitively impaired, had insulin injections in the last 5 days, and antipsychotics and antidepressants were administered in the last 7 days. The current Physician's Order Summary indicated: to administer Lantus (insulin) 15 units S.Q. (under the skin) at bedtime and hold if her blood sugar is less than 150; monitor her blood glucose twice a day at 6:00 a.m. and at 4:00 p.m.; Levothyroxine Sodium (hormone for thyroid) tablet 25 mcg (micrograms), give 1 tablet by mouth at bedtime; melatonin 3 mg, give two tablets by mouth at bedtime for insomnia; Remeron 15 mg, give 1 tablet by mouth at bedtime for depression; Depakote Sprinkles (mood stabilizer) 125 mg capsule, give 3 capsule by mouth every 8 hours for psychosis. The June 2022 Medication Administration Record indicated the following mediations, dates and			

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	times were not documented as given: - Lantus on 6/23 and 6/24 at 8:00 p.m. - Blood glucose on 6/25 at 6:00 a.m. Her blood sugar on 6/25 at 4:00 p.m. was 319. - Levothyroxine on 6/24 at 8:00 p.m. - melatonin on 6/24 at 8:00 p.m. - Remeron on 6/24/ at 8:00 p.m. - Depakote Sprinkles on 6/17, 6/21 and 6/24 at 10:00 p.m. and 6/25 at 6:00 a.m. A Care Plan, dated 9/17/20, indicated she had been at risk for complications and symptoms of low and high blood glucose. Interventions included, but were not limited to, diabetes medication as ordered by the doctor. A Care Plan, dated 9/17/20, indicated she had an altered endocrine status of hypothyroidism. Intervention included, but were not limited to, administer medications as ordered. A Care Plan, dated 9/17/20, indicated she had received psychotropic medication and was at risk for adverse side effects for her sleep aide, antidepressant and mood stabilizer. Interventions included, but were not limited to, administer medications as ordered by the physician, review behaviors/interventions and alternate therapies attempted and their effectiveness. A Care Plan, dated 11/17/21, indicated she exhibited physical aggression toward other residents and staff when irritated or annoyed by others. Interventions included, but were not limited to, administer medications as ordered. Interview with the Administrator on 6/30/22 at 3:57 p.m. , indicated the Nurse should have documented in the MAR if medications were administered.			

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3. Resident 129's record was reviewed on 7/5/22 at 1:43 p.m. Diagnosis were included, but not limited to, diabetes mellitus, wound infection, high blood pressure, and stroke.

A Significant Minimum Data Set assessment, dated 6/7/22, indicated she had short and long term memory impairments and in the last 7 days had received antipsychotics, antidepressants, and antibiotics.

The current Physician Order Summary indicated she was to have received neoprene solution reconstituted (antibiotic) 1 gram, use 500 mg (milligrams) intravenously (in the vein) every 8 hours for 37 days for wound infection; normal saline flush solution 10 ml (milliliters), use 10 ml intravenously every 8 hours for wound infection, Flush 10 ml of normal saline after the administration of the intravenous medication; normal saline flush solution 10 ml, use 10 ml intravenously every 8 hours for wound infection, Flush 10 ml of normal saline before the administration of the intravenous medication; enrapturing sodium (blood thinner) solution 40 mg/0.4 ml, inject 0.4 ml under the skin one time a day to prevent blood clotting; and hydralazine hydrochloride 25 mg, give 1 tablet by mouth every hours for high blood pressure.

The June 2022 Medication Administration Record indicated the following medications, dates and times were not documented as given:
- neoprene on 6/12, 6/16, 6/18, and 6/19 at 6:00 a.m.
- neoprene on 6/8, 6/9, 6/10, 6/14, 6/15, and 6/16 at 2:00 p.m.
- neoprene on 6/17 and 6/23 at 10:00 p.m.
- normal saline flush after the intravenous

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	medication on 6/12, 6/16, 6/18, and 6/19 at 6:00 am. - normal saline flush after the intravenous medication on 6/8, 6/9, 6/10, 6/12, 6/14, 6/15, and 6/16 at 2:00 p.m. - normal saline flush after the intravenous medication on 6/11, 6/12, 6/16, 6/17, and 6/23 at 10:00 p.m. - normal saline flush before the intravenous medication on 6/12, 6/16, 6/18, and 6/19 at 6:00 a.m. - normal saline flush before the intravenous medication on 6/8, 6/9, 6/10, 6/14, 6/15, and 6/16 at 2:00 p.m. - normal saline flush before the intravenous medication on 6/17 and 6/23 at 10:00 p.m. - enoxaparin on 6/12, 6/16, 6/18 and 6/19 at 6:00 a.m. - hydralazine hydrochloride on 6/3 and 6/17 at 10:00 p.m. A Care Plan, dated 6/1/22, indicated she required an intravenous antibiotic due to a wound infection. Interventions included, but were not limited to, administer intravenous antibiotics as ordered. A Care Plan, dated 11/9/21, indicated she was at risk for impaired cardiac output related to high blood pressure and stroke. Interventions included, but were not limited to, administer medications as ordered. A Care Plan, dated 5/4/22, indicated she was at risk for abnormal bleeding secondary to anticoagulant therapy from a post surgical procedure. Interventions included, but were not limited to, administer medications as ordered. Interview with the Director of Nursing on 7/5/22 at 2:05 p.m., indicated she was unaware of the missing documentation of the medications. The			

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	intravenous antibiotic and normal saline flushes were around shift change, and the nurse who helped the other nurse, probably had forgotten to sign out the medications. A policy titled, "Administering Medications," was provided by the Administrator on 7/1/22 at 11:47 a.m. This current policy indicated, "Policy Statement: Medications are administered in a safe and timely manner, and as prescribed...Policy Interpretation and Implementation:...4. Medication are administered in accordance with prescribe orders, including any required time frame... 22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones...." 3.1- 48(a)(6)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a			

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	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 an AIMS (abnormal involuntary movement scale) assessment was completed for a resident on a antipsychotic medication for 1 of 5 residents reviewed for psychotropic medications. (Resident 123) Finding includes: Resident 123's record was reviewed on 6/29/22 at	F 0758	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Regarding resident #123 the Unit Manager completed an AIMS assessment for this resident who currently takes an antipsychotic medication. Family and physician notified.	07/20/2022

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	11:47 a.m. Diagnoses included, but were not limited to, non-traumatic brain dysfunction, dementia with behavioral disturbances psychotic disorder, diabetes mellitus with polyneuropathy (a type of nerve damage), depression, high blood pressure, and thyroid disorder. A Significant Change Minimum Data Set assessment, dated 5/23/22, indicated she was cognitively impaired, and antipsychotic medications were administered in the last 7 days. A Physician's Order, dated 5/16/22, indicated to administer Seroquel 25 mg (milligrams), 1 tablet by mouth twice a day for psychosis. The May and June Medication Administration Records indicated Seroquel was given as ordered. An AIMS assessment was not completed when Seroquel was ordered and administered. A Care Plan, updated on 5/16/22, indicated she had received psychotropic medication and was at risk for adverse side effects for her sleep aide, antidepressant and mood stabilizer. Interventions included, but were not limited to, administer medications as ordered by the physician, review behaviors/interventions and alternate therapies attempted and their effectiveness, and administer AIMS assessment every 6 months and as needed. Interview with the Administrator on 6/30/22 at 3:00 p.m., indicated the AIMS assessment was not completed and the nurse should have completed the assessment when the medication had started. A Policy, titled, " Psychotropic Management," was provided by the Executive Director on 7/1/22 at 11:53 a.m. This current policy indicated, "...An		Physician gave no new orders. Residents are in stable condition and experienced no negative outcomes as a result of this observation **How other residents of the facility were identified to potentially be affected by the practice are:** All residents who are prescribed psychotropic medications have the potential to be affected by this practice. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** The Unit Manager/designee audited residents on antipsychotic medication to ensure an AIMS assessment was completed. Any deficiencies were corrected at that time. The Director of Nursing/designee educated the licensed staff on the AIMS assessment, the timeframe of completion, & the purpose of the assessment for residents taking antipsychotic medication. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** The Unit Managers/designee will audit five (5) resident medical records who take psychotropic medication per week per unit to ensure the AIMS evaluation was completed for six (6) months.	

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	AIMS assessment is required for residents who are taking antipsychotic medication. The assessment should be completed within 72 hours of a new order to initiate an antipsychotic and then every six months. 3.1-48(a)(3)		Family and physicians notified. Physician gave no new orders. Residents are in stable condition and experienced no negative outcomes as a result of this observation The DON/designee will report audit findings to the QAPI committee monthly for six (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	
F 0805 SS=D Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. Based on observation, record review, and interview, the facility failed to serve residents the appropriate food and food consistency for their ordered diets for 2 of 4 residents reviewed for food. (Residents C and L) Findings include: 1. On 6/29/22 at 11:36 a.m., Resident C was observed sitting in her wheelchair at a table in the dining room. At 11:51 a.m., the resident's lunch tray was delivered and consisted of a piece of beef, mashed potatoes and gravy, cooked carrots, and a blueberry crumble. The resident did not attempt to feed herself. The staff in the dining area had to continue to encourage the resident to eat.	F 0805	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Dietary manager corrected Resident C and Resident K food trays to ensure appropriate food and food consistency was served at each meal. Family, registered dietitian, and physicians were notified. Physicians gave no new orders. Residents are in stable condition and experienced no negative outcomes as a result of this observation.	07/20/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Record review for Resident C was completed on 6/28/22 at 3:56 p.m. Diagnoses included, but were not limited to, hypertension, and thyroid disorder. The Significant Change Minimum Data Set (MDS) assessment, dated 4/26/22, indicated the resident was cognitively impaired. The resident required supervision of 1 person for eating. The June 2022 Physician's Order Summary indicated an order for Finger foods diet, dated 6/10/22. A Nutrition/Dietary Note, dated 5/10/21, indicated they had spoken with the resident's daughter on the phone. They added finger food type items to her dietary card. Interview with Speech Therapist 1 on 6/29/22 at 2:15 p.m., indicated she was in the dining room when Resident C was having her lunch. She indicated the resident's meal was not finger foods. Finger food would consist of things like "chicken nuggets or grilled cheese". Interview with the Dietary Manager (DM) and Dietary Aide 1 on 6/29/22 at 2:38 p.m., indicated the carrots would have been considered finger foods. The resident should have received chicken tenders instead of the beef and potato chips instead of the mashed potatoes. The DM further indicated it was printed on the resident's dietary card for her to have finger foods. The kitchen should have given her finger foods for lunch. 2. On 6/29/22 at 9:20 a.m., Resident L was observed sitting in her wheelchair eating breakfast. She had eggs, a slice of ham, oatmeal, and coffee. The resident ate part of the ham slice.		**How other residents of the facility were identified to potentially be affected by the practice are:** All residents have the potential to be affected by this practice. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Dietary manager completed a whole house audit to ensure all tray cards correctly identified appropriate food and food consistency per resident individual needs. Dietary staff educated on following tray card preferences and food consistency. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** Dietary manager/designee will complete daily audits (5) per week for (3) months, then (3) per week for (3) months. The Dietary Manager/designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	

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	155214	A. BUILDING 00 B. WING	07/05/2022

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	She indicated she had to cut it up into tiny pieces and chew for a long time. Record review for Resident L was completed on 6/28/22 at 3:47 p.m. Diagnoses included, but were not limited to, diabetes mellitus, and atrial fibrillation. The Quarterly MDS assessment, dated 6/10/22, indicated the resident was cognitively intact. The resident required supervision of 1 person for eating. A current Care Plan indicated the resident had a swallowing problem and was at risk for aspiration. An intervention included a mechanical soft diet. A Physician's Order, dated 5/31/22, was for a reduced carbohydrate mechanical soft diet. Interview with QMA 1 on 6/29/22 at 9:22 a.m., indicated the resident's breakfast tray was not a mechanical soft diet. Interview with LPN 2 on 6/29/22 at 10:00 a.m., indicated the whole piece of ham was given to the resident in error and was not the first time dietary had done that. A policy titled, "Food and Nutrition Services", and received as current from the facility, indicated, "...7. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature. a. If an incorrect meal is provided to a resident, or a meal does not appear palatable, nursing staff will report it to the Food Service Manager so that a new food tray can be issued...."			

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	This Federal tag relates to Complaints IN00378664 and IN00383367. 3.1-21(a)(3)			
F 0807 SS=D Bldg. 00	483.60(d)(6) Drinks Avail to Meet Needs/Prefs/Hydration §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. Based on observation, record review, and interview, the facility failed to ensure a dependent resident had fluids accessible to maintain proper hydration for 1 of 5 residents reviewed for hydration. (Resident K) Finding includes: On 6/28/22 at 3:20 p.m., Resident K was observed lying in bed. She indicated no one had brought her fresh water until just then and she had been asking for fresh water all day. On 6/29/22 at 9:05 a.m., Resident K was observed lying in bed. No water to drink was observed at the resident's bedside. On 6/29/22 at 12:05 p.m., Resident K was observed sitting in a wheelchair in her room. No water to drink was observed in the room. Record review for Resident K was completed on 6/29/22 at 10:35 a.m. Diagnoses included, but were not limited to, diabetes mellitus, and arthritis.	F 0807	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Regarding resident K water was brought to her by the staff. Family and physicians notified. Physician gave no new orders. Residents are in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents have the potential to be affected by this practice. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Nurse Managers/designee	07/20/2022

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	The Quarterly Minimum Data Set (MDS) assessment, dated 5/29/22, indicated the resident was cognitively intact. The resident required an extensive 2+ person assist for bed mobility and transfers. The resident required supervision of 1 person for eating. Interview with LPN 3 on 6/29/22 at 12:05 p.m., indicated the residents were to have fresh water brought to them daily. The resident was not given water yet that day. This Federal tag relates to Complaint IN00378664. 3.1-46(b)		observed/audited all the residents who can have water pitchers at bedside. Any deficiencies were corrected at that time. The Director of Nursing/designee educated the staff on the hydration policy which includes the procedure for passing water to the residents. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** The Unit Managers/designee will audit five (5) residents per week per unit to ensure water is provided for six (6) months. The DON/designee will report audit findings to the QAPI committee monthly for six (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.			

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	(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food and utensils were properly stored under sanitary conditions in the freezers, refrigerators, and dry storage area for the Main Kitchen. This had the potential to affect 155 residents who received meals from the kitchen. (Main Kitchen) Findings include: During the initial tour of the kitchen on 6/27/22 at 8:56 a.m. with the Dietary Manger, the following was observed: 1. In Freezer 1: a. There were multiple boxes stored on the floor, covering half of the freezer's floor. b. Unlabeled and undated sausage crumbles. c. Open to air, unlabeled and undated bag of french fires. d. Undated bag of pepperoni slices. e. One unknown brown bag that was unlabeled and undated. f. Three boxes of food stored on the top shelves, less than 18 inches from the ceiling. 2. In Freezer 2: a. There were multiple boxes stored on the floor.	F 0812	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** All food and boxes were properly stored. Utensils have been placed in appropriate container that have been labeled to ensure efficiency. All food products have been labels and dated according to food service guidelines on expiration dates. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents have the potential to be affected by this practice. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Kitchen food storage, freezer, and refrigerator audit was completed. Dietary Manager educated dietary staff on proper food storage, utensil storage, labeling and dating food, and checking food	07/20/2022

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	b. On the top shelves, the boxes were stacked all the way up to the ceiling. 3. In the Dry Storage Area: a. A large bag of corn starch was open to air, undated and stored on the floor. b. There were 5 thickened Orange Juice containers that were expired. Two had a "best used by" of 2/2022 and three were dated 5/2022. 4. In the Preparation area in the Kitchen: a. There were 2 large containers of light colored substances with clear lids stored under the counter. They were not stored in their original container, and were unlabeled and undated. The Dietary Manger at that time indicated one container was oatmeal and one container was flour. b. In the flour container, a large scoop was observed to have been stored in with the flour. 5. In the Preparation Cooler: a. There was a clear package of meat, not in its original package, unlabeled and undated. The Dietary Manager indicated the meat was turkey meat and she did not know when the turkey was opened. 6. In the Paper Storage Area: a. There were 11 containers of kitchen utensils uncovered in plastic totes, exposed to air. Interview with the Dietary Manger at the end of the tour, indicated there was a person that was on vacation who usually rotated the stock and placed the food boxes in the freezers. There should not have been a scoop left in the flour container, the foods should have been closed, labeled and dated and the utensils should have been contained with a lid.		expiration dates. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** Dietary Manager/Designee will complete audit (5) per week for (3) months, then (3) per week for 3 months. The Dietary Manager/designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	

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	A Policy, titled, "Food Storage," was provided by the Administrator on 6/28/22 at 3:41 p.m. This current policy indicated, "...Food items in dry storage will be stored at least 6 inches from he floor...items removed from original packaging will be dated with date of delivery and will be rotated/used by following first in, first out, opened container will be resealed in a manner that protects the remaining food product and will be dated with open date and a discard date...." 3.1-21(i)(2)(3)			
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;			

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	§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 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			

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	of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure Infection Prevention and Control measures were implemented related to a resident's urinary catheter bag on the floor for 1 of 2 catheters reviewed. (Resident 143) Finding includes: On 6/27/22 at 10:43 a.m., Resident 143 was observed sitting in a Broda chair (positioning chair) in her room. A urinary catheter bag was hanging on the side of the Broda chair. The catheter tubing was touching the floor. On 6/28/22 at 3:47 p.m., Resident 143 was observed lying in bed. A urinary catheter bag was on the floor next to the bed. The bag had visible urine in it and was not covered. Record review for Resident 143 was completed on 6/29/22 at 10:38 a.m. Diagnoses included, but were not limited to, neurogenic bladder, stroke, and dementia. The Significant Change Minimum Data Set (MDS) assessment, dated 5/26/22, indicated the resident was cognitively impaired. The resident required an extensive 2+ person assist for bed mobility and toilet use. A total 2+ person assist for transfers. The resident had an indwelling urinary catheter. Interview with Agency LPN 1 on 6/28/22 at 3:51 p.m., indicated the resident's urinary catheter bag	F 0880	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Regarding resident 143 indwelling catheter bag and tubing were secured below the level of the bladder and positioned off the floor. Resident was assessed. Family and physicians notified. Physician gave no new orders. Residents are in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents with urinary catheter potential to be affected by this practice. IP/DNS/Administrator completed root cause analysis and CDC LTC infection control assessment. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Nurse Managers/designee audited/observed all the residents who require a urinary catheter to ensure all catheter bags are	07/20/2022

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	and tubing should not have been on the floor. 3.1-18(b)		correctly secured below the level of the bladder and positioned off the floor. Any deficiencies were corrected at that time. The Director of Nursing/designee educated the staff on indwelling catheters are cared for in a manner to prevent the possibility of infection by ensuring they are below the level of the bladder and the catheter drainage bag and tubing are positioned off the floor at all times. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** IP nurse/DON/Designee will conduct audit daily for 6 weeks and until compliance is maintained. IP nurse/DON/Designee will complete daily visual rounds for (6) week and until compliance is maintained, throughout the facility to ensure staff are practicing appropriate Infection Control Practices and compliance with solutions identified. The DON/designee will report audit findings to the QAPI committee monthly for six (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	

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F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on record review and interview, the facility failed to follow antibiotic use protocols related to not meeting McGreer's criteria for a true infection prior to use of antibiotics for 2 of 3 residents reviewed for antibiotic stewardship. (Residents 83 and K) Findings include: On 6/28/22 at 2:00 p.m., the Infection Control/Antibiotic Stewardship binder was reviewed. 1. The April 2022 Monthly Surveillance Log indicated Resident 83 was treated for a urinary tract infection (UTI) on 4/8/22. She had shown increased confusion and had a UA (urinalysis, lab test) completed. The UA showed 60-70,000 ESBL (a type of bacteria) and the resident was prescribed Macrobid 100 mg (milligrams) every 6 hours for 5 days. The McGreer's criteria (a standardized set of guidelines used to determine true infections) was evaluated on the "McGreer's Criteria for Signs/Symptoms of UTI Without an Indwelling Urinary Catheter" form, dated 4/14/22. It indicated the McGreer's criteria was not met. There was lack of documentation as to why the resident received the antibiotic when the criteria	F 0881	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Regarding resident #83 & K the Physician was notified of the infections not being validated by the McGgreer's criteria. Family and physicians notified. Physician gave no new orders. Residents are in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents with urinary catheter potential to be affected by this practice. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** The Infection Control Preventionist/designee audited resident records with an infection	07/20/2022

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	for a true infection had not been met. 2. The April 2022 Monthly Surveillance Log indicated Resident K was treated for a urinary tract infection (UTI) on 4/4/22 upon return from the hospital. She had a UA completed. The UA showed 50-100,000 VRE (a type of bacteria) and the resident was prescribed amoxicillin 500 mg (milligrams) every 8 hours for 4 days. The McGreer's criteria was evaluated on the "McGreer's Criteria for Signs/Symptoms of UTI Without an Indwelling Urinary Catheter" form, dated 4/12/22. It indicated the McGreer's criteria was not met. There was lack of documentation as to why the resident received the antibiotic when the criteria for a true infection had not been met. Interview with the Administrator and Infection Preventionist on 7/5/22 at 1:32 p.m., indicated the infections had not met the McGreer's criteria of a true infection. The Medical Director was new, and they were working on educating him on antibiotic stewardship. A facility policy, titled "Infection Control Antibiotic Prescribing Practices," indicated, "...2. The decision to prescribe an antibiotic will be guided by medical knowledge, best practices, and professional guidelines..."		in the past 30 days with the Medical Director to validate based on the McGreer's criteria. Any deficiencies were noted at that time. The Director of Nursing/designee educated the licensed nursing staff on the McGreer's criteria to validate a true infection. The Infection Preventionist educated the Medical Director on the McGreer's criteria to validate a true infection. The Infection Preventionist also educated Medical Director that if it is determined that antibiotic therapy is necessary but does not meet McGreer's criteria then the Medial Director will proceed with a progress note. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** The Infection Preventionist/designee will meet weekly with the Medical Director to review all residents on antibiotic therapy & validate the infection based on the McGreer's criteria. The Infection Control Preventionist/designee will report audit findings to the QAPI committee monthly for six (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	

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