STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	06/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE ARBORS MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

(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 Complaints IN00353542, IN00353639, and IN00353874. Complaint IN00353542 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00353639 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00353874 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: May 24, 25, 26, 27, 28, June 1 and 2, 2021 Facility number: 000076 Provider number: 155156 AIM number: 100271060 Census Bed Type: SNF/NF: 89 SNF: 15 Total: 104 Census Payor Type: Medicare: 18 Medicaid: 70 Other: 16 Total: 104 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

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

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	Quality review completed on 6/7/21.			
F 0550 SS=E 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 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			

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	be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, record review and interview, the facility failed to ensure each resident's dignity was maintained related to being exposed while in bed, hospital gowns being used during the day while in bed, and the posting of personal care signs by staff for 4 of 5 residents reviewed for dignity. (Residents 51, C, F, and 38) Findings include: 1. On 5/24/21 at 3:11 p.m., Resident 51 was observed in her room in bed with the door open. The resident was wearing a shirt and she had an incontinence brief in use. The resident was not covered and she was visible from the doorway. Staff and residents were in the hallway at that time. At 3:43 p.m., the door to the resident's room remained open. She had not been covered up and her incontinence brief was visible from the hallway. The record for Resident 51 was reviewed on 5/26/21 at 10:30 a.m. Diagnoses included, but were not limited to, stroke, vascular dementia with behavior disturbance, major depressive disorder, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 3/30/21, indicated the resident was severely impaired for daily decision making and needed extensive assistance with dressing. Interview with the Director of Nursing on	F 0550	**F550 - Resident's Rights (Dignity)** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Residents 51 was dressed properly and covers applied to prevent exposure. Resident C and F were dressed and assisted out of bed. Resident 38 the sign was removed from the wall in the room. **2) How the facility identified other residents:** Residents who receive assistance with ADL's have the potential to be	07/02/2021

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	5/28/21 at 3:00 p.m., indicated the resident should have been covered with a blanket or her door should have been closed. 2. On 5/24/21 at 2:46 p.m., Resident C was observed in bed dressed in a hospital gown. On 5/25/21 at 9:59 a.m., the resident was observed in bed dressed in hospital gown which was stained with food. On 5/27/21 at 8:41 a.m., 9:55 a.m., and 2:04 p.m., the resident was observed in bed dressed in a hospital gown. On 5/28/21 at 8:30 a.m., 9:10 a.m., and 12:15 p.m., the resident was observed in bed dressed in a hospital gown. The record for Resident C was reviewed on 5/27/21 at 8:48 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dysphagia, asthma, history of COVID 19, metabolic encephalopathy, anxiety, delusional disorder, major depressive disorder, psychosis, breast cancer, and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 3/2/21, indicated the resident was not alert and oriented. She received a mechanically altered diet and had 1 stage 3 pressure ulcer. In the last 7 days the resident received antipsychotic and antidepressant medication. There was no Care Plan the resident preferred to be dressed in a hospital gown during the day. Interview with the Director of Nursing on 5/28/21 at 1:30 p.m., indicated the resident should be dressed in street clothes if available.		affected by this deficient practice. An audit was completed to identify residents who spend the majority of time in bed and prefer to wear a gown while in bed and it was care planned accordingly. **3) Measures put into place/ System changes:** Interview residents on their preference for getting up and dressed. Rounds were completed to identify any other signs posted about care in resident rooms and w e r e removed accordingly. Staff will be educated on Resident's Rights as it pertains to dignity **4) How the corrective actions will be monitored:** Rounds will be completed at least 5x/week on various shifts and at various times to ensure dignity and privacy is maintained and residents are dressed based on their preference. The Director of Nursing or designee will be responsible for oversight of these audits. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to**	

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	3. On 5/26/21 at 9:55 a.m. and 2:05 p.m., Resident F was observed in bed wearing a hospital gown. On 5/27/21 at 8:30 a.m., 9:45 a.m., and 1:30 p.m., and 2:10 p.m., the resident was observed in bed dressed in a hospital gown. On 5/28/21 at 9:15 a.m., the resident was observed in bed dressed in a hospital gown. The record for Resident F was reviewed on 5/26/21 a 10:26 a.m. Diagnoses included but were not limited to, COPD (chronic obstructive pulmonary disease), dysphagia, major depressive disorder, anxiety, abnormal weight loss, alcohol induced dementia, and high blood pressure. The Annual Minimum Data Set (MDS) assessment, dated 3/24/21, indicated the resident not alert and oriented. She needed extensive assist with 2 person physical assist for bed mobility and transfers, and needed extensive assist with 1 person physical assist for personal hygiene. There was no Care Plan to indicate the resident preferred to be dressed in a hospital gown during the day. Interview with the Director of Nursing on 5/28/21 at 1:30 p.m., indicated the resident should be dressed in street clothes if available. 4. On 5/24/21 at 11:43 a.m., there was a sign posted on Resident 38's wall inside his room. The sign indicated "No water at bedside-dialysis resident." The resident indicated the nurse hung it up on the wall.		**revise the plan of correction as indicated.** **5) Date of compliance: 7/2/21**	

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	On 5/25/21 at 10:20 a.m., 5/26/21 at 1:35 p.m., 5/27/21 at 8:45 a.m., and 5/28/21 at 9:30 a.m., the sign was still hanging on the resident's room wall. The record for Resident 38 was reviewed on 5/27/21 at 2:30 p.m. Diagnoses included, but were not limited to, respiratory failure, COPD (chronic obstructive pulmonary disease), type 2 diabetes, high blood pressure, dependent on renal dialysis, major depressive disorder, schizophrenia, and end stage renal disease. The 3/30/21 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was alert and oriented, and received dialysis and oxygen while a resident. There was no Care Plan for signs to be posted in the resident's room. A Physician's Order, dated 9/5/20, indicated no water at the bedside. Only at meals and medication pass three times a day for dialysis resident. Interview with the Director of Nursing on 5/28/21 at 1:30 p.m., indicated there should be no staff signs hanging in the resident's room. 3.1-3(t)			
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.			

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	§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.			
	Based on observation, record review and interview, the facility failed to provide privacy during incontinence care for 1 of 3 observations of incontinence care. (Resident G) Finding includes: On 5/26/21 at 10:00 a.m., CNA 3 was providing incontinence care for Resident G. The resident	F 0583	F583 - Privacy/ Confidentiality of records The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of	07/02/2021

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	was observed rolled completely over on her left side with her head downwards on the pillow. The privacy curtain was not pulled around the resident nor was it pulled between the resident and her roommate. The resident's roommate was observed sitting next to her bed watching television and was in full view of Resident G. The CNA was cleaning up a large amount of bowel movement on the resident's bare buttocks and the back of her legs. After the CNA had finished the incontinence care, she left the room. Interview with CNA 3 on 5/26/21 at 10:24 a.m., indicated she had forgotten to pull the privacy curtain around the resident. The record for Resident G was reviewed on 5/26/21 at 11:17 a.m. Diagnoses included, but were not limited to multiple sclerosis, COPD (chronic obstructive pulmonary disease), dysphagia, type 2 diabetes, high blood pressure, anxiety, adult failure to thrive, major depressive disorder, delusions, and dementia with behavioral disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 5/13/21, indicated the resident had modified cognition abilities. The resident was an extensive assist with 2 person physical assist for bed mobility and personal hygiene. She had range of motion impairment and limitations on 1 side for both upper and lower extremities. Interview with the Director of Nursing on 5/28/21 at 1:30 p.m., indicated the privacy curtain should have been pulled around the resident during incontinence care . 3.1-3(p)(4)		this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident G- staff was educated to pull privacy curtain 2) How the facility identified other residents: All residents requiring assistance with ADL's have the potential to be affected by the deficient practice. 3) Measures put into place/ System changes: Staff will be re-educated regarding resident's privacy while providing care such as ensuring window coverings are closed , door closed and reporting of any curtains in need of replacement or repair. 4) How the corrective actions will be monitored: The Director of Nursing or designee will complete rounds at least 5 x per week on various shifts and times to ensure privacy is being maintained. An interview will be conducted on at least 3 residents per week to ensure staff	

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			are providing for privacy. The DON will be responsible for oversight. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 07/2/21	
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 antipsychotic and diuretic medication use for 1 of 25 MDS assessments reviewed. (Resident 28) Finding includes: The record for Resident 28 was reviewed on 5/28/21 at 12:39 p.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, Alzheimer's disease, psychosis, mood disorder, major depressive disorder, and lymphedema. The Quarterly Minimum Data Set (MDS)	F 0641	F641 – MDS Accuracy The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or	07/02/2021

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	assessment, dated 5/11/21, indicated the resident had severe impairment for daily decision making. Section N - Medications, indicated the resident had not received a diuretic, antidepressant, or antipsychotic within the last 7 days. A Physician's Order, dated 1/17/21, indicated the resident was to receive Furosemide (a diuretic) 40 milligrams (mg) daily for edema. A Physician's Order, dated 3/23/21, indicated the resident was to receive Risperdal (an antipsychotic medication) 0.25 mg daily and 0.5 mg in the evening. The May 2021 Physician's Order Summary (POS), indicated the resident was to receive Wellbutrin SR (an antidepressant) 100 mg daily. The May 2021 Medication Administration Record (MAR) indicated the resident had received the above medications 5/1 - 5/11/21. Interview with the MDS Coordinator on 6/2/21 at 11:30 a.m., indicated the MDS had been coded inaccurately related to the medications. 3.1-31(i)		executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: • Resident #28: MDS was corrected and resubmitted 2) How the facility identified other residents: All residents who have the potential to be affected by the alleged deficient practice. MDS's submitted since 5/18/21 through 6/18/21 will have sections N0300,N0350 A & B, and N0410 A, B, C, D, E, F,G, and H reviewed for accuracy and resubmitted if appropriate. 2) Measures put into place/ System changes: The MDS Regional will re-educate the MDSC's on accuracy of documentation and coding. The MDS Coordinator/designee will review 2 MDS's per week to ensure accurate coding and document on Accuracy of Assessments audit tool. The MDSC will be responsible for compliance. 4) How the corrective actions will	

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			be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 7/2/21	
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			

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	in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to provide documentation of care conferences held with the resident and facility staff for 2 of 3 residents reviewed for care planning decisions. (Residents 38 and H) Findings include: 1. During an interview on 5/24/21 at 11:41 with Resident 38, he indicated he had never been to a care plan conference since residing at the facility. The record for Resident 38 was reviewed on 5/27/21 at 2:30 p.m. Diagnoses included, but were not limited to, respiratory failure, COPD (chronic obstructive pulmonary disease), type 2 diabetes, high blood pressure, dependent on renal dialysis, major depressive disorder, schizophrenia, and end stage renal disease. The 3/30/21 Quarterly Minimum Data Set (MDS) assessment indicated the resident was alert and oriented, and received dialysis and oxygen while a resident. Interview with the Social Service Director on 5/27/21 at 10:45 a.m., indicated she could not remember when the last time the resident had a care conference. Neither the resident nor his family had participated in a care conference. There was no documentation of any care conference held with the interdisciplinary team with or without the resident and/or the family.	F 0657	F657 Care Plan Timing and Revision The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident 38 & H- Resident and/or Resident Representative will be invited to attend a care plan meeting. 2) How the facility identified other residents:	07/02/2021

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	She indicated the receptionist sends out the invites to the residents and their families. 2. During an interview on 5/24/21 at 3:08 p.m., Resident H indicated she had not been invited to attend any care conferences in the last year. The record for the Resident H was reviewed on 5/26/21 at 8:47 a.m. Diagnoses included but were not limited to, cervical spina bifida, paraplegia, neurological bladder, major depressive disorder, chronic osteomyelitis, anxiety, and left shoulder pain. The Modification of the Annual Minimum Data Set (MDS) assessment, dated 4/26/21, indicated the resident was alert and oriented. She was totally dependence on staff with 1 person physical assist for bathing. The resident had an urostomy for bladder control. There was no documentation the resident had care conference in the last year. Interview with the Social Service Director on 5/27/21 at 10:45 a.m., indicated neither the resident nor her family had participated in the last year for a care conference. There was no documentation of the care conference the interdisciplinary team had without the resident or her family. 3.1-35(d)(2)(B)		An audit will be completed of all residents with care plan reviews scheduled in the next 14 days to ensure the resident and/or their representative are invited to attend. 3) Measures put into place/ System changes: Social Service and MDS Coordinator will be re-educated regarding care plan invitations and documentation of care plan meetings. An audit will be completed weekly of at least 2 residents who had a care plan review completed in the prior 7 days to ensure that the resident and/or their representative were invited to attend, and that the care plan meeting was documented, including a record of attendees present. The Social Service Director and/or MDS Coordinator will be responsible for oversight of these audits. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or	

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	155156	A. BUILDING 00 B. WING	06/02/2021

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			greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 7/2/21	
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review and interview, the facility failed to ensure dependent residents received assistance with ADL's (activities of daily living) related to dressing, oral care, nail care, hair care, getting out of bed, and bathing for 6 of 6 residents reviewed for ADL's (Residents D, E, C, G, F, and H) Findings include: 1. On 5/25/21 at 10:09 a.m., Resident D was propelling up and down the hall in her wheelchair. The resident had dried food spillage on her pants. At 10:30 a.m., CNA 1 took the resident into her room for incontinence care. The resident continued to wear the same pair of pants. At 2:19 p.m., the resident was wearing the same food stained pants. The record for Resident D was reviewed on 5/27/21 at 10:10 a.m. Diagnoses included, but were not limited to, schizoaffective disorder,	F 0677	F677 - ADL Dependent Resident The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified:	07/02/2021

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	anxiety, dementia with behavioral disturbance, and mixed obsessional thoughts and acts. The Quarterly Minimum Data Set (MDS) assessment, dated 4/26/21, indicated the resident was severely impaired for daily decision making and required extensive assistance for dressing. The Care Plan, dated 9/23/20, indicated the resident had limited physical mobility/ADL deficits related to Alzheimer's, weakness, and needed assist with ADL's. Interventions included, but were not limited to, provide supervision and verbal (sic) for ADL's as needed. Interview with the Director of Nursing on 5/28/21 at 3:00 p.m., indicated the resident's pants should have been changed. 2. Interview with Resident E on 5/24/21 at 2:55 p.m., indicated he did not receive oral care on a consistent basis and he could not remember the last time his teeth were brushed. On 5/27/21 at 11:55 p.m., the resident was observed in his room seated in his wheelchair. The resident's teeth were discolored with a brown substance. The resident indicated his teeth were not brushed this morning. On 5/28/21 at 8:20 a.m., the resident was in his room watching television. The resident indicated he had not received morning care yet nor had his teeth been brushed. His teeth remained discolored with a brown substance. When asked if the resident had received morning care, on 5/28/21 at 10:30 a.m., CNA 2 indicated the resident was not assigned to her and he resided on the 300 hall. She was not aware that		Resident D- rounds completed to ensure residents clothing clean appropriate. Resident E- rounds completed to ensure all residents oral care was rendered for all residents requiring assistance. Resident C- Rounds completed to ensure all dependent residents were up and dressed appropriately. Resident G- rounds completed to ensure all residents oral care was rendered for all residents requiring assistance. Resident H- Receive hair care and bed bath immediately Resident F- Rounds completed on all dependent residents to ensure nails were clean and acceptable length. Rounds completed to ensure all dependent residents were up and dressed appropriately. 2) How the facility identified other residents: Audit completed and determined residents requiring assistance with ADL's have the potential to be affected. 3) Measures put into place/ System changes: Staff will be re-educated on providing assistance with all ADL' s as needed, including showers, Nail Care, bed baths, clean and appropriate clothing, and Oral	

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	he had changed rooms and was on her run for the day. She indicated that she had just returned from vacation and no one told her the resident had moved and she had not provided any care for the resident. Further interview with the CNA at 10:45 a.m., indicated the Wound Nurse had provided incontinence care prior to completing his treatment. On 6/2/21 at 10:40 a.m., the resident was observed in bed. He indicated his teeth had not been brushed this morning. His teeth continued to have areas of brown discoloration. The record for Resident E was reviewed on 5/28/21 at 9:25 a.m. Diagnoses included, but were not limited to, lack of coordination, bacterial agents as the cause of diseases, dysphagia (difficulty swallowing), anxiety, and major depressive disorder. The Significant Change Minimum Data Set (MDS) assessment, dated 4/7/21, indicated the resident was moderately impaired for daily decision making and required extensive assistance with personal hygiene. The Care Plan, dated 7/24/20, indicated the resident had an ADL self-care performance deficit related to Wernicke's encephalopathy (a neurological disease), weakness, and spinal stenosis (narrowing of the spinal canal). Interventions included, but were not limited to, brush teeth, rinse dentures, clean gums with toothette, and rinse mouth with wash. There was no documentation indicating oral care had been provided. Interview with the Director of Nursing on 6/2/21		care. 4) How the corrective actions will be monitored: The Director of Nursing or designee will complete care rounds on at least 5 dependent residents per week at varied times/shifts to ensure ADL assistance is provided per plan of care. Interviews will be conducted on 3 residents per week to ensure showers/baths are given per preference. The DON will be responsible for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 7/2/21	

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	at 2:30 p.m., indicated oral care should have been completed for the resident and documented. 3. On 5/24/21 at 2:46 p.m., Resident C was observed in bed dressed in a hospital gown. On 5/25/21 at 9:59 a.m., the resident was observed in bed dressed in hospital gown which was stained with food. On 5/27/21 at 8:41 a.m., 9:55 a.m., and 2:04 p.m., the resident was observed in bed dressed in a hospital gown. On 5/28/21 at 8:30 a.m., 9:10 a.m., and 12:15 p.m., the resident was observed in bed dressed in a hospital gown. The record for Resident C was reviewed on 5/27/21 at 8:48 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dysphagia, asthma, history of COVID 19, metabolic encephalopathy, anxiety, delusional disorder, major depressive disorder, psychosis, breast cancer, and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 3/2/21, indicated the resident was not alert and oriented. The resident was totally dependent on staff for bed mobility and transfers. The resident holds food in the mouth and had coughing and choking. In the last 7 days the resident received antipsychotic and antidepressant medication. The updated 3/2/21 Care Plan, indicated the resident had activities of daily living self care performance deficit related to pain and weakness. The approaches were to transfer the resident with a hoyer (mechanical lift).			

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	There was no Physician's Order for the resident to be on bed rest. Interview with the Director of Nursing on 5/28/21 at 1:30 p.m., indicated there was no Physician's Order for bed rest. 4. During an interview with Resident G on 5/24/21 at 11:25 a.m., she indicated she was ashamed to say how long it had been since her teeth had been brushed. She did not remember the last time. Interview with CNA 1 on 5/26/21 at 10:00 a.m., indicated she was taking care of the resident and had provided morning care for her before breakfast. She indicated she had washed the resident's face, under arms, provided incontinence care and changed her clothes. The CNA did not indicate oral care had been provided. On 5/28/21 at 7:17 a.m. CNA 3 and CNA 4 were going to provide morning care for the resident. CNA 4 washed the resident's face and combed her hair and they both provided incontinence care to the resident. After they were finished, they left the room. The resident's shirt was not changed, nor was oral care provided. Interview with CNA 3 on 5/28/21 at 7:30 a.m., indicated today was her shower day, so the hospice CNA comes in and will give her a complete bed bath. She was not sure when the hospice CNA would be in as it varied every day. The CNA indicated oral care had not provided. The record for Resident G was reviewed on 5/26/21 at 11:17 a.m. Diagnoses included, but were not limited to multiple sclerosis, COPD			

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	(chronic obstructive pulmonary disease), dysphagia, type 2 diabetes, high blood pressure, anxiety, chronic kidney disease, visual hallucinations, chronic respiratory failure, adult failure to thrive, major depressive disorder, delusions, and dementia with behavioral disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 5/13/21, indicated the resident had modified cognition abilities. The resident was an extensive assist with 2 person physical assist for bed mobility and personal hygiene. She had range of motion impairment and limitations on 1 side for both upper and lower extremities. The updated 5/7/20 Care Plan, indicated the resident had her own teeth which were in poor condition. The approaches were assist/remind/encourage the resident to perform oral hygiene at least daily A Care Plan, updated, 5/7/20, indicated the resident had an activities of daily living self care deficit. The approaches were to assist with personal hygiene as needed including oral and dental care. The hospice daily schedule for 5/2021 indicated the hospice CNA was at the facility on 5/24 from 5:45 - 6:15 p.m., 5/25 from 2:30 p.m., to 3:15 p.m., and 5/26/21 from 5 p.m., to 5:45 p.m. The hospice CNA visit documentation indicated oral care had not been provided during the visits on 4/28, 5/4, and 5/11/21. Interview with the Director of Nursing on 5/28/21 at 1:30 p.m., indicated oral care was to			

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	be provided with morning and evening care. 5. On 5/26/21 at 9:55 a.m. and 2:05 p.m., Resident F was observed in bed wearing a hospital gown. The resident's fingernails on both hands were long and dirty. On 5/27/21 at 8:30 a.m., 9:45 a.m., and 1:30 p.m., and 2:10 p.m., the resident was observed in bed dressed in a hospital gown. The resident's fingernails on both hands were long and dirty. On 5/28/21 at 9:15 a.m., the resident was observed in bed dressed in a hospital gown. The resident's fingernails on both hands were long and dirty. The record for Resident F was reviewed on 5/26/21 a 10:26 a.m. Diagnoses included but were not limited to, COPD (chronic obstructive pulmonary disease), dysphagia, major depressive disorder, anxiety, abnormal weight loss, alcohol induced dementia, and high blood pressure. The Annual Minimum Data Set (MDS) assessment, dated 3/24/21, indicated the resident not alert and oriented. She needed extensive assist with 2 person physical assist for bed mobility and transfers, and needed extensive assist with 1 person physical assist for personal hygiene. She wore oxygen while a resident. The updated 4/2/20 Care Plan, indicated the resident had a self care deficit for activities of daily living. The approaches were to transfer the resident with 1 or 2 staff assist. There was no Care Plan the resident refused nail care.			

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	There was no Physician's Order for the resident to be on bed rest. Interview with the Director of Nursing on 5/28/21 at 1:30 p.m., indicated there was no order for the resident to be on bed rest and her fingernails should be cleaned and clipped. 6. During an interview with Resident H on 5/24/21 at 3:00 p.m., she indicated she was not always getting complete bed baths. She was supposed to get a bed bath 2 times a week but lately it had only been 1 time a week. She indicated her hair had not been washed in weeks. The record for Resident H was reviewed on 5/26/21 at 8:47 a.m. Diagnoses included but were not limited to, cervical spina bifida, paraplegia, neurological bladder, major depressive disorder, chronic osteomyelitis, anxiety, and left shoulder pain. The Modification of the Annual Minimum Data Set (MDS) assessment, dated 4/26/21, indicated the resident was alert and oriented. She was totally dependence on staff with 1 person physical assist for bathing. The resident had an urostomy for bladder control. The Care Plan, updated 3/3/21, indicated the resident preferred a bed bath 2 times a week on Mondays and Thursdays. The shower/bath and shampoo of the hair documentation indicated the resident did not receive a bed bath or have her hair washed on 4/19 and 5/17/21. The last documented time the resident's hair was washed was on 5/10/21. Interview with the Director of Nursing on			

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	5/28/21 at 1:30 p.m., indicated the resident should have had her bed baths at least two times a week and her hair washed during those bed baths. This Federal tag relates to Complaint IN00353542. 3.1-38(a)(2)(A) 3.1-38(a)(2)(B) 3.1-38(a)(3)(B) 3.1-38(a)(3)(C)			
F 0679 SS=E Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review and interview, the facility failed to ensure an ongoing activity program was implemented for alert and oriented, cognitively impaired, and dependent residents for the Memory Care Unit (MCU) and 2 of 3 residents reviewed for activities. (Residents 154 and F, Memory Care Unit) Findings include: 1. On 5/25/21 at 10:07 a.m., music was being played on the Memory Care Unit (MCU). The unit consisted of higher and lower functioning	F 0679	F679 Activities The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the	07/02/2021

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	dementia residents. Activity staff were going around talking to some residents, no structured activity was taking place. At 10:10 a.m., Activity Aide 1 asked about 3-4 residents if they wanted to kick the ball. Other residents were observed sleeping in their wheelchairs or wandering up and down the hall. On 5/26/21 at 9:10 a.m., Activity Aide 1 arrived on the MCU. She indicated she would be on the unit until 10:30 a.m., then she had to take over family visits and someone else would relieve her at that time. Music was again playing. No activity was occurring. At 9:27 a.m., the Activity Aide got the ball out. At 9:36 a.m., three residents were seated in their wheelchairs sleeping in the lounge area. Two other residents were awake and seated by the nurses' station. The Activity Aide had the ball and asked 3 different residents if they wanted to kick the ball. No other residents were asked. At 10:20 a.m., the Activity Aide left the unit, music was playing and the eight residents in the area were either sleeping or sitting. No other activity besides the music was taking place. At 10:52 a.m., there was no activity staff on the unit and the staff on the unit were not interacting with the residents. The residents were either sleeping in their wheelchairs or wandering up and down the halls. The music CD ended. At 11:04 a.m., no activity staff were on the unit and the music remained off. On 5/26/21 at 2:00 p.m., some of the residents were seated in the lounge area listening to music. Some were wandering the halls and some were sleeping in their wheelchairs. At 2:29 p.m., five residents were playing bingo. Prior to starting bingo, Activity Aide 2 did not go room to room to see if some of the higher functioning		facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident 154- Facility immediately provided resident with a t.v. Resident F- Resident up in chair and properly dressed participating in activities listening to music. 2) How the facility identified other residents: All residents who reside in the facility have the risk to be affected by the alleged deficient practice. The 1:1 activity participation logs will be reviewed to identify other residents at risk for the alleged deficient practice. 3) Measures put into place/ System changes: Activity staff will be re-educated on the facility activity programs by the Activity Director. The Activities Review tool will be completed at least 3 times a week for 4 weeks and weekly thereafter to ensure compliance. The Activity Director will be responsible for compliance.	

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	residents wanted to participate. At 3:07 p.m., two residents were propelling themselves up and down the hall. Four residents were in the area where the music was playing, three of them were sleeping. On 5/27/21 at 9:15 a.m., music was being played on the MCU. Nine residents were in the area, six were sleeping and three others were seated in their wheelchairs. Three residents were seated in front of the television, two were sleeping. At 9:18 a.m., Activity Aide 3 attempted to exercise with the residents, only two residents were actively participating. At 9:53 a.m., five residents were taken outside to play kick ball. Music continued to play for the residents inside. At 10:20 a.m., the Activity Aide remained outside with the residents. Four residents inside were wandering the hallways. The other residents in the area were observed to be sleeping. At 1:43 p.m., the radio remained on. Nine residents were in the area and they were either sleeping or sitting. At 1:46 p.m., Activity Aide 3 offered two residents a picture to paint, he did not go room to room to see if some of the higher functioning residents wanted to participate. On 5/28/21 at 1:05 p.m., no music was being played on the MCU. A resident was observed wandering in her wheelchair and crying. Fourteen residents were seated in the area. No activity was taking place. Staff on the unit were not interacting with the residents. At 1:14 p.m., Activity Aide 3 entered the unit and put the music back on. At 1:20 p.m., the Activity Aide gave three residents pictures to paint, again, he did not go room to room asking if any other residents wanted to attend.		4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until I 00% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 07/02/21	

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(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
	There were 29 residents currently residing on the MCU. Interview with the Activity Director on 6/2/21 at 10:10 a.m., indicated the unit did have residents with varying levels of functioning. She indicated the MCU Director was working on restructuring the programming and an additional activity aide was going to be hired for the MCU. 2. On 5/25/21 at 10:07 a.m., Resident 154 was observed in her room. She did not have a television or radio. She indicated she would like to have something for background noise and to pass the time. On 5/26/21 at 2:29 p.m., bingo was taking place on the unit. The resident had not been asked to attend. On 5/27/21 at 3:10 p.m., the resident was in the lounge area seated in a rocking chair. She was not asked to participate in the painting activity. The record for Resident 154 was reviewed on 5/26/21 at 9:12 a.m. Diagnoses included, but were not limited to, Alzheimer's, dementia without behavior disturbance, anxiety, and history of falls. The resident was admitted to the facility on 5/12/21. The Admission Minimum Data Set (MDS) assessment, dated 5/19/21, indicated the resident was cognitively intact for daily decision making. and required extensive assistance with bed mobility and limited assistance with transfers. It was very important for the resident to have books, newspapers, and magazines to read. It was also very important to listen to music, be around animals, keep up with the news, do favorite			

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	155156	A. BUILDING 00 B. WING	06/02/2021

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	activities and go outside. The Care Plan, dated 5/26/21, indicated the resident would participate in activities of her choosing. Her interests included reminiscing, socializing with peers, watching TV/movies, current events, crafts, listening to music, pet interaction, crafts, going outside when the weather was nice, and spending time with my family. Interventions included, but were not limited to, staff will encourage resident to participate in activities and staff will remind resident when and where activities took place and escort if needed. Interview with the Activities Director on 6/2/21 at 10:10 a.m., indicated the resident should have been asked if she would like to attend bingo or the painting activity. She would also contact the resident's family about bringing in a television or radio. 3. On 5/26/21 at 9:55 a.m. and 2:05 p.m., Resident F was observed in bed wearing a hospital gown. At those times the resident was turned towards the window and her eyes were open. There was no radio or television turned on in the room. On 5/27/21 at 8:30 a.m., 9:45 a.m., and 1:30 p.m., and 2:10 p.m., the resident was observed in bed dressed in a hospital gown. At those times the resident was turned towards the window and her eyes were open. There was no radio or television turned on in the room. On 5/28/21 at 9:15 a.m. the resident was observed in bed wearing a hospital gown. She was turned towards the window and her eyes were open. There was no radio or television on. On 5/28/21 at 12:15 p.m., the resident was			

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	observed sitting in her wheelchair. Her lunch meal was in front of her. There was no radio or television turned on for the resident. The record for Resident F was reviewed on 5/26/21 a 10:26 a.m. Diagnoses included but were not limited to, dysphagia, major depressive disorder, anxiety, abnormal weight loss, alcohol induced dementia, and high blood pressure. The Annual Minimum Data Set (MDS) assessment, dated 3/24/21, indicated the resident not alert and oriented. She needed extensive assist with 2 person physical assist for bed mobility and transfers, and needed extensive assist with 1 person physical assist for personal hygiene. The updated 10/23/20, Care Plan, indicated the resident was dependent on staff for meeting social needs. The resident enjoyed watching movies and live entertainment. The 4/30/21 Quarterly Activity Interview, indicated the resident received 1 to 1 activities in her room. The resident enjoyed stop by visits, going outside when the weather was nice, watching television and movies. Interview with the Activity Director on 5/28/21 at 1:00 p.m., indicated the resident received 1 to 1 activities three times a week, however, there were no ongoing activities while the resident was in her room. 3.1-33(a)			
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care			

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	Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review and interview, the facility failed to ensure areas of bruising were assessed and monitored for 2 of 6 residents reviewed for skin conditions (non-pressure related). (Residents 80 and 154). The facility also failed to ensure edema was assessed and monitored for 1 of 2 residents reviewed for edema (Resident 260) and low blood pressure readings were monitored for 1 of 5 residents reviewed for unnecessary medications. (Resident 260) Findings include: 1. On 5/25/21 at 11:18 a.m., Resident 80 was observed with areas of dark purple/blue discoloration to the top of her left hand and extending to her fingers. On 5/26/21 at 8:54 a.m., 11:03 a.m., and 2:30 p.m., the resident was observed with multiple areas of bluish discoloration to the tops of her hands and left forearm. On 5/27/21 at 8:58 a.m. and 11:45 a.m., the discoloration remained to the resident's hands and fingers. The record for Resident 80 was reviewed on 5/27/21 at 9:31 a.m. Diagnoses included, but were not limited to, atrial fibrillation (irregular	F 0684	F684 - Quality of Care The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set.forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident 80- - Areas assessed MD and family notified. Resident 154-Areas assessed MD and family notified. Resident 260- - Resident sent to hospital and treated. 2) How the facility identified other	07/02/2021

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	heartbeat), anemia, history of falls and congestive heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 4/28/21, indicated the resident had severe impairment for daily decision making and required extensive assistance for bed mobility and transfers. A Physician's Order, dated 3/18/21, indicated the resident was to receive Aspirin 81 milligrams (mg) in the evening. A Physician's Order, dated 5/4/21, indicated bruising to the left posterior forearm and right index middle finger and knuckles were to be monitored every shift until 5/18/21. The weekly skin observation sheet, dated 5/24/21, indicated the resident's skin was intact and there was no documentation related to bruising. Interview with the Director of Nursing on 5/28/21 at 3:00 p.m., indicated the bruising to the resident's hands should have been documented and monitored every shift. Nurses' Notes, dated 5/28/21 at 7:47 p.m., indicated the resident was noted with bruising to the top of both of her hands dark purple in color and immeasurable. A Physician's Order, dated 5/29/21, indicated the bruising to the top of both of the resident's hands was to be monitored every shift until healed. 2. On 5/25/21 at 2:38 p.m., Resident 154 was observed with greenish/yellow bruising to the		residents: Skin sweep will be completed on all residents to identify any undocumented/untreated skin conditions Audit will be completed to identify any other residents with change in condition such as edema and/or abnormal vitals since 6/1/21 to ensure appropriate notification and monitoring were implemented as identified. 3) Measures put into place/ System changes: Nursing staff will be re-educated regarding identification, reporting, documentation and weekly monitoring of skin conditions, interventions to protect skin from injury, documentation and protocol. Nursing staff will be educated regarding monitoring and reporting of change in condition including but not limited to edema and abnormal vitals. 4) How the corrective actions will be monitored: An audit will be completed on at least 5 residents per week to ensure skin conditions are documented and monitored. The DON will be responsible for	

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	left temple area. On 5/26/21 at 8:50 a.m. and 10:43 a.m., the greenish/yellow discoloration remained to the left temple area. On 5/27/21 at 9:00 a.m., 11:45 a.m., and 3:10 p.m., the resident was observed with fading greenish/yellow bruising to the left temple area. The record for Resident 154 was reviewed on 5/26/21 at 9:12 a.m. Diagnoses included, but were not limited to, Alzheimer's, dementia without behavior disturbance, anxiety, and history of falls. The Admission Minimum Data Set (MDS) assessment, dated 5/19/21, indicated the resident was cognitively intact for daily decision making and required extensive assistance with bed mobility and limited assistance with transfers. The weekly skin observation sheet, dated 5/26/21, indicated abrasions remained to the resident's left elbow and left knee. There was no documentation related to the fading bruise on the resident's left temple. There had been no previous documentation related to the area of discoloration to the resident's left temple area. Interview with the Director of Nursing on 6/1/21 at 10:30 a.m., indicated the bruising should have been assessed and monitored until healed. 3. On 5/25/21 at 10:35 a.m., Resident 260 was observed seated on a sofa chair in his room. He had complaints of pain and swelling to both legs. Observation at the time indicated he had a large purple bruise to his right antecubital (crease/bend of the elbow) and his legs were very swollen with multiple areas of discolorations		compliance. Documentation will be reviewed during clinical meeting at least 3 times per week to identify residents with change in condition and ensure appropriate notifications and monitoring have been implemented as appropriate. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 07/02/21	

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	from his thighs to his lower legs. The record for Resident 260 was reviewed on 5/26/21 at 11:40 a.m. He was re-admitted on 5/21/21. Diagnoses included, but were not limited to, osteomyelitis, peripheral vascular disease (PVD), heart disease, anxiety, and hypertension. The Admission Minimum Data Set (MDS) assessment, dated 5/13/21, indicated the resident was alert and oriented and required limited 1 person physical assistance with transfers. He received anticoagulant (a blood thinner), diuretic (a water pill), and opioids (a pain pill) medications 5 of the 7 days during the look back period. Physician's Orders, dated 5/22/21, indicated Bumetanide 0.5 (mg) milligrams, give 2 tablets daily for fluid retention and Warfarin 5 mg, give 1 tablet at bedtime to treat/prevent blood clots, dated 5/26/21. A Care Plan, dated 5/4/21, indicated the resident had PVD. The interventions included, but were not limited to, monitor/document for excessive edema (swelling) and encourage resident to elevate his legs. Monitor/document/report as needed any signs and symptoms (s/s) of complications of extremities: coldness of extremity, pallor, rubor (redness), cyanosis and pain. Monitor/document/report as needed any s/s of skin problems related to PVD: redness, edema, blistering, itching, burning, bruises, cuts, and/or other skin lesions. The Re-Admission Observation Assessment, dated 5/21/21, indicated no documentation related to the large purple bruising to the			

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	resident's right antecubital. The 5/26/21 Weekly Skin Observation Assessment indicated generalized bruising and bilateral lower extremity (ble) edema. A Physician Progress Note, dated 5/24/21 at 11:06 a.m., indicated +2/3 ble (bilateral lower extremity)edema, +2/3 bilateral lower thigh edema. Monitor for worsening s/s of heart failure and worsening edema. There was no documentation to indicate the ble edema was being monitored at least daily for worsening. Interview with the Wound Nurse 2 on 5/27/21 at 1:56 p.m., indicated areas of discoloration and or bruising was to be assessed, measured, and documented upon admission. The areas were to then be monitored for 2 weeks. Interview with the Director of Nursing on 6/2/21 at 1:15 p.m., indicated there was no documentation to indicate the resident's edema was monitored and or assessed daily. All areas of discoloration and or bruising should have been assessed, measured, and documented upon admission and monitored for 2 weeks. 4. The record for Resident 260 was reviewed on 5/26/21 at 11:40 a.m. He was admitted on 5/3/21. Diagnoses included, but were not limited to, osteomyelitis, peripheral vascular disease (PVD), heart disease, anxiety, and hypertension. The Admission Minimum Data Set (MDS) assessment, dated 5/13/21, indicated the resident was alert and oriented and required limited 1			

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	person physical assistance with transfers. A Nursing Progress Note, dated 5/4/21 at 11:34 a.m., indicated the resident's blood pressure was 78/40. A late entry at 11:57 p.m., indicated the resident was sent to the hospital at 4:00 p.m., due to a critical lab. There was no documentation to indicate the resident's physician was notified of the low blood pressure. There was no documentation to indicate the resident's blood pressure was being monitored prior to the discharge. Interview with LPN 1 on 5/27/21 at 1:50 p.m., indicated she notified the Nurse Practitioner (NP) and continued to monitor the resident's blood pressure. She was told to wait on the resident's lab results. Interview with the Director of Nursing on 5/27/21 at 2:01 p.m., indicated the nurse should have documented the NP notification and the monitoring of the blood pressure. 3.1-37(a)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and			

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	§483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on record review and interview, the facility failed to obtain consent and arrange for vision services in a timely manner for 1 of 2 residents reviewed for vision. (Resident 3) Finding includes: Interview with Resident 3 on 5/24/21 at 2:56 p.m., indicated he had been asking to see the eye doctor and he had still not been seen. The record for Resident 3 was reviewed on 5/27/21 at 2:04 p.m. Diagnoses included, but were not limited to, fracture of facial bones, bipolar with psychotic features, and schizophrenia. The resident was admitted to the facility on 8/20/20. A Physician's Order, dated 8/20/20, indicated eye consult as needed. The Quarterly Minimum Data Set assessment, dated 5/14/21, indicated the resident was cognitively intact for daily decision making and his vision was adequate. A Care Plan, dated 9/1/20, indicated the resident had impaired visual function related to being near sighted and losing his glasses at the hospital. Interventions included, but were not limited to, monitor/document/report as needed any signs or symptoms of acute eye problems: change in ability to perform ADL's, decline in mobility, sudden visual loss, pupils dilated, gray or milky,	F 0685	F685 - Treatment/Services to Maintain Vision/Hearing The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident 3- Resident signed consent and will be seen next scheduled visit. 2) How the facility identified other residents: All residents receiving ancillary services have the potential to be affected by this deficient practice. An audit will be completed on all residents to ensure ancillary	07/02/2021

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	complaints of halos around lights, double vision, tunnel vision, blurred or hazy vision. A Physician's progress note, dated 5/4/21 at 1:46 p.m., indicated the resident was being seen for hearing loss and vision changes per his request. The resident indicated he was having more of a hard time with his vision in his right eye. The Physician indicated the resident was to be referred to an eye doctor either in house or outpatient and monitor for worsening vision loss. There was no documentation indicating the resident had been seen by the eye doctor or an appointment had been arranged. Interview with the Social Service Director on 6/1/21 at 11:30 a.m., indicated the resident had not been seen by the eye doctor and the signed consent was obtained today. She was not aware the resident had requested to see the eye doctor and she indicated he would be added to the list. 3.1-39(a)		services are arranged per request. 3) Measures put into place/ System changes: Nursing staff will be educated that all ancillary services requested by residents to be referred to Social Services. Social Service and Nursing managers will be re-educated regarding follow up of ancillary provider recommendations. 4) How the corrective actions will be monitored: All ancillary provider recommendations received after each visit will be reviewed by Social Service and DON or designee to ensure appropriate follow up is completed. The Administrator will be responsible for oversight. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 07/02/21	

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F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review and interview, the facility failed to ensure a resident with a contracture received the necessary treatment and services to prevent further decline for 1 of 3 residents reviewed for range of motion. (Resident G) Finding includes: On 5/24/21 at 11:34 a.m., Resident G's right hand was observed to be contracted and was clenched in a fist. There was no anti-contracture device in her hand. On 5/25/21 at 9:47 a.m., the resident was observed with her right hand clenched in a fist. There was no anti-contracture device in her hand.	F 0688	F688 - Prevent Decrease in ROM/Mobility The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions o.f	07/02/2021

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	On 5/26/21 at 8:34 a.m., 10:00 a.m., and 2:05 p.m., the resident was observed with her right hand clenched in a fist. There was no anti-contracture device in her hand. On 5/27/21 at 8:33 a.m., 10:30 a.m., 12:20 p.m. and 2:45 p.m., the resident was observed with her right hand clenched in a fist. There was no anti-contracture device in her hand. On 5/28/21 at 6:33 a.m. and 7:17 a.m., the resident was observed with her right hand clenched in a fist. There was no anti-contracture device in her hand. The record for Resident G was reviewed on 5/26/21 at 11:17 a.m. Diagnoses included, but were not limited to multiple sclerosis, dysphagia, type 2 diabetes, high blood pressure, anxiety, chronic kidney disease, visual hallucinations, chronic respiratory failure, adult failure to thrive, major depressive disorder, delusions, and dementia with behavioral disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 5/13/21, indicated the resident had modified cognition abilities. The resident was an extensive assist with 2 person physical assist for bed mobility and personal hygiene. She had range of motion impairment and limitations on 1 side for both upper and lower extremities. The Care Plan, updated 5/7/20, indicated the resident had impaired physical mobility to the right hand. An approach, dated 5/17/19 that had been resolved on 8/7/19, indicated hand splint to right hand as ordered.		federal and state law. 1) Immediate actions taken for those residents identified: Resident G - Wash cloth was applied and added to the residents plan of care and task initiated. 2) How the facility identified other residents: All residents who have contractures or at risk for contractures have the potential to be affected by the alleged deficient practice. An audit was completed on all resident that require the use of anti-contracture devices. Care plans were updated as needed. 3) Measures put into place/ System changes: Nursing staff will be re-educated on appropriate anti contracture measures/devices by the DON/designee. Anti-contracture measures will be checked during angel rounds and Managers at least 5 days per week. Manager findings will be reviewed at the daily meetings. The DON will responsible for compliance. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as	

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	155156	A. BUILDING 00 B. WING	06/02/2021

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	A restorative assessment, dated 7/23/19, indicated the right hand and fingers were fixed with no range of motion ability. Physician's Orders, dated 7/23/19 and 8/11/19, indicated to discontinue the right hand splint to don in the morning and doff after lunch. Occupation Therapy notes, dated 10/5/19 with a discharge date of 10/29/19, indicated educated client regarding sequencing of doffing resting hand splint. Client responded by accurately doffing the splint with proper sequencing. There was no documentation in nursing progress notes why the splint was discontinued. Interview with the Director of Nursing on 6/1/21 at 10:00 a.m., indicated the contracture to the right hand was old. There needed to be something in the resident's hand to prevent skin on skin contact, whether it was a wash cloth or palm protector. 3.1-42(a)(2)		indicated. 5) Date of compliance: 07/02/21	
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 record review and interview, the	F 0689	F689 - Free from	07/02/2021

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	facility failed to ensure residents were free from accidents related to ensuring proper interventions were in place for 1 of 1 residents reviewed for accidents. (Resident K) Finding includes: The closed record for Resident K was reviewed on 5/28/21 at 11:18 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, major depression, cognitive deficit, heart failure, hypertension, schizophrenia, psychosis, and insomnia. The Quarterly Minimum Data Set (MDS) assessment, dated 5/12/21, indicated the resident was severely cognitively impaired. She required extensive assistance with bed mobility and transfers, and had 2 or more falls since admission or prior to assessment, 1 with injury. A Care Plan, dated 4/23/21 and revised 5/25/21, indicated the resident had the potential for falls. The interventions included, but were not limited to, high back wheelchair for safety. An Incident Report, dated 5/4/21, indicated the resident was seated in her wheelchair in front of the nursing station, she was leaning forward, slid from the chair and fell on her right side. An IDT (Interdisciplinary Team) Note, dated 5/5/21, indicated the root cause of the resident's fall was her inability to maintain an upright posture and a general overall physical decline. She also had very poor safety awareness due to cognitive decline. The recommended Intervention was a geri chair. A Fall Initial Occurrence Note, dated 5/6/21 at		Accidents/Hazards The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the.facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident K has expired. 2) How the facility identified other residents: An audit will be completed on all residents with falls since 5/17/21 to ensure appropriate interventions are in place and care plan updated. 3) Measures put into place/ System changes: Staff will be re-educated on fall prevention/accidents and to ensure proper interventions to prevent falls are in place according to the care plan.	

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	5:10 p.m., indicated the resident was found on the floor on 5/4/21 lying on her right side in the fetal position. Upon assessment, she was noted to have a bump on her forehead. Interview with the Director of Nursing on 6/2/21 at 1:59 p.m., indicated the resident's intervention for a geri chair (high back wheelchair) should have been in place prior to her fall on 5/4/21 to assist in preventing further falls from her wheelchair. This Federal tag relates to Complaint IN00353639. 3.1-45(a)(2)		4) How the corrective actions will be monitored: Director of Nursing or designee will review fall occurrences at least 5 days per week to verify interventions are in place and care plan is updated. The DON will be responsible for oversight. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 07/02/21	
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			

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	this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to ensure residents maintained acceptable parameters of nutritional status related to meal consumption records not completed as well as supplement documentation not completed for residents who were nutritionally at risk for 2 of 5 residents reviewed for nutrition. (Residents E and C) Findings include: 1. The record for Resident E was reviewed on 5/28/21 at 9:25 a.m. Diagnoses included, but were not limited to, lack of coordination, bacterial agents as the cause of diseases, dysphagia (difficulty swallowing), anxiety, and major depressive disorder. The Significant Change Minimum Data Set (MDS) assessment, dated 4/7/21, indicated the resident was moderately impaired for daily decision making and required supervision with eating. The resident was also identified as having a significant weight loss. A Care Plan, dated 4/6/21, indicated the resident had an overweight body status as evidenced by a body mass index (BMI) greater than 25. The resident had a gastrostomy (feeding tube in the	F 0692	F692 Nutrition/Hydration This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident C & Resident E- unable to correct missing documentation 2) How the facility identified other	07/02/2021

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	stomach) tube that was not being used for nutrition at that time and he had several skin alterations. Interventions included, but were not limited to, offer substitutes if 50% or less is consumed, provide dietary supplements as ordered, and provide/observe intake of diet and fluids. A Physician's Order, dated 4/2/21, indicated the resident received a regular diet. A Physician's Order, dated 4/8/21, indicated the resident was to receive Pro Heal Sugar Free 30 cubic centimeters (cc's) three times a day for wound healing. A Physician's Order, dated 5/11/21, indicated the resident was to receive Med Pass 2.0 (supplement) 120 milliliters (mls) three times a day. The food consumption logs for May 2021 indicated the following: - No breakfast or lunch intake was documented on 5/12/21. - No lunch or dinner intake was documented on 5/30/21. - No dinner intake was documented on 5/15, 5/19, 5/20, 5/21, 5/24, and 5/31/21. The May 2021 Medication Administration Record (MAR) indicated the Med Pass 2.0 was signed out as being given, but there was no documentation indicating how much was consumed. The Pro Heal was not signed out as being given on the following dates: - 5/6/21 at 9:00 a.m., and 12:00 p.m. - 5/7/21 at 12:00 p.m.		residents: All residents who receive meals and/or supplements have the potential to be affected by the alleged deficient practice. 3) Measures put into place/ System changes: The Nursing staff will be re-educated on documentation of meal & supplement consumption. 4) How the corrective actions will be monitored: The DON/designee will observe and audit at least 5 residents per week receiving meals and supplements to ensure meals and supplements are being offered and consumption documented. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 90% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 7/2/21	

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	- 5/13/21 at 9:00 a.m., and 12:00 p.m. - 5/14/21 at 12:00 p.m., and 6:00 p.m. Interview with the Director of Nursing on 6/2/21 at 2:00 p.m., indicated the resident's food consumption should have been documented as well as his supplements. 2. On 5/27/21 at 8:30 a.m. Resident C was observed in bed. She had just finished eating breakfast, for which she ate all of her hot cereal, bites of a magic cup supplement, and 1/4 of the breakfast burrito. On 5/27/21 at 12:15 p.m., the resident was observed in bed and had just received her lunch tray. She received chicken stir fry, mixed vegetables, fruit, and a magic cup supplement. CNA 1 was in the room to assist the resident with lunch. The record for Resident C was reviewed on 5/27/21 at 8:48 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dysphagia, asthma, history of COVID 19, metabolic encephalopathy, anxiety, delusional disorder, major depressive disorder, psychosis, breast cancer, and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 3/2/21, indicated the resident was not alert and oriented. The resident was totally dependent on staff for bed mobility and transfers. The resident holds food in the mouth and had coughing and choking. The resident's weight was 104 pounds with no significant weight loss noted. She received a mechanically altered diet and had 1 stage 3 pressure ulcer. The Care Plan, updated on 2/11/21, indicated the resident was to receive a therapeutic and mechanically altered diet. The resident had a			

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	history of low body weight and body mass index. The approaches were to provide diet as ordered and document intake each meal. The resident's weights were as follows: 5/19/21, 96.2 Lbs 5/15/21, 96.0 Lbs 5/12/21, 96.0 Lbs 5/5/21, 96.0 Lbs 4/8/21, 102.8 Lbs 3/5/21, 102.5 Lbs 2/23/21, 103.8 Lbs The resident had a 6.8% weight loss from 4/8/21 to 5/5/21. The meal intake consumption log for 4/2021 indicated there was no breakfast documented on 4/27/21, no lunch documented on 4/14 and 4/27/21, and no dinner documentation on 4/11, 4/12, 4/16, 4/17, 4/19, 4/24, 4/29, and 4/30/21. The meal consumption log for 5/2021 indicated there was no breakfast documented on 5/2, 5/11, and 5/26, no lunch documented on 5/2, 5/11, 5/26, and no dinner documented on 5/9, 5/12, 5/16, 5/17, 5/19, 5/20, 5/21, and 5/25/21. Interview with the Director of Nursing on 5/28/21 at 1:30 p.m., indicated the resident's food consumption was to be completed for every meal. 3.1-46(a)(1)			
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.			

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	The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review and interview, the facility failed to provide proper respiratory care and services related to oxygen at the correct flow rate and connected to the concentrator, having orders for oxygen and monitoring of humidification bottles for 3 of 5 residents reviewed for oxygen. (Residents G, F and 38) Findings include: 1. On 5/24/21 at 11:28 a.m., Resident G was observed in bed. Her oxygen was off and not in the nares, it was lying in bed with the resident. There was about 1/4 amount of water in the humidification bottle and there was no date on bottle or the oxygen tubing. The flow rate was set at 4.5 liters per minute on the oxygen concentrator in the room On 5/25/21 at 9:47 a.m., the resident was observed in bed. Her oxygen flow rate was set at 4.5 liters and there was minimal water in the humidification bottle. There was no date noted on the bottle or the tubing. On 5/26/21 at 8:34 a.m., 10:00 a.m., and 2:05 p.m., the resident was observed bed wearing oxygen. The flow rate was set at 4.5 liters. On 5/27/21 at 8:33 a.m., 10:30 a.m., 12:20 p.m., and 2:45 p.m., the resident was observed in bed	F 0695	F695 Respiratory This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident G- verified correct placement of nasal cannula, verified oxygen set to correct flow rate, replaced & dated humidity bottle and tubing. Resident F- verified correct placement of nasal cannula,	07/02/2021

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	wearing oxygen per nasal cannula at 4.5 liters. The water humidification bottle was empty. On 5/28/21 at 6:33 a.m., and 7:17 a.m., the resident was observed in bed wearing oxygen per nasal cannula at 4.5 liters. The water humidification bottle was empty. The record for Resident G was reviewed on 5/26/21 at 11:17 a.m. Diagnoses included, but were not limited to multiple sclerosis, COPD, dysphagia, type 2 diabetes, high blood pressure, anxiety, chronic kidney disease, visual hallucinations, chronic respiratory failure, adult failure to thrive, major depressive disorder, delusions, and dementia with behavioral disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 5/13/21, indicated the resident had modified cognition abilities. The resident was an extensive assist with 2 person physical assist for bed mobility and personal hygiene. She had range of motion impairment and limitations on 1 side for both upper and lower extremities. A Care Plan, updated 5/7/20, indicated the resident had shortness of breath. Physician's Orders, dated 10/4/19, indicated to check oxygen saturation every shift for hypoxia. Physician's Orders, dated 4/4/20, indicated to change oxygen humidifier 500 cc every night shift on Sunday. Physician's Orders, dated 8/4/20, indicated may titrate oxygen between 2-4 Liters per nasal cannula to keep oxygen saturation >90%.		replaced and dated tubing Resident 38- replaced and dated humidity bottle and tubing, verified oxygen set to correct flow rate 2) How the facility identified other residents: All residents who receive oxygen have the potential to be affected by the alleged deficient practice. An audit was completed on all residents who receive oxygen therapy to ensure physician order is followed and equipment changed/replaced and dated at least weekly or as needed. 3) Measures put into place/ System changes: The licensed nursing staff will be re-educated on ensuring oxygen is administered per physician order at the correct flow rate, nasal cannula properly applied in nares, and equipment such as humidity bottle and tubing are replaced and dated at least weekly or as needed. Stickers will be placed on portable tanks and concentrators to identify flow rate ordered for easy verification during rounds. 4) How the corrective actions will be monitored:	

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	Physician's Orders, dated 8/9/20, indicated to change oxygen tubing weekly and as needed every night shift on Sunday. Interview with the Director of Nursing on 5/28/21 at 1:30 p.m., indicated the nurses were to label the oxygen tubing as well as the bottle of water for the humidification. The oxygen should be at the rate per Physician's orders. 2. On 5/24/21 at 2:37 p.m., Resident F was observed in bed. Her oxygen was in the bed and not in her nose. The tubing was not labeled for the last time it had been changed. On 5/26/21 at 8:42 a.m., the resident was observed in bed. Her oxygen tubing was noted in one nares and not the other. On 5/26/21 at 9:55 a.m., 5/27/21 at 8:30 a.m., and 5/28/21 at 12:15 p.m., the resident was observed in bed. At that time her oxygen was not in her nose. The record for Resident F was reviewed on 5/26/21 a 10:26 a.m. Diagnoses included but were not limited to, dysphagia, major depressive disorder, anxiety, abnormal weight loss, alcohol induced dementia, and high blood pressure. The Annual Minimum Data Set (MDS) assessment, dated 3/24/21, indicated the resident not alert and oriented. She needed extensive assist with 2 person physical assist for bed mobility and transfers, and needed extensive assist with 1 person physical assist for personal hygiene. She wore oxygen while a resident.		The DON/designee will observe at least 3 residents receiving oxygen on varied shifts at least twice weekly for 4 weeks then weekly thereafter to ensure oxygen is administered at the correct flow rate per physician order, nasal cannula properly placed in nares, and equipment changed and dated appropriately. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 7/2/21	

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	There was no Care Plan to indicate the resident removed her oxygen at times. Physician's Orders, dated 3/3/20, indicated oxygen at 2 liters per minute per nasal cannula continuously. Monitor saturations every shift. Physician's Orders, dated 3/21/20, indicated may increase oxygen to 3 liters for low saturation as needed. Physician's Orders, dated 3/22/20, indicated to change the humidifier 500 cc and oxygen tubing weekly every night shift on Sunday. Interview with the Director of Nursing on 5/28/21 at 1:30 p.m., indicated the oxygen tubing was to be changed weekly and then labeled after doing so. The resident should be wearing the oxygen as per Physician's Orders. 3. On 5/24/21 at 11:44 a.m., Resident 38 was observed sitting in his wheelchair. He was wearing oxygen per nasal cannula at 3.5 liters per the concentrator in his room. There was no date on humidification bottle of water or tubing. On 5/26/21 at 8:46 a.m., and 1:35 p.m., the resident was in the wheelchair in the hall. At that time he was wearing oxygen per nasal cannula by the way of a portable tank on the back of his wheelchair. The tank was set at 3 liters. On 5/27/21 at 12:14 p.m., the resident eating his lunch in his room. He was wearing oxygen per the concentrator in his room which was set at 3.5 liters. The record for Resident 38 was reviewed on			

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	155156	A. BUILDING 00 B. WING	06/02/2021

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	5/27/21 at 2:30 p.m. Diagnoses included, but were not limited to, respiratory failure, type 2 diabetes, high blood pressure, dependent on renal dialysis, major depressive disorder, schizophrenia, and end stage renal disease. The 3/30/21 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was alert and oriented, and received dialysis and oxygen while a resident. Physician's Orders, dated 6/3/20, indicated oxygen at 2 liters to keep saturations > 90% as allows every shift. Physician's Orders, dated 7/12/20, indicated change oxygen humidifier 500 cc and tubing every Sunday night shift. A new order, dated 5/25/21, indicated oxygen titration between 2-4 liters to keep saturations > 90% as allows. Interview with the Director of Nursing (DON) on 5/28/21 at 1:30 p.m., indicated she was unaware of the Physician's Order to titrate the oxygen between 2 and 4 liters, however the oxygen on the concentrator should be the same as the portable tank. The nurses should be dating and labeling the oxygen tubing and humidifier after changing them out. The current and revised 1/7/19 "Oxygen and Respiratory equipment" policy provided by the DON on 6/1/21 at 1:00 p.m., indicated the nasal cannula will be dated with the date the tubing was changed. Oxygen humidifiers should be change weekly or as needed and will be dated when changed.			

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	3.1-47(a)(6)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to document a dialysis post-assessment for a resident receiving dialysis three times a week for 1 of 1 residents reviewed for dialysis. (Resident 38) Finding includes: The record for Resident 38 was reviewed on 5/27/21 at 2:30 p.m. Diagnoses included, but were not limited to, respiratory failure, type 2 diabetes, high blood pressure, dependent on renal dialysis, major depressive disorder, schizophrenia, and end stage renal disease. The 3/30/21 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was alert and oriented, and received dialysis and oxygen while a resident. The Care Plan, updated 9/24/20, indicated the resident received hemodialysis 3 times per week on Tuesday, Thursday, and Saturday due to renal failure. Physician's Orders, dated 7/11/20, indicated obtain vital signs (blood pressure and pulse) and monitor pre and post dialysis for altered mental status, lethargy, edema, chest pain, shortness of	F 0698	F698 Dialysis The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident 38- unable to correct missing documentation 2) How the facility identified other residents:	07/02/2021

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	breath, abdominal pain, nausea, vomiting, unusual itching, bleeding at site, bruises, abnormal muscle cramps, redness, swelling, tenderness, or signs of infection at dialysis site. Indicated N = No, Y= Abnormal symptoms observed and reported. Document findings two times a day every Tuesday, Thursday, and Saturday for dialysis. The Treatment Administration Record (TAR) for 4/2021 indicated there was no documentation of the post-dialysis assessment on 4/3, 4/15, and 4/17/21. It was coded with a 3 indicating the resident was absent from the nursing home. The 5/2021 TAR indicated there was no documentation of a post dialysis assessment on 5/1, 5/6, 5/11, 5/15, and 5/29/21. There was no pre-dialysis assessment documented on 5/8, 5/15, 5/18, 5/22, and 5/29/21. Interview with the Director of Nursing (DON) on 5/28/21 at 1:30 p.m., indicated the pre- and post-dialysis charting was to be completed on the TAR and should be done when the resident leaves and returns from dialysis. The current and revised "Dialysis Monitoring and Observations" policy, dated 2/13/18, provided by the DON on 6/1/21 at 1:00 p.m., indicated obtain vital signs (blood pressure and pulse at a minimum) following dialysis treatment. 3.1-37(a)		All residents receiving dialysis have the potential to be affected. 3) Measures put into place/ System changes: Licensed nurses will be in-serviced regarding pre- and post-dialysis assessments and documentation requirements. 4) How the corrective actions will be monitored: The Director of Nursing or designee will audit documentation records for all residents receiving dialysis at least 2x/week to ensure that pre- and post-dialysis assessments are completed and documented prior to and following dialysis treatments. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 7/2/21	

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F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, record review and interview, the facility failed to ensure residents received the appropriate treatment and services per plan of care related to residents with dementia who had a lack of ongoing structured activities and/or were observed wandering for 3 of 5 residents reviewed for dementia care. (Residents 28, D, and C) Findings include: 1. On 5/26/21 at 9:22 a.m., Resident 28 was seated in her wheelchair in the hallway. She was sleeping at that time. She was not asked to participate in the kick ball activity on the unit. At 2:04 p.m., she was observed again sleeping in her wheelchair in the hall. On 5/27/21 at 9:13 a.m., the resident was seated in her wheelchair in the hallway. She was sleeping at that time. At 10:20 a.m., she remained sleeping and had not been asked to participate in any activity. At 1:45 p.m., the resident was again sleeping in her wheelchair and she was not asked to participate in the painting activity. The record for Resident 28 was reviewed on 5/28/21 at 12:39 p.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, Alzheimer's disease, psychosis, mood disorder, major depressive disorder, and	F 0744	F744 Treatment/service for Dementia This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident 28-An activities interest and preference assessment was completed for to determine activities of interest and an activity plan of care was developed.	07/02/2021

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	lymphedema. The Quarterly Minimum Data Set (MDS) assessment, dated 5/11/21, indicated the resident had severe impairment for daily decision making and had physical behaviors. The Care Plan, dated 7/20/20, indicated the resident relied on staff for socialization and mental stimulation. She enjoyed bingo, movies, happy hour, entertainment, nail care, outside, and religious services. She had a history of growing up on a farm so she enjoyed farm related things. Interventions included, but were not limited to, staff will encourage to participate in group activities of her choosing and provide 1:1 visits three times a week. The Quarterly Activity Review, dated 3/10/21, indicated the resident's 1:1 participation was stable and the resident enjoyed entertainment, music, Happy Hour, Old Time Taste, snacks, watching TV, friendly visits, and reminiscing. Will attend group activity of interest at least once a week and receive 1:1's 3 times weekly. Interview with the Activity Director on 6/2/21 at 10:10 a.m. indicated there was an MCU Director who was reorganizing the program to provide more structure on the unit. 2. On 5/25/21 at 10:09 a.m., Resident D was observed in her wheelchair propelling up and down the hallways. At 2:19 p.m., the resident continued to wander up and down the hallways in her wheelchair. On 5/26/21 at 8:48 a.m., 10:30 a.m., and 2:13 p.m., the resident was propelling herself up and down the hallway in her wheelchair. The resident		Resident D- Resident is being redirected when attempting to go in other residents' rooms. Resident C- Resident was up and properly dressed participating in activities listening to music. Tv was adjusted to face towards the bed. 2) How the facility identified other residents: Residents with dementia and/or dependent on staff for activities and stimulation have the risk to be affected by the alleged deficient practice. An audit was completed to identify residents affected. Activities assessments will be completed for those identified to determine activities of interest, and plan of care will be developed and/or updated. . 3) Measures put into place/ System changes: The Activity Director will implement and maintain a 1:1 activity log to ensure 1:1 activities are being provided and documented. Activity staff will be re-educated on the facility activity programs and following the plan of care for residents with dementia and/or those that are dependent on staff	

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	was also observed wandering in and out of resident rooms with no redirection provided. On 5/27/21 at 9:48 a.m. and 12:00 p.m., the resident was propelling herself up and down the hallway in her wheelchair. The resident was also observed wandering in and out of resident rooms with no redirection provided. On 5/28/21 at 1:27 p.m., the resident was observed going in and out of resident rooms. She took a shoe from a resident's room and tried to put it on and left it in the hall. No redirection was provided. The record for Resident D was reviewed on 5/27/21 at 10:10 a.m. Diagnoses included, but were not limited to, schizoaffective disorder, anxiety, dementia with behavioral disturbance, and mixed obsessional thoughts and acts. The Quarterly Minimum Data Set (MDS) assessment, dated 4/26/21, indicated the resident was severely impaired for daily decision making. The resident was readmitted to the facility on 1/24/21. There was no current activity assessment available for review. The Care Plan, dated 6/23/17, indicated the resident was capable of independently choosing programs in which to participate. Her interests included: sewing knitting, crocheting, cooking, puzzle books, and religion. Interventions included, but were not limited to, evaluate plan and adjust as needed. The Care Plan, dated 9/27/17, indicated the resident had impaired cognition as evidenced by short and long term memory impairment related		to provide sensory stimulation and activities or 1:1 visits such as residents who spend majority of time in bed, residents with dementia who need encouragement and assistance to participate, who are unable to actively participate or do not wish to participate in group activities. 4) How the corrective actions will be monitored: The Activities Director will ensure through a combination of documentation audits and observations that 1:1 activities are being provided according to plan of care developed based on assessment. The Activities Director will complete audits and observations on at least 3 residents 2x/week x4 weeks, then 3 residents per week x4 weeks, then 3 residents per month thereafter to ensure compliance. The Administrator/Designee is responsible for oversight of these audits. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as	

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	to dementia. Interventions included, but were not limited to, provide a supportive, therapeutic environment that may include: lower noise and distractions, conduct regular safety checks, provide adequate lighting, use calendars, clocks and other personal items that establish orientation (if applicable). Interview with RN 1 on 6/2/21 at 9:05 a.m., indicated the resident was a "tough" one, all she does is propel up and down the halls and is difficult to distract. Interview with the Activity Director on 6/2/21 at 10:10 a.m., indicated there was an MCU Director who was trying to add more structure to the unit. Another activity aide was also going to be hired for the MCU unit. Interview with the Administrator on 6/2/21 at 10:15 a.m., indicated the resident was hard to redirect and her care plan would be reviewed. 3. On 5/25/21 at 9:59 a.m., Resident C was observed in bed wearing a hospital gown. There was a small television that was turned on, however, it was turned towards the window. The volume was turned very low. There was no radio in the room. The resident was awake and the head of her bed was elevated. At that time, she was putting the top sheet in her mouth and chewing on it. On 5/26/21 at 8:41 a.m., the resident was observed in bed and dressed in a hospital gown. There was drool coming from her mouth. She was awake and there was no radio or television turned on. On 5/26/21 at 9:55 a.m., the resident was lying in bed still dressed in a hospital gown. The		indicated. 5) Date of compliance: 7/2/21	

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	television was on but the volume was very low. On 5/26/21 at 2:04 p.m., the resident was observed in bed wearing a hospital gown. The small television was turned on but not facing her. The volume was very low. On 5/27/21 at 8:30 a.m. the resident was observed in bed wearing a hospital gown. The television was turned towards the window and turned on very low. No radio was noted in the room. On 5/27/21 at 1:30 p.m., the resident was sitting up in bed wearing a hospital gown. Her eyes were open and she was talking out loud to herself. The television was turned on but facing the window. The record for Resident C was reviewed on 5/27/21 at 8:48 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dysphagia, asthma, history of COVID 19, metabolic encephalopathy, anxiety, delusional disorder, major depressive disorder, psychosis, breast cancer, and high blood pressure. The Significant Change Minimum Data Set (MDS) assessment, dated 1/6/21, indicated the resident enjoyed listening to music and participating in favorite activities. The Quarterly MDS assessment, dated 3/2/21, indicated the resident was not alert and oriented. The resident holds food in the mouth and had coughing and choking. She received a mechanically altered diet and had 1 stage 3 pressure ulcer. In the last 7 days the resident received antipsychotic and antidepressant medication.			

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The Care Plan, updated on 2/23/21, indicated the resident would receive 1:1 activities 3 times weekly. The resident enjoyed watching movies, watching television, going outside, spending time with family, and listening to music.

A Care Plan, updated on 12/4/20, indicated the resident had a potential for aggressive behavior related to dementia. The approaches were to encourage participation in activities.

A Care Plan, updated on 3/4/21, indicated the resident had impaired cognition. The approaches were to invite, remind and escort to activity programs consistent with resident's preferences as resident will allow. Maintain and establish consistency in daily routine when able.

An Annual Activity assessment, dated 7/28/20, indicated the resident's current interests were crafts, spiritual events, pets, exercise, current events, television and movies, cards and music.

An Activities Quarterly Participation Review Assessment, dated 4/20/21, indicated the resident enjoyed attending group activities such as bingo, "Old Time Taste", happy hour, and bible discussions. The resident enjoyed manicures, hand massages, and live entertainment as well. The goal was for the resident to participate in group activities of their choosing three times weekly.

Interview with the Director of Nursing on 5/28/21 at 1:30 p.m., indicated there was really no structured activities for the resident while she was in bed

Interview with the Activity Director on 5/28/21

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	at 2:20 p.m., indicated the resident has had a decline since her admission. She used to be able to propel her wheelchair and go to and from activities of her choice. The 4/20/21 activity assessment was not accurate and the resident had not changed much since that assessment had been completed. The assessment did not match the resident's current situation and needs. One to one activities were provided to the resident only 3 times a week, however there was a lack ongoing activities in the resident's room while she was in bed during the day and evening shifts. 3.1-37(a)			
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 2 of 7 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%. (Residents 74 and 57) Findings include: 1. On 5/27/21 at 12:10 p.m., LPN 2 was observed preparing medications for Resident 74. She administered Fluticasone (nasal spray) 50 mcg (micrograms/spray) 1 spray into each nostril. The record for Resident 74 was reviewed on	F 0759	F 759 Med Error Rates 5% or more This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the	07/02/2021

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	6/2/21 at 12:42 p.m. Diagnoses included, but were not limited to, end stage renal disease, dialysis, and heart failure. Physician's Orders, dated 3/15/21, indicated Fluticasone Propionate Suspension 50 mcg/spray, administer 2 sprays in each nostril one time a day. Interview with the LPN at the time indicated she should have administered 2 sprays into each nostril as ordered. 2. On 5/27/21 at 2:00 p.m., LPN 3 was observed preparing medications for Resident 57. She administered Hydralazine (a blood pressure medication) 50 mg (milligrams) 1 tablet. The record for Resident 57 was reviewed on 6/2/21 at 12:48 p.m. Diagnoses included, but were not limited to, hypertension, vascular dementia, and heart failure. A Physician's order, dated 2/27/18, indicated Hydralazine 50 mg, give 100 mg 3 times a day. Interview at the time with the LPN indicated she should have administered 2 tablets, 100 mg as ordered. 3.1-48(c)(1)		facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident 74- Received second dose of nasal spray. Resident 57- Resident received second tablet. 2) How the facility identified other residents: All residents receiving medications have the potential to be affected. 2) Measures put into place/ System changes: All licensed nurses and QMA's were in serviced on following physician orders and manufacturer recommendations when administering medication, 4) How the corrective actions will be monitored: DON/Designee will conduct 5 medication pass audits per week on various shifts x's 4 weeks then 3x's a week for 4 weeks, then one time a week for 2 weeks to ensure accuracy of medication	

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			administration. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 07/02/21	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive			

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	155156	A. BUILDING 00 B. WING	06/02/2021

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	Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review and interview, the facility failed to ensure over the counter medications were not stored in the residents' rooms for 2 of 2 residents reviewed for medication storage. (Residents 3 and H) Findings include: 1. On 5/24/21 at 2:51 p.m., Resident 3 had an over the counter (OTC) bottle of nasal spray on his over bed table. The resident indicated he bought it when he was out on pass. He also indicated the staff didn't know he had it. On 6/2/21 at 10:40 a.m., the OTC nasal spray was observed on the resident's bedside stand. The record for Resident 3 was reviewed on 5/27/21 at 2:04 p.m. Diagnoses included, but were not limited to, fracture of facial bones, bipolar with psychotic features, and schizophrenia. The Quarterly Minimum Data Set (MDS) assessment, dated 5/14/21, indicated the resident was cognitively intact for daily decision making. The June 2021 Physician's Order Summary (POS) indicated the resident had no order to self administer medications and he did not have an order for the OTC nasal spray. Interview with the Director of Nursing on 6/2/21 at 11:00 a.m., indicated the resident should not	F 0761	F761 Labels/Store Drugs & Biologicals The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident 3- Medication was removed and immediately locked in the med cart. Resident H.- Medication removed and locked in med cart. 2) How the facility identified other residents: Any resident can be affected by the deficient practice. 3) 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 will be re-educated	07/02/2021

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	have had the medication at the bedside. 2. On 5/26/21 at 1:50 p.m., 5/27/21 at 9:40 a.m. and 2:10 p.m., and 5/28/21 at 10:00 a.m., Resident H was observed in bed. There was a tube of Biofreeze pain relieving ointment on her over bed table. The tube was observed with a pharmacy label with the resident's name and directions for use. The record for the Resident H was reviewed on 5/26/21 at 8:47 a.m. Diagnoses included but were not limited to, cervical spina bifida, paraplegia, neurological bladder, major depressive disorder, chronic osteomyelitis, anxiety, and left shoulder pain. The Modification of the Annual Minimum Data Set (MDS) assessment, dated 4/26/21, indicated the resident was alert and oriented. She was totally dependence on staff with 1 person physical assist for bathing. There was no Physician's Order to self administer medications nor was there an assessment to self administer medications. Interview with the Director of Nursing on 5/28/21 at 1:30 p.m., indicated the resident did not have an order or an assessment to self administer her own medications. 3.1-25(b)		on the proper procedure on medication administration as it pertains to resident's request to keep medication at bedside, including over-the-counter medications and the proper procedure for evaluating a resident for self-administration of medications. DON/Designee will complete an observation audit of at least 5 residents per week to ensure no over-the-counter or other medications are kept at the residents beside. Identified issues will be addressed immediately with. The Executive Director/Designee will be responsible for compliance. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 7/2/21	
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			

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	approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview, the facility failed to store, serve and prepare food under sanitary conditions related to, dirty food equipment, food crumbs on clean pans, the improper storage of trays and food lids, undated food in the reach in cooler, food crumbs on the floor of the walk-in cooler and freezer, food storage bins and transportation carts with dried food spillage and stains, not ensuring the heater was turned on for the dish machine and not replacing gloves before touching uncooked food for 1 of 1 kitchens observed. (The Main Kitchen) This had the potential to affect the 102 out of 104 total residents who receive food from the kitchen. Findings include: 1. During the brief kitchen sanitation tour on 5/24/21 at 9:45 a.m. with the Assistant Dietary Manager (ADM) the following was observed:	F 0812	F812 Sanitation 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All kitchen surfaces and areas were thoroughly cleaned including the grill, stove, ovens, oven hood, walk-in cooler, walk-in freezer, shelves, reach-in cooler, transport carts, storage racks and food warmer. All undated food was removed and discarded. Gauges on the dish machine was repaired. Dietary Cook 2 was educated on drying all dishes and utensils before stacking or storing. Dietary Cook 1 was educated on	07/02/2021

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	a. The grill was dirty with a large amount of dried burned food noted on top of the grates and below the grates. The aluminum foil under the grates had a heavy of accumulation of burned and old food. Interview with the ADM at that time, indicated it does not work and just sits there and gets dirty. b. The stove top was dirty with dried grease. c. The oven hood had a large amount of grease, dust and dirt noted on and in between the slats. The lights in the hood were dusty and dirty as well as the pipes. d. The oven had a large amount of burned charred food noted on the bottom. The inside of the oven doors had a heavy accumulation of dried food. e. Inside of both convection ovens had a large amount of dried and burned food. The oven doors had a heavy accumulation of grease and grime. f. There was food and debris on the walk-in cooler floor. g. There was a large accumulation of food crumbs and frozen food on the floor in the walk-in freezer. h. There was a large amount debris and food crumbs noted on the shelves where clean pans were located. i. The flour, sugar, and dry oats bins were soiled with a heavy accumulation of dried food substance on the outsides and lids.		proper glove use, hand hygiene and cross-contamination. 2) 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 consume food and liquids from the dietary department have the potential to be affected by this alleged deficient practice. All equipment was checked for proper functioning. 3) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All dietary staff will be in-serviced on proper cleaning of the kitchen, the equipment cleaning schedule, monitoring equipment for proper functioning and reporting issues to maintenance, ensuring dishes & utensils are properly dried before storing/ stacking, and proper food handling and storage principles including dating of food, glove use, hand hygiene and cross-contamination.	

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	j. The reach in cooler handles and the outside of cooler were sticky to touch with food and/or beverage spillage. There was a large amount of food spillage noted on the inside of the cooler. Inside the cooler there were 4 bowls of pineapple covered and not dated. There were 13 individual plastic cups of salad dressing with no date, 30 individually wrapped turkey sandwiches with no date of preparation, and 4 large containers of punch with no date of preparation. Interview with the ADM at that time, indicated all of the above was in need of cleaning and or repair. 2. During the full kitchen sanitation tour with the ADM on 6/1/21 at 10:15 a.m., the following was observed: a. There were 6 three tiered transport carts stained and dirty. b. There were 4 wired storage racks housing clean dishes that were dirty, greasy, and dusty. c. The gauges on the dish machine were not working. The wash and rinse cycle gauges stayed in one place and did not move when the dish machine was started. Interview with Dietary Cook 2 at that time, indicated she had just returned from vacation and was told nothing about the dish machine not working. She had not observed the gauges after starting up the machine. There were only 2 dietary employees in the kitchen and she was focused on getting the dishes done in time for lunch. Interview with the ADM on 6/1/21 at 12:15 p.m.,		4) 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; The administrator/designee or dietary manager will audit the cleanliness of the kitchen week 5x a week x 4 weeks and then 3x a week x 4 weeks, and then weekly. The administrator/designee or dietary manager will check equipment for proper functioning at least weekly and report any issues to maintenance. The administrator/designee or dietary manager will observe storage/ stacking of dishes & utensils to ensure they are properly dried, food preparation and point of service for proper glove use, hand hygiene and food handling to prevent cross-contamination at varied meals at least 5 times per week. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	indicated the gauges worked fine, the heater switch was not turned on. d. Dietary Cook 2 was observed taking the clean food trays off of the dish machine and stacking them wet on the crates. She also removed a crate of dome lids and stacked them wet on top of each other as well. e. There were 12 wire racks in the dry food storage room that were dirty and dusty. f. There were four 4 tiered carts that were dirty with stains. g. The food warmer was dirty with crumbs on the inside. There were 5 stained dirty pans noted on the inside h. At 10:47 a.m., Dietary Cook 1 donned a pair of clean gloves to both hands. He picked up a knife and cutting board and placed it on the counter. He moved other items on the table with the same gloved hands. He picked up the uncooked turkey breast with the same gloved hands and placed it on the scale. After measuring the meat, he picked up the uncooked turkey with the same gloved hands and placed it in the mixer/blender for pureed preparation. Interview with the Dietary Cook 1 at that time, indicated he did not change his gloves after touching other items before picking up the uncooked turkey breast. Interview with ADM on 6/1/21 at 12:15 p.m., indicated all of the above was in need of cleaning or correction. 3.1-21(i)(3)		Date of compliance: 7/2/21	

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F 0825 SS=D Bldg. 00	483.65(a)(1)(2) Provide/Obtain Specialized Rehab Services §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. Based on record review and interview, the facility failed to ensure specialized rehabilitation (rehab) services were initiated upon admission for 1 of 1 residents reviewed for rehab. (Resident 34) Finding includes: Interview with Resident 34 on 5/25/21 at 10:04 a.m., indicated she was recently re-admitted to the facility post a recent hospital stay for a above the knee amputation, she had not started therapy and wanted to know when it would start. The record for Resident 34 was reviewed on 6/2/21 at 8:26 a.m. She was re-admitted on	F 0825	F825- Rehab Services The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of	07/02/2021

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	5/12/21. Diagnoses included but not limited to, above the knee amputation, diabetes, blindness, and hypertension. The Significant Change Minimum Data Set (MDS), dated 5/18/21, indicated the resident was alert and oriented for decision making. Physician's Orders, dated 5/27/21, indicated PT (Physical Therapy) Evaluation and Treatment 4 to 6 times a week for 8 weeks which may include therapeutic exercise, therapeutic activity, NMR, gait training, patient/caregiver training, modalities as needed. OT (Occupational Therapy) Evaluation and Treatment 4 to 6 times a week for 8 weeks to address ADL/IADL independence, therapeutic exercise, wheelchair management, safety education and client/family/staff education. A Physician Progress Note, dated 5/12/21 at 3:02 p.m., indicated the resident was recently re-admitted back to the facility after a stay in the hospital. She went for an angiogram and had to have her foot amputated. Here for physical and occupational therapy, wound care, and medical management. A Physician's Progress Note, dated 5/19/2021 7:35 a.m., indicated the resident was re-admitted to the facility for therapy and medical management. No other needs identified at the time. No concerns from therapy. No needs from nursing. Will continue to monitor. Interview with PTA 1 on 5/27/21 at 3:30 p.m., indicated the resident had not started therapy services due to complaints of pain. She was just evaluated and would begin services today. Review of the Patient Screening form, dated		correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident 34 received order for rehab services on 5/27/21 2) How the facility identified other residents: An audit will be completed of all admissions in the last 30 days to ensure therapy orders were written and evaluations completed in a timely manner. 3) Measures put into place/ System changes: Licensed nurses will be in-serviced on obtaining orders for therapy evaluations upon admission. Therapists will be in-serviced regarding timeliness of evaluations and documentation of refusals. 4) How the corrective actions will be monitored: Director of Nursing/designee will audit orders for any admissions during clinical meeting 5x/week to ensure therapy evaluations orders are entered timely and Therapy Director will verify evaluations	

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	5/24/21, provided by the PTA at the time indicated, "Patient still states she's in too much pain to participate in rehab at this time." There was no documentation to indicate the resident had orders for therapy services prior to 5/27/21. There was no documentation to indicated the resident refused therapy services due to pain prior to 5/24/21. Interview with the Director of Nursing on 6/2/21 at 1:06 p.m., indicated the resident should have had orders for therapy services upon re-admission. There should have been proper documentation to indicate the resident was assessed for services and/or if she refused due to pain. 3.1-23(a)(1)		have been completed and/or appropriate documentation is present for refusals. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 7/2/21	
F 0880 SS=E 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,			

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	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 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.			

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	§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. 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 hand hygiene not completed after direct resident contact and glove removal, catheter drainage bags on the floor, and transmission based precautions (TBP) not initiated for random observations for infection control. (Residents 28, G, H, 17, and 102) Findings include: 1. On 5/25/21 at 10:18 a.m., CNA 1 approached Resident 28 and attempted to put a surgical mask on her. The CNA then approached Resident 48 and pulled her mask up to cover her nose. The CNA then pulled up Resident D's mask and then proceeded to pull Resident 8's mask up. The CNA touched the edges of the mask and did not perform hand hygiene in between touching each resident's mask. Interview with the Director of Nursing on 6/1/21 at 3:00 p.m., indicated the CNA should have washed her hands in between each resident	F 0880	F880 Infection control This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident 28- Aide was re-educated and competency was given on proper hand hygiene. Resident H.-Urostomy bag placed in basin	07/02/2021

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(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
	contact. 2. On 5/26/21 at 10:00 a.m., CNA 3 was providing incontinence care for Resident G. The CNA had a pair of clean gloves on both hands. She proceeded to clean the resident and roll her over to finish cleaning her front side. She placed the soiled linens into the garbage bag and placed the brief into another bag. She removed her gloves and donned another pair of clean gloves to both hands without performing hand hygiene. After the CNA had finished the incontinence care, she left the room. Interview with CNA 3 on 5/26/21 at 10:24 a.m., indicated she did not perform hand hygiene after she removed the gloves and before donning another pair. Interview with the Director of Nursing on 5/28/21 at 1:30 p.m., indicated hand hygiene should have been performed after glove removal. The current and revised 1/10/18 "Hand Hygiene" policy, provided by the Director of Nursing on 6/1/21 at 4:20 p.m., indicated hand hygiene was to be performed after glove removal. 3. On 5/24/21 at 3:17 p.m., Resident H was observed in bed. At that time, her urostomy catheter bag was observed on the floor. The resident indicated she does not like it in a dignity bag because it pulls on her urostomy. The bag was face down directly on the floor. On 5/25/21 at 10:12 a.m., 5/26/21 at 1:50 p.m., and 5/27/21 at 9:40 a.m., and 2:10 p.m., the urostomy catheter bag was observed directly on the floor face down. The record for the Resident H was reviewed on 5/26/21 at 8:47 a.m. Diagnoses included but		Resident 17- LPN was re-educated and competency was given on proper hand hygiene. Resident 102- Signs posted on door, isolation bin placed outside the door 2) How the facility identified other residents: All residents receiving medications and care have the potential to be affected by the alleged deficiency. Residents with catheter or urostomy drainage bag have the potential to be affected. Residents in transmission-based precautions have the potential to be affected. Residents were identified and ensured placement of signage and PPE in bins outside the door. 3) Measures put into place/ System changes: Staff will be re-educated regarding infection control practices, including but not limited to proper hand hygiene and glove use, infection control during medication administration, indwelling catheter care and drainage bag placement to avoid contamination, implementing transmissions based precautions and PPE requirements for transmission based precautions.	

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	155156	A. BUILDING 00 B. WING	06/02/2021

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	were not limited to, cervical spina bifida, paraplegia, neurological bladder, major depressive disorder, chronic osteomyelitis, anxiety, and left shoulder pain. The Modification of the Annual Minimum Data Set (MDS) assessment, dated 4/26/21, indicated the resident was alert and oriented. She was totally dependence on staff with 1 person physical assist for bathing. The resident had an urostomy for bladder control. A Care Plan, updated 4/29/20, indicated the resident had an urostomy and had chronic urinary tract infections. Interview with the Director of Nursing on 5/28/21 at 1:30 p.m., indicated the urostomy catheter bag should not have been on the floor. The current and revised 2/14/19 "Urinary Catheter Care" policy, provided by the Director of Nursing on 6/1/21 at 1:00 p.m., indicated urinary drainage bags and tubing shall be positioned to prevent either from touching the floor directly. May place drainage bag and excess tubing in a secondary vinyl bag or other similar device to prevent primary contact with the floor or other surfaces.4. On 5/26/21 at 9:05 a.m., LPN 4 was observed preparing medications for Resident 17. She pulled 4 medication punch cards from her medication cart then dispensed one pill from each card directly into her bare hand prior to placing them into a pill cup. Interview at the time with the LPN indicated she was unaware she should not use her bare hand to dispense medications without sanitizing her hands.		4) How the corrective actions will be monitored: The DON or designee will complete daily infection observation audits on various shifts daily x6 weeks to ensure all infection control measures are followed including but not limited to observing isolation rooms to ensure appropriate transmission based precaution signage is present, PPE is available and stored in storage bin outside of each room, proper PPE use, placement of catheter drainage bags, and observe infection control during at least one medication administration daily. After the initial 6 weeks, if compliance has shown improvement will then reduce to 5x/week on varied shifts x4 weeks, then at least 3x/week on varied shifts thereafter. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 07/02/21	

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Interview with the Director of Nursing on 5/27/21 at 12:25 p.m., indicated the nurse should have dispensed the medications directly in the pill cup and sanitized her hands before handling the pills.

5. Observation on 5/26/21 at 2:30 p.m., and on 5/27/21 at 9:20 a.m., indicated no transmission based precaution (TBP) signs were on the outside of Resident 102's room door. There also was no isolation bin containing personal protective equipment (PPE) outside of the room.

On 5/27/21 at 11:53 a.m., LPN 1 was observed leaving the resident's room. Interview at the time indicated she did not don or doff PPE before entering the room. There was no TBP signs on the outside of the resident's room door. There also was no isolation bin containing PPE outside of the room.

On 5/27/21 at 11:55 a.m., CNA 5 was observed in the resident's room, she was wearing proper face coverings and gloves, however, she was not wearing a gown. There was no TBP signs on the outside of the resident's room door. There also was no isolation bin containing PPE outside of the room. Interview at the time with the CNA indicated she had just changed the resident's linen due to him having a bowel movement. He was not on TBP, if he was there would have been proper signage on the door, red biohazard bags in the room for laundry, and PPE outside of the room.

The record for Resident 102 was reviewed on 5/27/21 at 12:12 p.m. Diagnoses included, but were not limited to, surgical amputation,

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	diabetes, peripheral vascular disease, dementia, hypertension, and psychosis. The Admission Minimum Data Set (MDS) assessment, dated 2/18/21, indicated the resident was severely cognitively impaired and required extensive 2 person physical assistance with bed mobility and transfers. A Nursing Progress Note, dated 5/24/21 at 5:20 p.m., indicated the resident had loose stools. New orders received for stool for C-diff (clostridium difficile). The C-diff toxin report, dated 5/26/21 at 16:52, indicated the resident's results were positive. Interview with the Director of Nursing on 5/27/21 at 12:29 p.m., indicated the resident should have been placed on TBP with appropriate signage when he had initially showed symptoms of loose stools. 3.1-18(b)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure assistive devices were in good repair for 5 randomly observed residents. (Residents 97, 48, 80, 8, and 154) The facility also failed to ensure the Kitchen was clean and in good repair related to dirt, crumbs, debris, and grease, leaky sinks, dirty PVC pipes, food splatter, dirty ceiling vents, burnt out light bulbs,	F 0921	F921 - Environmental The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.	07/02/2021

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	and lime build up for 1 of 1 kitchens (Main Kitchen) and the residents' environment was clean and in good repair related to rust, missing base boards, chipped paint, missing toilet paper holders, marred walls and doors, leaking toilets, dried food spillage on shelves, dirt and debris on floors, sticky floors and carpets, and dusty ceiling vents for 2 of 4 units. (Units 100 and 200) Findings include: 1. On 5/26/21 at 10:25 a.m., the wheelchair arms had torn plastic with either the foam exposed or the foam missing for Residents 97, 48, 80, 8, and 154. Interview with the Administrator on 6/2/21 at 2:00 p.m., indicated the wheelchair arms needed to be replaced. 2. During the brief kitchen sanitation tour on 5/24/21 at 9:45 a.m. with the Assistant Dietary Manager (ADM) the following was observed: a. There was a large accumulation of adhered dirt, food crumbs and debris on the floor against the wall by the base board throughout the entire kitchen. b. The faucet on the food prep sink was leaking. Interview with the ADM at the time, indicated it had been leaking for awhile now and a work order had been noted. c. The lid on the white trash can by the hand washing sink was discolored pink and red and there was a large accumulation of food spillage noted. d. There was a heavy accumulation of dried food		Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Residents 97.48,80,8 and154 wheelchair arms were replaced. Room 102-base of the wall painted. Room 103-Base board replaced. Room 106-Bathroom holder replaced, walls in entry way painted. Room 110- Closet door and heat register painted. Room 114-room and bathroom doors marred and scratched were painted. Room 124- Closet doors chipped and marred were repaired and painted. Room 129-Toilet was repaired for leak, food spillage on shelves clean. Room 201-Dried food on wall was cleaned, and toilet leaking repaired. Room 205-Heat register cover repaired, base of walls chipped and marred painted. Room 211-carpet was replaced with vinyl flooring. Room 218-Carpet replaced with	

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	spillage on the lower wall throughout the kitchen. e. The white PVC pipes under the food prep sink were black colored with dried food, grease and grime. f. There was a large amount of grease and food debris noted behind the ice machine, the grill, the stove, and the convection ovens. Interview with the ADM at that time, indicated all of the above was in need of cleaning and or repair. 3. During the full kitchen sanitation tour with the ADM on 6/1/21 at 10:15 a.m., the following was observed: The Dish Room: a. There were food crumbs on the floor and under racks and the dish machine. There was adhered dirt and food crumbs a long the base board. b. The ceiling was food splattered and stained. c. There was 1 dusty ceiling vent and 3 rusted return vents. d. There were 14 ceiling lights burned out. e. The floor under the dish machine was noted with white lime build up. f. There was a heavy accumulation of food crumbs on the floor and under storage racks in the dry food storage room. Interview with ADM on 6/1/21 at 12:15 p.m.,		vinyl flooring and tube feeding pole clean, ceiling vents cleaned. 2) How the facility identified other residents: All residents who reside in the facility have the potential to be affected by the alleged deficient practice. Audit of room repairs needed will be completed. 3) Measures put into place/ System changes: All staff will be educated on the use of the Maintenance Request Form by the DON/designee. Rounds will be completed at least 5 days per week by managers and they will complete a Maintenance Request form for any issues identified. Items needing repaired will be reviewed daily in the morning meeting. The Administrator will review the Maintenance Requests daily with the Maintenance Department to ensure repairs are completed. The Administrator/designee will complete the Environment Quality Assurance Worksheet on 5 rooms weekly x 8 weeks and at least monthly thereafter. The Maintenance Director will be responsible for compliance. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or	

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	indicated all of the above was in need of cleaning and/or repair. 4. During the Environmental Tour with the Administrator and the Assistant Maintenance Director on 5/27/21 at 10:45 a.m., the following was observed: The 100 Unit: a. Room 102, the base of the wall near the heat register was rust stained. One resident resided in the room. b. Room 103, there was a section of the base board missing near the heat register. One resident resided in the room. c. Room 106, the walls in the entry way into the room were chipped and there was no toilet paper holder in the bathroom. One resident resided in the room and 2 residents shared the bathroom. d. Room 110, the closet door and the heat register were marred. One resident resided in the room. e. Room 114, the room and bathroom doors and walls were scratched and marred. One resident resided in the room. f. Room 124, the closet doors and bathroom walls were chipped and marred. Two residents shared the room and 3 residents shared the bathroom. g. Room 129, the toilet was leaking and there was dried food spillage on the shelves next to the bed. Two residents shared the bathroom and 1 resident resided in the room.		until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated 5) Date of compliance: 07/2/2021	

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	The 200 Unit: a. Room 201, there was dried food spillage on the wall next to the bed and the toilet was leaking. Two residents resided in the room and 4 residents shared the bathroom. b. Room 205, the base of the walls were chipped and marred and the cover to the heat register was hanging off. Two residents resided in the room. c. Room 211, the floor was sticky. One resident resided in the room. d. Room 218, the carpet was sticky throughout the room. There was a large hole in the wall, dusty ceiling vents, and the tube feeding pole had an accumulation of dried spillage. Two residents shared the room. Interview at the time with the Administrator and Assistant Maintenance Director indicated the above was in need of cleaning and or repair. 3.1-19(f)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (p) Initial orientation of all staff must be conducted and documented and shall include the following: (1) Instructions on the needs of the specialized population or populations served in the facility (2) A review of residents' rights and other pertinent portions of the facility's policy manual. This rule is not met as evidenced by:	F 9999	F9999 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Dietary Aide 1-resident rights and abuse training completed.	07/02/2021

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	Based on record review and interview, the facility failed to ensure new hires completed resident rights and abuse training for 3 of 5 employee records reviewed. (Dietary Aide 1, LPN 5 and CNA 6) Findings include: The employee records were reviewed on 6/2//21 at 9:00 a.m. and indicated the following: a. Dietary Aide 1, hired on 5/10/21, did not have her resident rights or abuse training completed. b. LPN 5, hired on 3/10/21, did not have her resident rights or abuse training completed. c. CNA 6, hired on 5/12/21, did not have her resident rights or abuse training completed.		LPN 5- resident rights and abuse training completed. CNA 6- resident rights and abuse training completed. 2) 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 employee files will be audited to ensure all staff have been trained on resident rights and abuse. Any employees identified will complete training by 7/1/21. 3) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Resident rights and abuse training will occur during new hire orientation. 4) 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; The administrator or designee will audit all new hire employee files to ensure resident rights and abuse training has occurred prior to the employee's first day on the floor.	

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			The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 7/2/21	