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	155077	A. BUILDING 00 B. WING	07/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW MANOR	45 BEACHWAY DR INDIANAPOLIS, IN 46224

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00356310 and IN00358219. Complaint IN00358219 - Unsubstantiated due to lack of evidence. Complaint IN00356310 - Unsubstantiated due to lack of evidence. Survey dates: July 12, 13, 14, 15, and 16, 2021. Facility number: 000032 Provider number: 155077 AIM number: 100273330 Census Bed Type: SNF/NF: 90 Total: 90 Census Payor Type: Medicare: 3 Medicaid: 84 Other:3 Total: 90 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 26, 2021.	F 0000	Submission of this Directed Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted in accordance with requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance as of 8/14/2021.	
F 0574 SS=E Bldg. 00	483.10(g)(4)(i)-(vi) Required Notices and Contact Information §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a			

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

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	language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care			

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	Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.			
	Based on observation, interview, and record review, the facility failed to ensure contact information for the long-term care Ombudsman was posted on the Behavioral Health Unit (BHU) for 5 of 5 residents interviewed during resident council. This deficient practice had the potential to effect 59 of 59 residents residing on the unit. Findings include: On 7/16/21 from 10:45 a.m. until 11:00 a.m., a Resident's Council interview was conducted on the Behavioral Health Unit (BHU). The local	F 0574	The facility posted the contact information for the long-term care Ombudsman throughout the Behavioral Health Unit (BHU). The Ombudsman provided the residents who reside on the BHU with brochures related to the long-term care Ombudsman program. Residents who reside on the BHU have the potential to be affected by this alleged deficient practice.	08/14/2021

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	long term care Ombudsman was present as were Residents 16, 24, 27, 35 and 71. When asked if the Resident's knew where to find the Ombudsman's name and contact information, all the residents indicated they did not know who the Ombudsman was or how to get in contact with them. The Ombudsman passed out brochures related to the long-term care Ombudsman program and explained that she was a non-profit advocate for residents who lived in long-term care facilities who could advocate/mediate with the facility on the resident's behalf to resolve complaints and answer questions. Resident 27 indicated he had issues with his guardian. Resident 71 indicated he had concerns and questions related to the facilities smoking policies and procedures. Resident 24 indicated he had questions related to his desire to transfer to a different facility. On 7/16/21 at 11:07 a.m., a focused tour of the BHU was conducted. The Ombudsman's contact information could not be located on the BHU unit. During an interview on 7/16/21 at 11:10 a.m., the Administrator indicated, residents on the BHU could not leave the unit without staff supervision. They did not have the code to the doors and should not be allowed out by visitors. During an interview on 7/16/21 at 11:14 a.m., Activity Assistant 20 indicated he did not think		The Administrator, Director of Nursing, Social Services Director, and BHU Manager received education related to ensuring that the facility posts the contact information for the long-term care Ombudsman throughout the building, including the BHU. To ensure ongoing compliance, the Administrator/Designee is responsible for conducting daily visualizations on his/her scheduled days of work to ensure the long-term care Ombudsman's contact information is posted in the BHU. Daily observations shall continue for a period of three months and then three times weekly for a period of three months thereafter. Should concerns be identified, immediate corrective action shall be taken. The Quality Assurance Committee will review the results of these audits, and any corrective actions taken, during monthly meetings for a minimum of six months. Monitoring/frequency will be reviewed/revised, as warranted, on the basis of compliance.	

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	the Ombudsman's contact information was posted on the BHU, even though many of the residents could and did use the phone regularly. On 7/16/21 at 1:00 p.m., the Regional Clinical Consultant provided a copy of current, but undated facility policy titled, "Resident Rights." the policy indicated, "...The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care... A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State Licensure Office, the State Long-Term Care Ombudsman, the protection and advocacy agency, adult protective services where state law provides for jurisdictions in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit..." 3.1-4(j)(3)(C)			
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for			

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	those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission			

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	to the facility must not conflict with the requirements of these regulations. Based on interview and record review, the facility failed to notify residents in writing 2 days prior to the end of their covered benefits when discharged from a Medicare Part A stay of their remaining benefit days for 2 of 3 random residents reviewed for Notice of Medicare Non-Coverage (NOMNC) (Residents 191 and 192). Findings include: On 7/12/21 at 10:04 a.m., during the entrance conference, the facility provided a list of residents discharged in the past 6 months, who had a Medicare Part A stay. Three random residents were selected from the list provided by the Business Office Manager (BOM) on 7/13/21. 1. Resident 191's NOMNC indicated the resident's skilled nursing service end date was 1/6/21. There was no signature on the form. A note, on the bottom of the form, indicated the resident's family member had been called to inform him of the ending date, and the form needed signed. On 7/14/21 at 11:00 a.m., during an interview, the BOM indicated the regulation required the facility to give residents a 2-day notice prior to the expiration of benefits. The resident, or responsible party should have signed the notices. The date they signed was the date they were given the notice. Resident 191's husband had been called on the phone. A phone message was left for him. They should have had him sign the form when he picked her up, for discharge, but he did	F 0582	Prior to the survey, Residents 191 and 192 discharged from the facility. All residents on a Medicare Part A stay have the potential to be affected by this alleged deficient practice. The facility reviewed all residents with upcoming discharges from a Medicare Part A stay to ensure no other concerns were identified related to the notification of the end of their covered benefits. No other concerns were identified. The Administrator and Business Office Manager received education related to ensuring all residents who are on a Medicare A stay receive written notice 2 days prior to the end of their covered benefits when discharged from a Medicare Part A stay. To ensure ongoing compliance, the Administrator/Designee is responsible for conducting ongoing audits of all “Notice of Medicare Non-Coverage” documents to ensure they are issued in a timely manner and completed appropriately. The Administrator/Designee will review all potential residents discharge from a Medicare A stay with the Business Office Manager on a weekly basis during Utilization	08/14/2021

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	not. A notification was not sent by mail. 2. On 7/14/21 at 11:00 a.m., during an interview, the BOM indicated Resident 192 had originally been given notice on 5/23/21, then stayed two more days, a copy of the initial one was not kept. She was given a new one because she didn't leave. It did not reflect a 2-day notification. On 7/17/21 at 11:15 a.m., the BOM provided a copy of the regulation titled "Notice of Medicare Non-Coverage (NOMNC) /Determination on Continued Stay." This document indicated "...at the signature line, the resident or authorized representative must sign. Bottom of page 2. The resident or authorized representative must fill in the date that he/she signs the document. (This is critical to demonstrating the 2-day notice requirement.) ...Responsible party must come in to sign the NOMNC or it needs to be sent out by mail with a return envelope...." 3.1-4(f)(3)		Review meeting. On a weekly basis and for a period of three months, The Administrator will conduct a weekly audit to ensure that all notices were issued in accordance with facility policy and procedure. Thereafter, the Administrator will conduct a monthly audit for a period of three months. Should concerns be identified, immediate corrective action shall be taken. The Quality Assurance Committee will review the results of these observations, and any corrective actions taken, during monthly meetings for a minimum of six months. Monitoring/frequency will be reviewed/revised, as warranted, on the basis of compliance.	
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 interview, and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment was properly coded related to Preadmission Screening and Resident Review (PASRR) for 2 of 3 residents reviewed for PASSR (Residents 83 and 3). Findings include: 1. On 7/14/21 at 1:31 p.m., the medical record	F 0641	The MDS assessments were modified to reflect accurate coding related to the PASRR Level II requirement. The MDS Coordinator received education related to ensuring the MDS assessment accurately reflects the PASRR Level II assessment.	08/14/2021

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	for Resident 83 was reviewed. The diagnoses included but were not limited to bipolar disorder (a mental illness), anxiety disorder, and major depressive disorder. A Level I PASSR Mental Health assessment, dated 1/12/21, indicated a PASRR Level II Assessment was required. Resident 83's PASRR Levell II Assessment, dated 1/27/21, indicated Resident 83 was mentally ill, and "Since this evaluation has determined that you have a PASRR condition, if you admit to a nursing facility, or you are currently in a Medicaid-certified nursing facility, the facility will need to document your PASRR condition in the Minimum Data Set (MDS) assessment record. The facility should mark yes for question A1500 on the MDS, 'Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?'. Also, your specific PASRR condition(s) should be checked in question A1510, 'Level II Preadmission Screening and Resident Review (PASRR) Conditions." A review of Resident 83's quarterly Minimum Data Set (MDS) assessment, dated 6/27/21, and a significant change MDS, dated 3/27/21, indicated he did not have a PASRR Level II assessment. On 7/14/21 at 2:26 p.m., during an interview the Social Services Director indicated Resident 83 did have a PASRR Level II Assessment. She provided a copy for review. The MDS Assessment should have been coded to show Resident 83 had a PASRR Level II Assessment. She was not sure who was responsible to code it		All residents have the potential to be affected by this alleged deficient practice. A house-wide audit of PASSR Level II assessments and MDS coding was completed. Any concerns identified were immediately corrected. To ensure ongoing compliance, the Social Services Director will maintain and accurate list of all residents who require a PASRR Level II assessment. On a weekly basis and for a period of three months, the Administrator, Social Services Director, and MDS Coordinator will review the MDS coding for those residents who require a PASRR Level II assessment to ensure the accuracy of MDS Coding. These reviews and audits will continue for a period of three months thereafter. Should concerns be identified, immediate corrective action shall be taken. The Quality Assurance Committee will review the results of these observations, and any corrective actions taken, during monthly meetings for a minimum of six months. Monitoring/frequency will be reviewed/revised, as warranted, on the basis of compliance.	

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	on the MDS. On 7/15/21 at 9:00 a.m., during an interview the MDS Coordinator indicated Resident 83 had dementia and she believed the person at (Name of Provider Company) who completed the assessment, failed to recognize his dementia diagnosis, (pointed to the on the PASRR screen assessment). That diagnosis should have resulted in him not being required to have a Level II assessment. He did have a level II done and the outcome form from (Name of Provider Company) did indicate to mark yes on the MDS A1500. On 7/15/21 at 9:47 a.m., the MDS Coordinator provided a correction submission for the MDS assessment, dated 7/15/21. It indicated Resident 83 had a serious mental illness and required a PASRR Level II assessment. On 7/15/21 at 11:09 a.m., the Reginal Clinical Consultant provided a current undated policy, titled "PASARR Level II Referral." This policy indicated "This facility shall coordinate assessments with the preadmission screening and resident review (PASARR) program under Medicaid to the maximum extent practicable to avoid duplicative testing and effort." During a review of CMS's (Centers of Medicare and Medicaid) RAI (Resident Assessment Instrument) Version 3.0 Manual, on 3/26/18, it indicated, "Residents should be the primary source of information for resident assessment items...," and instructions for discharge information, "Review the medical record including the discharge plan and discharge orders for documentation of discharge location...."2. On 7/12/21 at 1:25 p.m., the Business Office Manager provided PASRR documentation for			

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	Resident 3. A review of the, "Notice of PASRR Level I Screen Outcome," dated 3/19/21, indicated, " ...PASRR Level I Determination: Refer for Level II Onsite...A PASRR Level II evaluation must be conducted ...." An Indiana Summary of Findings, dated 3/26/21, indicated Resident 3 diagnoses included schizophrenia, unspecified schizophrenia spectrum and other psychotic disorder, and dementia without behavioral disturbance. During an interview, on 7/15/21 at 11:31 a.m., the MDS Coordinator indicated there was a PASRR inaccuracy regarding Resident 3's information. On 3/12/21 Admission MDS information, he was coded as having no mental illness. She indicated he did have serious mental illness of traumatic brain injury, schizophrenia, psychosis, and cognitive impairment and she would correct the information. On 7/16/21 at 11:07 a.m., the MDS Coordinator provided a document titled, "CMS (Centers for Medicaid and Medicare Services) RAI (Resident Assessment Instrument) Version 3.0 Manual," dated October 2019, and indicated it was the policy currently being used by the facility. The policy indicated, "...A1500: Preadmission Screening and Resident Review (PASRR) ...Coding Instructions ...Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness ...and continue to A1510, Level II Preadmission Screening and Resident Review Conditions...." 3.1-31(i)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility.			

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	§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, interview, and record review, the facility failed to ensure a resident's preferences for positioning in an electronic wheelchair with the use of a scarf to tie his legs together was assessed to be safe and failed to initiate appropriate positioning devices for the resident's legs for 1 of 2 residents reviewed for positioning (Resident 65). The facility failed to ensure current physician's orders were followed for the application of a brace/splint for a resident for 1 of 2 residents reviewed for positioning and range of motion services (Resident 42). Findings include: 1. On 7/12/21 at 3:02 p.m., Resident 65 was observed in his room. He was in a seated position in an electronic, motorized wheelchair with elevated leg rests. The leg rests were padded with towels and pillows, and his legs were tied	F 0688	Resident 65 was provided with and trained on the use of a specialized device to assist with positioning/repositioning of his legs. The scarf is no longer in use. Licensed staff has received education related to the use of the device. A new order was received authorizing the use of the electric/motorized wheelchair. All care plans have been updated accordingly. Per physician's order, Resident 42's brace was discontinued as he prefers not to don it. He continues to be treated by therapy at this time and will transition to a restorative therapy program for contracture management. All residents who require	08/14/2021

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	together with a green piece of cloth material. On 7/14/21 at 2:34 p.m., Resident 65 was observed in the Behavioral Health Unit outside courtyard during a smoking break. His legs were elevated on the leg/footrests and observed tied together with a green piece of cloth. On 7/15/21 at 1:56 p.m., Resident 65 was observed in his room. He was in a seated position in an electronic, motorized wheelchair with elevated leg rests. The leg rests were padded with towels and pillows, and his legs were tied together with a green piece of cloth material. He indicated the green cloth was a special scarf that his mother had given him. He used it to tie his legs together to keep them from falling off the leg rest since he was paralyzed. Resident 65 was not able to demonstrate how to take the scarf on and off, because he could not reach his toes. He indicated the Certified Nursing Assistants (CNAs) would put it on for him when they got him up. During an interview on 7/15/21 at 2:22 p.m., the Director of Therapy indicated Resident 65 preferred to keep his legs together. When he first admitted, he had used a gait belt to tie his legs together, but therapy removed the gait belt and informed the resident he should not tie his legs together as it was a restraint. The therapy department ordered a "U-cushion" for Resident 65 to position his legs with instead. On 7/15/21 at 2:30 p.m., the Director of Therapy observed Resident 65 during a smoke break in the courtyard. Resident 65's legs remained tied together with the green scarf. Therapist 45 indicated he was not aware the resident had been tying his legs together but Resident 65 was not		assistance with positioning and/or require the use of a devices, such as a splint/brace and/or electric/motorized wheelchair, per physician's order have the potential to be affected by this alleged deficient practice. The facility conducted a house-wide audit to ensure positioning devices and electric/motorized wheelchairs were utilized per physician order, assessment updated, and care plans accurately reflect all interventions. Any other concerns identified were immediately corrected. All licensed personnel will receive education related to positioning, use of splints/braces and motorized wheelchairs, documentation of refusals/availability of positioning devices, physician notification, and ensuring all are executed appropriately. To ensure ongoing compliance, the Director of Nursing/Designee shall be responsible for maintaining an accurate list of all residents who require positioning devices and utilize electric/motorized wheelchairs. On days of work and for a period of one month, the Director of Nursing shall be responsible for conducting audits to ensure positioning and mobility devices are utilized in accordance with physician's order, appropriately documented, and care planned	

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	on therapy case load at that time, so he did not see the resident often. Therapist 45 indicated the use of a scarf to tie his legs together would not be recommended, and he would look into getting something else. During an interview on 7/15/21 at 3:08 p.m., the Behavioral Health Unit Program Director, Licensed Practical Nurse (LPN) 15) indicated Resident 65 had used that sash as long as she had worked with him. It was his preference to tie his legs together to keep them on the leg rest, but he could take it on and off himself. During an interview on 7/15/21 at 3:10 p.m., CNAs 46 and 47 indicated, Resident 65 had used that green scarf since he had been admitted. He asked for help to get the scarf in place when he got up in his wheelchair. He was not capable of doing it himself, so the CNAs did it for him. It was already tied, so it just slipped on and off when needed. During an interview on 7/15/21 at 3:18 p.m., The Director of Therapy indicated he did not think an actual order had been placed for the referred U-cushion. A copy of the order, if there had been one, and additional information related to Resident 65's use of the electronic wheelchair and positioning was requested. On 7/16/21 at 9:00 a.m., therapy notes on Resident 65's U-cushion, and/or wheelchair positioning was requested a second time. On 7/14/21 at 9:05 a.m., a comprehensive record review for Resident 65 was completed. A quarterly Minimum Data Set (MDS) assessment, dated 6/4/21, indicated Resident 65		appropriately. These audits will then continue a weekly basis for a period for two months. Then, audits will continue monthly for a period of three months. Should concerns be identified, immediate corrective action shall be taken. The Quality Assurance Committee will review the results of these observations, and any corrective actions taken, during monthly meetings for a minimum of six months. Monitoring/frequency will be reviewed/revised, as warranted, on the basis of compliance.	

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	was cognitively intact with a BIMS (brief interview for mental status) score of 15 of 15. No rejection of care was coded for the look back period. He had current diagnoses which included but were not limited to Bipolar disorder (a mental illness that brings severe high and low moods and changes in sleep, energy, thinking, and behavior) and a traumatic spinal cord injury with paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease.) The MDS indicated he was at risk for the development of pressure ulcer. A care plan, dated 2/7/20 and most recently revised on 6/16/21, which indicated Resident 65 was at risk for the development of pressure ulcers related to paraplegia, decreased sensation in his bilateral lower extremities. A care plan, dated 7/3/20 and most recently revised on 5/28/21, which indicated Resident 65 had physical behavior symptoms directed towards others such as hitting, grabbing, and attempting to use his wheelchair to intimidate or cause harm. A care plan, dated 7/3/21and most recently revised on 5/24/21, which indicated Resident 65 rejected care such as medications, assistance with activities of daily living (ADLs), bathing/showers, and had improper use of his wheelchair including speeding and hitting others with it. There was no care plan or interventions for positioning in his electric/motorized wheelchair. There was no care plan or interventions for the use of positioning devices such as the tied scarf or U-cushion.			

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	Resident 65 had current physician orders, dated through 7/31/21, which included, but were not limited to, "elevate feet when in bed ...pressure reducing cushion to wheelchair check placement each shift ...skin prep to bil [bilateral] heels twice daily as a preventative ...." There was no physician order for the use of an electric/motorized wheelchair. On 7/16/21 at 11:53 a.m., therapy notes on Resident 65's U-cushion, and/or wheelchair positioning was requested a third time, but not provided. On 7/16/21 at 1:00 p.m., the Regional Clinical Consultant provided copies of current facility policies. The first policy was titled, "Electronic (motorized) Wheelchair," dated 10/2014. The policy indicated, "...It is the policy of this facility to review each resident who utilizes an electronic/motorized wheelchair to ensure the residents is able to safely maneuver the device without placing self or others at risk... a physician's order will be obtained for the resident to utilize the device in the facility... the care plan will reflect the use of the electric/motorized wheelchair and shall be reviewed quarterly and with any significant change...." The second policy was titled, "Positioning in Chair," dated 10/2014. The policy indicated, "...Resident is positioned to maintain correct body alignment when seated in a chair. Resident will be seated in a position that ensures comfort, correct body alignment and optimum pressure relief. Cushions, wedges and/or other assistive devices for seating will be properly applied after assessment and implementation...." 2. On 07/12/21 at 10:54 a.m., Resident 42 was observed seated in his room, in a wheelchair. The resident's left arm was drawn into the side of his			

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	body, and his left wrist and hand were tightly contracted (A permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff). He did not have any brace or splint on the left arm, wrist, or hand. The resident indicated he had very little ability to use his left hand and arm. He used his right hand and his feet to move himself from place to place in his wheelchair. On 7/13/21 at 8:54 a.m., Resident 42 was observed in his room, sitting up in a wheelchair. He did not have a brace or splint on his left hand, wrist, or arm. On 7/14/21 at 8:57 a.m., Resident 42 was observed lying in bed. He was sitting up, with his eyes open and his glasses on. He did not have a brace or splint on his left hand, wrist, or arm. On 7/14/21 at 1:46 p.m., Resident 42 was observed as he wheeled himself about his room, and into the attached bathroom. He used his right hand to push the wheel on his right side. His left arm and hand were drawn up against his side, and tightly contracted. He did not have a brace or splint on his left hand, wrist, or arm. On 7/15/21 at 9:08 a.m., Resident 42 was observed lying in bed. He was sitting up, with his eyes open and his glasses on. He did not have a brace or splint on his left hand, wrist, or arm. During an interview with the resident at that time, he indicated had a brace for his left arm "a while ago," but had not used it for a long time. On 7/15/21 at 3:24 p.m., Resident 42 was observed sitting in a wheelchair, in his room. He did not have a brace or splint on his left hand, wrist, or arm.			

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On 7/16/21 at 8:46 a.m., Resident 42 was observed resident in a hallway, sitting in a wheelchair. He indicated he was waiting for someone to take him outside to smoke. He did not have a brace or splint on his left hand, wrist, or arm.

During an interview on 7/15/21 at 9:12 a.m., Certified Nursing Aide (CNA) 16 indicated, she had worked with Resident 42 for over a year and had never seen a brace or a splint for the resident's left hand and arm contracture.

During an interview on 7/15/21 at 9:24 a.m., Registered Nurse (RN) 32 indicated, Resident 42 had an active order for bilateral (both sides) hand splint, to be put on at 8:00 a.m., and removed at 8:00 p.m. The brace was supposed to be put on in the morning and taken off in the evening. RN 32 indicated nursing staff should put their initials under the date they completed the order. If the resident refused the brace, nursing staff should put a circle around the date the resident refused and document the refusal in a nursing note. A blank spot could mean that the nurse just did not sign it (the MAR/ TAR). At that time, Resident 42's MAR and TAR for July 2021 were reviewed with RN 32. The record indicated, nursing staff initials were present for 8:00 a.m. on 7/1, 7/4, 7/5, 7/6, 7/12, 7/13, and 7/14/21. Nursing staff initials were present for 8:00 p.m. on 7/2, 7/6, 7/10, 7/12, 7/13/21. There was no documentation for either 8:00 a.m. or 8:00 p.m. on 7/8 or 7/9/21. There were no dates circled on the MAR/ TAR related to the hand splint.

During an interview on 7/16/21 at 9:00 a.m., CNA 34 indicated, therapy used to put a brace on Resident 42's arm, but she had not seen it in a

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	long time. During an interview on 7/16/21 9:03 a.m., Qualified Medication Aide (QMA) 35 indicated, Resident 42's left arm and hand were badly contracted. Therapy had been working with him but could not relieve the contracture. Therapy tried a brace, but the resident complained the brace hurt him. She was not sure if another brace had been tried or if anything was done to alleviate the resident's discomfort with the brace. She knew therapy was no longer working with the resident. During an interview on 7/16/21 at 9:10 a.m., Program Director (PD) 15 indicated, Resident 42 refused to wear the brace on his left hand. She would check the resident's medical record for documentation of the resident's refusals. On 7/16/21 at 11:12 a.m., PD 15 and the Regional Clinical Consultant (RCC) were interviewed. The PD indicated, the order for the brace for Resident 42 was active at that time. The RCC indicated an initial (the initials of the nursing staff) on the MAR/TAR indicated the activity was initiated and executed by the licensed nurse. If there was a blank (on the MAR/TAR), would investigate to see if a behavior memo was filled out to match that date. A circle (on the MAR/TAR) means that the order was not executed, for a variety of reasons. A Behavior memo would indicate if a resident had refused. Triage logs were completed to notify physicians. The RCC indicated, he would need to pull triage logs and behavior memos to see if the doctor had been notified and if Resident 42 had refused the brace. The RCC indicated, he would also check physical and occupational therapy record to see if there was documentation about			

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	Resident 42's refusals. On 7/16/21 at 12:16 p.m., the RCC indicated he looked in Resident 42's record and did not see any documentation of the resident's refusals or any physician notification of the resident refusing the brace. On 7/14/21 at 10:02 a.m., Resident 42's record was reviewed. His diagnoses included, but were not limited to, cerebral infarction (a stroke caused by lack of blood flow to the brain), weakness, dysphagia (difficulty swallowing), chronic pain, and muscle spasm. An Admission/ Re-Admission resident assessment, dated 1/19/21, indicated, " ...resident with contracture of left hand and left side weakness, Transfer ability total assist of 2, Ambulation ability- wheelchair, weight bearing- full weight, Eating/ nutrition- needs assist, swallowing problems; Dependent in all personal hygiene tasks...." A Joint Mobility Screen document, dated 1/19/21, indicated, "Resident is unable to touch the back of neck with both hands, touch opposite shoulder with and, start with arm at side and raise lower arm (bending at elbow), make a fist and fully open..." A Physicians' Order dated 1/20/21, indicated, "Bil [bilateral] hand splint on at 8am, off at 8pm." An Admission/ Re-Admission Resident assessment, dated 2/11/21, indicated, " ...resident with contracture of left hand, Transfer ability total assist of 2, Ambulation ability hoyer & wheelchair, weight bearing non-weight bearing, supportive devices hoyer & wheelchair, Eating/			

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	nutrition needs assist, Dependent in all personal hygiene tasks ...." A Smoking Assessment, dated 5/13/21, indicated, "Recommendations smoking with supervision (facility policy) and smoking apron r/t L shoulder and arm contracted." A Smoking Assessment, dated 5/21/21, indicated, "Recommendations smoking with supervision (facility policy) and smoking apron r/t Resident's left shoulder and arm are contracted" A Physician Progress note dated 6/11/21, indicated, "Chief complaint: follow up for a face to face encounter... He [Resident 42] is almost fully dependent in ADLs [Activities of Daily Living]." A Physicians' Order dated 7/6/21, indicated "Discharge skilled physical therapy services at this time because patient has reached max functional status at this time" A Care Plan focus dated 7/9/21, indicated, "The resident requires the use of AFO [ankle-foot orthoses, a type of brace], hand splints due to decrease function, in an effort to maintain the highest practicable physical, mental, and psychosocial well-being for the resident." Care Plan interventions included, but were not limited to, "1. monitor for potential negative outcomes and or functional decline and intervene as needed. 2. Educate the resident representative regarding the reasons for positions device use and the potential negative outcomes...5. Evaluate device for efficacy and appropriateness PRN [as needed]." The Care Plan lacked documentation of Resident 42 refusing to wear a brace on his			

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	hands. Nursing notes lacked documentation of, but not limited to, brace application, brace functional assessment, resident refusals, physician notification, or education provided to the resident regarding the brace. On 7/16/21 at 12:09 p.m., the RCC provided a policy titled, "Medication Administration," revised 4/2017. The RCC indicated, this was the current policy in use by the facility at that time. The policy indicated, " ...Refusal of medication(s) will be identified by circling the nurse or QMA's initials and documenting on the back of the MAR/TAR the date, time, and reason, if known. The nurse/ QMA should attempt to explain the potential negative outcome(s) of the refusal to the alert and oriented resident...Refusals/ omitted doses should be communicated to the oncoming shift for applicable monitoring, if warranted, and any physician notification documented in the resident's clinical record ...." On 7/16/21 at 12:09 p.m., the RCC provided a policy titled, "Care Plan Development and Review," revised 9/2017. The RCC indicated, this was the current policy in use by the facility at that time. The policy indicated, " ...The comprehensive care plan shall then be developed and shall describe the following...Any services that would otherwise be required but are not provided due to the resident's exercise of rights, including the right to refuse treatment ...." 3.1-42(a)(2)			
F 0761 SS=D	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals			

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Bldg. 00	§483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure a Licensed Nurse did not hand off her medication cart keys, which included keys to the Narcotic lock box, to a non-nursing licensed staff member. This deficient practice had the potential to effect 59 of 59 residents residing on the Behavioral Health Unit (BHU). The facility failed to ensure all medications were disposed of properly and were not left unattended and out-of-reach for 59 of 59 residents who resided on the locked unit, expired medications were removed from the medication storage rooms and carts for 1 of 1 observation	F 0761	RN 44 and the Maintenance Director received immediate education related to ensuring medication cart keys always remain in possession of only licensed personnel only. The night shift QMA, who failed to dispose of the refused medications, received immediate education related to the proper disposal of medications. All medications, supplements, and nutritional items identified during	08/14/2021

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	(Resident 41, 48, 10, 47, 32), all open medications requiring open date were dated for 1 of 12 residents observed for open date labelling (Resident 3), and temperature logs were completed for medication storage refrigerators for 4 of 6 medication storage room refrigerators observed. Findings include: 1. On 7/14/21 at 1:59 p.m., the Maintenance Director came to the D-Wing nurse's station. He requested the medication care (med-cart) keys from Registered Nurse (RN) 44. RN 44 asked what he needed the keys for, and the MD indicated he needed to unlock a gate out back. RN 44 removed two sets of keys from her pocket, on a pink and yellow plastic scrunchie that were connected and handed them to the MD. the MD left the nurse's station, and RN 44 remained at the nurse's station. On 7/14/21 at 2:16 p.m., the Maintenance Director returned to the D-Wing nurse's station and gave the set of keys back to RN 44. During an interview on 7/16/21 at 9:51 a.m., the Maintenance Director indicated he took the nurse's cart keys to unlock a gate in the courtyard so the yard technicians would be able to cut the grass. He pointed to a general industrial metal lock that was on a fence in the BHU courtyard and indicated there were two locks which had the same master keys. A master key had been placed on both C and D wing med-cart keys. He used those cart key about every two weeks to open the locks. During an interview on 7/16/21 at 9:53 a.m., the BHU Program Director, Licensed Practical		the survey process to be without labels, open dates and/or past the designated expiration date were immediately disposed of, and replacements items were ordered if necessary. C and D Hall refrigerators' temperatures were checked. No concerns were identified. Temperature logs were immediately placed on the refrigerators. All missing thermometers were immediately replaced. All residents have the potential to be affected by this alleged deficient practice. The facility conducted a house-wide audit of all medication storage areas, including refrigerators and carts, to identify and correct any other potential concerns related to the storage, disposal, and labeling of medications, supplements, and nutritional items. Any other potential concerns were immediately corrected. All licensed personnel shall receive education related to the appropriate storage, disposal, labeling and administration of medications. To ensure ongoing compliance, the Director of Nursing/Designee shall be responsible for ensuring all medications, supplements, nutritional items are stored, labeled, and disposed of in	

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	Nurse (LPN) 15 indicated a nurse should not hand off keys except to another nurse or a Qualified Medication Aid (QMA). The Narcotic lock box key should never be handed off to non-licensed personnel. At this time, the D-wing nurse's medication cart keys were observed, LPN 15 confirmed the Narcotic keys were on both sets of scrunchies. On 7/16/21 at 1:00 p.m., the Regional Clinical Consultant provided a copy of current facility policy titled, "Narcotic Count/Disposal," dated, 10/2014. The policy indicated, "...to deter potential drug diversion through ongoing accountability of narcotic use/disposal... The medication nurse on duty maintains possession of the key or code to the medications and a back of key is kept by the Director of Nursing..." 3.1-25 2. On 7/15/21 at 7:48 a.m., during an observation of medication administration, on the locked unit, with Registered Nurse (RN) 32, a medication cup of unknown, unsecured medications were observed, in the Back C Hall Medication Cart trash can. Until the unknown medications were secured by the Director of Nursing (DON), Residents 46, 67, 53, 7, and 3 stood by or moved past the unknown, unsecured medications in the medication cart trash can. On 7/15/21 at 7:49 a.m., during an observation of medication administration, on the locked unit, RN 32 dropped an Aspirin 80 mg, it was meant for Resident 20. He picked it up and placed it in the red needle box. On 7/15/21, from 8:03 to 8:06 a.m., during a medication pass with Resident 67, RN 32 left the locked medication cart with the unknown,		accordance with facility policy and procedures. On days of work and for a period of one month, the Director of Nursing shall be responsible for conducting daily audits of all medication storage areas, including refrigerators and medication carts. These audits will then continue a weekly basis for a period for two months. Then, audits will continue monthly for a period of three months. Should concerns be identified, immediate corrective action shall be taken. The Quality Assurance Committee will review the results of these observations, and any corrective actions taken, during monthly meetings for a minimum of six months. Monitoring/frequency will be reviewed/revised, as warranted, on the basis of compliance.	

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	unsecured medications unattended in the trash can. On 7/15/21 at 8:38 a.m., RN 32 indicated to Resident 7 to throw a drinking cup away in the trash can of the Back C Hall Medication Cart. The unknown, unsecured pills were visible to Resident 7 in the trash can. On 7/15/21 at 8:45 a.m., RN 32 indicated he was not aware of the unknown, unsecured pills in the trash can of the cart where he was dispensing medications. On 7/15/21, during a continuous observation from 8:43 to 8:46 a.m., RN 32 walked away from the locked medication cart with the unknown, unsecured medications in the trash can. During an interview, on 7/15/21 at 8:49, the DON indicated she had a big problem with unsecured, open medications in the medication cart trash can on the locked unit. The residents could have taken them. The unknown pills could have been blood pressure medications, or a resident may have been allergic to them. On 7/15/21 at 8:51 a.m., the DON retrieved the medication cup from the medication cart trash can, with the unknown, unsecured medication. On 7/15/21 at 9:06 a.m., the DON indicated she reviewed the unknown, unsecured medications found in the medication cart trash can, with the Locked Unit Program Manager, the medications were as follows: 1. Naproxyn 250 mg, used to reduce pain levels. 2. Metformin 1000 mg, used to lower a resident's blood sugar. 3. Potassium 20 mEq (unit of measure), used to			

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	prevent low potassium levels. 4. Flomax 0.4 mg, used to treat benign prostatic hyperplasia (enlarged prostate). 5. Famotidine 20 mg, used to treat heartburn. 6. Vimpat 100 mg, used to treat seizures. 7. Amantadine Hcl 100 mg, used to treat Parkinson's disease. During an interview, on 7/15/21 at 9:19 a.m., the DON indicated the unsecure medication were from the night shift and should have been given by the night shift nurse. The biggest problem with the medications being unsecure on the locked unit was the locked unit residents had access to them and could have swallowed them. On 7/16/21 at 1:25 p.m., the Regional Nurse Consultant provided a document, titled, "Teachable Moment," dated 7/15/21, for QMA 48, signed by the DON. The "Issue," was medication were observed in a trash can, the night shift QMA disposed of the medications improperly. The medications were as follows: 1. Flomax 0.4 mg 2. Amantadine 100 mg 3. Metformin 1000 mg 4. Pepcid 20 mg 5. Vimpat 100 mg 6. Benzotropine 2 mg, used as an anti-tremor medication. 7. K+ (potassium) 20 mEq 8. Propanolol 20 mg, used to reduce high blood pressure. A Nurse's Note, dated 7/15/21 at 10:00 a.m., was provided by the DON, on 7/16/21 at 1:41 p.m. It indicated Resident 34's 9:00 p.m. medications were found in the trash. He did not receive his 9:00 p.m. medications with no adverse reactions. Resident 34's vital signs were stable, and his MD			

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	(medical doctor) was notified with no new orders given. 3. On 7/15/21 at 10:33 a.m., the C Hall Medication Storage room was observed with Qualified Medical Assistant (QMA) 36. In the unlocked refrigerator, a partially frozen (Name of company) Thick and Easy Nectar Thick, the open date was 6/4/19, and the expiration date was 3/18/20. QMA 36 indicated after it was open, it was good for 7 days. A Nepro 8-ounce drink expired on August 2018, and several cans of diet coke with no resident name. On 7/15/21 at 11:04 a.m., the B Front Hall Medication Cart was observed with QMA 38. A cough syrup, Siltussin, for Resident 41 was unsealed with no open date, and expired 3/23/21. Four boxes of Cepacol cough lozenges, 16 per box, with only one missing, for Resident 48 were expired on 5/21/21. On 7/15/21 at 10:51 a.m., the B Hall Medication Storage room was observed with the A-B (A Hall and B Hall) Unit Manager (UM) Licensed Practical Nurse (LPN) 37. Three open containers of insulin were observed: one container of Novolog, for Resident 10, with an open date of 5/4/21, another open container of Novolog, for Resident 47, with an open date of 4/24/21, and a container of Humalog, for Resident 32, with an open date of 5/6/21. A-B UM LPN 37 indicated she would dispose of them in the red needle box. 4. On 7/15/21 at 10:45 a.m., the C-D Split Medication Cart was observed with QMA 36. An eye drop medication, Systane, for Resident 3 had no open date. QMA 36 indicated she did not know, once eye drops were opened, how long they were good. A nasal spray, Fluticasone, for			

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	Resident 55 had no open date. 5. On 7/15/21 at 10:24 a.m., the D Hall Medication Storage room was observed with QMA 36. There were no daily temperature logs on the locked and unlocked refrigerators. QMA 36 indicated the temperatures should have been taken daily and the temperatures should have been logged. On 7/15/21 at 10:33 a.m., the C Hall Medication Storage room was observed with QMA 36. There were no daily temperature logs on the locked and unlocked refrigerators. The unlocked refrigerator had no thermometer. A policy, titled, "Medication Destruction, Refused, Contaminated/Dropped or Unable to be Returned for Credit," dated 9/2019, was provided by the Regional Nurse Consultant on 7/15/21 at 10:15 a.m. A review of the policy indicated, " ...It is the policy of this facility that any medication that is refused by the resident, dropped by the resident or staff administering medication, or unable to be returned to the credit for pharmacy and/or pharmacy destruction will be disposed in an environmentally responsible manner...should medication(s) be expired or ineligible for return to pharmacy for credit and/or disposal, said medication(s) will be disposed using the Drug Buster production ...." A policy, titled, "Medication Administration," dated 4/2017, was provided by the Assistant Director of Nursing (ADON) on 7/15/21 at 10:30 a.m. A review of the policy indicated, " ...Purpose: To safely administer medication as per physicians' orders ...Licensed or qualified personnel shall be responsible to follow accepted practice of medication administration			

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	...." 3.1-25(j) 3.1-25(m) 3.1-25(o)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on interview, observation, and record review, the facility failed to ensure the kitchen was kept in a clean state to prevent risk of cross contamination, food items were covered and labeled appropriately, and employee food and drinks were not stored with food for residents for 2 of 2 kitchen observations.	F 0812	The coffee makers were maintenance to ensure no further dripping occurred. Stained and soiled towels were laundered and/or disposed of. The entirety of the kitchen was deep cleaned, including the areas under the metal counter. The employee lunch box was removed from	08/14/2021

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	Findings include: On 07/12/21 at 9:13 a.m., the facility kitchen was observed with the Certified dietary manager (CDM). Coffee makers were observed on a metal counter. The spouts of the coffee makers were observed dripping onto a towel that had been placed on the floor. On the counter, next to the coffee makers, was a pile of small towels, some of which were stained with dark spots. The CDM indicated, the towels were placed on the counter so that kitchen staff could wipe up spills as they went throughout the day. A metal counter, greater than 10 feet long, had steam compartments on top, and shelving and drawers on the sides. The shelves contained boxes of packages of single serving syrup, jam, and jelly. There were also boxes of plastic silverware. On the floor, under the entire length of the long metal counter were copious amounts of dirt and debris, including, but not limited to, a milk carton, a dinner roll, a package of crackers, plastic ware, and a plastic serving tray. The CDM indicated, the metal counter was used for holding food at the correct temperature prior to serving to the residents. On a metal wire rack were multiple bowls of dry cereal. The CDM indicated the cereal was pre-portioned into the bowls to make serving more efficient. A stained kitchen rag hung on the rack, above the bowls of cereal. The CDM indicated, the rag should not be hung over food that was intended to be served to the residents. The CDM indicated, staff had cleaned the kitchen, but staff were not cleaning under the counter surfaces. He indicated a kitchen not keeping a clean rag a risk for insects and other pests. On 7/12/21 at 9:35 a.m., the inside of a walk-in refrigerator, walk-in #2, was observed. A cloth		walk-in #2, and the employee received education that personal items are held in areas designated for resident food storage. All food and drink items without lids, labels, or dates were immediately disposed of. The plastic dish rack holding bowls was cleaned, and the bowels were washed. The oven was deep cleaned. All residents who receive food and other nutritional items from the kitchen have the potential to be affected by this alleged deficient practice. The facility conducted a thorough deep clean of the kitchen and evaluated all food items for the appropriate storage and labeling. All kitchen personnel shall receive education related to the appropriate storage, labeling, and disposal of food items in accordance with expiration dates. All kitchen personnel shall receive education that personal items are not to be stored in areas designated for resident food storage. To ensure ongoing compliance, on his days of work, Dietary Services Manager is responsible for daily conducting observations related to food storage, kitchen cleanliness and dating/labeling of food items. Daily observations will be conducted for a period of one	

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	bag was hung from one of the shelves. The CDM indicated, the bag was an employee lunch box, and should not be stored with food served to residents. On 7/12/21 at 9:38 a.m., the inside of walk-in refrigerator #1 was observed. There were 2 opened, and unlabeled 2-liter bottles of soda on a shelf. There was also an unlabeled, clear plastic condiment bottle with an unidentified white substance inside. The CDM indicated, the substance inside the condiment bottle may have been mayonnaise at one time, but he was unsure. He was unsure how long it had been in the walk-in. The CDM indicated, he thought the opened bottles of soda were placed in the walk-in by someone from the activities department. He was unsure how long the soda had been in the walk-in or when it was last served to residents. The CDM indicated, all food served to residents should have a label of what the item is, when it arrived, when it was opened, and when it would expire. On 7/12/21 at 9:46 a.m., a reach-in refrigerator was observed. The CDM indicated, the reach-in was used by the dietary aides for food preparation and storage of leftover food. Inside the reach-in were 2 Styrofoam cups, without a lid or a label. The CDM indicated, the cups belonged to kitchen staff who had placed their personal drinks into the reach-in. Also observed in the reach-in refrigerator were sandwiches wrapped in cling wrap, an opened container of applesauce, an opened container of sliced peaches, a container of sliced ham, an opened jar of Dijon mustard, a container of creamed corn, 10 pitchers of pink lemonade, 8 pitchers of iced tea, and a pitcher of a red liquid the CDM indicated was vegetable juice; none of which had labels that indicated		month. Twice weekly observations will be conducted for a period of two months. Weekly audits will be conducted for a period of three months. The kitchen will be deep cleaned on a no less than weekly basis. Should concerns be identified, immediate corrective action shall be taken. The Quality Assurance Committee will review the results of these audits, and any corrective actions taken, during monthly meetings for a minimum of six months. Monitoring/frequency will be reviewed/revised, as warranted, on the basis of compliance.	

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	when the food item was opened or prepared, or when the food item would expire. On 7/12/21 at 9:56 a.m., a stack of plastic dish racks with bowls was observed. Ten of the bowls on the top rack were observed with spilled food that resembled oatmeal and eggs. The CDM indicated the bowls stored on the plastic rack should have been clean as they were bowls used to serve the residents' food. On 7/12/21 at 9:59 a.m., the oven was observed with built up food and ashen debris between the glass on each of the 4 oven doors. The CDM indicated food and debris built up inside the oven doors could increase the risk of a fire in the oven. During a second kitchen observation, on 7/15/21 at 11:07 a.m., a plastic pitcher, filled with an unidentified liquid, was observed inside the reach-in refrigerator, without a lid. The pitcher did not have a label to indicate what the liquid was, when it was prepared, or when it would expire. Inside walk-in #1 were opened 2-liter bottles of root beer, and 1 opened 2-liter bottle of orange soda. The soda bottles did not have a label of when they were opened or would expire. The CDM indicated he was not sure how long the soda had been inside the walk-in. During an interview on 7/15/21 at 11:16 a.m., the District Manager indicated kitchen cleanliness was important, it was a safety issue. The residents depended on the kitchen to keep them and the food safe. On 7/12/21 at 1:30 p.m., the Regional Clinical Consultant (RCC) provided a policy titled, "Food Storage: Cold Foods," revised 9/2017. The RCC			

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	indicated, this was the current policy in use by the facility at that time. The policy indicated, " ...All foods will be stored and wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination ...." On 7/15/21 at 11:53 a.m., the RCC provided a policy titled, "Nourishment Pantries," dated 5/2018. The RCC indicated, this was the current policy in use by the facility at that time. The policy indicated, " ...No employee food items should be stored with resident's nourishments ...." The Indiana Department of Health, "Retail Food Establishment Sanitation Requirements," 410 IAC 7-24-295, Section 295, indicated, " ...(a) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (b) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (c) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of: (1) dust; (2) dirt; (3) food residue; and (4) other debris ...." 3.1-21(i)(2) 3.1-21(i)(3)			