STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. BUILDING 00 B. WING	11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00415423, IN00417326, IN00417794, and IN00417955. Complaint IN00415423 - Federal/State deficiencies related to the allegations are cited at F921. Complaint IN00417326 - No deficiencies related to the allegations are cited. Complaint IN00417794 - Federal/State deficiencies related to the allegations are cited at F580. Complaint IN00417955 - No deficiencies related to the allegations are cited. Survey dates: October 29, 30, 31 and November 1 and 2, 2023 Facility number: 000366 Provider number: 155469 AIM number: 100288900 Census Bed Type: SNF/NF: 94 Total: 94 Census Payor Type: Medicare: 20 Medicaid: 61 Other: 13 Total: 94 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
Rosa McGowen	VP of Operations	12/07/2023

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

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	Quality review completed on 11/6/23.			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders for medications and an assessment to self-administer their own medications for 2 of 2 residents reviewed for self-administration of medication. (Residents 76 and 195) Findings include: 1. During a random observation on 10/29/23 at 1:45 p.m., a bottle of Milk of Magnesia (MOM) was observed on Resident 76's bedside stand. Interview with the resident at that time, indicated he took the MOM once or twice a week for constipation. During random observations on 10/30/23 at 2:21 p.m. and 3:30 p.m., the MOM remained on the resident's bedside stand. During random observations on 10/31/23 at 9:58 a.m., 11:25 a.m., and 2:05 p.m., the MOM remained on the resident's bedside stand. During random observations on 11/1/23 at 9:20 a.m. and 11:15 a.m., the MOM remained on the resident's bedside stand. The record for Resident 76 was reviewed on 11/1/23 at 11:01 a.m. Diagnoses included, but were not limited to, type 2 diabetes and end stage	F 0554	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F554 Resident Self Admin Meds-Clinically Appropriate What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A self-administration assessment was completed for Resident 76 and MD order received for self-administration of medication Milk of Magnesium. A self-administration assessment was completed for Resident 195 and an MD order was received for self-administration of medication Nasal spray. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action	11/24/2023

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	renal disease. The Significant Change Minimum Data Set (MDS) assessment, dated 8/1/23, indicated the resident was cognitively intact. The October 2023 Physician's Order Summary (POS), indicated there was no order for the resident to receive Milk of Magnesia. The resident had no Physician's Order for self administering medications and no Self-Administration of Medication assessment had been completed. Interview with Nurse Consultant 1 on 11/1/23 at 3:30 p.m., indicated the resident needed an order for the medication and a Self-Administration of Medication assessment needed to be completed. 2. During an interview with Resident 195 on 10/29/23 at 1:26 p.m., the resident was observed with an over the counter bottle of nasal spray on his over bed table. He indicated he had brought it with him from the hospital. During random observations on 10/30/23 at 9:36 a.m. and on 10/31/23 at 8:25 a.m., the bottle of nasal spray was still on his over bed table. The record for Resident 195 was reviewed on 10/31/23 at 9:36 a.m. The resident was admitted to the facility on 10/22/23. Diagnoses included, but were not limited to, difficulty walking, infection of the left knee, hypertensive kidney disease, gout, diverticulosis of the large intestine, osteoarthritis, heart failure, atrial fibrillation, and contusion of the left knee. The Admission Minimum Data Set (MDS) assessment, dated 10/29/23, indicated the resident		will be taken; All facility residents with medication orders have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff were educated on not leaving medications at resident bedside unless there is an order for self-administration in place. Licensed Nurses were also educated on the need for a physician order and a medication self-administration assessment when a resident self-administers medication. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Facility Angel's will audit 5 residents 3 days per week to ensure no medication is improperly stored at the bedside and any medication noted at bedside has orders for self-administration. The Director of Nursing/designee will present a summary of the	

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	was cognitively intact and was independent with his activities of daily living. There were no Physician's Orders for the nasal spray and there were no orders for the resident to self administer his own medications. There was no Self Administration of Medication assessment completed for the resident. Interview with Nurse Consultant 2 on 11/1/23 at 2:00 p.m., indicated there was no order for the nasal spray and there was no self administration of medication assessment completed for the resident. The current 2/15/21 "Self-Administration of Medication" policy, provided by Nurse Consultant 1 on 11/1/23 at 4:51 p.m., indicated a resident may only self-administer medications after the IDT (Interdisciplinary Team) had determined which medications may be self-administered. 3.1-11(a)		audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 11/24/2023	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or			

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	psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to ensure the resident's Responsible Party	F 0580	Please accept the following as the facility's credible allegation of	11/24/2023

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	was notified of medication changes for 1 of 1 residents reviewed for notification of change. (Resident B) Finding includes: The record for Resident B was reviewed on 10/31/23 at 2:46 p.m. Diagnoses included, but were not limited to, stroke, history of falls, and legally blind. The Quarterly Minimum Data Set (MDS) assessment, dated 7/13/23, indicated the resident was cognitively impaired for daily decision making. A Physician's Order, dated 6/17/23, indicated the resident was to receive Haloperidol Lactate Concentrate (an antipsychotic medication) 2 milligrams (mg) per milliliter (ml), give 2.5 mg daily. There was no documentation of the resident's Responsible Party being notified of the new medication order. A Physician's Order, dated 7/4/23, indicated the resident was to receive Zoloft (an antidepressant) 25 mg daily for major depression. There was no documentation of the resident's Responsible Party being notified of the new medication order. Interview with Nurse Consultant 2 on 11/2/23 at 1:50 p.m., indicated there was no documentation indicating the resident's Responsible Party was notified of the new medications that were initiated. This citation relates to Complaint IN00417794.		compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F580 Notify of changes (Injuries/Decline/Room, Etc.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident B no longer resides in the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents with a change in condition have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Nurses were in- on ensuring the physician, resident, and resident responsible party are notified of residents' change in condition and notification is documented in the resident's medical record. Nurses were in- on ensuring the resident/resident responsible party is notified of order changes including treatment and medication orders and notification is documented in the medical record. How the corrective action(s) will be monitored to	

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	3.1-5(a)(2)		ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; DON/Designee will randomly audit 5 residents with change in condition 2 times per week with special focus on new medication orders to ensure resident/responsible party notification is completed timely and documented in the medical record. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 11/24/2023	
F 0623 SS=A Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in			

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	accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing			

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	and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey			

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	Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). Based on record review and interview, the facility failed to ensure the resident's Responsible Party was notified in writing related to a transfer to the hospital for 2 of 3 residents reviewed for hospitalization. (Residents 28 and 46) Findings include: 1. The record for Resident 28 was reviewed on 10/30/23 at 3:16 p.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, delusional disorder, hallucinations, and anxiety disorder. A 5 day Medicare Minimum Data Set (MDS) assessment, dated 9/29/23, indicated the resident was cognitively impaired for daily decision making. The resident was sent to the hospital on 9/10/23 and returned to the facility on 9/22/23. Nurses' Notes, dated 9/10/23 at 1:21 p.m., indicated the resident was sent to the emergency room due to having a low blood pressure. Report was given to the emergency room nurse and all relevant paperwork was sent with the resident to the hospital. There was no indication the State transfer form was mailed to the resident's Responsible Party. Interview with Nurse Consultant 1 on 11/2/23 at 1:25 p.m., indicated a copy of the State transfer	F 0623	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F623 Notice Requirements Before Transfer/Discharge What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Facility of transfer discharge including the bed hold policies were mailed to the responsible parties for Resident 28 and resident 46. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents that are transferred or discharged have the potential to be affected by the same alleged deficient practice. What measures will be put into	11/24/2023

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	form was not sent to the resident's Responsible Party. 2. The record for Resident 46 was reviewed on 10/31/23 at 11:46 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, schizoaffective disorder, stroke, and stage 4 sacral pressure ulcer. The Significant Change Minimum Data Set (MDS) assessment, dated 8/4/23, indicated the resident was moderately impaired for daily decision making. The resident was admitted to the hospital on 8/21/23 and returned to the facility on 9/19/23. Nurses' Notes, dated 8/21/23 at 1:02 p.m., indicated the resident had an elevated temperature and she was receiving an antibiotic for a wound infection. She was sent to the emergency room for evaluation and admitted to the hospital. There was no indication the State transfer form was mailed to the resident's Responsible Party. Interview with Nurse Consultant 1 on 11/2/23 at 1:25 p.m., indicated a copy of the State transfer form was not sent to the resident's Responsible Party. 3.1-12(a)(6)(ii) 3.1-12(a)(6)(iii)		place or what systemic changes will be made to ensure that the deficient practice does not recur; The Facility Medical Records Coordinator was educated to mail (Via USPS) a copy of the notice of discharge including the Bed hold policy to the resident's responsible party within of the resident's transfer and upload proof into the resident's medical record. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Administrator/Designee will audit weekly to ensure the notice of transfer discharge including bed hold policy is provided to residents' responsible parties upon transfer/discharge. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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			Date by which systemic corrections will be completed: 11/24/2023	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's 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 ensure residents were invited to attend and participate in care planning conferences for 3	F 0657	Please accept the following as the facility's credible allegation of compliance. This plan of	11/24/2023

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	of 4 residents reviewed for participation in care planning. (Residents 76, 17, and 61) Findings include: 1. Interview with Resident 76 on 10/29/23 at 1:45 p.m., indicated he did not recall being invited to his care conference. The record for Resident 76 was reviewed on 11/1/23 at 11:01 a.m. Diagnoses included, but were not limited to, type 2 diabetes, and end stage renal disease. The Significant Change Minimum Data Set (MDS) assessment, dated 8/1/23, indicated the resident was cognitively intact. Social Service Progress Notes, dated 8/1/23 at 2:19 p.m., indicated the staff member met with the resident to discuss his annual assessment. There was no documentation about inviting the resident to his care conference. Social Service Progress Notes, dated 12/21/22 at 10:37 a.m., indicated the resident's plan of care was reviewed with him and his Power of Attorney (POA) over the phone. There was no documentation after 12/21/22 of the resident being invited to attend his care conference. Interview with Nurse Consultant 1 on 11/2/23 at 1:25 p.m. indicated there was no documentation related to the resident being invited to attend his care conference after 12/21/22. 2. During an interview on 10/29/23 at 9:37 a.m., Resident 17 indicated he had not been invited or attended a Care Plan conference.		correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F657 Care Plan Timing and Revision What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A care conference was scheduled for resident 76 and resident 76 was invited to attend. A care conference was scheduled for resident 61 and resident 61 was invited to attend. A care conference was scheduled for resident 17 and resident 17 was invited to attend. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by this alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;	

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	155469	A. BUILDING 00 B. WING	11/02/2023

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	The record for Resident 17 was reviewed on 10/31/23 at 3:35 p.m. The resident was admitted to the facility on 3/8/23. Diagnoses included, but were not limited to, sepsis, type 2 diabetes, pressure ulcer, adult failure to thrive, renal dialysis, colostomy, high blood pressure, major depressive disorder, and neuromuscular dysfunction of the bladder. The Quarterly Minimum Data Set (MDS) assessment, dated 9/16/23, indicated the resident had some moderate impairment for decision making. A Social Service Progress Note, dated 3/23/23 at 1:45 p.m., indicated the initial Care Plan conference was held with the resident and his family. There were no other Care Planning conferences held with the resident or family. Interview with the Social Service Director on 11/1/23 at 1:30 p.m., indicated the resident has had only 1 care conference since admission.3. On 10/29/23 at 10:01 a.m., Resident 61 indicated that he had not been invited to a care plan conference. The record for Resident 61 was reviewed on 10/30/23 at 11:19 a.m. Diagnoses included, but were not limited to, dementia, hyperlipidemia (high cholesterol), bipolar, anxiety, seizure disorder and schizophrenia. The resident was admitted to the facility on 10/6/20. The Quarterly Minimum Data Set (MDS) assessment, dated 10/7/23, indicated the resident was cognitively intact for daily decision making. The resident had a Care Plan dated 8/4/23.		Social Service was re-educated on: Scheduling Quarterly/Annual Care Conferences. Ensuring the resident/Responsible Party is invited to attend the conference. Documenting Conference Date and Attendees in the resident's medical record. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Administrator/Designee will audit care conferences scheduled for the week to ensure the resident is invited to attend and the conference is documented in the resident's medical record. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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	There was no documentation indicating the resident had been invited to the care planning conference. Interview with Nurse Consultant 1 on 11/1/23 at 4:10 p.m., indicated the resident should have been invited to his care conferences. 3.1-35(d)(2)(B)		Date by which systemic corrections will be completed: 11/24/2023	
F 0677 SS=D 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 were provided assistance with activities of daily living (ADL's) related to assistance with shaving for 1 of 6 residents reviewed for ADL's. (Resident 85) Finding includes: On 10/29/23 at 1:05 p.m., Resident 85 was observed sitting in a broda chair in his room. He was unshaven. Interview with the resident at that time, indicated he "could use a shave" and he liked to be clean shaven. On 10/31/23 at 8:30 a.m., 2:00 p.m., and on 11/1/23 at 7:45 a.m., the resident was observed unshaven. The record for Resident 85 was reviewed on 10/30/23 at 2:20 p.m. The resident was admitted to the facility on 8/17/23. Diagnoses included, but were not limited to, stroke, end stage renal	F 0677	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F677 ADL Care Provided for Dependent Residents** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 85 was shaved as per preference. **How the facility will identify other residents having the**	11/24/2023

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	disease, sepsis, renal dialysis, high blood pressure, chronic kidney disease, and left leg below the knee amputation. The Admission Minimum Data Set (MDS) assessment, dated 8/24/23, indicated the resident was moderately impaired for decision making. The resident needed extensive assist with 1 person physical assist for personal hygiene. A Care Plan, revised on 8/20/23, indicated the resident required assistance with ADL's. The approaches were to assist with personal hygiene including dressing and grooming as needed. The resident received a shower on 10/25 and 10/27/23 and there was no documentation he was shaved. Interview with Nurse Consultant 2 on 11/1/23 at 2:00 p.m., indicated the resident should be offered a shave and if refused, then that should be documented. 3.1-38(a)(3)(D)		**potential to be affected by the same deficient practice and what corrective action will be taken;** All dependent residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were re-educated on providing dependent residents with assistance with Activities of Daily Living (ADL's) per resident's plan of care/preferences including shaving. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Facility Angel's will Audit 5 residents weekly, to ensure assistance with ADL's is being provided with a focus on shaving. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic**	

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			corrections will be completed: 11/24/2023 ="" p="">	
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 §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 ensure residents were able to see the Audiologist and Optometrist on a regular basis and referrals had follow up completed for 2 of 2 residents reviewed for communication and sensory. (Residents 17 and 61) Findings include: 1. During an interview on 10/29/23 at 9:42 a.m., Resident 17 indicated he had seen the eye doctor, however, he had not received his glasses. He also indicated he had trouble hearing but had not seen anyone for that issue. The record for Resident 17 was reviewed on 10/31/23 at 3:35 p.m. The resident was admitted to the facility on 3/8/23. Diagnoses included, but were not limited to, sepsis, type 2 diabetes,	F 0685	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F685 Treatment /Devices to Maintain Hearing/Vision** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 17 and resident 61 were placed on the optometry list. **How the facility will identify other residents having the**	11/24/2023

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	pressure ulcer, adult failure to thrive, renal dialysis, colostomy, high blood pressure, major depressive disorder, and neuromuscular dysfunction of the bladder. The Quarterly Minimum Data Set (MDS) assessment, dated 9/16/23, indicated the resident had some moderate impairment for decision making. His hearing and vision were adequate and he did not wear a hearing aid or have corrective lens. A Social Service Note, dated 5/23/23 at 11:56 a.m., indicated referrals were faxed to assist with eye care, audiology, and podiatry services. A Social Service Note, dated 6/27/23 at 11:21 p.m., indicated the resident was seen by the Optometrist on 6/27/23. An Optometry Progress Note, dated 6/27/23, indicated the plan was for new bifocals as he had none currently. The resident was to use his new glasses full time for distance and reading. New glasses were recommended and would be delivered upon approval. The Audiologist was scheduled to come to the facility on 11/1/23, however, they canceled. There were no other visits from the Audiologist for 2023. Interview with the Administrator on 11/1/23 at 4:32 p.m., indicated the Audiologist had rescheduled for 12/20/23. They switched companies in the summer, and there had been no Audiologist in the facility thus far for 2023. Interview with the Social Service Director on 11/2/23 at 10:30 a.m., indicated the resident had not received his glasses as of today.2. During an		**potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents requiring vision services have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Social Services were educated on ensuring residents are added to the optometry visit list as needed and follow-up is completed for referrals including obtaining glasses. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Administrator/designee will audit weekly to ensure any optometry referrals are followed up timely and glasses are obtained as ordered. Administrator /designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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	interview with Resident 61 on 10/29/23 at 10:06 a.m., he indicated he needed to see the eye doctor. He had signed the consent and had not been seen since 2021 when his glasses were ordered. The record for Resident 61 was reviewed on 10/30/23 at 11:19 a.m. Diagnoses included, but were not limited to, dementia, hyperlipidemia (high cholesterol), bipolar, anxiety, seizure disorder and schizophrenia. The Quarterly Minimum Data Set (MDS) assessment, dated 10/7/23, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 9/11/23, indicated the resident could receive services of the Eye Care physician, Audiologist, Dentist and Podiatrist. On 8/30/21, the resident signed an eye service agreement with the contracted company. The resident was seen by the eye consultants on 3/9/22. Findings indicated the resident had dry eyes and secondary cataracts in both eyes. The plan was to obtain a surgical consultation and a referral was left with the facility. There was no documentation the resident had been seen for his follow up surgical eye consultation. Interview with the Social Service Director (SSD) on 11/1/23 at 10:26 a.m., indicated there was no documentation indicating that Resident 61 was scheduled or seen for his surgical consultation appointment. 3.1-39(a)(1)		**Date by which systemic corrections will be completed: 11/24/2023** ="" p="">	

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F 0686 SS=E Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure a resident with pressure ulcers received the treatment and services necessary to promote healing related to completing treatments as ordered and obtaining weekly measurements for 5 of 5 residents reviewed for pressure ulcers. (Residents 34, 46, 17, 41, and 85) Findings include: 1. On 10/30/23 at 2:20 p.m., Resident 34 was observed in his room in bed. The resident was positioned on a low air loss mattress and he had bilateral heel boots in place. The record for Resident 34 was reviewed on 10/31/23 at 10:04 a.m. Diagnoses included, but were not limited to, mild intellectual disabilities, history of behavioral disorder, schizophrenia, and palliative care.	F 0686	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F686 Treatment/ to Prevent/Heal Pressure Ulcers What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 34, 46, 17, 85, and 41's treatment orders were clarified with the physician and have been updated on the Treatment Administration Record.	11/24/2023

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	The Significant Change Minimum Data Set (MDS) assessment, dated 7/17/23, indicated the resident was cognitively impaired for daily decision making. He required extensive assistance with bed mobility and he was admitted to the facility with 2 Stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle) pressure areas. A Care Plan, dated 7/28/23 and reviewed on 10/17/23, indicated the resident had impaired skin breakdown to the left heel and coccyx due to a history of ulcers and immobility. Interventions included, but were not limited to, administer treatments as ordered and monitor for effectiveness. Assess, record, and monitor wound healing as per facility policy. Measure length, width, and depth where possible. Assess and document the status of the wound perimeter, wound bed, and healing progress. Report improvements and declines to the Physician. A Physician's Order, dated 8/2/23, indicated Betadine External Solution 10% (a topical antiseptic) was to be applied to the resident's left heel and sacrum one time daily. The areas were to be cleansed with normal saline or wound cleanser, pat dry, cover the wound bed with betadine soaked dressing, and cover with a dry dressing. The October 2023 Treatment Administration Record (TAR), indicated the treatment to the left heel and sacrum had not been signed out as being completed on 10/2, 10/3, 10/9, 10/16, 10/19, and 10/26/23. The weekly Wound Assessment Details report, dated 9/4, 9/18, 10/13, 10/21, and 10/27/23, indicated the area to the resident's sacrum measured 9 centimeters (cm) x 7.5 cm x 1.0 cm.		How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents with treatment orders have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff were re-educated on the following: Ensuring treatment orders are updated and completed per physician orders ·Treatments are properly documented in Electronic Treatment Administration Record (ETAR) at the time care is rendered. ·Weekly wound assessment is completed and documented timely in the resident record. How the corrective action(s) will be monitored to ensure the deficient	

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	The weekly Wound Assessment Details report, dated 9/4, 9/18, 10/21, and 10/27/23, indicated the area to the resident's left heel measured 4.5 cm x 6 cm x und (undetermined). On 10/30/23, the resident was seen by the Wound Physician. The area to the sacrum was a Stage 4 that measured 8 cm x 9 cm x 1 cm. The area to the left heel was a Stage 4 that measured 3.5 cm x 1.7 cm x 0.3 cm. Interview with Nurse Consultant 1 on 11/1/23 at 3:30 p.m., indicated the resident's treatments should have been signed out as ordered and weekly measurements should have been obtained. 2. On 10/30/23 at 11:16 a.m., Resident 46 was observed in her room in bed. She was positioned on a low air loss mattress and a wound vac was observed on her over bed table. The wound vac was set at 125 millimeters (mm) of mercury (Hg) The record for Resident 46 was reviewed on 10/31/23 at 11:46 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, schizoaffective disorder, stroke, and stage 4 sacral pressure ulcer. The Admission Minimum Data Set (MDS) assessment, dated 9/26/23, indicated the resident was moderately impaired for daily decision making and she required extensive assistance with bed mobility. She had 1 Stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle) pressure area. A Care Plan, dated 8/23/23, indicated the resident had a pressure area and was at risk for further skin break down due to incontinence of bowel and bladder and decreased mobility. Interventions		practice will not recur, i.e., what quality assurance programs will be put into place; DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 11/24/2023	

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	included, but were not limited to, provide wound care per treatment order. A Physician's Order, dated 10/18/23, indicated to check the placement of the wound vac to the sacrum every shift to ensure there were no leaks in the dressing, the tubing was patent, and no alarms were noted. The October 2023 Treatment Administration Record (TAR), indicated the wound vac placement was not signed out as being checked on the following dates and times: - 10/18/23 evening and night shift - There was no documentation for all 3 shifts on 10/19, 10/20, 10/21, and 10/22/23 - 10/26/23 day shift - 10/28/23 evening shift - 10/30/23 day shift The resident had no order for the wound vac on the October 2023 Physician's Order Summary (POS) or on the October 2023 TAR. A Wound Physician Progress Note, dated 10/16/23, indicated negative pressure wound therapy was to be applied three times per week for 30 days, setting of 125 "VAC" intermittent. Interview with Nurse Consultant 1 on 11/2/23 at 8:47 a.m., indicated there should have been a treatment order for the wound vac. 3. On 10/29/23 at 2:07 p.m., Resident 17 was observed sitting on his rollator in his room. At that time, he indicated he had a pressure ulcer "on his butt" and stood up and pulled down his pants for it to be observed. The bandage was dated 10/27/23. On 11/1/23 at 8:16 a.m., the Wound Nurse was observed performing the treatment for the			

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	resident. The old bandage was removed and the pressure sore was observed. The area was deep and clean with pink tissue. The record for Resident 17 was reviewed on 10/31/23 at 3:35 p.m. The resident was admitted to the facility on 3/8/23. Diagnoses included, but were not limited to, sepsis, type 2 diabetes, pressure ulcer, adult failure to thrive, renal dialysis, colostomy, high blood pressure, major depressive disorder, and neuromuscular dysfunction of the bladder. The Quarterly Minimum Data Set (MDS) assessment, dated 9/16/23, indicated the resident had some moderate impairment for decision making. He had 1 unhealed Stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer that was present on admission. A Care Plan, revised on 7/28/23, indicated the resident had a pressure ulcer to the coccyx. The approaches were to provide weekly treatment documentation which was to include a measurement of each area of the skin breakdown's width, length, depth, type of tissue and exudate (drainage) and any other notable changes or observations. Physician's Orders, dated 8/22/23, indicated cleanse the sacrum with normal saline and pat dry. Pack the wound bed with 1/2 inch of iodofoam gauze and cover with a dry dressing one time a day. The August and September 2023 Treatment Administration Records (TARs), indicated the treatment was not signed out as being completed 8/22-8/31/23, 9/2, 9/3, 9/5, 9/8, 9/10, 9/16, 9/17, 9/19, and 9/23/23.			

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	155469	A. BUILDING 00 B. WING	11/02/2023

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Physician's Orders, dated 9/26/23, indicated Santyl Ointment (a debriding agent), apply to the sacrum topically every day shift for wound care after cleansing the sacrum with normal saline. Apply Santyl to the wound base and pack the wound with alginate rope and cover with a dry dressing.

The September and October 2023 TARs indicated the treatment was blank and not completed on 9/26, 9/29, 10/4, 10/10, and 10/11/23.

Physician's Orders, dated 10/17/23, indicated oil emulsion apply once weekly for 23 days; Alginate calcium apply once weekly for 23 days; Skin substitute application apply once weekly for 7 days: Do Not Remove or disturb the wound bed. Change the secondary dressing with care every day shift.

The 10/2023 TAR, indicated the treatment was not signed out as being completed on 10/28 and coded with a "9" (see nurses' notes) on 10/29/23.

The Wound Physician was seeing the resident on a weekly basis, however, he was absent for 4 weeks due to an illness. A Wound Physician Note, dated 8/21/23, indicated the Stage 4 coccyx pressure ulcer measured 1 centimeter (cm) by 1.8 cm by 3.0 cm and was 70% granulation tissue with 30% slough.

The facility Wound Nurse had documentation for the coccyx pressure ulcer on 8/30, 9/3, 9/15, and 9/20/23. The wound measurements were all the same with the exact same information as the Wound Physician's last Progress Note on 8/21/23 before he got sick. All of the dates indicated the exact measurements and same documentation of 1 cm by 1.8 cm by 3.0 cm and was 70% granulation

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	tissue with 30% slough. A 9/25/23 Wound Physician Progress Note, indicated the coccyx measured 2 cm by 1.8 cm by 3.2 cm and had 90% granulation and 10% slough. The last documented and most recent Wound Physician Progress Note, dated 10/30/23, indicated the pressure ulcer measured 1.4 cm by 1.3 cm by 3 cm and was 100% granulation tissue. Interview with the Wound Nurse on 11/1/23 at 8:16 a.m., indicated the Wound Doctor had put a skin graft in place on 10/23/23 and it was not to be changed for 1 week. The outer border gauze bandage was to be changed every day due to a lot drainage. She indicated when the Wound Doctor came in and they changed the bandages on 10/30/23, she saw the outer border gauze bandage was dated 10/27/23, which was the last time she had changed it herself. Interview with Nurse Consultant 1 on 11/1/23 at 2:00 p.m., indicated the treatments were to be completed by staff as ordered by the Physician. While the Wound Physician was off, the facility's Wound Nurse was supposed to be measuring the area each week. The wound measurements documented during the absence of the Wound Doctor were all the same. 4. On 11/1/23 at 8:04 a.m., Resident 41 was observed lying in bed. At that time, the Wound Nurse was going to change the resident's bandage on his coccyx. The old bandage was removed and the pressure ulcer was pink with no drainage. The record for Resident 41 was reviewed on 10/31/23 at 2:30 p.m. Diagnoses included, but were			

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	not limited to, chronic kidney disease, high blood pressure, angina, Parkinson's disease, atrial fibrillation, and anorexia. The 8/24/23 Modification of the Annual Minimum Data Set (MDS) assessment, indicated the resident rarely understood or understands and was severely impaired for decision making. The resident had unhealed pressure ulcers that were not present on admission. The Care Plan, revised on 10/12/23, indicated the resident had a pressure ulcer. The approaches were to administer treatments as ordered and monitor for effectiveness. Physician's Orders, dated 9/8/23, indicated to cleanse the coccyx with wound cleanser, apply Medihoney (a debriding agent), and 4 by 4 comfort form border dressing to the coccyx. The facility nurse was to change every shift. The Treatment Administration Record (TAR) for 10/2023, indicated the treatment was not signed out as being completed on 10/8 and 10/12 for the night shift, 10/9 and 10/26 for the day shift, and 10/28/23 for the evening shift. Interview with the Wound Nurse on 11/1/23 at 8:10 a.m., indicated the treatment should have been completed as ordered by the Physician. 5. On 10/29/23 at 1:05 p.m., Resident 85 was observed sitting in a broda chair. At that time, he had a large black necrotic pressure ulcer noted to his right foot. Interview with the resident at that time, indicated the nurses did not put the iodine on his heel every day like they used to. On 11/1/23 at 7:45 a.m., the Wound Nurse was			

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	observed performing the treatment to the resident's right heel. She washed her hands with soap and water and donned clean gloves to both hands. She then opened the betadine swabs and used them on the pressure ulcers to the right ankle and right outer foot. She then poured the betadine solution onto a gauze sponge and applied it to the right heel. She did not clean any of the wounds prior with normal saline or wound cleanser. The record for Resident 85 was reviewed on 10/30/23 at 2:20 p.m. The resident was admitted to the facility on 8/17/23. Diagnoses included, but were not limited to, stroke, end stage renal disease, sepsis, renal dialysis, high blood pressure, chronic kidney disease, and left leg below the knee amputation. The Admission Minimum Data Set (MDS) assessment, dated 8/24/23, indicated the resident was moderately impaired for decision making. The resident was at risk for pressure ulcers. A Care Plan, revised on 9/1/23, indicated the resident had actual skin impairment to the right heel. The approaches were to render the treatment as per physician orders. Physician's Orders, dated 9/12/23, indicated to cleanse the right heel with normal saline, pat dry, and paint the right heel with betadine one time a day. Physician's Orders, dated 8/18/23 and discontinued on 10/17/23, indicated to cleanse the right heel with normal saline, pat dry and apply skin prep to the area and leave open to air. The Treatment Administration Record (TAR),			

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	indicated the skin prep treatment was signed out as being completed 9/1-10/17/23. The TAR indicated there was no documentation the betadine treatment was completed 9/12/23 through 10/29/23. The last measurement of the right heel was on 10/30/23 by the Wound Physician. The pressure ulcer was 6.5 centimeters (cm) by 3.5 cm and was 100% thick adherent black necrotic tissue (eschar). Interview with the Wound Nurse on 11/1/23 at 8:00 a.m., indicated she was to complete his treatment on Monday, Wednesday and Friday. At times, she would complete the treatment and tell the nurse to sign it out for her. She did not realize the order for the betadine was not on the Treatment or Medication Administration records. She put in a new order for the betadine on 10/30/23 for the right ankle and heel. She had no idea the order for the skin prep was being signed out the month of October after the Wound Doctor had discontinued it. She was supposed to clean the wound with normal saline prior to administering the betadine. Interview with Nurse Consultant 2 on 11/1/23 at 8:35 a.m., indicated there was no documentation of the treatment of betadine being completed every day since 9/2023. The treatment was not transcribed onto the treatment record. interview with Nurse Consultant 2 on 11/1/23 at 2:00 p.m., indicated the treatment should have been completed as ordered by the doctor. 3.1-40(a)(2)			

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on random observations, record review, and interview, the facility failed to ensure oxygen humidification canisters were changed weekly for 1 of 2 residents reviewed for oxygen. (Resident 41) Finding includes: During random observations on 10/29/23 at 1:10 p.m. and 3:00 p.m., Resident 41 was observed in bed wearing oxygen at 2 liters with a humidification bottle on the concentrator. The bottle was dated 10/5/23. The record for Resident 41 was reviewed on 10/31/23 at 2:30 p.m. Diagnoses included, but were not limited to, chronic kidney disease, high blood pressure, angina, Parkinson's disease, atrial fibrillation, and anorexia. The 8/24/23 Modification of the Annual Minimum Data Set (MDS) assessment, indicated the resident rarely understood or understands and was severely impaired for decision making. He used oxygen as a resident of the facility. A Care Plan, revised on 8/21/23, indicated the resident required oxygen therapy.	F 0695	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F695** **Respiratory/Tracheostomy care and Suctioning** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 41's oxygen humidifier bottle was changed. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents with oxygen have the potential to be affected by the same alleged deficient practice.	11/24/2023

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	Physician's Orders, dated 7/6/23, indicated oxygen via nasal cannula at 2 liters per minute continuously. Change Oxygen tubing, mask, or cannula one time a day every Sunday. The Treatment Administration Record (TAR) dated 10/2023, indicated the canister change was signed out as being completed on 10/29/23 at 6:00 a.m. Interview with Nurse Consultant 2 on 11/1/23 at 2:00 p.m., indicated the canister was to be changed every week. The current 9/20/21 "Oxygen Therapy" policy provided by the Administrator on 11/2/23 at 10:02 a.m., indicated change oxygen tubing weekly and as needed. 3.1-47(a)(6)		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Staff were educated on ensuring oxygen tubing and humidifier bottle is changed as per physician orders. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Facility Angel's will audit 5 residents receiving oxygen weekly to ensure oxygen tubing and humidifier bottle is changed as per physician orders. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 11/24/2023** ="" p="">	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who			

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	require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, record review, and interview, the facility failed to ensure pain medications were available when requested, side effects were monitored, and the medication was signed out on the Medication Administration Record (MAR) as being administered for 2 of 2 residents reviewed for pain. (Residents 195 and 12) Findings include: 1. During an interview with Resident 195 on 10/29/23 at 1:26 p.m., he indicated he had a lot of pain in his left knee due to a fall and infection. When he first arrived at the facility, they told him they did not have his pain medication. He was not able to get any pain medication until 10/25/23 (3 days after admission). He also indicated he had not had a bowel movement in 3 days. On 10/31/23 at 8:30 a.m. the medication cart was observed with QMA 1. She removed the Oxycodone (a narcotic pain medication) blister pack from the locked box. The date on the medication was 10/25/23 (arrival to the facility) and there were 14 pills gone and there were 16 left in the card. The record for Resident 195 was reviewed on 10/31/23 at 9:36 a.m. The resident was admitted to the facility on 10/22/23. Diagnoses included, but were not limited to, difficulty walking, infection of the left knee, hypertensive kidney disease, gout, diverticulosis of the large intestine, osteoarthritis, heart failure, atrial fibrillation, and contusion of the left knee.	F 0697	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F697 Pain Managment** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 195's script obtained, pain medication noted on-hand/being administered as per orders and the resident is being monitored for side effects of medication. Resident 12's scripts obtained, pain medication noted on-hand/being administered as per orders and the resident is being monitored for side effects of medication. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents that require pain medication have the potential to be affected by the same alleged deficient practice.	11/24/2023

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	The Admission Minimum Data Set (MDS) assessment, dated 10/29/23, indicated the resident was cognitively intact and was independent with his activities of daily living. He received as needed pain medication and had occasional pain that interfered with his activities in the last 5 days. The resident indicated his pain level was a 7 out of 10. The resident received opioid medications. A Care Plan, dated 10/22/23, indicated the resident was at risk for pain. The approaches were to anticipate the resident's need for pain relief and respond immediately to any complaint of pain. A Care Plan, dated 10/22/23, indicated the resident was at risk for complications secondary to constipation. The approaches were to follow the facility bowel protocol for bowel management and record his bowel movement pattern each day. The resident arrived to the facility on 10/22/23 at 2:09 p.m. Nurses' Notes, dated 10/22/23 at 2:21 p.m., indicated the resident had orders for narcotics. The hospital nurse was called for the prescription. The Physician indicated he would send an "e-script" to the pharmacy for the resident's medication. The Admission Clinical Observation Assessment, dated 10/22/23 at 2:45 p.m., indicated the resident had acute pain. Physician's Orders, dated 10/22/23, indicated Oxycodone (a narcotic) tablet 10-350 milligrams (mg), 1 tablet by mouth every 4 hours as needed for pain and Docusate Sodium (a stool softener)100 mg daily.		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Nurses were re-educated on: Ensuring pain medication is administered as per orders. Pain Medication is signed out on Medication Administration Record (MAR). Narcotic medication is to be signed out on the narcotic count sheet as well as the MAR at the time of administration. If pain medication is unavailable: Nurses are to pull medication from EDK (if possible) call the physician and obtain a temporary order for an alternative medication, ensure scripts are obtained prior to depletion of medication on hand. Residents are monitored for side effects to pain medications. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/Designee will audit 5 residents 2 times per week receiving pain medication to ensure the medication is available, medication is being signed out on the MAR, Medication is administered per physician orders, and resident is monitored for side effects of pain medication.	

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	The Medication Administration Record (MAR) for 10/2023, indicated the Oxycodone was only signed out as being administered on 10/29/23 at 6:51 p.m. and on 10/30/23 at 5:49 p.m. The narcotic sheet for the Oxycodone indicated 30 pills arrived to the facility on 10/25/23. The Oxycodone was administered on 10/25, 10/26, 10/27, 10/28, 10/29, 10/30, and 10/31/23, however, only the above mentioned dates of 10/29 and 10/30/23 were documented on the MAR. The bowel movement record, indicated the resident had no bowel movement on 10/23, 10/26, 10/28, 10/29, and 10/30/23. Interview with Nurse Consultant 2 on 11/1/23 at 3:45 p.m., indicated the physician had seen the resident on 10/30/23 and did not have any issues with the resident's abdomen. She indicated the resident may be having bowel movements, but they were not being documented. Nursing staff were to make sure and ask the resident if he had a bowel movement. Interview with Nurse Consultant 1 on 11/1/23 at 4:15 p.m., indicated the hospital did not send the script for the Oxycodone, therefore it was not available. If there were no scripts from the hospital for the narcotic then they would not be able to get the medication out of the EDK (Emergency Drug Kit) box as well. The medication was not signed out on the MAR for most of the administrations, just the narcotic sheet.2. Interview with Resident 12 on 10/29/23 at 10:01 a.m., indicated she was always in pain. The record for Resident 12 was reviewed on 10/31/23 at 8:58 a.m. Diagnoses included, but		The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 11/24/2023** ="" p="">	

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	were not limited to, fibromyalgia (widespread muscle pain and tenderness), vascular dementia, type 2 diabetes mellitus, and scoliosis (curvature of the spine). The Annual Minimum Data Set (MDS) assessment, dated 9/1/23, indicated the resident was moderately impaired for daily decision making. The resident was on a scheduled pain medication regimen and had received opioids in the last 7 days. The Care Plan, dated 9/1/23, indicated the resident was at risk for pain. Interventions included, but were not limited to, administer analgesia as per orders. A Physician's Order, dated 6/13/23, indicated the resident was to receive Norco (a pain medication) 7.5-325 milligrams (mg) 1 tablet, four times a day for pain management. The October 2023 Physician's Order Summary (POS), indicated the resident was to receive Soma (a musculoskeletal therapy medication) 250 mg two times a day for pain management. A Nurse's Note, dated 10/29/23 at 2:06 p.m., indicated the resident needed a new prescription for the Norco tablets and the Physician was notified. A Nurse's Note, dated 10/29/23 at 10:12 a.m., indicated the resident needed a new prescription for the Soma tablets and the Physician was notified. The October 2023 Medication Administration Record (MAR), indicated the Norco 7.5-325 mg was not signed out as being given on the			

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	following dates and times: - 10/7/23 at 9:00 p.m. - 10/8/23 at 1:00 p.m., 6:00 p.m., and 9:00 p.m. - 10/29/23 at 8:00 a.m. and 1:00 p.m. - 10/30/23 at 6:00 p.m. The October 2023 MAR indicated the Soma 250 mg was not signed out as being given on the following dates and times: - 10/10/23 at 8:00 a.m. - 10/24/23 at 8:00 a.m. - 10/25/23 at 8:00 a.m. - 10/26/23 at 8:00 a.m. - 10/28/23 at 8:00 a.m. and 8:00 p.m. - 10/29/23 at 8:00 a.m. Interview with the Main Unit Manager on 11/1/23 at 4:35 p.m., indicated the physician needed to sign the prescriptions. He was going to call the pharmacy to see when the medication would be delivered. Interview with Nurse Consultant 1 on 11/1/23 at 4:45 p.m., indicated she would look into the medication issue. 3.1-37(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or			

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	155469	A. BUILDING 00 B. WING	11/02/2023

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	§483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to manage medications appropriately related to not administering Ambien (a hypnotic) and not obtaining labs to monitor an anticoagulant medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 195) Finding includes: The record for Resident 195 was reviewed on 10/31/23 at 9:36 a.m. . The resident was admitted to the facility on 10/22/23. Diagnoses included, but were not limited to, difficulty walking, infection of the left knee, hypertensive kidney disease, gout, diverticulosis of the large intestine, osteoarthritis, heart failure, atrial fibrillation, and contusion of the left knee. The Admission Minimum Data Set (MDS) assessment, dated 10/29/23, indicated the resident was cognitively intact. The resident received anticoagulant and opioid medications. A Care Plan, dated 10/23/23, indicated the resident was at risk for complications, such as bleeding or bruising, secondary to anticoagulant	F 0757	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F757 Drug Regimen is Free from Unnecessary Drugs** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 195's PT/INR was drawn on 10/31/2023 and results were relayed to the physician. Resident 195's Ambien received/on-hand and is being administered as per physician orders. **How the facility will identify other residents having the potential to be affected by the same deficient practice and**	11/24/2023

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	therapy. The approaches were to obtain labs as ordered. Physician's Orders, dated 10/22/23, indicated Zolpidem (Ambien) 5 milligrams (mg) 1 tablet by mouth at bedtime for difficulty sleeping and Warfarin Sodium (an anticoagulant) 2.5 mg, 1 tablet by mouth in the morning for blood clot prevention. Please monitor INR (international normalized ratio (INR) - blood test to determine how long it takes the blood to clot). PT/INR (Protime) one time a day every Monday for monitoring. A PT/INR, dated 10/31/23 at 12:22 p.m., indicated the PT was high at 26.7 (12-15 normal range) and the INR was 2.6 (normal). The results were reported to the facility at 1:57 p.m. on 10/31/23. The Medication Administration Record (MAR) for 10/2023, indicated the Zolpidem was not signed out as being administered on 10/22/23 and 10/24/23. A "5" was coded on 10/23/23 which indicated to hold and to see nurses notes. Nurses' Notes, dated 10/23/23 at 9:08 p.m., indicated the Zolpidem was pending delivery from the pharmacy. Interview with Nurse Consultant 2 on 11/1/23 at 3:45 p.m., indicated the lab had missed the PT/INR blood draw on Monday 10/30/23 and it was ordered stat (immediately) on 10/31/23. Interview with Nurse Consultant 1 on 11/1/23 at 2:45 p.m., indicated the hospital did not send the prescriptions for the Zolpidem, therefore it was not administered. 3.1-48(a)(3)		**what corrective action will be taken;** All residents with medication orders have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Nurses were educated on: Obtaining orders from the physician for collection of PT/INR's and ensuring specimen Is collected as per orders. Notifying MD of need for script for controlled medications to prevent delay in administration. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will audit 2 residents weekly receiving coumadin/warfarin to ensure PT/INR is obtained as ordered. DON/designee will audit 2 residents weekly with medications that require scripts such as Ambien are available and being administered as per orders. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee,	

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			auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 11/24/2023**<br="" "" p="">>	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review, and interview, the facility failed to ensure medications	F 0761	Please accept the following as the facility's credible allegation of	11/24/2023

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	were labeled correctly related to inhalers and an antacid bottle for 1 of 4 medication carts observed. (Blueberry Lane Medication Cart) Findings include: On 10/30/23 at 10:59 a.m., the Blueberry Lane Medication Cart was observed with LPN 2. The following medications were found in the cart: a. Albuterol Sulfate HFA Inhalation Aerosol Solution (an inhaler) 108 (90 Base) microgram (MCG) was labeled with the resident's name but no administration orders were listed on the inhaler. b. There was a Spiriva HandiHaler Inhalation Capsule 18 MCG (inhaler) in a drawer with no label. c. There was a bottle of Calcium Carbonate (tums) that was labeled with a first name only. There was no physician name or last name of the resident listed on the bottle. Interview at the time with LPN 2, indicated she was unaware the medication required the physician's name on the tums bottle and directions for use on the inhalers. Interview with the Vice President of Operations on 11/1/23 at 1:40 p.m., indicated the medication should have been properly labeled. 3.1-25(j) 3.1-25(k)(1) 3.1-25(k)(2) 3.1-25(k)(5)		compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F761 Label/Storage Drugs & Biologicals** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Medications without appropriate label (spiriva/calcium carbonate) and medication without active order (albuterol) were removed from the medication cart. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Nurses were re-educated on: Ensuring medication bottles, containers, eye drops, insulins are appropriately labeled and stored properly. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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			recur, i.e., what quality assurance programs will be put into place; DON/designee will audit medication carts 2 times per week to ensure medications are labeled appropriately and stored properly. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 11/24/2023**<br="" "" p="">	
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if			

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	requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.			
	Based on observation, record review, and interview, the facility failed to ensure a resident was seen by the dentist for routine dental services for 2 of 3 residents reviewed for dental services. (Residents 63 and 61) Findings include: 1. During an interview with Resident 63 on 10/29/23 at 8:52 a.m., he indicated he requested to see the dentist and he had not heard anything else about it. Some of the resident's teeth were	F 0791	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F791 Routine/Emergency Dental Services in SNFs** **What corrective action(s) will be accomplished for those**	11/24/2023

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	observed to be missing and broken. The record for Resident 63 was reviewed on 11/1/23 at 10:30 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, chronic obstructive pulmonary disease, anxiety disorder, and schizoaffective disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 9/21/23, indicated the resident was moderately impaired for daily decision making. Interview with the Social Service Director on 11/1/23 at 9:44 a.m., indicated that he would put the resident on the list for the dentist. He indicated the dentist usually came to the facility every three months. Interview with the Administrator on 11/1/23 at 2:10 p.m., indicated the resident had stated that he didn't want to see the dentist. Interview with Nurse Consultant 1 on 11/2/23 at 10:40 a.m., indicated the resident had never been seen by the dentist.2. During an interview with Resident 61 on 10/29/23 at 10:07 a.m., he indicated he told social service that he needed to see the dentist. He had signed the consent and had not been seen by a Dentist in 5 years. The record for Resident 61 was reviewed on 10/30/23 at 11:19 a.m. Diagnoses included, but were not limited to, dementia, hyperlipidemia (high cholesterol), bipolar, anxiety, seizure disorder and schizophrenia (psychiatric disorder). The Quarterly Minimum Data Set (MDS) assessment, dated 10/7/23, indicated the resident was cognitively intact for daily decision making.		**residents found to have been affected by the deficient practice;** Resident 63 was noted to have no emergent dental needs. Resident 63 was added to the facilities next dental visit list. Resident 61 was noted to have no emergent dental needs. Resident 61 was added to the facilities next dental visit list. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents requiring dental services have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Facility staff were educated on: Notifying the nurse/social services of need for dental services so that resident can be placed on the facility dental services list. Social service was educated on: Ensuring consent for dental services are obtained and resident is added to dental list timey. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	A Care Plan, updated 8/4/23, indicated the resident was at risk for oral/dental health problems. Interventions included, but were not limited to, coordinate arrangements for dental care and transportation as needed and as ordered. Physician's Orders, updated 9/11/23, indicated the resident could receive services of the Eye Care physician, Audiologist, Dentist and Podiatrist. On 9/29/21, a dental service agreement was signed by the resident for contracted dental services. Interview with the Social Service Director (SSD) on 11/1/23 at 10:26 a.m., indicated there was no documentation indicating Resident 61 had been seen by a Dentist. The resident was added to the dental list. 3.1-24(a)(1)		**assurance programs will be put into place;** Administrator/Designee will audit weekly to ensure new admissions and residents with needs for dental services are added to the dental schedule. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 11/24/2023** ="" p="">	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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			

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	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 food under sanitary conditions related to outdated food in the reach in cooler and walk in cooler, clean lids stacked on top of each other, and a dirty griddle and convection ovens for 1 of 1 kitchens. (The Main Kitchen) This had the potential to affect the 91 residents who received food from the kitchen. Findings include: During the initial kitchen sanitation tour with Cook 1 on 10/29/23 at 8:47 a.m., the following was observed: a. The griddle was dirty with grease on the sides. All the convection oven doors were dirty on the inside as well crumbs on the top of the ovens. b. There were 4 homemade pizzas dated 10/24/23, 9 cheese sandwiches, and 8 peanut butter and jelly sandwiches dated 10/25/23 in the reach in cooler. c. There were containers of puree bread, cheese soup, and tossed salad all dated 10/24/23 in the walk in cooler. Interview with Cook 1 at that time, indicated they should have been discarded after 3 days. d. There were 50 clean dome lids that were stacked wet on top of each other.	F 0812	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F812 Food Procurement, Store/Prepare/Serve/Sanitary Wha t corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Outdated left-over food was removed and disposed of immediately, griddle was cleaned, convection door was cleaned, dome lids were washed, dried and stored properly. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Dietary managers/dietary staff were re-educated on: Labeling left-over	11/24/2023

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	Interview with the Dietary Food Manager on 11/1/23 at 9:30 a.m., indicated all of the above were in need of cleaning and leftover food was to be discarded after 3 days. The current 2020 "Handling Leftover Food" policy, provided by the Dietary Food Manager on 11/1/23 at 10:30 a.m., indicated leftover food stored in the refrigerator shall be wrapped, dated, labeled with a use by date that was no more than 72 hours from the time of first use. Refrigerated leftovers stored beyond 72 hours shall be discarded. 3.1-23(i)(3)		food and disposing of food in the appropriate timeframe. Ensuring the cleanliness of the convection oven and griddle Proper cleaning, drying, and storing of dome lids. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Administrator/Designee will audit kitchen 2 times per week to ensure left-over food is dated, disposed of by the expiration date, and cleanliness/sanitation of the kitchen areas is maintained. /designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Date by which systemic corrections will be completed: 11/24/2023	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.			

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	§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge			

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	when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to monitoring food consumption for 1 of 1 residents reviewed for nutrition. (Resident 76) Finding includes: The record for Resident 76 was reviewed on 11/1/23 at 11:01 a.m. Diagnoses included, but were not limited to, type 2 diabetes and end stage renal disease. The Significant Change Minimum Data Set (MDS) assessment, dated 8/1/23, indicated the resident was cognitively intact. The resident required supervision with eating and he received a mechanically altered, therapeutic diet. He had no weight issues during the assessment reference period. The current Care Plan, indicated the resident was	F 0842	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F842 Resident Records-Identifiable Information** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 76's plan of care was updated. Resident had no adverse reaction. **How the facility will identify other residents having the potential to be affected by the same deficient practice and**	11/24/2023

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	155469	A. BUILDING 00 B. WING	11/02/2023

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	at risk for impaired nutritional status due to a therapeutic diet, mechanically altered diet, and was at risk for malnutrition. Interventions included, but were not limited to, offer a substitute if less than 50% of his meal was consumed. The October 2023 Food Consumption record indicated there was no documentation of the resident's food consumption on the following dates: - 10/3 no breakfast documented - 10/8 no lunch documented - 10/3, 10/6, 10/7, 10/8, 10/9, 10/11, 10/14, 10/16,10/18, 10/19, 10/22,10/23, 10/27, and 10/28/23 no dinner documented - All 3 meals were not documented on 10/4 and 10/12/23 Interview with Nurse Consultant 2 on 11/2/23 at 2:15 p.m., indicated the resident's food consumption should have been documented. 3.1-50(a)(1) 3.1-50(a)(2)		**what corrective action will be taken;** All residents have the potential to be affected by this alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nursing staff were educated on completing timely, complete, and accurate documentation in the resident's medical record. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will audit 5 residents Point of Care (POC) charting with special focus on meal intake consumption 2 times per week to ensure compliance. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 11/24/2023**<br="" p="">>	

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F 0867 SS=F Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and			

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	information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.			

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	§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen			

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	reviews, and act on available data to make improvements. Based on record review and interview, the facility failed to identify unresolved quality deficiencies, some of which had been cited on previous surveys, and ensure actions were developed and implemented to attempt to correct the deficiencies through the quality assessment and assurance (QAA) process, as evidenced by the number of repeated deficiencies cited for pressure ulcers related to not completing treatments as ordered and not completing weekly wound assessments. This deficient practice had the potential to affect 94 of 94 residents residing in the facility. Finding includes: Interview with the Administrator on 11/2/23 at 2:05 p.m., indicated the Quality Assessment and Assurance (QAA) Committee had a meeting on 10/19/23 and the committee consisted of the Medical Director, the Administrator, the Director of Nursing (DON), Infection Control Nurse, the Minimum Data Set (MDS) Nurse, the Food Sanitation Supervisor, the Social Service Director, the Activity Director and Maintenance. The Department Heads also met on a monthly basis. The Quality Assurance and Performance Improvement (QAPI) plan was a general outline of how to set up a QAPI committee and what the committee should do. The QAPI plan was a data driven, proactive approach for improving the quality of life, care and services in long term care. The activities of QAPI involved members at all levels of the organization to identify opportunities for improvement, address gaps in systems or processes, develop and implement and improvement or corrective plan and continuous monitoring of interventions.	F 0867	=”” p=””> Please accept Pthe following as the facility’s credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F867 QAPI/QAA Improvement Activities** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** QAPI plan was developed related to pressure ulcers. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** DON, ADON, Wound Nurse were educated on the importance of developing a QAPI Plan when deficiencies are identified. DON/ADON/Wound Care were also educated on the monitoring required to prevent further repeated	11/24/2023

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	The following deficiency was cited on this survey at a pattern scope with potential for more than minimal harm and had been cited previously: - F686 Treatment and Services to Prevent/Heal Pressure Ulcers was previously cited on Complaint surveys dated 7/6/23 and 4/19/23 and on the Annual with Complaints survey on 9/27/22. Cross reference F686. There was no evidence the facility had identified, developed, or implemented action plans and/or continued to monitor any corrective actions taken when these deficiencies were cited previously. Interview with the Administrator on 11/2/23 at 2:15 p.m., indicated the current Wound Nurse was being transitioned to the Infection Preventionist role. Pressure ulcers were discussed at the 10/19/23 QAPI meeting and it was determined the Wound Nurse was not inputting the treatment orders into the computer as she should have, however, a Performance Improvement Plan (PIP) was not put into place. He indicated a PIP would be implemented and discussed at the November meeting. 3.1-52(b)(2)		deficiencies. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will review and update Pressure Ulcer QAPI Plan monthly. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 11/24/2023**	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.			

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	§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or 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			

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	must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation and interview, the facility failed to provide a sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections related to disinfecting a mattress for 1 of 4 treatments observed and the storage of wash basins on 1 of 5 units. The facility also failed to ensure hand hygiene was completed after direct resident contact for 1 of 6 residents observed for medication administration. (Residents 34, 56, and Apple Lane) Findings include: 1. On 11/1/23 at 10:00 a.m., the pressure ulcer treatment for Resident 34 was observed with the Wound Nurse. The resident's left heel boot was	F 0880	p="" paraid="1356624852" paraeid="{482a1950-87ac-4e98-9a43-ca3f18b3723e}{186}" please="" accept="" the="" following="" as="" facility's="" credible="" allegation="" of="" compliance. ="" this="" plan="" correction="" does="" not="" constitute="" an="" admission="" guilt="" or="" liability="" by="" facility="" and="" is="" submitted="" only="" in="" response="" to="" regulatory="" requirement. F880 Infection Prevention & Control What corrective action(s) will be accomplished for those residents	11/24/2023

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	removed. The Wound Nurse hand sanitized, donned gloves, and removed the dressing to the resident's left heel. Once the dressing was removed, the resident's heel started bleeding and blood was dripping onto the resident's low air loss mattress. The Wound Nurse removed her gloves, hand sanitized, and donned new gloves. The area was cleansed with normal saline and the Wound Nurse indicated once she applied the Calcium Alginate to the wound bed, the area would stop bleeding. At the completion of the treatment, the Wound Nurse wiped up the blood with gauze pads. She did not use a disinfecting wipe. Interview with Nurse Consultant 2 on 11/2/23 at 11:55 a.m., indicated the area of the mattress where the blood had dripped should have been disinfected after being cleaned up by the nurse. 2. On 10/30/23 at 8:34 a.m., LPN 1 was observed preparing Resident 56's medication. The LPN opened the medication cart, pulled out a medication card, and prepared the resident's medication. The LPN entered the resident's room and handed the medication and a cup of water to the resident. The resident swallowed the medication and handed the medication and water cup back to the LPN. The cups were disposed of and the LPN proceeded back to the medication cart. LPN 1 did not complete hand hygiene before or after the medication administration. LPN 1 proceeded with the medication pass and pulled another resident's medication card from the medication cart. Hand hygiene was not observed between the residents during medication administration. Interview with the Regional Vice President of		found to have been affected by the deficient practice; Resident's basins in room 21 were properly contained/stored immediately. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All facility residents have the potential to be affected by the same alleged deficient practice. Staff were educated on: When and how to perform proper hand hygiene. How to properly clean/sanitize after a blood spill. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Facility Angel's will audit 5 residents 3 days per week to ensure wash basins and personal care items are contained/stored appropriately. Facility Angel's will randomly observe 5 staff members perform hand hygiene weekly to ensure compliance. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic	

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	Operations on 11/1/23 at 1:50 p.m., indicated the nurse should have completed hand hygiene during the medication pass. 3. On 10/30/23 at 9:34 a.m., a wash basin with a resident's sponge and a roll of toilet paper stored inside was observed on top of the bathroom trash can uncovered in Room 28. Two residents resided in the room. Interview with Nurse Consultant 1 on 11/2/23 at 1:59 p.m., indicated the basin needed to be covered due to a shared environment. 3.1-18(b)		corrections will be completed: 11/24/2023	
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 maintain a sanitary, safe, and homelike environment related to greasy kitchen pipes, rusty equipment, adhered dirt on floors, marred walls, scuffed doors and floors, cracked tile and missing window blinds for 1 of 1 kitchens and on 4 of 5 halls. (Main Kitchen, and Cherry, Apply, Blueberry and Bakersfield Hallways) Findings include: 1. During the initial kitchen sanitation tour with Cook 1 on 10/29/23 at 8:47 a.m., the following was observed: a. There was a large amount of lime build up on the faucet in the hand washing sink.	F 0921	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F921** **Safe/Functional/Sanitary/Comfortable Environment** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Work orders were created for: room 18-bathroom door marred,	11/24/2023

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	b. The pipes behind the food equipment had a large amount of caked on grease and grime. c. The steamer was observed with rusty and broken knobs. d. There were rust spots on the shelf below the steamer and there was adhered dirt under the food prep tables and under the dish machine. Interview with the Dietary Food Manager on 11/1/23 at 9:30 a.m., indicated all of the above was in need of cleaning and/or repair.2. During the Environmental Tour on 11/2/23 at 11:15 a.m., with the Directors of Environmental Services and Maintenance, the following was observed: Cherry Lane: a. In Room 18, the bathroom door was marred and the grout in between the floor tiles was dirty. There was a cracked tile along the base of the wall in the bathroom. Two residents resided in the room. Apple Lane: a. In Room 28, the floor was scuffed in several areas and the walls were marred. There were 2 residents who resided in the room. Blueberry Lane: a. In Room 37, the blinds were broken. Two residents resided in the room. b. In Room 38, there was a red stain on the privacy curtain next to bed 1. There were 2 residents who resided in the room.		grout dirty, and cracked tiles, Room 28 marred wall and scuffed floor, Room 37 and Room 41 broken blinds, Room 39 missing blinds left side, Room 38 red stain on privacy curtain, Room 43 was provided a bedside table, and the footboard was removed from the shower chair. Room 70's marred wall. Work order was created for: lime build up in sinks, grease and grim on pipes behind the food equipment, rust on steamer and broken knob, rust spots/debris under the food prep table and dish machine. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were educated on: Notifying maintenance/environmental services of any necessary repairs or cleaning needed. Keeping the kitchen area clean/sanitary including the food preparation areas and floors. **How the corrective action(s)**	

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CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	c. In Room 39, there was no blind on the left window. Two residents resided in the room. d. In Room 41, the window blinds were broken. Two residents resided in the room. e. In Room 43, there was no bedside table in the room and there was a foot boot positioned on the shower chair uncovered. There were 2 residents who used the bathroom and resided in the room. Bakersfield: a. In Room 70, there was a marred wall next to bed 1. Two residents resided in this room. Interview with the Director of Environment on 11/2/23 at 11:40 a.m., indicated that he would make a schedule to fix the floors and would change the stained curtain out. Interview with the Director of Maintenance on 11/2/23 at 11:44 a.m., indicated he would take measurements today and order the window blinds. He would make a schedule to start fixing the marred areas. Interview with Nurse Consultant 1 on 11/2/23 at 1:59 p.m., indicated she was aware the facility needed new blinds for some residents and that there were concerns with scuffed floors and marred walls. This citation relates to Complaint IN00415423. 3.1-19(f)		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** The Maintenance Director will audit 5 rooms per week on alternating units for maintenance issues. Any issues will be corrected. The Administrator will audit the kitchen 2 times per week to ensure compliance with cleanliness and sanitation. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 11/24/2023** ="" p="">	