STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	04/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00351562. Complaint IN00351562 - Substantiated. Federal/ State deficiencies related to the allegations are cited at F550, F676, F677, and F686. Survey dates: April 21, 22, 23, 24, 26, and 27, 2020 Facility number: 000368 Provider number: 155845 AIM number: 100275220 Census Bed Type: SNF/NF: 22 Total: 22 Census Payor Type: Medicare: 4 Medicaid: 18 Total: 22 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on 5/4/21.	F 0000		
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is 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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	§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, record review and interview, the facility failed to ensure each resident's dignity was maintained related to dining assistance for a dependent resident, the use of disposable plates and utensils, and a resident being pulled backwards down the hallway for 2 of	F 0550	F 550 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	05/28/2021

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	2 residents reviewed for dignity and for 11 of 11 meals observed. (Residents B and C) Findings include: 1. On 4/27/21 at 9:00 a.m., Resident B was seated at a table in the main dining room with another resident. At that time, PCA 1 was assisting the resident with his meal while Resident B watched. Resident B had not received his breakfast. The other residents in the dining room at that time had also received their breakfast. Resident B received his tray at 9:20 a.m., and he was then fed by PCA 1. The record for Resident B was reviewed on 4/27/21 at 1:12 p.m. Diagnoses included, but were not limited to, intellectual disabilities and cerebral palsy. The Quarterly Minimum Data Set (MDS) assessment, dated 4/3/21, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. The resident was dependent on staff for eating. Interview with the MDS Coordinator on 4/27/21 at 1:45 p.m., indicated the resident should not have had to wait for his meal and to be fed. 2. On 4/21/21 at 8:46 a.m., 14 residents were observed in the dining room eating breakfast. The residents were served their meal on paper plates and bowls and they were using plastic utensils. Paper and styrofoam cups were being used for hot and cold beverages. On 4/21/21 at 12:38 p.m., the lunch meal was served on paper plates. Plastic utensils were again being used as well as paper cups.		Disposable plates and utensils were approved by the surveyors during infection control several surveys. I request that that this finding be removed from the record. The facility will continue to use disposable plates and utensils until COVID-19 has been fully eradicated. The facility continues to use the covered take-out containers for new residents and residents who are served in their rooms. This facility practice has kept the residents and staff safe throughout the deadliest pandemics that we have seen in our lifetime. The residents held a meeting to discuss the survey finding of dignity issue in serving disposable plates and utensils. The resident counsel president discussed this with the residents and upon their consensus they do not wish for any changes in the way their meals are served by using disposable supplies. This practice will continue until the residents feel more comfortable and will accept changes since COVID-19 pandemic. Resident Council will discuss this at their meeting every month to evaluate. No resident has complained about the use of disposable plates and utensils. In fact, they prefer the disposable plates and utensils due to their fear of COVID. All our residents are treated with dignity	

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	During breakfast and lunch on 4/22/21, the meals were again served on paper plates. Plastic utensils and paper cups were used as well. Interview with the Dietary Food Manager (DFM) on 4/22/21 at 1:00 p.m., indicated paper products were being used based on the Administrator's wishes. Up until recently, the residents were eating in their rooms so using paper products was easier. Since in person dining had resumed, the DFM indicated she would have to talk to the Administrator and bring the dishes up from the basement. Paper products and plastic utensils continued to be used as follows: - breakfast and lunch on 4/23, 4/26 and 4/27/21 - breakfast on 4/24/21 Interview with Cook 1 on 4/27/21 at 11:56 a.m., indicated paper products were being used because they were safer. She also indicated the facility had plates and silverware in the basement. 3. On 4/21/21 at 9:14 a.m., PCA 2 was observed pulling Resident C backwards down the hallway in a wheelchair with his feet dragging. On 4/22/21 at 9:39 a.m., the PCA was observed pulling the resident down the hallway backwards, he was reclined back in a geri chair. The record for Resident C was reviewed on 4/23/21 at 12:07 p.m. Diagnoses included, but were not limited to, end stage renal disease, dialysis, diabetes, hemiplegia, and dementia with behavior disturbance. The Quarterly Minimum Data Set (MDS)		and facility will ensure that the food temps are maintained while utilizing the disposable plates. Deficient practices were reviewed with all P.C.A.'s One on one education provided for proper transport of resident by C.N.A. and P.C.A. Supervisor. Deficient practice was discussed, and in-service completed with all nursing staff, charge nurses and C.N.A.'s and P.C.A.'s on dignity of the residents and ensuring that they are not pulled backwards during transport. Instructed on proper procedure for transporting residents has been added to the orientation packet and as an ongoing in-service on an annual basis. Residents that need assistance will be seated together and mealtimes will be staggered to ensure that residents are assisted with their meal in a timely manner (as soon as their tray is delivered). 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. 2 residents out of the 11 residents were affected that require wheelchair and geri-chair transport. No other deficient practice noted.	

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	assessment, dated 2/14/21, indicated the resident was alert and oriented and totally dependent with bed mobility and transfers. Interview with the Director of Nursing on 4/26/21 at 4:10 p.m., indicated the resident should not have been propelled down the hallway backwards. This Federal tag relates to Complaint IN00351562. 3.1-3(t)		Seating is limited in the dining room due to 6-foot distancing therefore residents requiring assistance with meals will be served at the second feeding to allow adequate time to provide the meal service to residents leaving the facility for dialysis and appointments. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. A. Nurse Supervisor and C.N.A. and P.C.A. Supervisor will provide in-service with entire nursing staff, R.N.'s, L.P.N.'s, C.N.A.'s and P.C.A.'s on resident dignity on proper transporting of residents. B. Charge Nurse will monitor C.N.A.'s and P.C.A.'s for proper transporting residents throughout the facility throughout each shift. C. Nurse Supervisor and C.N.A. and P.C.A. Supervisor will monitor proper resident transport 5 days a week and monitor Nurse assignment sheet documentation of monitoring. D. Nurse Supervisor and C.N.A. and P.C.A. Supervisor will consult with D.O.N. weekly to review any concerns of resident dignity improper transporting of residents. E. Two mealtimes will be established the first mealtime will be for residents who have appointments and do not require extensive or totally dependent for	

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			feeding. Unit manager will do monitoring audits to ensure residents are transported in the appropriate way and that residents needing assistance during meals are getting required assistance in a timely manner. Daily (Monday – Friday) for 4 weeks and monthly ongoing. Results of audits/monitoring will be reviewed by QAA Committee to identify any trending in deficiencies. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. A. Nurse Supervisor and C.N.A. and P.C.A. Supervisor will provide in-service with entire nursing staff, R.N.'s, L.P.N.'s, C.N.A.'s and P.C.A.'s on resident dignity on proper transporting of residents. B. Charge Nurse will monitor C.N.A.'s and P.C.A.'s for proper transporting residents throughout the facility throughout each shift. C. Nurse Supervisor and C.N.A. and P.C.A. Supervisor will monitor proper resident transport 5 days a week and monitor Nurse assignment sheet documentation of monitoring.	

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			D. Nurse Supervisor will consult with D.O.N. weekly to review any concerns of resident dignity improper transporting of residents. F. Every charge nurse is responsible for ensuring that each resident is treated with respect and dignity. G. Nurse Supervisor will ensure staff is providing care that is respectful to each resident during rounds 5 days a week times ongoing until new staff has completed orientation then monthly. H. Feeding times will be established by the Dietary Manager and Dietician and reviewed monthly to ensure all residents are feed at the same time at 2 of the tables that seat 2 people. I. Q.A. Committee will review D.O.N recommendations and concerns in regard to resident dignity during transporting and the residents request to continue the use of disposable plates, cups and eating utensils monthly for 3 months then quarterly times 6 months. Results of audits/monitoring will be reviewed by QAA Committee to identify any trending in deficiencies. Q.A. Committee on a semi-annual basis will review of orientation of new employees on	

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			resident dignity during transport. Q.A. Committee will review dining room schedule monthly for 3 months then quarterly times 6 months. 5. Completion Date: 5/28/2021. **Addendum:** The facility has just hired a Registered Nurse who holds a PhD. She the Assistant Professor of Nursing at Lewis University and educates students to the BSN level. She will be the Nurse Supervisor and Trainer for the nursing department. She will train the staff 3 days a week and audit for deficient practices ongoing. The D.O.N. and Nurse Supervisor have determined the needs of the staff according to the deficient practices noted in the report and are developing a training program to include but not limited to the deficient practices. · Policies will be reviewed and updated to current proper practices. · In-Servicing/Educational Tools will be updated to the latest technology including but not limited to current textbook information, videos, U-Tube training and other resources that will be beneficial to staff training. · The training will be ongoing, and areas of deficient practices reviewed every 90 days with current employees and with new hires during orientation. · Evaluation of staff will be	

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			done and need for staff replacements will be discussed with QAA Committee. · PCA's will be trained through the LAD Publishing tools for CNA's. The workbook, skill cards, video and PowerPoint presentations will be used in this training. · We are asking if we can train our PCA's to C.N.A.'s at our facility.	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.			

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	§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on record review and interview, the facility failed to ensure a resident had the right to choose what time he got up in the morning for 1 of 1 residents reviewed for choices. (Resident E) Finding includes: Interview with Resident E on 4/21/21 at 2:19 p.m., indicated staff get him up too early. He indicated they get him up at 5:00 a.m. The record for Resident E was reviewed on 4/22/21 at 2:37 p.m. Diagnoses included, but were not limited to, chronic fatigue and chronic pain syndrome. The Quarterly Minimum Data Set (MDS) assessment, dated 2/1/21, indicated the resident was cognitively intact for daily decision making and required extensive 2 person assistance for transfers. A resident preference sheet was not available for review. Interview with PCA 1 on 4/27/21 at 11:00 a.m., indicated her shift starts at 7:00 a.m. and the midnight shift gets the resident up around 5:00 a.m. Interview with the MDS Coordinator on 4/27/21 at 1:45 p.m., indicated the resident's choice for getting up later should be honored. 3.1-3(u)(1)	F 0561	F 561 1. Residents are bathed on all 3 shifts and are given the preference on when they would like to have their ADL's to occur. Resident E has never been awakened at 5:30a.m. for am care. This resident does not like to get out of bed at any time. He will yell and scream so staff makes him last every morning. It is our goal to promote the best quality of life. Charge nurse will document the time he is receiving his am care since we have been made aware of his statement. 2. No resident was affected. 3. Staff will continue to provide ADL care according to the resident's request. Social Designee will assess residents request and discuss it with him and his family during team conference. Residents' social history and choices will be reviewed at the time of admission, reviewed at quarterly Care Conferences, and as needed. 4. Social Service department will evaluate all residents according to their preference and	05/28/2021

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			indicate it in their record. C.N.A. Supervisor will add the task into the computer system to include resident preference. Q.A. Committee will review changes and ensure all residents have choices forms q 3 months. 5. 5/28/21 **Addendum** Clock provided in room for resident. Social Worker did not show up for the job, so others are being interviewed. Until a Social Worker can be hired the Unit Manager will perform the duties of the Social Designee. Social Designee will assess residents request and discuss it with him and his family during team conference. Residents' social history and choices will be reviewed at the time of admission, reviewed at quarterly Care Conferences, and as needed. Evaluation of staff will be done to see whom the best would be to enroll in the Indiana Social Designee Program in the next 60 days to 90 days as the employment situation improves. Facility would like to train C.N.A. students and from that pool we would like to promote one to a C.N.A. supervisor, currently the C.N.A. pool is very short, and we	

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			have not had success in hiring new C.N.A.'s. It is our hope that employment situation will improve over the next 60 days.	
F 0563 SS=F Bldg. 00	483.10(f)(4)(ii)-(v) Right to Receive/Deny Visitors §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety			

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	restriction or limitation. Based on record review and interview, the facility failed to offer indoor visitation without stipulations related to requiring all visitors to be COVID tested and fully vaccinated before entering the facility. This had the potential to affect 22 of 22 residents who resided in the facility. Finding includes: During a random interview with Resident 13 on 4/21/21 at 11:01 a.m., indicated there was no indoor visitation at that time. "No one is allowed to come to the rooms yet and I have been fully vaccinated." Interview with LPN 1 on 4/23/21 at 8:20 a.m., indicated she had been instructed by the Director of Nursing (DON) to swab every visitor before entering, no exceptions. Visitors were only able to visit outside on the patio or through the glass doors if they have not been vaccinated. On 4/24/21 at 10:27 a.m., Resident D's son entered the facility to visit his mother. At that time, Unit Manager 1 made him get a COVID test prior to the visitation. The visitor was not pleased and was upset the facility had required him to get a rapid COVID test before the visit. The Unit Manager would not allow the visitor inside the glass doors because he had not been fully vaccinated, however, Resident D was full vaccinated. At that time, copies of the CMS memo were handed to the Unit Manager by survey staff which explained indoor visitation. The visitor was then allowed to enter the facility and embrace his mother. Interview with Unit Manager 1 on 4/24/21 at 10:37 a.m., indicated she was instructed by the DON to	F 0563	F563 1. The residents of the facility have determined at their last resident council meeting that they do not want unvaccinated visitors in their rooms. Their preference is for all unvaccinated visitors and visitors unwilling to take a COVID Rapid Test to be allowed to visit thru the front glass doors or outside on the patio. 2. The facility will update the residents on the changes in the guidelines monthly and review their preferences with the resident council president. 3. What the findings neglected to state is that the visitor was intoxicated and even though the resident was happy to see her son she asked him to leave within 10 minutes after seeing him. The staff always ask this resident prior to his visits if she would like to see him if he is intoxicated because it upsets her. Surveyor further stated the resident called for her sister to visit not her son. The facility reserves the right to act on the resident's wishes since we know the history. Out of the 21 residents only 7 residents receive visitors, and they are giving the opportunity to determine where they would like to visit with the visitor.	05/28/2021

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	swab anyone who comes into the building and not permit them in to see their family members if they have not been vaccinated. Visitors who were not fully vaccinated were only allowed patio visits and could visit through the glass doors. Interview with the DON on 4/26/21 at 4:00 p.m., indicated they have only been allowing visitation with the residents on the patio and up front in between the glass doors if the family members were not fully vaccinated. Anyone who entered the facility, visitors or vendors had to have a rapid COVID test before entering the facility. She was unaware of the updated 3/11/21 CMS memo. The current and revised "CMS QSO-20-39-NH Nursing Home Visitation-COVID 19" policy, indicated "Facilities should allow indoor visitation at all times and for all residents (regardless of vaccination status), except for a few circumstances when visitation should be limited due to a high risk of COVID-19 transmission. While not required, we encourage facilities in medium- or high-positivity counties to offer testing to visitors, if feasible. If so, facilities should prioritize visitors that visit regularly (e.g., weekly), although any visitor can be tested. Facilities may also encourage visitors to be tested on their own prior to coming to the facility (e.g., within 2-3 days). Similarly, we encourage visitors to become vaccinated when they have the opportunity. While visitor testing and vaccination can help prevent the spread of COVID-19, visitors should not be required to be tested or vaccinated (or show proof of such) as a condition of visitation." 3.1-8(b)(7)		4. Charge nurse will inform the resident of the visitor and will adhere to the resident's wishes. Q.A. Committee will review residents request for visitation quarterly. 5. 5/28/21 **Addendum** F563: Since visitation, including indoor, is very specifically mandated by CMS and IDOH and not subject to any group decision by a resident council vote or discussion, please indicate how the facility will monitor and document each individual resident's (or representative for all cognitively impaired residents) uninfluenced visitation preference on an ongoing basis (choice being given for any instance of requested visitation, not a one time preference question). Please indicate how the facility will ensure all staff are aware there can be no requirement or request for proof of vaccination or onsite testing for visitation to occur, including the new requirement for posting of the IDOH visitation guidance sheet sent out in the LTC Newsletter. Please indicate who will be monitoring that staff are following all visitation mandates, including off shifts and weekends. 1. Facility will ensure all staff are in-service on the new visitation guidelines and these guidelines are posted within the facility to	

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			ensure compliance. Facility will ensure that all visitation is allowed regardless of vaccination status and/or onsite testing. Visitation will only be limited for unvaccinated resident is county positivity rate is >10% and < 70% of residents in facility are fully vaccinated or any resident with confirmed COVID-19 infection until meet criteria to discontinue transmission based precautions. Visitation will only be suspended during an active COVID outbreak as outlined in the guidelines. Monitoring will be completed by the DON and/or DON designee every shift seven days a week for 8 weeks, Every day for 4 weeks, Every other week for 2 months and monthly thereafter to ensure compliance with all guidelines. If at any time a deficiency is observed it will be corrected and addressed with staff immediately, Audits/monitoring tools will be presented to the QAPI Committee for review and identify any non-compliance with adjustments to the POC as needed. Monitoring will continue until 100% compliance is reached and sustained. The new guidelines issued on 6/11/21 will be discussed with the Resident's Council President on 6/21/21. He will be asked to schedule a meeting so that the DON will review the new visitation	

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			guidelines presented by the CDC and ISDOH. 2. All resident receives visitors if they choose to see them. 3. Visitors Log will be reinstated, and visitors will sign in after being screened. The location of where the visit took place will also be included on the log sheet. This information will be completed by the screener. We allow all visitors into the facility and do not require them to make an appointment to see their love ones. Visitor Poster will be posted throughout the facility and at front entrance. Until social service staff can be hired nursing and unit manager will record visitations. 4. QAA will review resident council and evaluate visitations monthly x 3 months then semi-annually. QAA Committee reserves the right to make changes if COVID positive case occurs. 5. 6/25/21	
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			

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	requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or 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			

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	room changes between its different locations under §483.15(c)(9). Based on observation, record review and interview, the facility failed to ensure the Physician was promptly notified of a change in condition related to complaints of dizziness, headache, and increased lethargy for 1 of 1 residents reviewed for change of condition and 1 of 2 residents reviewed for hospitalization. (Residents 6 and 7) Findings include: 1. The record for the Resident 6 was reviewed on 4/22/21 at 1:10 p.m. Diagnoses included, but were not limited to, high blood pressure, chronic pain, dysphagia, type 2 diabetes, assault by shotgun, stroke, hemiparesis, major depressive disorder, convulsions, and psychosis. The Quarterly Minimum Data Set (MDS) assessment, dated 1/10/21, indicated the resident was not cognitively intact, and severely impaired for decision making. The resident needed extensive assist with 2 person assist for bed mobility and transfers, and extensive assist with 1 person assist for eating, toileting, and dressing. The resident weighed 155 pounds and a significant weight loss noted. The resident received a mechanically altered and therapeutic diet. In the last 7 days the resident received insulin, an antidepressant medication, and a hypnotic medication. Bed rails were coded as being used daily. Nurses' Notes, dated 1/19/21 at 10:25 a.m. and recorded as a late entry on 1/20/21 at 1:34 a.m., indicated the resident was received in bed and in a deep sleep. His vital signs were pulse 58, respirations 18, and blood pressure was 90/61.	F 0580	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Review on change in condition and physician notification in-service was held with all nursing staff.** - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Only 2 residents were found to be deficient out of the 22 resident records reviewed by surveyor, no other deficiencies were noted. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; In-Service held with licensed nurses to review change in condition policy and updating of P.O. according to treatment. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Licensed Nurse will notify physicians for all changes in conditions as they occur according to facility policy. D.O.N. Designee will review all new orders and documentation of	05/28/2021

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	The resident woke up for dinner and consumed 75% of his food. No medication was given to the resident. At 9:00 p.m., his blood pressure was 98/69 and pulse was 59. The Director of Nursing was notified. Will continue to monitor. The next entry in Nurses' Notes was on 1/21/21 at 7:51 a.m., which indicated the nurse was summoned to the resident's room by the CNA. The resident was in full seizure activity. 911 was called. The resident continued the seizure from 7:04 a.m., until 7:12 a.m. The resident was assessed by the medics. His speech was garbled and the right side of his face was drooping. He was unable to raise his right arm or grasp with the right hand. The resident was transported to the hospital for evaluation and treatment. Nurses' Notes, dated 1/22/21 at 1:43 p.m., indicated the resident was admitted to the hospital with the diagnoses of hypoglycemia, hypotension, and sepsis. There was no evidence the resident's physician was notified of the change in condition on 1/19/21 and the decreased blood pressure. The 1/2021 Medication Administration Record (MAR) indicated the resident did not receive his Glargine Insulin 15 units at bed time on 1/19 and 1/20/21. There were no Physician's Orders to hold the insulin. There was no documentation the physician was notified. The 1/2021 MAR indicated the Divalproex Sodium tablet (Depakote, a medication used for seizures) 500 milligrams (mg) was held on 1/19/21 at 6 p.m., with a code of sleeping.		resident change in conditions and provide education as needed to licensed nurses. D.O.N. will be informed of all changes in conditions by nursing staff. D.O.N. will monitor 72 hour report every 3 days for one month, then weekly times three months ongoing due to potential changes in staff. Q.A. Committee will review hospitalizations and new order log at quarterly meeting. Q.A. Committee will determine if any other revisions are needed. - by what date the systemic changes for each deficiency will be completed. 5/28/21 F580: Please indicate what, if anything, was done for the residents affected by the deficient practice. Please indicate what the facility did to determine no other residents were affected. Residents received the modifications necessary and are stable. No residents have been hospitalized. Documentation for delay in services are documented in the resident's chart. All resident's status and plan of care were reviewed, and no others were found to be deficient at that time	

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Interview with the MDS Coordinator on 4/26/21 at 5:00 p.m. indicated she was unaware of the resident's situation back in 1/2021.

The Director of Nursing was not available for interview.

2. On 4/21/21 at 3:18 p.m., Resident 7 was observed in bed. At that time, she had complaints of dizziness and headache. She indicated she was scared to get out of bed and was afraid she would fall she was so dizzy.

The record for Resident 7 was reviewed on 4/22/21 at 2:00 p.m. Diagnoses included, but were not limited to, encephalopathy, altered mental status, chronic kidney disease, high blood pressure, cardiac arrhythmia, and muscle weakness.

The Quarterly Minimum Data Set (MDS) assessment, dated 1/29/21, indicated the resident was alert and oriented with some cognitive impairment. She needed extensive assist with 2 person physical assist with transfers and supervision with set up with dressing, eating, and toilet use.

A Care Plan, dated 2/5/21, indicated the resident had hypertension. The goal was for the resident to maintain a blood pressure within normal parameters through review date. The approaches were to give medications as ordered and monitor for side effects such as orthostatic hypotension and increased heart rate. Monitor blood pressure - hold blood pressure medication for systolic less than 130. Obtain blood pressure readings as indicated per physician orders. Take blood pressure readings under the same conditions each time.

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Nurses' Notes, dated 3/15/21 at 3:12 p.m., indicated the resident had syncope this morning because she got out of her bed too fast. The resident was placed in the chair and instructed not to rise up from the bed too fast. No other complaints of dizziness noted.

There was no documentation the physician was notified.

Nurses' Notes, dated 4/16/21 at 2:46 p.m., indicated the resident stated this morning that she was dizzy and not feeling well. She refused breakfast but did get up for lunch and consumed 100%. Will continue to monitor.

There were no Nurses' Notes on 4/17/21.

Nurses' Notes, dated 4/18/21 at 7:11 p.m., indicated the resident's blood pressure was elevated slightly. It was 142/89. After medication administration, the blood pressure was 137/81. Will continue to monitor.

There was no documentation the physician was notified of the resident's complaints and increased blood pressure.

Nurses' Notes, dated 4/20/21 at 2:24 p.m., indicated the physician was notified regarding the resident's blood pressure, head ache and dizziness. New orders received to increase hydralazine (a blood pressure medication) to 50 milligrams (mg) three times a day, obtain an urinalysis, and EKG.

Nurses' Notes, dated 4/25/21 at 4:33 p.m., indicated the resident's blood pressure was elevated at 166/89. Her blood pressure was 141/79

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	after the blood pressure medications were given. The resident remained in bed for breakfast. There was no documentation the physician was notified of the increased blood pressure. Nurses' Notes, dated 4/26/21 at 1:47 p.m., indicated the resident had complaints of dizziness with an elevated blood pressure of 169/79. There was no documentation the physician was notified of the increased blood pressure. Interview with the Director of Nursing on 4/26/21 at 4:00 p.m., indicated nursing staff should have been notifying the physician in a timely manner when the resident had complaints of dizziness and her blood pressure was high. 3.1-5(a)(2)			
F 0641 SS=B Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.			
	Based on observation, record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to antipsychotic medication use, anticoagulant medication use, restraints, and behaviors for 5 of 15 MDS assessments reviewed. (Residents 9, E, 6, 13, and 3) Findings include: 1. The record for Resident 9 was reviewed on 4/23/21 at 12:03 p.m. Diagnoses included, but were not limited to, insomnia, and stroke.	F 0641	**F-641 MDS** 1. Resident using bilateral half side rails as enablers to help the resident reposition self in bed are not coded as restraints. 2. Resident receiving any anticoagulants (blood thinners) and anti-depressants, hypnotics medication will be coded properly on MDS. 3. All side rails were tightened by maintenance personnel.	05/28/2021

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	The Annual Minimum Data Set (MDS) assessment, dated 3/10/21, indicated the resident was moderately impaired for daily decision making. Section N - Medications, indicated the resident had received a hypnotic and an anticoagulant within the last 7 days. A Physician's Order, dated 3/4/21, indicated the resident was to receive Plavix (an antiplatelet medication) 75 milligrams (mg) daily. The April 2021 Physician's Order Summary (POS), indicated the resident was to receive Melatonin (an herbal sleep aid) 3 mg at bedtime for insomnia and Tylenol PM ES (an over the counter sleep aid) 500-25 mg give 500 mg at bedtime for pain. Interview with the MDS Coordinator on 4/26/21 at 5:15 p.m., indicated the MDS had been coded incorrectly related to hypnotics and anticoagulants. 2. The record for Resident E was reviewed on 4/22/21 at 2:37 p.m. Diagnoses included, but were not limited to, stroke and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 2/1/21, indicated the resident was cognitively intact for daily decision making. Section N - Medications, indicated the resident had received an antidepressant and hypnotic within the last 7 days. The April 2021 Physician's Order Summary (POS), indicated the resident was to receive Trazodone		4. Behaviors will be properly coded on the MDS, - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - New MDS Coordinator was hired and will review and conduct a full audit to ensure MDS's for accuracy and will complete MDS's ongoing. - MDS Coordinator will meet with MDS team weekly according to MDS calendar. - D.O.N./ Designee will meet monthly with MDS team to ensure accuracy prior to submission. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents MDS Assessments and Care Plans will be reviewed by new MDS Coordinator and corrections made. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; In-Service held with staff to indicating drug categories and side rails are used as enablers and not indicated them as a restraint. D.O.N. has hired a new for MDS	

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	(an antidepressant that can be used for sleep) 50 milligrams (mg) daily on Monday, Tuesday, Wednesday, Thursday, Friday and Saturday. Interview with the MDS Coordinator on 4/27/21 at 1:45 p.m., indicated the Trazodone should have been coded as an antidepressant only.3. On 4/21/21 at 2:45 p.m., Resident 6 was observed in bed. He had a 1/4 side rail attached to the left side of the bed and the right side of the bed was against the wall. The side rail was loose and pulling away from the bed. The record for the Resident 6 was reviewed on 4/22/21 at 1:10 p.m. Diagnoses included, but were not limited to, high blood pressure, chronic pain, dysphagia, type 2 diabetes, assault by shotgun, stroke, hemiparesis, major depressive disorder, convulsions, and psychosis. The Quarterly Minimum Data Set (MDS) assessment, dated 1/10/21, indicated the resident was not cognitively intact, and severely impaired for decision making. The resident needed extensive assist with 2 person assist for bed mobility and transfers, and extensive assist with 1 person assist for eating, toileting, and dressing. The resident weighed 155 pounds and a significant weight loss noted. The resident received a mechanically altered and therapeutic diet. In the last 7 days the resident received insulin, an antidepressant medication, and a hypnotic medication. Bed rails were coded as being a restraint and used daily. A Care Plan, dated 3/10/21, indicated the resident used (1/2 bed rails) to enable repositioning. The resident utilized side rails for turning and repositioning purposes.		Coordinator who will review all MDS Assessments and Care Plans to ensure accuracy. D.O.N. will monitor MDS calendar weekly and address compliance at morning meetings on Wednesdays. MDS Coordinator will express any concerns with D.O.N. as they occur. D.O.N. will meet weekly to review progress and concerns related to the MDS process prior to monthly transmission. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and D.O.N. will be responsible for transmitting all completed MDS and present reports to Q.A. Committee for review. Q.A. Committee will review the submission reports and assess the need for further training and new staff according to report assessment quarterly. D.O.N. will be responsible to report any deficient practices to the Administrator and Q.A. Committee as it occurs. **Addendum** New MDS Coordinator corrected all deficient errors on MDS. Orientation of new MDS Coordinator and RN Supervisor is	

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	155845	A. BUILDING 00 B. WING	04/27/2021

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	Physician's Orders, dated 11/24/20, indicated Trazodone (antidepressant medication) 50 milligrams every night. The resident was not receiving a hypnotic medication. Interview with the Director of Nursing (DON) on 4/26/21 at 4:00 p.m., indicated the side rail was not a restraint and should not be coded on the MDS as such. Interview with the MDS Coordinator on 4/26/21 at 4:00 p.m., indicated she was unaware the 1/4 side rails were not a restraint and should not be coded on the MDS. She was unaware Trazodone was not a hypnotic. 4. During an observation on 4/21/21 at 11:10 a.m., the 1/4 side rail on Resident 13's bed was loose and was pulling away from the side of the bed. The resident indicated the side rail moves when she uses it to get out of bed. The record for Resident 13 was reviewed on 4/24/21 at 9:40 a.m. Diagnoses included but were not limited to, sciatica, hallucinations, bipolar disorder, high blood pressure, carpal tunnel, and osteoarthritis. The Quarterly Minimum Data Set (MDS) assessment, dated 3/9/21, indicated the resident was cognitively intact. She does not receive scheduled or PRN (as needed) pain medication. Bed rails were coded as a restraint and used daily. A Care Plan, dated 3/9/21, indicated the resident used 1/2 bilateral side rails when in bed as an enabler to reposition.		currently occurring and within the next 30 days new systems of communication and changes in practices will be determined and reviewed by QAA Committee.	

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	Interview with the Director of Nursing on 4/26/21 at 4:00 p.m., indicated the side rail was not a restraint. Interview with the MDS Coordinator on 4/26/21 at 4:00 p.m., indicated she was unaware the 1/4 side rails were not a restraint and should not be coded on the MDS as such.5. The record for Resident 3 was reviewed on 4/22/21 at 1:46 p.m. Diagnoses included, but were not limited to, end stage renal disease, dialysis, diabetes, hypertension, schizophrenia, anxiety, pseudobulbar affect, psychosis, and dementia with behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 1/23/21, indicated the resident was moderately cognitively impaired for decision making and he had no moods or behaviors. A Care Plan, dated 10/12/20, indicated the resident had a behavior problem (vulgar language/ conversation) related to cognitive status. The interventions included, but were not limited to, monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. The January 2021 Medication Administration Record (MAR) indicated the only shifts the resident did not have continuous behaviors were on the following days: - Day: 1/20, 1/22, 1/27, and 1/28/21 - Evenings: 1/11, 1/14, 1/15, 1/19 - 1/21, 1/24, 1/27, and 1/29/21 Interview with the Director of Nursing on 4/26/21 at 4:10 p.m., indicated the MDS was coded			

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	incorrectly for behaviors. 3.1-31(i)			
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for			

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	future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on observation, record review and interview, the facility failed to initiate Care Plans related to diuretic use, pressure ulcers, hospice, and respiratory services for 2 of 15 residents whose Care Plans were reviewed. (Residents E and G) Findings include: 1. The record for Resident E was reviewed on 4/22/21 at 2:37 p.m. Diagnoses included, but were not limited to, stroke and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 2/1/21, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 3/14/21, indicated the resident was to receive Lasix (a diuretic) 40 milligrams (mg) daily. The current Care Plan was reviewed. There was no Care Plan related to the use of the Lasix. Interview with the MDS Coordinator on 4/26/21 at 5:15 p.m., indicated a Care Plan for the Lasix would be initiated. 2. The record for Resident G was reviewed on 4/22/21 at 12:30 p.m. Diagnoses included, but were not limited to, hypotension, weakness, and sepsis.	F 0656	F656 - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; New MDS Coordinator hired and will review all Care Plan for each resident. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had potential to be affected. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; D.O.N. and MDS Coordinator will meet weekly to discuss care plans. D.O.N. is still seeking to hired additional licensed nurses with critical thinking skills and for potential in leadership, excellent work ethic. D.O.N. will monitor Care Plan	05/28/2021

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	The Significant Change Minimum Data Set (MDS) assessment, dated 1/27/21, indicated the resident was never/rarely understood, he had an unstageable pressure ulcer, required oxygen, and was receiving hospice care. Physician's Orders, dated 1/28/21, indicated admit to hospice, cleanse coccyx wound with normal saline, pat dry and apply medihoney, cover with allevyn dressing, and oxygen at 8-10 liters via non-rebreather mask continuously. There were no plans of care related to hospice care, pressure ulcers, or oxygen therapy. Interview with the Director of Nursing on 4/26/21 at 4:10 p.m., indicated plans of care related to the resident's hospice care, pressure ulcer treatments, and oxygen therapy should have been initiated. 3.1-35(a)		calendar weekly and address compliance at weekly meetings. MDS Coordinator and D.O.N. will meet weekly to review progress and concerns related to the Care Plan process of new admissions, changes in treatment plan and quarterly reviews. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and MDS Coordinator will be responsible for reviewing interim care plans and ongoing updating of care plan. Q.A. Committee will review care plan reviews quarterly for next 6 month and assess the need for further training and new staff according to report. D.O.N. will be responsible to report any deficient practices to the Administrator and Q.A.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.			

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	(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 Care Plans were reviewed and revised as needed related to psychotropic medication and failed to ensure residents were invited to attend and participate in care planning conferences for 1 of 15 residents whose Care Plans were reviewed and 2 of 2 residents reviewed for participation in care planning. (Residents 6, 13 and D) Findings include: 1. The record for the Resident 6 was reviewed on 4/22/21 at 1:10 p.m. Diagnoses included, but were not limited to, high blood pressure, chronic pain, dysphagia, type 2 diabetes, assault by shotgun, stroke, hemiparesis, major depressive disorder, convulsions, and psychosis. The Quarterly Minimum Data Set (MDS) assessment, dated 1/10/21, indicated the resident was not cognitively intact, and severely impaired for decision making. The resident needed	F 0657	F657 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 6 and 13 care plan was updated and reviewed with resident 6 family and resident 13 and family. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All care plans will be reviewed and updated as needed according to review date. Family will be invited to participate in care plan conference and social designee will provide documentation in resident's record.	05/28/2021

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	extensive assist with 2 person assist for bed mobility and transfers, and extensive assist with 1 person assist for eating, toileting, and dressing. The resident weighed 155 pounds and a significant weight loss noted. The resident received a mechanically altered and therapeutic diet. In the last 7 days the resident received insulin, an antidepressant medication, and a hypnotic medication. Bed rails were coded as being a restraint and used daily. A Care Plan, dated 3/10/21, indicated the resident was on sedative/hypnotic therapy related to insomnia. A Care Plan, dated 3/10/21, indicated the resident used antidepressant medication related to major depression. Physician's Orders, dated 2/16/21, indicated Celexa, Trazodone, Cymbalta, and Lexapro (all antidepressants) were discontinued. Interview with the MDS Coordinator on 4/26/21 at 4:00 p.m., indicated she was unaware the Care Plans were outdated. 2. During an interview with Resident 13 on 4/21/21 at 11:02 a.m., she indicated she had not been invited to participate in any care conferences. The record for Resident 13 was reviewed on 4/24/21 at 9:40 a.m. Diagnoses included but were not limited to, sciatica, hallucinations, bipolar disorder, high blood pressure, carpal tunnel, and osteoarthritis. The Quarterly Minimum Data Set (MDS) assessment, dated 3/9/21, indicated the resident		3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Care Plan In-service held with nursing staff by D.O.N. MDS Coordinator will monitor updates for all care plans weekly. D.O.N. Designee will consult with MDS Coordinator for necessary changes and updates. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. D.O.N. will have a Care Plan In-service held with nursing staff. Unit Manager will monitor updates for all care plans after morning meetings. Nurses will consult with MDS Coordinator for necessary changes and updates. MDS Coordinator will complete the care plan tickler file and submit it to D.O.N. weekly for review. Care plan conference documentation will be reviewed by Q.A. Committee monthly times 3 months and semi-annually. Completion Date 5/28/2021	

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was cognitively intact. She did not receive scheduled or PRN (as needed) pain medication. Bed rails were coded as a restraint and used daily.

A Social Service Progress Note, dated 9/14/20 at 11:59 a.m., indicated the resident's care plans were reviewed with her, no concerns at this time.

There was no other documentation the resident had a care plan conference since 9/2020.

Interview with the MDS Coordinator on 4/26/21 at 5:00 p.m., indicated she was aware the residents were supposed to be involved in a care conference at least quarterly.

3. During an interview with Resident D on 4/21/21 at 9:04 a.m., she indicated she did not know what a care plan conference was and had never been to one.

The record for the resident was reviewed on 4/23/21 at 2:17 p.m. Diagnoses included, but were not limited to end stage renal disease, dependence on renal dialysis, hypotension, depressive disorder with psychotic symptoms, anxiety, and syncope.

The Quarterly Minimum Data Set (MDS) assessment, dated 1/30/21, indicated the resident was cognitively intact. The resident needed supervision with one person physical assist for personal hygiene.

There was no evidence the resident had been invited to participate in a care conference in the last year.

Interview with the MDS Coordinator on 4/26/21 at 5:00 p.m., indicated she was aware the resident

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	should have a care plan conference at least quarterly. 3.1-35(d)(2)(B)			
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks,			

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	§483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. Based on observation, record review and interview, the facility failed to ensure residents who needed limited assist with activities of daily living (ADLs) received help related to nail care and eating assistance for 1 of 3 residents reviewed for activities of daily living (Resident D) and 1 of 14 residents observed for dining. (Resident 9) Findings include: 1. During an interview with Resident D on 4/21/21 at 9:39 a.m., she indicated her nails were very long and were in need of being cleaned and trimmed, which she needed help doing. On 4/22 at 1:10 p.m., 4/23 at 2:00 p.m., and 4/24/21 at 10:03 a.m., the residents nails remained long and in need of cleaning. The record for the resident was reviewed on 4/23/21 at 2:17 p.m. Diagnoses included, but were not limited to end stage renal disease, dependence on renal dialysis, hypotension, depressive disorder with psychotic symptoms, anxiety, and syncope. The Quarterly Minimum Data Set (MDS) assessment, dated 1/30/21, indicated the resident was cognitively intact. The resident needed supervision with one person physical assist for personal hygiene. A Care Plan, dated 2/5/21, indicated the resident had an activity of daily living self-care performance deficit related to disease process.	F 0676	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident D refused to have nails cut but nails were cleaned and encouraged to cooperate with showering. Nails will be monitored for cleaning. Charge nurse responsibility is to ensure every resident is bathed and shaved daily unless they refuse and it should be indicated in the documentation. If a resident refuses ADL care on one shift it is offered on another shift. Charge nurse is responsible for each resident eating their meals and documented any problems. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No other deficient practices in routing resident to and ADL care noted at this time. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. In-service held with nursing staff on nail care and ADL	05/28/2021

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	The approaches were to check nail length, trim and clean on bath days, and as necessary. Interview with the Director of Nursing on 4/26/21 at 4:00 p.m., indicated the resident should have been provided nail care. 2. 2. On 4/22/21 at 12:40 p.m., Resident 9 was observed playing with her food with her fingers. She ate bites of her meal. No redirection or assistance was provided by staff. On 4/23/21 at 8:45 a.m., the resident was seated at a table in the dining room. At 9:00 a.m., the resident left the dining room. She ate bites of her breakfast and covered the plate with her napkin. No redirection was provided by staff. On 4/24/21 at 9:05 a.m., the resident ate bites of her bacon. She did not eat her eggs, or scoop of potato looking substance. At 9:40 a.m., the resident remained in her wheelchair in the dining room. She had not eaten anymore breakfast and had not received any cuing from staff. On 4/26/21 at 8:45 a.m., the resident was seated at a table in the dining room. She had a juice box in front of her at that time. At 9:02 a.m., the resident left the dining room on her own. The Occupational Therapist brought the resident back to the dining room. The resident was served 2 sausage links, a scrambled egg, 1 slice of toast and oatmeal with berries. She ate bites of her scrambled egg and her toast. The resident left the dining room again at 9:15 a.m., and no redirection was provided by staff. At 9:42 a.m. the resident propelled herself into the dining room and asked Unit Manager 1 for something to eat. At 9:43 a.m., PCA 1 removed the resident from the dining room for cleaning. At 11:30 a.m. and 12:10 p.m., the		tracking. Nursing staff identifies each resident for ADL needs: tub bath, shower, bed bath, shampoo, shave, nails cut, linen changed and skin changes. Charge Nurse will monitor food consumption at all meals daily. DON designee will monitor bathing schedule and NAR residents weekly. Every charge will monitor resident's appearance throughout every shift every day. D.O.N. and MDS Coordinator will refer residents with eating problems to O.T. for evaluation and treatment. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. Charge nurse will monitor ADL tracking daily on every shift resident's appearance Daily on all shifts. D.O.N. ADL sheets and NAR weekly. D.O.N. and MDS Coordinator will review any concerns related to ADL's and NAR weekly. Q.A. Committee monthly times 3 months and semi-annually. Addendum F676: Please indicate what, if anything, was done for the	

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	resident came into the dining room asking for food. At 12:59 p.m., the resident was served 3 pieces of chicken, which were a combination of drumettes and wings (restaurant style size), mashed potatoes and gravy, mixed vegetables and dinner roll. On 4/27/21 at 9:00 a.m. the resident's breakfast plate was on the table. She ate her cereal but she did not eat her scrambled egg, 2 sausage links, oatmeal with berries, or danish. No staff provided cueing or assist with her meal. The record for Resident 9 was reviewed on 4/23/21 at 12:03 p.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, anorexia, stroke, and anemia. The Annual Minimum Data Set (MDS) assessment, dated 3/10/21, indicated the resident was moderately impaired for daily decision making, needed supervision for eating and had suffered a significant weight loss. The Care Plan, dated 10/12/20, indicated the resident had an ADL (activities of daily living) self-care performance deficit related to dementia, muscle weakness, and lack of coordination. Interventions included, but were not limited to, the resident required setup by one staff to eat. Interview with the Director of Nursing on 4/26/21 at 5:00 p.m., indicated the resident needed to be provided cueing during her meals. This Federal tag relates to Complaint IN00351562. 3.1-38(a)(3)(E)		residents affected by the deficient practice. Please indicate what the facility did to determine no other residents were affected. All residents nails were checked 4 residents needed their nails cut. ADL's are performed on all 3 shift training provided to fill out shower sheets properly. DON and RN Supervisor are currently updating duties and responsibilities of the charge nurse which includes but not limited to ADL's.	

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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 received assistance with ADL's (activities of daily living) related to nail care and facial grooming for 2 of 3 residents reviewed for ADL's (Residents E and F) and eating assistance for 1 of 14 residents observed for dining. (Resident 15) Findings include: 1. On 4/21/21 at 2:27 p.m., Resident E was observed with long fingernails to both hands. There was also a dark substance underneath some of his fingernails. Interview with the resident at that time, indicated he preferred short nails. On 4/22/21 at 11:34 a.m. and 12:30 p.m., the resident's fingernails remained long and were in need of cleaning. The residents fingernails remained long and in need of cleaning on 4/23 at 8:40 a.m. and 10:20 a.m., 4/24 at 9:20 a.m., 4/26/21 at 9:19 a.m., and 4/27/21 at 9:00 a.m. The record for Resident E was reviewed on 4/22/21 at 2:37 p.m. Diagnoses included, but were not limited to, stroke, muscle weakness following a stroke, chronic fatigue, and chronic pain syndrome. The Quarterly Minimum Data Set (MDS)	F 0677	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Nursing staff in-service was held on proper nail care, removal of facial hair and proper completion of shower sheets and properly feeding residents. Teamwork between licensed nurses, P.C.A.'s and C.N.A. staff. Charge nurse is responsible in ensuring all residents have proper ADL care each day every shift. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No other deficient practices. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. In-service held with nursing staff on ADL Care. Interviewing for a C.N.A. Supervisor is ongoing so that they can ensure proper C.N.A. and P.C.A. training, ensure proper	05/28/2021

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	assessment, dated 2/1/21, indicated the resident was cognitively intact for daily decision making and required extensive 1 person assistance for personal hygiene. The revised Care Plan, dated 2/1/21, indicated the resident had an ADL self-care performance deficit related to having a stroke. Interventions included, but were not limited to, the resident was totally dependent on 1 staff person for personal hygiene and oral care. Interview with the Director of Nursing on 4/26/21 at 5:00 p.m., indicated she would tell staff to cut the resident's fingernails. 2. On 4/21/21 at 3:26 p.m., Resident F was observed with long dirty nails and outgrown facial hair. On 4/22/21 at 9:50 a.m., the resident's long dirty nails and outgrown facial hair remained. The record for Resident F was reviewed on 4/26/21 at 9:00 a.m. Diagnoses included, but were not limited to diabetes, schizophrenia, bipolar disorder, and hemiplegia. The Quarterly Minimum Data Set (MDS) assessment, dated 3/9/21, indicated the resident was alert and oriented, he required extensive 1 person physical assistance with personal hygiene, and supervision with 1 person physical assistance with bathing. A Care Plan, dated 10/7/20, indicated the resident had an ADL (activities of daily living) self-care performance deficit. The interventions included, but were not limited to, staff to provide assist as needed with shaving process and check nail length, trim and clean on bath day and as necessary.		development of the task in POC for the resident's preferences and documentation. Charge nurse will monitor ADL and resident's appearance every shift every day. D.O.N. will monitor best tools for proper documentation of care. program software and resident's appearance 3 days a week. MSW hired and scheduled to start first part of June. Social Service department will review resident preferences. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. Charge Nurse will monitor ADL tracking and resident's appearance daily on all shifts. D.O.N. Designee will monitor licensed nurses for task completion. C.N.A. Supervisor/ Unit Manager will monitor for P.C.A. and C.N.A. task completion. D.O.N. will monitor documentation weekly and discuss the need for modifications with Q.A. Committee monthly times 3 months then quarterly. 5. Completion Date: 5/28/21	

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	The 4/2021 CNA Shower Sheets indicated the resident received showers on 4/3/21 and 4/23/21. Interview with PCA 1 on 4/26/21 at 12:00 p.m., indicated the residents are showered at a minimum of twice per week. She and the other PCA on the day shift were very busy and forget to document the residents' showers. Interview with the Director of Nursing on 4/26/21 at 4:10 p.m., indicated the resident's nails and facial hair should have been groomed. 3. On 4/22/21 at 12:45 p.m., Resident 15 was observed being served his lunch in the dining room. The resident was picking up his food with his fingers and walking around the dining room. He was not assisted with eating. On 4/24/21 at 11:00 a.m., the resident was observed seated in his wheelchair in the dining room feeding himself breakfast with his fingers. No staff were in the dining room and he was not assisted with eating. The record for Resident 15 was reviewed on 4/24/21 at 11:41 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, psychotic disorder with hallucinations, insomnia, major depressive disorder, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 4/4/21, indicated the resident was severely impaired for daily decision making, had hallucinations, delusions, physical and verbal behaviors and wandered. The resident also required extensive one person assistance with eating.		Addendum F677: Please indicate what, if anything, was done for the residents affected by the deficient practice. Please indicate what the facility did to determine no other residents were affected. All residents were checked for long nails and facial hair. Resident E & F nails were cut. Resident F facial hair removed. Shower sheets were reviewed. Shower sheets are under review because they have still been found deficient in filling out forms properly even after being in-serviced. RN Supervisor will in-service all nursing staff again. D.O.N., R.N. Supervisor and MDS Coordinator will update the shower form and see if it can be placed in PCC to indicate if Bed Bath, Shower, Tub Bath, Shampoo, Nails Cut and Linen changes are performed so that there is one place to document information. Once plan is developed it will be presented to the QAA Committee for approval. Current shower form will be used until revision is completed and monitored daily by charge nurse.	

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	The Care Plan, dated 10/7/20 and reviewed on 3/4/21, indicated the resident had a poor appetite related to an eating disorder. Interventions included, but were not limited to, offer hand over hand assistance when help is needed during meals. Interview with the Director of Nursing on 4/26/21 at 5:00 p.m., indicated the resident should have been assisted with eating. This Federal tag relates to Complaint IN00351562. 3.1-38(a)(3)(E)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.			
	Based on observation, record review and interview, the facility failed to ensure an ongoing activity program was implemented for alert and oriented, cognitively impaired, and dependent residents, including no 1:1 activities for 3 of 5 residents reviewed for activities. (Residents 13, 3, and G) Findings include:	F 0679	F679 Addendum Based on observation, record review, and interview, the facility failed to provide ongoing activities 3 of 5 residents reviewed for activities. (Residents 13 , 3, and G) Findings include: Activities were discussed with D.O.N. on 4/23/2021. Please	05/28/2021

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	1. Interview with Resident 13 on 4/21/21 at 11:01 a.m., indicated there was not much going on at the facility. They have not had an activity director for a long time. On 4/22/21 from 9 a.m. until 12 p.m., there were no structured activities going on anywhere in the facility. On 4/22/21 from 1:30 p.m. until 3:30 p.m., the resident was observed in the dining room watching TV, there were no structured activities happening. On 4/23/21 from 9:30 a.m. until 12:30 p.m. and 1:30 p.m. until 3:30 p.m., there were no structured activities happening. On 4/24/21 from 10:00 a.m. until to 12:00 p.m., Resident 11 was observed playing the piano on her own after access to the piano was facilitated by survey staff. There were no structured activities happening. Throughout the survey, there were no 1:1 activities provided. The record for Resident 13 was reviewed on 4/24/21 at 9:40 a.m. Diagnoses included but were not limited to, sciatica, hallucinations, bipolar disorder, high blood pressure, carpal tunnel, and osteoarthritis. The Quarterly Minimum Data Set (MDS) assessment, dated 3/9/21, indicated the resident was cognitively intact. She did not receive scheduled or PRN (as needed) pain medication. There was no Care Plan for activities.		correct record surveyor did not speak with D.O.N. 4/26/21. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility is still looking to hire people to function in the activity and social service department. People interviewed did not complete pre-employment paperwork. Unit Manager will hold an afternoon activity. PTA will hold a morning activity. Activity Volunteer will hold activity on Monday and Friday. D.O.N. is reaching out to church organizations to come and volunteer for activities with residents until staff can be secured. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents have been affected. Facility is pursuing an activity designee to ensure that the designee will provide activities at routine times throughout the day. Therapy staff will provide and/or ensure that residents are offered some type of 1:1 activity and/or	

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	The last Quarterly Activities Care Plan assessment, dated 7/9/2020, indicated the resident really enjoyed taking part in the activities provided at the facility. The resident expressed that she liked music, going outside, bingo, watching Let's Make a Deal and The Price is right. Physician's Orders, dated 3/29/21, indicated the resident may participate in the activity program. Interview with the Director of Nursing on 4/26/21 at 4:00 p.m., indicated there were no structured or 1:1 activities going on in the facility at this time. The facility had just hired an new Activity Director who starts next week.2. On 4/21/21 at 9:38 a.m., Resident 3 was observed propelling his wheelchair aimlessly in the hallways. On 4/22/21 at 11:15 a.m., the resident was observed propelling himself aimlessly around the dining room. At 11:34 a.m., the resident was observed seated in his wheelchair the hallway across from the nursing station. At 11:45 a.m., the resident was observed propelling himself back into the dining room, he then stopped in front of the television and began talking out load, disturbing the others who were watching the television. At 2:56 p.m., there were 4 residents in the dining room, 2 were talking with each other, 1 was sleeping, and the other resident was watching television. There was no staff present at that time. All the other residents were in their rooms. On 4/23/21 at 9:30 a.m., the resident was observed propelling himself to the kitchen door, he then began banging on it. From 10:07 a.m. through 11:47 a.m., he was observed propelling himself in and out of the dining room. On 4/26/21 9:15 a.m., the resident was observed		group activity. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Social Worker and Activity Designee will be responsible for developing the activity program after assessing each resident. Resident council president will develop a monthly calendar to address the likes of the Residents. Unit Manager will monitor adherence to the calendar by staff members. Social Worker and/or Activity Designee will consult with resident's council president to develop new programs for the residents and holding resident's monthly council meetings. Social Worker and /or Activity Designee will consult with Activities Director while on sick leave. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. The Administrator will evaluate the Activity Departments performance and get resident's response monthly for next 3 months.	

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	propelling himself aimlessly around the dining room with his cup of cereal, then in and out of the dining room. Throughout the survey, there were no 1:1 activities provided for the resident. The record for Resident 3 was reviewed on 4/22/21 at 1:46 p.m. Diagnoses included, but were not limited to, end stage renal disease, dialysis, diabetes, hypertension, schizophrenia, anxiety, pseudobulbar affect, psychosis, and dementia with behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 1/23/21, indicated the resident was moderately cognitively impaired for decision making. Physician's Orders, dated 3/29/21, indicated monitor for inappropriate sexual behavior and inappropriate verbal outburst every shift. A Care Plan, dated 5/6/19, indicated the resident sometimes displayed inappropriate behaviors during activity group, cursing at peers, saying inappropriate things, and yelling out. The interventions included, but were not limited to, involve resident in smaller activity groups for more assistance and less distraction, seat here near activity aide or volunteer for assistance if needed, and provide him with activities involving tactile stimulation or manipulation. There was no documentation to indicate the resident was receiving any structured 1:1 programming and none was observed throughout the survey. The facility did not have an Activity Director nor		Activity Designee will submit any changes in staffing needs monthly to Administrator and Q.A. Committee. Q.A. Committee will evaluate activity program and staffing every 3 months for 6 months. Q.A. Committee will determine effectiveness of activity program and reserve the right to increase monitoring or changes to meet the needs of each resident. 5. Completion Date: 5/28/2021 F679: Please indicate if any onsite observations will be conducted at different times during the day, as well as weekends, to ensure residents are receiving improved activity stimulation to meet their group and individual needs. Addendum Administrative staff are interviewing seeking to hire people for the activity department. Administrative designee will monitor activities held during the day and weekends to ensure residents are receiving activity stimulation. Activity plans will increase as new employees are hired. It is anticipated that the employment situation should change within the next 30 – 60 days. 1. Currently a priority for 1-1 is for the wandering and restless	

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	any activity aides staffed on 4/21/21 - 4/27/21. Interview with the Director of Nursing on 4/26/21 at 4:10 p.m., indicated the residents had no structured or 1:1 activities at this time. She hired a new staff person whose role would include Social Services and Activities. She was scheduled to begin on 4/29/21. 3. On 4/21/21 at 9:37 a.m., Resident G was observed in bed with eyes open, mouth breathing, and non-verbal. There was no television or radio in his room. On 4/22/21 at 11:43 a.m., and at 1:44 p.m., the resident was observed in bed with eyes open, mouth breathing, and non-verbal. There was no television or radio in his room. On 4/23/21 at 9:23 a.m., and at 2:14 p.m., the resident was observed in bed with eyes open, mouth breathing, and non-verbal. There was no television or radio in his room. On 4/24/21 at 9:00 a.m., and at 11:21 a.m., the resident was observed in bed with eyes open, mouth breathing, and non-verbal. There was no television or radio in his room. The record for Resident G was reviewed on 4/22/21 at 12:30 p.m. Diagnoses included, but were not limited to, hypotension, weakness, and sepsis. The Significant Change Minimum Data Set (MDS) assessment, dated 1/27/21, indicated the resident was never/rarely understood, he had an unstageable pressure ulcer, required oxygen, and was receiving hospice care.		resident. Setting up activity for active residents to perform and encouraging residents to continue the activity. Example: Reading the newspaper out loud for current events, Reading a Bible Scripture, Call off BINGO and music hour. The program will grow once new employees hired.	

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	The Quarterly/Annual Participation Interview, dated 3/9/21, indicated the resident's favorite activity was music. There was no documentation to indicate the resident was receiving any structured 1:1 programming and none was observed throughout the survey. The facility did not have an Activity Director nor any activity aides staffed on 4/21/21 - 4/27/21. Interview with the Director of Nursing on 4/26/21 at 4:10 p.m., indicated the residents had no structured or 1:1 activities at this time. She hired a new staff person whose role would include Social Services and Activities. She was scheduled to begin on 4/29/21. 3.1-33(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			
	Based on record review and interview, the facility failed to complete an assessment prior to a psychiatric hospital stay for 1 of 1 residents reviewed for hospitalization. The facility also failed to ensure ongoing monitoring and prompt treatment was obtained related to monitoring blood pressure and scheduling cardiac tests for a	F 0684	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Please make the following correction to this report. This was discussed with the D.O.N. on	05/28/2021

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

(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
	resident with complaints of headache and dizziness for 1 of 1 residents reviewed for change in condition. (Residents 23 and 7) Findings include: 1. On 4/22/21 at 9:00 a.m. and 11:00 a.m., Resident 23 was not observed in his room. Interview with LPN 2 on 4/22/21 at 11:42 a.m., indicated the resident was sent to the psychiatric hospital the previous evening. The record for Resident 23 was reviewed on 4/22/21 at 11:44 a.m. Diagnoses included, but were not limited to, alcohol abuse with alcohol induced anxiety disorder, traumatic brain injury, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 3/19/21, indicated the resident was cognitively intact for daily decision making and he had no mood or behavior issues during the assessment reference period. The resident had received antidepressant and hypnotic medications within the past 7 days. There was no Physician's Order to transfer the resident to the hospital on 4/21/21. Nurses' Notes, dated 4/21/21 at 6:53 a.m., indicated the resident was verbally aggressive with staff when care was being given to his room mate. The resident was yelling profanities at the CNA. He was informed that his behavior was unacceptable and that he should apologize. He refused. An entry in the nursing progress notes, dated 4/21/21 at 11:29 a.m., indicated the resident was resting quietly in bed watching television. He had		Friday 4/24/2021 @ 3:00 p.m. not on 4/26/21 no conference was held with D.O.N. EKG was ordered timely no one was available to come and do the EKG until 2 days later. EKG technician traveled from Ohio to perform the EKG. This documentation should have been available in resident's record. Proper documentation is continuously reviewed with licensed nurses one on one continuously by the D.O.N. Clinical morning meetings held with D.O.N. to ensure documentation is completed and that orders/tests are being executed in a timely fashion and complete documentation is done when there is a delay in treatment and fulfilling of an order. Nurse Supervisor was hired to provide one to one teaching with each nurse. Orientation was provided to her for 2 days and she did not return to the job. D.O.N. and Nurse Consultant provided in-service with licensed staff. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. Every resident is affected.	

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	no complaints of pain or distress at that time. The next entry in the nursing progress notes, dated 4/23/21 at 12:37 p.m., indicated the resident was in the psychiatric hospital. There was no documentation indicating why and when the resident was sent to the psychiatric hospital. Interview with the Director of Nursing on 4/26/21 at 5:00 p.m., indicated an assessment of the resident's condition should have been documented prior to him being sent to the hospital. 2. On 4/21/21 at 3:18 p.m., Resident 7 was observed in bed. At that time, she had complaints of dizziness and headache. She indicated she was scared to get out of bed in fear she would fall she was so dizzy. The record for Resident 7 was reviewed on 4/22/21 at 2:00 p.m. Diagnoses included, but were not limited to, encephalopathy, altered mental status, chronic kidney disease, high blood pressure, cardiac arrhythmia, and muscle weakness. The Quarterly Minimum Data Set (MDS) assessment, dated 1/29/21, indicated the resident alert and oriented with some cognitive impairment. She needed extensive assist with 2 person physical assist with transfers and supervision with set up with dressing, eating and toilet use. A Care Plan, dated 2/5/21, indicated the resident had hypertension. The goal was for the resident to maintain a blood pressure within normal parameters through review date. The approaches were to give medications as ordered and monitor for side effects such as orthostatic hypotension and increased heart rate. Monitor blood pressure		3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Nurses will receive ongoing in-servicing and monitoring of nurse's documentation 3 times a week by D.O.N. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. D.O.N. will continue to seek qualified nursing staff able to perform basic nursing skills adequately. No licensed nurses are applying for jobs at this time. D.O.N. will monitor documentation 3 times a week. Q.A. Committee will review licensed nursing staffing needs and performance of nurses monthly ongoing. 5. Completion Date: 5/28/2021	

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- hold blood pressure medication for systolic less than 130. Obtain blood pressure readings as indicated per physician orders. Take blood pressure readings under the same conditions each time.

Physician's Orders, dated 10/22/19, indicated to monitor blood pressure and hold blood pressure medication for systolic less than 130.

The Medication Administration Records (MARs) for the months of 2/2021, 3/2021 and through 4/19/2021 indicated there were no blood pressures monitored or documented at least daily.

Nurses' Notes, dated 3/15/21 at 3:12 p.m., indicated the resident had syncope this morning because she got out of her bed too fast. The resident was placed in the chair and instructed not to rise up from the bed too fast. No other complaints of dizziness noted.

Nursing Progress Notes, dated 3/21/21 at 8:15 a.m., indicated the resident's blood pressure medications of Norvasc and Cilostazol were not available.

Nursing Progress Notes, dated 3/28/21 at 9:58 a.m., indicated the blood pressure medication of Cilostazol was not available.

Nurses' Notes, dated 4/16/21 at 2:46 p.m., indicated the resident stated this morning that she was dizzy and not feeling well. She refused breakfast but did get up for lunch and consumed 100%. Will continue to monitor.

There were no Nurses' Notes for monitoring on 4/17/21.

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Nurses' Notes, dated 4/18/21 at 7:11 p.m., indicated the resident's blood pressure was elevated slightly. It was 142/89. After medication administration, the blood pressure was 137/81. Will continue to monitor.

There were no Nurses' Notes for monitoring on 4/19/21.

Nurses' Notes, dated 4/20/21 at 2:24 p.m., indicated the nurse had contacted the resident's physician regarding her blood pressure, headache and dizziness. New orders were received to increase the hydralazine to 50 mg three times a day and obtain an urinalysis, and EKG (echocardiogram).

This was the first documentation the resident's physician had been notified of her change in condition.

There were no Nurses' Notes for monitoring on 4/21/21.

Nurses' Notes, dated 4/22/21 at 7:02 p.m., indicated the technician arrived at the facility and performed an EKG for the resident. This was 2 days after it had been ordered.

Nurses' Notes, dated 4/22/21 at 11:46 p.m., indicated the lab had been notified to pick-up the urine specimen at 8:36 p.m. The lab indicated they would schedule a pick up time in the morning.

The EKG report, dated 4/22/21 at 4:44 p.m., indicated the results were abnormal.

Nurses' Notes, dated 4/23/21 at 3:12 p.m., indicated the EKG results were texted to the physician and the lab will be here around 4 p.m. to

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pick up the urine.

Nurses' Notes, dated 4/23/21 at 3:29 p.m., indicated the resident had complaints of light headedness and dizziness and her blood pressure was 162/90. The physician was notified.

Nurses' Notes, dated 4/23/21 at 7:02 p.m., indicated the physician had texted back and ordered an Echocardiogram.

There were no Nurses' Notes for monitoring on 4/24/21.

Nurses' Notes, dated 4/25/21 at 4:33 p.m., indicated the resident's blood pressure was elevated at 166/89. Her blood pressure was 141/79 after blood pressure medications given. The resident remained in bed for breakfast.

There was no documentation the physician was notified of the increased blood pressure.

Nurses' Notes, dated 4/26/21 at 1:47 p.m., indicated the resident had complaints of dizziness with an elevated blood pressure of 169/79.

There was no documentation the physician was notified of the increased blood pressure.

There was no documentation the echocardiogram had been completed as of 4/27/21.

Interview with LPN 1 on 4/23/21 at 2:30 p.m., indicated she just found the results on the fax in the medication room of the EKG. She also noted the resident's urine was still in a biohazard bag in the refrigerator in the medication room. She was getting ready to call the lab for pick up.

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	Interview with the Director of Nursing (DON) on 4/26/21 at 4:00 p.m., indicated nursing staff should have been notifying the Physician in a timely manner when the resident had complaints of dizziness and her blood pressure was high. The DON was unavailable for interview on 4/27/21 regarding the delay in obtaining the echocardiogram. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			
	Based on observation, record review and interview, the facility failed to ensure treatments and services were provided to prevent and or treat pressure ulcers for 1 of 1 residents reviewed for pressure ulcers. (Resident G) Finding includes: On 4/27/21 at 2:52 p.m., observation with LPN 2 indicated the resident's nasal cannula was resting	F 0686	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Surveyor questioned the hospice nurse, LPN, and D.O.N. about why this hospice resident did not use mask but instead used nasal cannula to receive oxygen on	05/28/2021

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	between his mattress, bed linen, and the side left side rail. He had a bright red area to his bilateral nares and septum. Interview at the time indicated she was not aware of the area. The record for Resident G was reviewed on 4/22/21 at 12:30 p.m. Diagnoses included, but were not limited to, hypotension, weakness, and sepsis. The Significant Change Minimum Data Set (MDS) assessment, dated 1/27/21, indicated the resident was never/rarely understood, he had an unstageable pressure ulcer, required oxygen, and was receiving hospice care. Physician's Orders, dated 1/28/21, indicated oxygen at 8-10 liters via non-rebreather mask continuously. The Skin Observation Tool, dated 4/13/21, indicated no documentation related to the pressure area on the resident's nose. There were no Care Plans in the resident's record related to current or at risk for pressure ulcers or for oxygen use. There was no documentation to indicate the redness to the resident's nasal area had been previously identified. Interview with the Hospice Nurse on 4/23/21 at 11:48 a.m., indicated the resident was maintaining his oxygen saturations in the low 90's via nasal cannula. She had told staff it was ok to switch to the cannula from the non-rebreather mask as the mask had been breaking down the skin on the bridge of his nose.		4/23/21 at 11:48 a.m. in D.O.N.'s office. The change was due to the resident having redness and start of breakdown to the bridge of his nose. This skin lubricant was applied to this area and his lips to prevent skin breakage. At this conference it would have been more beneficial to address this issue on 4/23/21 instead of 4/27/21 at 4:10p.m. There was no change in the redness of his nose from 4/23/21 until 4/27/21. The surveyor found a .2x.2 cm area on the skin area below the skin fold center of the nasal septum and above the center of the lip under the center of the nasal cannula in which the MDS Coordinator had to use her flashlight on her cell phone to locate the area. Physician was called and Bacitracin ordered. No other residents receive oxygen. Criteria for nurses to follow was developed and all nursing staff in-serviced. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No other residents have pressure areas. 3. What measures will be put into place or what systemic changes	

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	Interview with the MDS Coordinator on 4/27/21 at 4:10 p.m., indicated the resident now had a stage 2 pressure ulcer to his bilateral nares and septum. The area had not been previously identified by the nursing staff. This Federal tag relates to Complaint IN00351562. 3.1-40(a)(2)		will be made to ensure that the deficient practice does not recur. In-service all nursing staff on Skin Assessment of Pressure Injuries and treatment. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. Charge nurse responsible for weekly skin assessments, contacting physician for proper treatment and notifying the family. D.O.N. will review weekly pressure area wound sheets. D.O.N. will consult with MDS Coordinator to discuss any new and need for revisions of care plans according to each resident's needs. Q.A. Committee will review all care plans and wound sheets monthly times 3 months then quarterly thereafter. 5. Completion Date: 5/28/21	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices			

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	to prevent accidents. Based on observation, record review and interview, the facility failed to ensure adequate intervention to prevent choking and aspiration was provided related to an improper diet given to a resident who received a mechanically altered diet for 1 of 1 residents who received an altered diet. (Resident B) Finding includes: Interview with the Dietary Food Manager (DFM) on 4/21/21 at 9:40 a.m., indicated Resident B was the only resident in the facility receiving a pureed (blended smooth to baby food consistency) diet. On 4/22/21 at 9:37 a.m., Resident B was seated at a table in the dining room. PCA 3 was carrying a tray of food and proceeded to sit down next to the resident. The meal consisted of slices of french toast and syrup, sausage links cut into bite sized pieces, and a scrambled egg. The PCA proceeded to put some french toast on the fork and lift the fork towards the resident's mouth. The PCA was stopped and asked what type of diet the resident was to receive. She looked at the tray card and indicated a mechanical soft diet. The tray card next to the resident's plate was for another resident. The PCA went to the kitchen to clarify with the DFM and returned with a pureed food tray. The record for Resident B was reviewed on 4/27/21 at 1:12 p.m. Diagnoses included, but were not limited to, intellectual disabilities and cerebral palsy. The Quarterly Minimum Data Set (MDS) assessment, dated 4/3/21, indicated the resident had short and long term memory problems and	F 0689	D.O.N. was not informed on any day about this deficiency please correct from report. - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Tray Cards and diet orders reviewed for all residents One on one in-service held with P.C.A. 3 on properly reading diet cards. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No other resident affected. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Nursing Staff and Dietary in-service held by D.O.N. Unit Manager in-serviced on tray card audit and proper auditing of meals served to residents. Dietary Manager will audit diet orders monthly. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and	05/28/2021

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	was severely impaired for daily decision making. The resident was dependent on staff for eating and received a mechanically altered therapeutic diet. The Care Plan, dated 10/9/20 and reviewed on 3/4/21, indicated the resident required total assistance for meal and fluid consumption. Interventions included, but were not limited to, follow diet per Physician's Order and staff would feed the resident his meals. The April 2021 Physician's Order Summary (POS), indicated the resident was to receive a no added salt pureed diet with nectar thickened liquids. Interview with the Director of Nursing on 4/26/21 at 5:00 p.m., indicated the resident should have received his pureed diet as ordered. 3.1-45(a)(2)		Unit Manager will perform tray card audit 3 times a week to ensure proper meals are served to residents. Dietary Manager will audit diet orders monthly. D.O.N. will monitor mealtime once weekly for each meal. Q.A. Committee will audit reports monthly times 3 months then semi-annually. by what date the systemic changes 05/28/21	
F 0692 SS=G Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;			

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	§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.			
	Based on observation, record review and interview, the facility failed to ensure residents maintained acceptable parameters of nutritional status related to assistance with meals, meal consumption records not completed, supplements discontinued and/or not provided and weights not obtained for residents who were nutritionally at risk, which resulted in a significant weight loss (Residents 9 & 15) and potential for weight loss (Resident C) for 3 of 4 residents reviewed for nutrition. Finding includes: 1. On 4/22/21 at 12:40 p.m., Resident 9 was observed playing with her food with her fingers. She ate bites of her meal. No redirection or assistance was provided by staff. On 4/23/21 at 8:45 a.m., the resident was seated at a table in the dining room. At 9:00 a.m., the resident left the dining room. She ate bites of her breakfast and covered the plate with her napkin. No redirection was provided by staff. On 4/24/21 at 9:05 a.m., the resident ate bites of her bacon. She did not eat her eggs, or scoop of potato looking substance - later identified as oatmeal. At 9:40 a.m., the resident remained in her wheelchair in the dining room. She had not eaten any more breakfast and had not received any cuing from staff. On 4/26/21 at 8:45 a.m., the resident was seated at	F 0692	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Discussion with staff on deficient practices was held with D.O.N. Charge Nurse responsibilities include: Ensuring every resident receives the proper nutrition and documentation of intake. Properly ordering and administering properly labeled medication. Monitoring residents' weights and consulting with dietician and physician. Responsible for administering all medication as ordered by the physician. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No one else affected but potential noted. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Weekly NAR meetings for all	05/28/2021

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	a table in the dining room. She had a juice box in front of her at that time. At 9:02 a.m., the resident left the dining room on her own. The Occupational Therapist brought the resident back to the dining room. The resident was served 2 sausage links, a scrambled egg, 1 slice of toast and oatmeal with berries. She ate bites of her scrambled egg and her toast. The resident left the dining room again at 9:15 a.m., and no redirection was provided by staff. At 9:42 a.m. the resident propelled herself into the dining room and asked Unit Manager 1 for something to eat. At 9:43 a.m., PCA 1 removed the resident from the dining room for cleaning. At 11:30 a.m. and 12:10 p.m., the resident came into the dining room asking for food. At 12:59 p.m., the resident was served 3 pieces of chicken, which were a combination of drumettes and wings (restaurant style size), mashed potatoes and gravy, mixed vegetables and dinner roll. On 4/27/21 at 9:00 a.m. the resident's breakfast plate was on the table. She ate her cereal but she did not eat her scrambled egg, 2 sausage links, oatmeal with berries, or danish. No staff provided cueing or assist with her meal. The record for Resident 9 was reviewed on 4/23/21 at 12:03 p.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, anorexia, stroke, and anemia. The Annual Minimum Data Set (MDS) assessment, dated 3/10/21, indicated the resident was moderately impaired for daily decision making, needed supervision for eating and had suffered a significant weight loss. The Care Plan, dated 10/12/20, indicated the resident had a diagnosis of anorexia.		residents that have a >5% weight loss or gain and all new admissions X 4 weeks to ensure weight is stable. Nutritional policy reviewed and updated with dietician and D.O.N. D.O.N. designee held In-Service held with dietary and nursing departments pertaining to nutritional policy. D.O.N. reviewed monthly weights. Residents will be identified in weekly NAR meetings. Dietary Manager will monitor food intake, weights and review recommended dietary interventions for residents with weight loss. Dietary Manager will consult with RD after weekly NAR meeting. RD will review and make recommendation for dietary supplements for residents at risk (super cereal, increased protein, Medpass supplemental shake, etc). All meal intakes for all residents should be recorded in PCC for every meal. Dietician will complete tray accuracy audit upon each visit 2 times a month and indicate any concerns to Administrator and Dietary Manager. Designated Charge Nurse	

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	Interventions included, but were not limited to, weights as ordered by Physician. The Care Plan, dated 10/12/20, indicated the resident had an ADL (activities of daily living) self-care performance deficit related to dementia, muscle weakness, and lack of coordination. Interventions included, but were not limited to, the resident required setup by one staff to eat. The April 2021 Physician's Order Summary (POS), indicated the resident was to receive a regular diet. The 2021 weight sheet indicated the following: 2/24/21 153 pounds 3/3/21 142 pounds (a 7% weight loss) 3/5/21 140 pounds 3/10/21 140 pounds 3/17/21 140 pounds 3/24/21 140 pounds 3/31/21 134 pounds (an additional 4% weight loss) 4/7/21 134 pounds 4/14/21 134 pounds 4/21/21 135 pounds The Registered Dietitian (RD) Progress Note, dated 3/20/21 at 3:00 p.m., indicated the resident was showing a 9.3% decrease in 30 days and 9.0% decrease in 90 days, followed by previous weight increase. Per discussion with nursing, the resident was eating pretty good at her meals, usually 75% or more secondary to good intake of meals. Height 63" BMI (body mass index) 24.7. Estimated calorie needs 1590-1908 calories, estimated protein needs 52 grams, estimated fluid needs 1590-1908 cubic centimeters (cc). Diet order regular with regular consistency and with protein powder. Skin remains intact. Recommend discontinuing protein powder, monitor weight and		assigned to monthly weight recordings. Unit Manager will audit tray accuracy 3 times a week for 1 month then weekly thereafter. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. Nutritional policy reviewed and updated with dietician and D.O.N. and given to Q.A. Committee for review to ensure compliance. D.O.N. will supply monthly weights for Q.A. Committee review. D.O.N. and Nurse Consultant held In-Service held with dietary staff and nursing staff on weights, dietary supplements, orders, dietary intake documentation and options given to residents. Dietician will provide completed tray accuracy audit for all meals for Q.A. Committee for review quarterly. Q.A. Committee review NAR meeting documentation monthly x 3 months then quarterly. D.O.N. will submit monthly weights to Administrator and Q.A. Committee for review. Interdisciplinary team NAR	

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	intake, follow up as needed. Nurses' Notes, dated 4/22/21 at 11:53 p.m., indicated the resident refused dinner but took her medications with ease. Drank a box of Ensure. No behavioral problems noted. Will continue to monitor. Nurses' Notes, dated 4/24/21 at 4:28 a.m., indicated the resident had a decreased appetite consuming 50% of meals. Resident was at risk for weight loss. The physician was notified, and orders were received for Megace (an appetite stimulant) 10 milliliters (ml) daily to stimulate appetite. Order faxed to pharmacy. Family made aware. The April 2021 Medication Administration Record (MAR) was reviewed. The Megace was signed out as being unavailable on 4/24 and 4/26/21. The Megace was signed out as being administered on 4/25/21. Interview with LPN 2 on 4/26/21 at 10:30 a.m., indicated on 4/25/21, she used the resident's old bottle of Megace that had been discontinued in November 2020. The food consumption log for the month of April 2021 indicated only one meal was documented on 4/4/21 at 5:23 p.m. There was no food consumption documented on 4/8, 4/11, and 4/12/21. She consumed 76 -100% of her meals on 4/22-4/25/21. There were 5 different entries related to the resident's food consumption on 4/25/21. Interview with the Director of Nursing on 4/26/21 at 5:00 p.m., indicated the resident needed to be provided cueing during her meals. 2. On 4/22/21 at 9:50 a.m. Resident 15 was seated		meeting with DON, RD, Dietary, Admin, and MDS Coordinator will be held and documentation will be available in residents record. 5. Completion Date: 5/28/21 F692: Please indicate what, if anything, was done for the residents affected by the deficient practice. Please indicate what the facility did to determine no other residents were affected. Addendum Resident 9 is on our NAR list due to the advancement of her Alzheimer's, according to family history she never liked breakfast and only likes fried fish and chicken. Family has been included to help with this issue. Resident continues to receive Megace and weight is stable. Resident 15 is served first and weight is stable. Resident 6 -New MDS Coordinator is aware of diet orders and how to read and locate them in PCC. Resident C still receives protein powder but not Resource. I was unable to gather the problem according to the nurse she was aware of the orders. Current order includes Protein Powder and weight is stable. No other residents at that time had any weight loss. All weights reviewed and currently weights are stable. Please clarify the intent of this	

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	in his wheelchair in his room in front of his sink sleeping. He had not been brought down to the dining room for breakfast. At 12:45 p.m., the resident was served his lunch in the dining room. The resident was picking up his food with his fingers and walking around the dining room. On 4/23/21 at 8:50 a.m., 10:10 a.m., 11:30 a.m., and 1:40 p.m., the resident was observed in his room in bed sleeping. The resident did not come to the dining room for breakfast or lunch. On 4/24/21 at 9:40 a.m., the resident was in his room in bed sleeping. At 11:00 a.m., he was seated in his wheelchair in the dining room feeding himself breakfast with his fingers. No staff were in the dining room. At 11:07 a.m., PCA 2 entered the dining room and went straight into the kitchen. At 11:10 a.m., the PCA walked out of the kitchen and out of the dining room. At 11:14 a.m. and 11:24 a.m., the resident was still eating and no staff were in the dining room. At 11:36 a.m., PCA 1 took the resident's empty container and threw it away. On 4/26/21 at 9:35 a.m., the resident was in his room in bed. He did not come to the dining room for breakfast. The record for Resident 15 was reviewed on 4/24/21 at 11:41 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, psychotic disorder with hallucinations, insomnia, major depressive disorder, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 4/4/21, indicated the resident was severely impaired for daily decision making, had hallucinations, delusions, physical and verbal		statement on report: At 12:59 p.m., the resident was served 3 pieces of chicken, which were a combination of drumettes and wings (restaurant style size), mashed potatoes and gravy, mixed vegetables and dinner roll. Restaurant style size for the chicken drumettes and wings. They are refereed to as party wings which are disjointed chicken wings without the tip. The chicken was weighed properly and resident received menu portion size. All of our residents receive additional portions upon their request unless contraindicated.	

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behaviors and wandered. The resident also required extensive one person assistance with eating.

The Care Plan, dated 10/7/20 and reviewed on 3/4/21, indicated the resident had a poor appetite related to an eating disorder. Interventions included, but were not limited to, offer hand over hand assistance when help is needed during meals.

The Care Plan, dated 10/7/20 and reviewed on 3/4/21, indicated the resident had an unplanned/unexpected weight loss related to fluctuating food intake, constant wandering behavior, vitamin deficiency and anorexia. Interventions included, but were not limited to, if weight decline persists, contact physician and RD (Registered Dietician) immediately.

The 3/28/21 Mini Nutritional Assessment, indicated the resident scored an 11, which was at risk for malnutrition.

The April 2021 Physician's Order Summary (POS), indicated the resident received a regular diet.

A Physician's Order, dated 3/29/21, indicated the resident was to be weighed weekly for 2 weeks.

On 9/30/20, the resident weighed 150 pounds. The next documented weight was on 11/24/20, the resident weighed 137 pounds. The next weight on 1/11/21 was 138 pounds. The next documented weight was on 4/24/21, which was 129 pounds, a 14% weight loss since September 2020. There were no weekly weights times two weeks recorded on 3/29/21 and after as ordered.

RD progress notes, dated 11/30/20 at 10:46 p.m.,

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indicated RD follow up to significant weight change, November: decreased 7.5% since August. Height 66" BMI - 22.1 (reference range 18.5-24.9) is on Seroquel (an antipsychotic) also physician added Restoril (a hypnotic). Has behaviors of not sleeping at night and walking the halls and then sleeping during the morning hours. Intake records show decreased amounts of food, secondary to behaviors. Offer meals/snacks as he allows during the day/night hours. Plan continue diet.

RD progress notes, dated 1/27/21 at 8:58 p.m., indicated an annual nutrition assessment was completed. The resident's January 2021 weight was 138 pounds. His height was 66" and his BMI was 21 (reference range 18.5-24.9). His diet order was regular with regular consistency and thin liquids. His intake records were reviewed and showed good meal intake, usually 75% or more. Estimated calorie needs were 1568-1881 calories, estimated protein needs were 65 grams, estimated fluid needs were 1568-1881 ml (milliliters). Continue diet, monitor weight and intake, follow up as needed.

RD progress notes, dated 4/17/21 at 3:29 p.m., indicated the resident's intake records were reviewed and showed good intake of meals, usually 75% or more. He was fed by staff due to poor eyesight. Often had delayed meals as he was "up" at nighttime and slept during the day. Observed being fed lunch meal by nursing staff today and ate 100%. Continue diet, monitor weight and intake, follow up as needed.

The April 2021 food consumption log indicated there was no documentation of food consumption on 4/5, 4/11, 4/12, 4/19, and 4/22/21.

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Interview with the Director of Nursing on 4/26/21 at 5:00 p.m., indicated the resident's weight should have been monitored as well as his food consumption.

3. On 4/27/21 at 9:44 a.m., Resident C was observed being fed his morning meal. There were no dietary drink supplements on his tray.

The record for Resident C was reviewed on 4/23/21 at 12:07 p.m. Diagnoses included, but were not limited to, end stage renal disease, dialysis, diabetes, hemiplegia, and dementia with behavior disturbance.

The Quarterly Minimum Data Set (MDS) assessment, dated 2/14/21, indicated the resident was alert and oriented and totally dependent with bed mobility, transfers, and eating.

A Physician's Order, dated 4/11/21, indicated protein powder, three times a day related to moderate protein-calorie malnutrition. Add 10.5 grams of protein to Resource liquid nutrition.

There was no documentation to indicate the resident had an order for Resource.

A Care Plan, dated 10/12/20, indicated the resident had an unplanned/unexpected weight loss related to poor food intake. The interventions included, but were not limited to, give the resident supplements as ordered. Alert nurse/dietitian if not consuming on a routine basis.

The Mini Nutritional Assessment, dated 2/28/21, indicated the resident was malnourished.

Nutrition/Dietary Notes, dated 2/28/21 and 4/12/202, indicated the resident was receiving

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	Ensure shakes with extra protein twice a day to aid in increasing albumin and had an order for protein powder three times a day added to supplement drink. Interview with PCA 3 on 4/26/21 at 2:19 p.m., indicated the resident was not served Ensure with his meals, the nurses were to give the resident his ensure. Interview with LPN 2 on 4/26/21 at 2:29 p.m., indicated she administered protein powder to the resident during her shifts, however, she was not aware of the resident having orders for Ensure twice a day. Interview with the Director of Nursing (DON) on 4/26/21 at 4:10 p.m., indicated there were no orders for Ensure twice a day and/or documentation for the amount consumed, and she would look into the concern. On 4/27/21, the DON was not present for a follow-up interview and had left town on vacation. 3.1-46(a)(1)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral			

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	feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.			
	Based on observation, record review and interview, the facility failed to provide proper feeding tube care as per professional standards related to water flushes not administered before and after supplements were given through a peg (feeding tube directly into the stomach) tube for 1 of 1 residents observed with a peg tube during medication pass. (Resident G) Finding includes: On 4/23/21 at 12:30 p.m., LPN 1 was observed preparing to administer Arginaid powder supplement through Resident G's peg tube. LPN 1 washed her hands with soap and water and donned clean gloves to both hand. She opened the package of Arginaid, poured and emptied it into a plastic container, and added 100 cubic centimeters (cc) of water. She stirred the mixture with the piston syringe. After checking for placement of the peg tube, she placed the syringe into the peg tube and administered the Arginaid mixture directly into the tube. She did not flush the tube with water prior to the administration. She removed the syringe and clamped the peg tube. She did not flush the peg tube with water after the administration of the Arginaid powder solution.	F 0693	The current "Enteral tube medication administration policy" policy was reviewed with all licensed nurses which indicates proper flushing of peg tube before and after medication administration. 2.No other deficient practice noted. No residents receive peg tube feedings. 3. D.O.N. and Nurse Consultant reviewed policy with all licensed nurses on proper flushing of peg tube before and after medication administration. Policy will be reviewed quarterly and upon admission of resident requiring peg tube feedings. D.O.N. Designee will monitor each licensed nurse practice and give corrective in-servicing ongoing. 4. D.O.N. will monitor licensed nurse practices and discuss any deficient practice with the nurse and record findings in their personnel file. Competency check off with your licensed nurses for peg tube medication	05/28/2021

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	Interview with LPN 1 at that time indicated she was unaware she needed to flush before or after the administration of the Arginaid powder mixture. The record for Resident G was reviewed on 4/26/21 at 11:53 a.m. Physician's Orders, dated 4/23/21, indicated to flush tube three times a day with 100 ml (milliliters) of water. Physician's Orders, dated 3/11/21, indicated Arginaid powder two times a day for wound healing add 1 pack to water flush. Interview with the MDS Coordinator on 4/26/21 at 5:00 p.m., indicated the nursing staff were to flush before and after anything that was administered through the peg tube. The current and revised 8/2020 "Enteral tube medication administration" policy, provided by the MDS Coordinator on 4/27/21 at 2:00 p.m., indicated, " .... place 15 ml [milliliters] of water in the syringe and flush the tube using gravity flow, pour diluted or dissolved mixture of medication in the syringe and flush the tube with 15 ml of water in between each medication ...." 3.1-47(a)(2)		administration will be completed by D.O.N. Q.A. Committee will review D.O.N. reports and evaluate need for licensed nurse replacement quarterly, ongoing. F695 Conference was held with D.O.N. on 4/23/2021 please correct record. date on oxygen tubing and humidifier no physician to change tubing weekly. The current "Oxygen Administration Policy-515" was reviewed with all licensed nurses which indicates proper labeling oxygen tubing and physician orders. 2. No other deficient practice noted. No resident currently receives oxygen. 3. D.O.N. Designee will monitor orders for oxygen use and proper labeling of supplies. In-Service on Oxygen Administration provided to all licensed nurses. D.O.N. Designee will monitor physician orders for oxygen and labeling of tubing weekly. 4. D.O.N. and MDS Coordinator will monitor for changes in oxygen orders weekly. Q.A. Committee monitor proper policy practices during oxygen administer to residents.	

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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 observation, record review, and interview, the facility failed to provide proper respiratory care and or services for residents receiving oxygen for 1 of 1 residents reviewed for oxygen. (Resident G) Finding includes: On 4/21/21 at 9:37 a.m., Resident G was observed in bed with eyes open, mouth breathing, and non-verbal. His oxygen was infusing at 8 liters with humidification via nasal cannula. There was no date on the tubing or the humidification. On 4/22/21 at 11:43 a.m., and at 1:44 p.m., the resident was observed in bed with eyes open, mouth breathing, and non-verbal. His oxygen was infusing at 8 liters with humidification via nasal cannula. There was no date on the tubing or the humidification. On 4/23/21 at 9:23 a.m., and at 2:14 p.m., the resident was observed in bed with eyes open, mouth breathing, and non-verbal. His oxygen was infusing at 8 liters with humidification via nasal cannula. There was no date on the tubing or the humidification.	F 0695	D.O.N. and Nurse Consultant reviewed Pain Assessment documentation, medication administration, professional responsibilities, and critical thinking skills of a charge nurse policy with all licensed nurses. Resident 13 has a history of requesting medication, physician is contacted to secure new medication orders then resident will not take prescribed medication. Inquiry by D.O.N. and Nurse Consultant to see if Resident 13 was willing to take a diuretic for edema of lower legs and feet she stated “No, I pee all the time,” benefits of the short-term use was explained resident still stated No. Additional or change in medication was offered she stated she will not take anything orally for pain she only wants to use a rub. Resident is offered to receive a	05/28/2021

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	On 4/24/21 at 9:00 a.m., and at 11:21 a.m., the resident was observed in bed with eyes open, mouth breathing, and non-verbal. His oxygen was infusing at 8 liters with humidification via nasal cannula. There was no date on the tubing or the humidification. On 4/27/21 at 2:52 p.m., observation with LPN 2 indicated the resident's nasal cannula was resting between his mattress, bed linen, and the side left side rail. Interview at the time with the nurse indicated the resident's nasal cannula should have been positioned in his nares. The record for Resident G was reviewed on 4/22/21 at 12:30 p.m. Diagnoses included, but were not limited to, hypotension, weakness, and sepsis. The Significant Change Minimum Data Set (MDS) assessment, dated 1/27/21, indicated the resident was never/rarely understood, he had an unstageable pressure ulcer, required oxygen, and was receiving hospice care. A Physician's Order, dated 1/28/21, indicated 8-10 liters via non-rebreather mask continuously. There were no Physician's orders related to changing the oxygen delivery method to a nasal cannula or for changing the oxygen tubing weekly. Interview with the Hospice Nurse on 4/23/21 at 11:48 a.m., indicated the resident was maintaining his oxygen saturations in the low 90's via nasal cannula. She had told staff it was ok to switch to a cannula from the non-rebreather mask since the mask was breaking his skin down on the bridge of		bath daily she refuses and states she will only take it on Monday. Physician visited resident she cursed him out. Resident 13 displays attention seeking behavior when someone new is present in the facility. Licensed nurses will consult with MD and have pain relieving gel changed from PRN to a standing order. Licensed nurses will document resident's complaints of pain and responses to interventions. 2.No other deficient practice noted. 3. Nursing staff will document her complaints of pain and documentation her willingness to accept pain relieving measures. Nursing staff will offer non-pharmacological interventions to help control and/or relieve resident's pain. MDS Coordinator will ensure Care Plan us updated with resident's complaints and interventions she is willing to follow. Physician and Psychiatric N.P. will be consulted to review psychotropic medication ongoing to help with resident's diagnosis of bipolar depression and hallucinations. D.O.N. will monitor each licensed nurse abilities to do proper resident assessment and	

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	his nose. Interview with the Director of Nursing on 4/26/21 at 4:10 p.m., indicated the resident's oxygen tubing should be dated and changed every 7 days. 3.1-47(a)(6)		documentation of all residents monthly. D.O.N., Physician, N.P., MDS Coordinator and Pharmacy Consultant will perform medication review monthly to ensure proper medical regime for each resident. Q.A. Committee will review reports monthly and deficient practice addressed. Q.A. Committee will review all nurse deficiencies in their employment file and determine if replacement is needed every 3 months, ongoing. ADDENDUM F695: **Note - this citation POC was merged under POC for F693. Please indicate what, if anything, was done for the residents affected by the deficient practice. Please indicate if any visual observation and monitoring of correct oxygen use will be completed should any resident require oxygen The hospice resident passed away before any changes could occur to address cited deficiencies. Future residents requiring oxygen will follow the Oxygen Policy which includes but not limited to the following: **The facility has just hired a Registered Nurse who holds a PhD. She the Assistant Professor of Nursing at Lewis University and educates students to the BSN level. She**	

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			will be the Nurse Supervisor and Trainer for the nursing department. She will train the staff 3 days a week and audit for deficient practices ongoing. The D.O.N. and Nurse Supervisor have determined the needs of the staff according to the deficient practices noted in the report and are developing a training program to include but not limited to the deficient practices. · **Policies will be reviewed and updated to current proper practices.** · **In-Servicing/Educational Tools will be updated to the latest technology including but not limited to current textbook information, videos, U-Tube training and other resources that will be beneficial to staff training.** · **The training will be ongoing and areas of deficient practices reviewed every 90 days with current employees and with new hires during orientation.** · **Evaluation of staff will be done and need for staff replacements will be discussed with QAA Committee.** Oxygen Administration **Procedure 515**	

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			BASIC RESPONSIBILITY Licensed Nurse. PURPOSE To administer oxygen to the resident when insufficient oxygen is being carried by the blood to the tissues. Assessment Guidelines May include, but are not limited to: Rate, rhythm, depth and quality of respirations. Pain or discomfort. Congestion. Respiratory distress. Change in level of consciousness. Dehydration and fluid balance. Blood gas measurement. Position of comfort. Temperature, pulse and blood pressure. Cyanosis of lips, skin or nail beds. Chronic cardiac or pulmonary conditions. Appropriate type of delivery system. EQUIPMENT Oxygen cylinder on stand, wall oxygen outlet or concentrator. Safety strap or chain if using oxygen cylinder on a stand. Nasal cannula, face mask, or nasal catheter as ordered. Connecting tubing. Oxygen flowmeter and gauges. Appropriate oxygen signs. Humidifier bottle, prefilled and	

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			sealed if necessary Water-soluble lubricant. Pulse oximeter if necessary. PROCEDURE NOTE: Do not use petroleum-based hand lotion on your hands when handling oxygen; explosion could be generated. Humidifiers may be used for low-flow oxygen administration as ordered. 1. Check physician's order for liter flow and method of administration. 2. Place appropriate oxygen sign per facility procedure. 3. A reserve oxygen tank should be available to provide continuity of care. 4. When using oxygen cylinders, secure oxygen cylinder at bedside per facility procedure. 5. Prefilled, sealed, disposable humidifiers may be changed per facility procedure. a. Open sealed bag and take out unit. b. Remove the cannula port cap and remove oxygen inlet port cap. c. Attach humidifier to flow meter by screwing nut onto the flow meter. If the humidifier has an audible alarm, check this by adjusting the flow rate and pinching the tubing until the alarm sounds. d. Attach mask or cannula tubing to humidifier. e. Set the flow meter to the rate	

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			ordered by the physician. f. Place mask or cannula on resident as indicated above. g. Label humidifier with date and time opened. Change humidifier and tubing per facility procedure. 6. Nasal Cannula: Connect tubing to humidifier outlet and adjust liter flow as ordered. Place prongs of cannula into the resident’s nares. Adjust elastic loosely around head, above the ears. If cannula does not have elastic adjustment, loop the plastic around the ears and under the chin. Adjust the plastic slide to hold cannula in place. 7. Face Mask: Connect tubing to humidifier outlet and adjust liter flow as ordered. Place mask over nose and mouth. Adjust elastic loosely around head, above the ears. If mask does not have elastic adjustment, loop the plastic around the ears and under the chin. Adjust the plastic slide to hold mask in place. 8. Nasal Catheter: Nasal catheters may be used unless contraindicated. The catheter is connected to the humidifier with a connector tubing. It is lubricated with water-soluble lubricant, fits into the nostril and is secured to the forehead. Pass the catheter gently along the nasal passage into the nasopharynx just until the tip is visible slightly below the soft palate.	

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			NOTE: Observe resident for gastric distention. Remove nasal catheter from one nostril to the other every eight hours; cleanse cannula and nares well. With profuse nasal discharge, cannula is not indicated. 9. PRECAUTION: CONSTANT FLOW OF OXYGEN CAN CAUSE DRYING AND THICKENING OF NORMAL SECRETIONS RESULTING IN LARYNGEAL ULCERATION. 10. At regular intervals, check and clean oxygen equipment, mask **Procedure 515** s, tubing and cannula. 11. At regular intervals, check liter flow contents of oxygen cylinder, fluid level in humidifier and assess resident’s respirations to determine further need for oxygen therapy. 12. When oxygen therapy is discontinued, dispose of all disposable equipment properly. 13. Check resident’s respirations and observe at regular intervals to assess need for further oxygen therapy after oxygen has been discontinued. 14. Monitor resident’s response to therapy with pulse oximetry as necessary. 15. Inspect and cleanse mouth and nares as necessary. DOCUMENTATION GUIDELINES	

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			Documentation may include: Date, time, method of administration and liter flow as ordered. Condition of the resident before procedure and effectiveness of oxygen therapy. How well resident tolerated procedure. Vital signs before oxygen was started and periodically after initiation of therapy. Signature and title of person initiating oxygen therapy. If prefilled oxygen humidifiers are used, it is recommended that the date the humidifier is to be changed be entered on a nursing form (i.e., medication or treatment form) and initialed each time humidifier is changed. Humidifier should be labeled with the date and time changed. CARE PLAN DOCUMENTATION GUIDELINES Problem: Identify the appropriate problem under which to list oxygen administration as an approach. Consider listing possible risks and complications. Goal: List MEASURABLE goal(s) to be accomplished (i.e. Control or resolution of signs or symptoms that indicate the need for oxygen therapy.). List target date.	

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			Approaches: List responsible discipline for each approach. List instructions unique to this resident. List necessary monitoring and observation of the resident' **Procedure 515** s respiratory function. List observation for effectiveness of treatment. List monitoring for dehydration, if appropriate. List monitoring for congestion, if appropriate. List monitoring for edema, if appropriate. List monitoring of face and ears for redness or soreness. List monitoring for complications such as toxicity, hyperventilation, etc.	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure a resident with complaints of pain received as needed (PRN) or scheduled medication to relieve the pain for 1 of 1 residents reviewed for pain. (Resident 13)	F 0697	D.O.N. and Nurse Consultant reviewed Pain Assessment documentation, medication administration, professional responsibilities, and critical	05/28/2021

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	Finding includes: During an interview on 4/21/21 at 11:07 a.m., Resident 13 indicated she has pain all the time and she only took Tylenol. She did not think the physician was addressing her pain. When staff ask her what her pain level was she told them it was a 20. The resident indicated her arthritis was very bad in her legs and feet and she does have topicals for pain, but has to ask for them. She would like it every day and she would like to soak her feet every day as well, but that does not happen. On 4/26/21 at 9:56 a.m., during medication pass observation with LPN 2, the resident indicated she would like a Tylenol. The LPN told the resident she did not have an order for Tylenol, but she would call the doctor and get one for her. The resident indicated she had received Tylenol on Friday and Saturday from LPN 1 who had worked during the day and part of the evening shift. The record for Resident 13 was reviewed on 4/24/21 at 9:40 a.m. Diagnoses included but were not limited to, sciatica, hallucinations, bipolar disorder, high blood pressure, carpal tunnel, and osteoarthritis. The Quarterly Minimum Data Set (MDS) assessment, dated 3/9/21, indicated the resident was cognitively intact. She did not receive scheduled or PRN pain medication. A Care Plan, dated 9/16/20, indicated the resident has pain related to arthritis, carpal tunnel, and sciatica. The patient refused to take medication for pain relief, even after offered pain medication. The patient will complain of pain, but will not want		thinking skills of a charge nurse policy with all licensed nurses. Resident 13 has a history of requesting medication, physician is contacted to secure new medication orders then resident will not take prescribed medication. Inquiry by D.O.N. and Nurse Consultant to see if Resident 13 was willing to take a diuretic for edema of lower legs and feet she stated “No, I pee all the time,” benefits of the short-term use was explained resident still stated No. Additional or change in medication was offered she stated she will not take anything orally for pain she only wants to use a rub. Resident is offered to receive a bath daily she refuses and states she will only take it on Monday. Physician visited resident she cursed him out. Resident 13 displays attention seeking behavior when someone new is present in the facility. Licensed nurses will consult with MD and have pain relieving gel changed from PRN to a standing order. Licensed nurses will document resident’s complaints of pain and responses to interventions. 2.No other deficient practice	

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	anything to be done about it at times. Offer medication at a different time to make as comfortable as possible. The approaches were to administer Diclofenac gel as ordered by the doctor. Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Monitor/record/report to nurse resident complaints of pain or requests for pain treatment. Physician's Orders on the current 4/2021 Physician Order Summary indicated the resident had no PRN or scheduled pain medication. She had no Tylenol or topical cream ordered for pain. Physician's Orders, dated 10/19/20, indicated Diclofenac Sodium Gel 1 % apply 1 gram transdermally every 8 hours as needed for pain, discontinued on 3/29/21. Review of the 2/2021 and 3/2021 Medication Administration Records indicated the topical cream for pain had not been signed out as being administered. A Pain Tool assessment, completed on 4/5/21, indicated the resident had pain in the back of her left and right hands. A Pain Tool assessment, completed on 3/5/21, indicated the resident had pain in her left and right knees and was unable to bend her legs. She had pain in her left and right hands due to carpal tunnel. A Pain Tool assessment, dated 2/5/21, indicated the resident had pain in her bilateral lower extremities. She also complains of carpal tunnel syndrome to bilateral wrists and wears gloves and wrist bands daily.		noted. 3. Nursing staff will document her complaints of pain and documentation her willingness to accept pain relieving measures. Nursing staff will offer non-pharmacological interventions to help control and/or relieve resident's pain. MDS Coordinator will ensure Care Plan us updated with resident's complaints and interventions she is willing to follow. Physician and Psychiatric N.P. will be consulted to review psychotropic medication ongoing to help with resident's diagnosis of bipolar depression and hallucinations. D.O.N. will monitor each licensed nurse abilities to do proper resident assessment and documentation of all residents monthly. D.O.N., Physician, N.P., MDS Coordinator and Pharmacy Consultant will perform medication review monthly to ensure proper medical regime for each resident. Q.A. Committee will review reports monthly and deficient practice addressed. Q.A. Committee will review all nurse deficiencies in their employment file and determine if replacement is needed every 3 months, ongoing. F697: **Note - this POC was duplicated under the label for	

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	A Physician Visit and Progress Note, dated 3/23/21, indicated she was receiving Diclofenac gel and the plan was to continue the same medications. Interview with LPN 2 on 4/26/21 at 10:30 a.m., indicated the resident had nothing ordered for pain, including no Tylenol or her pain gel like she used to have. She does not know who had given the resident any Tylenol. Interview with the MDS Coordinator on 4/26/21 at 5:00 p.m., indicated she was unaware the resident was having any pain. 3.1-37(a)		F695. Please indicate what the facility did to determine no other residents were affected. No other residents have complained of pain. All residents on pain medication current plan of care is effective. Pain assessment is done prior to giving pain medications. Resident 13 still complains of pain but is non-complaint with recommendations from physician and therapy recommendations. Staff continues to educate and provide her with treatment in which she agrees with.	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to provide the necessary care and services for residents who received Hemodialysis related to not assessing bruit and thrill nor monitoring the access site for 2 of 3 residents reviewed for dialysis. (Residents D and 3) Findings include: 1. Interview with Resident D on 4/21/21 at 9:38 a.m., indicated she goes to hemodialysis on	F 0698	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Audit performed on which licensed nurses did not do proper assessment of fistula for Resident D. D.O.N. held in-service with all	05/28/2021

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	Mondays, Wednesdays, and Fridays. She indicated staff do not always assess her shunt. The record for the resident was reviewed on 4/23/21 at 2:17 p.m. Diagnoses included, but were not limited to end stage renal disease, dependence on renal dialysis, hypotension, depressive disorder with psychotic symptoms, anxiety, and syncope. The Quarterly Minimum Data Set (MDS) assessment, dated 1/30/21, indicated the resident was cognitively intact. The resident needed supervision with one person physical assist for personal hygiene. The resident received dialysis while at the facility. A Care Plan, dated 2/5/21, indicated the resident needs dialysis treatment. The approaches were to check for bruit and thrill every shift. Physician's Orders, dated 3/29/21, indicated to check AV fistula site for signs and symptoms of infection. Listen for bruit and thrill every shift. The Medication Administration Record (MAR) for 3/2021 indicated the bruit and thrill was not assessed during the day shift on 3/2-3/6, 3/11-3/15, 3/25, 3/27, and 3/28/21. The fistula site was not assessed for infection on those days as well. The MAR, dated 4/2021, indicated the bruit and thrill was not assessed during the day shift on 4/1, 4/2, 4/5, 4/8, 4/10, 4/11, 4/15, 4/16, 4/19, and 4/20/21. The fistula site was not assessed for infection on those days as well. Interview with the Director of Nursing on 4/26/21 at 4:00 p.m., indicated the resident's AV access		licensed nurses on proper assessment and documentation of fistula access site for all dialysis residents. In-Service held with licensed nursing staff on TARs (Treatment Administration Records), documenting status of AV Fistula assessment, and not using a resident's arm Which has the fistula access site for dialysis and removal of pressure dressing from site 12 hours after dialysis is completed or upon awakening in the am. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No other resident needing dialysis treatment affected. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; In-service on proper assessment, documentation and treatment of dialysis access sites Charge Nurse will review all residents who have fistula orders. MDS Coordinator will update care plan for all dialysis residents to indicate access site and monitor monthly for changes. D.O.N. will review TAR for AV	

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	site should have been assessed including the bruit and thrill at least every day and every shift.2. The record for Resident 3 was reviewed on 4/22/21 at 1:46 p.m. Diagnoses included, but were not limited to, end stage renal disease, dialysis, AV (arteriovenous) graft, diabetes, hypertension, schizophrenia, anxiety, pseudobulbar affect, psychosis, and dementia with behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 1/23/21, indicated the resident was moderately cognitively impaired for decision making and received dialysis treatments. Physician's Orders, dated 3/29/21, indicated monitor left Permacath for signs and symptoms of infection every shift, dialysis treatments every Tuesday, Thursday, and Saturday, and check bruit and thrill on left graft every shift. A Care Plan, dated 10/12/20, indicated the resident needed dialysis three times weekly related to end stage renal disease. The interventions included, but were not limited to, do not draw blood or take blood pressure in the left arm with catheter, monitor left Permacath (a catheter used for short term dialysis treatment) for signs and symptoms of infection, placement, and dressing. The April 2021 Treatment Administration Record (TAR) indicated the resident's left Permacath was being assessed every shift for signs and symptoms of infection. There was no documentation the resident's actual access site, the left upper arm AV graft, was being assessed every shift for thrill and bruit. Interview with the Director of Nursing (DON) on 4/26/21 at 4:10 p.m., indicated the resident's access		Fistula documentation of licensed nurses weekly then monthly to ensure proper documentation ongoing. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and D.O.N. will monthly monitor residents receiving dialysis and what port is used either perma cath or fistula. weekly x2months then monthly ongoing D.O.N. designee will secure proper orders and indicate them in the TAR. D.O.N. will provide a monthly listing of dialysis residents and access points to Q.A. Committee. Q.A. Committee will review this issue in 90 days and determine outcome and recommendations. 5. 5/28/21 F698: Please indicate what the facility did to determine no other residents were affected. Please indicate how long initial DON weekly TAR monitoring will occur before transitioning to monthly. DON audited records to see which nurse was deficient and held a conference. The shift change to the 12 hour shifts instead of 8 hour shifts affected the nurse in knowing which shift she should	

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	site should be assessed and documented every shift as ordered. Interview with the Dialysis Nurse on 4/27/21 at 11:58 a.m., indicated the resident had a left upper arm AV graft. The site has been used for access since 2018. Interview with the MDS Coordinator on 4/27/21 at 12:43 a.m., indicated the resident's dialysis access site was located in the left upper arm, it was an AV fistula and/or graft. The DON was not available for a follow-up interview on 4/27/21 to verify the staff were not documenting assessments of the resident's actual dialysis access site. 3.1-37(a)		document on. So instead of 3 shifts in the past we now have 2 – 12 hour shift. Residents who have shunts are monitored each shift. DON asked each nurse about the site used for dialysis and they were able to correctly tell her. All residents have a AV Fistula that is used for dialysis. I am not sure of the source of confusion between permacath and fistula. DON will have to monitor TAR ongoing until all nurses have completed a newly developed training class being developed by the RN Supervisor. This monitoring will have to be continuously done due to the possible changes in personnel. DON and Nurse Supervisor will meet with the QAA Committee and determine if staff is responsible enough to decrease monitoring.	
F 0725 SS=F Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment			

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	required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.			
	Based on observation, record review and interview, the facility failed to ensure sufficient nursing staff was present to provide timely and complete hygiene, correct assistance with transfers, assistance with eating and activities, and sufficient RN coverage. This had the potential to affect 22 of 22 residents who resided in the building. Findings include: 1. The staffing schedule from 3/1-4/26/21 was reviewed on 4/26/21 at 3:30 p.m. There was only 1 CNA on the schedule who worked the midnight shift or from 7:00 p.m., to 7:00 a.m. The rest of the direct care staff were Personal Care Assistants (PCA's). On 4/22/21 PCA's 1, 2, and 3 were scheduled to work. There was no CNA scheduled. On 4/23/21 PCA's 1 and 2 were scheduled for day shift and no CNA was scheduled. Both worked by themselves.	F 0725	F725 Employment ads have been placed for every department and hundreds of calls have been placed trying to set up interviews with potential employees however applicants do not respond or state they are living off their stimulus check and not seeking employment. Numerous C.N.A.'s had been hired but they either do not show up for work or exhibit behavior that is unprofessional i.e.: stealing, cursing, inappropriate sexual behavior, drinking…bad seeds. Licensed nurses R.N.'s and L.P.N.'s are not seeking employment numerous ads have been placed with no responses. Clarification LPN 2 comment "DON here for 45 minutes and left," I arrived at the facility 7:00a.m. observed tour check and	04/28/2021

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	On 4/24/21 PCA's 1 and 2 were scheduled for day shift and worked that day. No CNA was scheduled to work. On 4/26/21 Only PCA 2 was scheduled to work with no other PCA or CNA. PCA 1 came in later that morning. On 4/27/21 PCA 2 was the only scheduled staff. The custodian, who was also listed as a PCA but had not had recent training, was going to work as a PCA and help with transfers with the residents. 2. The Facility Assessment Tool, dated 3/1/20, indicated the overview of the Assessment Tool was to provide competent care for residents, including staff, staffing plan, staff training/education and competencies, education and training. The facility total capacity was 46 residents and the current census was 22. The staffing Plan: Resident population and their needs for care and support, describe our general approach to staffing to ensure that you have sufficient staff to meet the needs of the residents at any given time. Evaluation of overall number of facility staff needed to ensure a sufficient number of qualified staff was available to meet each resident's needs included: Licensed Nursing providing direct care total of 6. Nurse aides total of 8 to 10. Interview with PCA 2 on 4/27/21 at 10:45 a.m., indicated 3 residents required hoyer lift for transfers, 2 residents need extensive assist with 2 person physical assist for transfers and toileting, 4 residents needed extensive assist with 1 person physical assist for eating and 4 residents needed		shift report. At 9:00am I exited the building and moved my car to the back and unloaded 40 bags of mulch for the yard then entered the basement. I continued to organize the storage areas in the basement which is what I was doing on the first day of survey. I unpacked boxes of supplies and placed items on shelves, inventoried supplies because staff was turning in supply orders and saying we were out of items when the D.O.N. had ordered the supplies. The supplies were never taken out of the cases and placed in their proper location. Custodian left at 2:30p.m. D.O.N. did not leave until 5:00p.m. Cook saw D.O.N. leave for the day. D.O.N. works a minimum of 8 hour on R.N. coverage days and she reports to the Administrator not the staff. The P.C.A. discussed with surveyor that the D.O.N. had contacted an instructor who teaches an approved Indiana C.N.A. course and would charge the students $800.00 each. COVID positive rates in nursing homes continued to rise and the facility associated with her training had COVID positive residents therefore having great potential to introduce COVID into our COVID-Free building. D.O.N. has intermediately contacted her and she will be re-starting her classes in June 2021. This was never	

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	extensive assist with 2 person physical assist for bathing. 3. Cross reference F676 for Activities of Daily Living related to lack of hygiene and eating assistance. 4. Cross reference F677 for Activities of Daily Living related to lack of hygiene and eating assistance for dependent residents. 5. Cross reference F679 for Activities related to no Activities Director or staff available to conduct or provide activities. 6. Cross reference F726 for competent staff related to PCA's completing tasks outside their scope of training. 7. Cross reference F727 for lack of RN coverage related to an insufficient number of RN's employed. 3.1-17(a)		discussed with D.O.N. by surveyor but PCA did explain the situation to surveyor near the unit managers office, but the details of the conversation were not included in the report. Custodial and laundry staff were trained as a P.C.A.'s to help provide care. They were all trained according to the emergency order allowing the employment of P.C.A.'s which we started in March 2020 and have continued due to the lack of C.N.A. applicants. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility has an ongoing ad for employment of Nurses and C.N.A.'s. Management staff will fill in on the floor when there is a call off that cannot be replaced to ensure proper staffing on the floor. All hands-on deck for meals from all departments will be present for mealtime. New nursing staff is being orientated for C.N.A. positions some are from out of state and will require to become Indiana certified when scheduling opens currently no testing will be available until June or July. P.C.A.'s will enroll in a C.N.A.	

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			program as it becomes available. Licensed nurses both R.N. and L.P.N. are still trying to be recruited by facility. Activity, Social Service, Dietary, Housekeeping, Laundry, Custodial, and Secretarial personnel are still being recruited. – The acuity level is low and currently the ratio is 7:1. A re-evaluation of duties will be done by Administration and D.O.N. to address concerns. 1. Facility will continue to seek the employment of new C.N.A's. 2. All 21 residents are served meals timely. All hands-on deck at meal times to ensure trays are served timely and all residents needing assistance are being tended too. 3. Administration and D.O.N. as continually determined the is a need for more staffing but will adjust hours to solve employment issues. 2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents are affected when scheduled staff does not show. Facility will ensure that staff are replaced when there is a call off or	

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			no show to ensure adequate staffing numbers to care for the residents. Cross reference F676, F677, F679, F726, F727. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Facility will continue to place ads for employment of A.D.O.N., R.N.'s, L.P.N.'s and C.N.A.'s, housekeepers, laundry, custodian, social service, activity, secretarial staff that will be an asset to the care of our residents. Everyone will continue to be trained as a PCA after a week of employment to ensure they will come to work. Administrator and D.O.N. will re-evaluate the duties of the nursing staff. The facility will also do a R.N. Coverage waiver due to the lack of R.N.'s available for employment in our area. The D.O.N. is on-call 24 hours per day and is in the building over 8 hours on the day the night RN is scheduled off. Even though the MDS Coordinator is not scheduled to do the 8-hour coverage her hours can be counted toward the 8 consecutive hours of coverage since she is a R.N. also. This will be discussed	

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			with previous MDS Coordinator. Administrator and D.O.N. will continue to evaluate for additional staff. Administrator/designee will interview residents to determine if they feel their needs are being met monthly then quarterly. Social Service Department will meet with residents weekly and communicate to Administration any resident concerns. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. D.O.N. will continue to place ads for employment of A.D.O.N., R.N.'s, L.P.N.'s and C.N.A.'s perform interviews and evaluate job performance. Administrator and D.O.N. will re-evaluate the duties of the nursing staff monthly x 3 months then quarterly. Administrator and D.O.N. will re-evaluate time frames when additional staff is needed according to census and acuity of care. Q.A. Committee will monitor	

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staffing and discuss all staffing needs monthly.

5. Completion Date: 05/28/21

F725: This citation does not pertain specifically to DON/RN coverage, only sufficient staffing to ensure ADLs and care is provided across all areas of care (cross referenced). Please adjust POC to specifically address how the facility will correct the issue going forward in correlation with the Facility Assessment. In addition, the corrected date listed of 4/28/21 would not be reasonable given the steps and ongoing process needed to correct.

Sufficient Staffing: We would love to have more staff but we can not find people who want to work. Everyone employed tries very hard to meet all the needs of the residents. We have continued to interview and hire staff but they do not show up or work out. So we still have the faithful staff members which you saw.

Plan to increase staffing:

1.Request ISDOH allows us to train or PCA to C.N.A. since we have a RN who has been hired for education.

2. Since the facility has remained COVID free this will encourage the PCA's to take the course instead

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			of worrying of potentially being exposed to COVID. In our community we still have a lot of people who refuse to take the COVID vaccination. 3. Fighting to secure more help will remain a problem for the next 60 days. We have a new casino which opened that is giving $2,000.00 bonus, McDonalds giving $500.00 bonus and we are still dealing with people not wanting to work due to receiving increased unemployment benefits and stimulus checks. I do not have a solution to this problem all we can say is that we are doing everything to secure additional help. Continued in-servicing is being done so that the ADL sheets are completed and increased training is scheduled by RN Supervisor. All of our residents are clean, nails cut and appropriately dressed. We have no Decubitus so good skin care is provided. No weight loss noted so residents are eating appropriate intake. Nurse documentation is improving. New MDS Coordinator has addressed all deficient practices and is developing better practices. 5/28/2021	
F 0726 SS=F Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff			

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	with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.			
	Based on observation, record review and interview, the facility failed to ensure there was a sufficient number of competent nursing staff available to provide nursing related services to assure resident safety was maintained related to two person transfers and repositioning for 2 of 3 residents who required the use of a hoyer lift. (Residents B and 6)	F 0726	F726 Hoyer lift D.O.N. was not informed of this on 4/26/21 but she was informed on 4/24/2021 @ 3:15p.m. of PCA asking custodian for help with hoyer that was all that was stated. Surveyor did not inform D.O.N. on 4/23/21 at 10:45a.m. that P.C.A.'s could not transfer	05/28/2021

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	Findings include: 1. On 4/22/21 at 12:52 p.m., Resident B was observed in his room. Upon entering the room, the resident was observed in a hoyer lift sling and being transferred to his bed. PCA 1 and Custodian 1 were in the room with the resident. The PCA was guiding the resident and the Custodian was holding on to the lift. The PCA instructed the custodian on where to position the base of the lift underneath the resident's bed. The PCA indicated she knew this was wrong, but she needed someone to spot her and there was no one else available. The PCA completed incontinence care and positioned the resident on the hoyer pad. The PCA attempted to lift the resident but the handle was not working on the hoyer lift. The PCA asked the Custodian to get the other hoyer lift out of the shower room. The custodian returned with another hoyer lift and the handle on it did not work as well. The PCA then asked the custodian to stay in the room with the resident while she went and got another hoyer lift. The PCA returned with the hoyer and the resident was lifted up and placed in his wheelchair. The PCA guided the resident into his wheelchair and she advised the custodian where to position the hoyer and where to release the lift so the resident could be lowered into his wheelchair. The resident then needed to be repositioned in his chair. The PCA and the custodian lifted the resident up underneath his arms and repositioned the resident. Interview with Custodian 1 at that time, indicated he had no CNA or PCA background and had only been working at the facility for a week.		using hoyer or residents that require 2 assists. Points of clarification: D.O.N. has completed the C.N.A. Instructor training when ISBOH first started the 105-hour C.N.A. course after grandfathering in C.N.A.'s who worked as C.N.A.'s prior to new requirements, and Q.M.A. instructor training. The MDS Coordinator is also a C.N.A. Instructor. P.C.A. completed a 105-hour C.N.A. course but before she was able to take her exam she was shot in her arm. Enclose please find a copy of her course completion. P.C.A. 2 completed requirements of a home health aide and completed C.N.A. and CPR training in Florida. P.C.A. relocated due to the pandemic. In each case both PCA 1 and PCA 2 have had formal training C.N.A. instruction. - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. D.O.N. interviewed P.C.A. and charge nurse to determine why she did not wait for assistance. P.C.A. was aware of the hoyer rule of always using 2 people and to ask a licensed nurse, P.T.A, or O.T.A., D.O.N. were available for help. Staff was discipline for her actions she and charge nurse are aware of the proper practice and	

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	The record for Resident B was reviewed on 4/27/21 at 1:12 p.m. Diagnoses included, but were not limited to, intellectual disabilities and cerebral palsy. The Quarterly Minimum Data Set (MDS) assessment, dated 4/3/21, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. The resident was dependent on staff for bed mobility and transfers. The Care Plan, dated 10/9/20 and reviewed on 3/4/21, indicated the resident required total assistance for transfers with 2 people from the bed to chair and chair to chair due to being non weight bearing. Interventions included, but were not limited to, will provide all transfers using a hoyer lift with two staff assist. Interview with the Director of Nursing on 4/26/21 at 5:00 p.m., indicated the Nurse should have helped the PCA with the hoyer lift. 2. The staffing schedule was reviewed on 4/26/21 at 3:30 p.m. There was only 1 CNA on the schedule who worked the midnight shift or from 7:00 p.m. to 7:00 a.m. The rest of the direct care staff were Personal Care Assistants (PCA's). On 4/22/21 PCA's 1, 2, and 3 were scheduled to work. There was no CNA scheduled. On 4/23/21 PCA's 1 and 2 were scheduled for day shift and no CNA was scheduled. Both worked by themselves On 4/24/21 PCA's 1 and 2 were scheduled for day shift and worked that day. No CNA was scheduled to work.		did not follow facility policy. In-service one on one of proper policy and procedure provided to staff with deficient practices. There was enough staff to transfer the 2-resident requiring a hoyer lift and 2 residents require a 2 person assist transfer. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. No other resident affected. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; 100% of Nursing Staff re-in serviced on hoyer policy.. Charge Nurse is to be present for hoyer transfers and 2 person assist transfers. D.O.N. will monitor proper use of hoyer lift according to policy and in-service new staff to ensure the safety of each resident requiring the use of a hoyer lift and 2 person assist transfers. Therapy department will be available for staff support in hoyer and 2 person assist transfers ongoing. - how the corrective action(s) will be monitored to ensure the	

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	On 4/26/21 PCA 2 was only scheduled to work with no other PCA or CNA. PCA 1 came in later that morning. On 4/27/21 PCA 2 was the only scheduled staff. The custodian, who was also listed as a PCA but had not had any recent training, was going to work as a PCA and help with transfers with the residents. Interview with PCA 1 on 4/23/21 at 9:10 a.m., indicated he received his training from 2 nurses at the facility and CNA 2. The PCA indicated he was a home health aide from the state of Florida. He currently had no CNA certificate for the state of Indiana. Interview with PCA 2 on 4/23/21 at 9:30 a.m., indicated she and PCA 1 help each other out all the time when they work together, she tackles the women's side and he does the men's side. She said she helps him with the residents who were hoyer lifts and all of the 2 assist residents. She indicated there was no CNA who helped them with the hoyer lifts or 2 person assists. Interview on 4/23/21 at 10:00 a.m., with PCA's 1, 2, and 3 indicated they were not currently enrolled in a CNA class. All 3 of them knew what their limitations were and what they could and could not do. They all had worked with only 2 of them and no other CNA. They had used the hoyer lift with just themselves and no other staff. PCA 2 and PCA 3 had worked by themselves on 4/22/21 with no CNA during the day shift, and they both confirmed they did duties (transferring with the hoyer lift) without a licensed staff member. They indicated all of the CNA's had walked out and quit. The situation with only PCA's working had		deficient practice will not recur, i.e., what quality assurance program will be put into place; and Nursing Staff re-inserviced on hoyer policy with P.C.A.'s Charge Nurse assist with all hoyer transfers and 2 person assist transfers. Therapy Department will provide staffing support for hoyer lift and 2 person assist residents. D.O.N. Designee will monitor proper use of hoyer lift according to policy for residents requiring the use of a hoyer lift and 2 person assist, ongoing. Hoyer monitoring and 2 person assist will be added to D.O.N. Designee round sheet. Q.A. Committee will review all deficient practices submitted by D.O.N. in transferring of residents with hoyer lift and 2 person assist transfers, ongoing. CAN Training Course is not available until June 21, 2021. PCA's are encouraged to register for the course. D.O.N. will update Q.A. Committee on staffing issues monthly in securing additional staff, ongoing. by what date the systemic changes 5/28/21 F726: Please indicate what the facility did to determine no other residents were affected.	

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	been going on since March 2021. Interview with the PCA 4 on 4/26/21 at 1:50 p.m., indicated she had worked with PCA 2 or PCA 1 and they were the only direct care staff and had no other CNA work with them. The LPN would help when she could, otherwise they were left to do the work by themselves. On 4/27/21 at 8:30 a.m., Custodian 2 was observed passing out silverware and beverages to the residents during the breakfast meal and then mopping the dining room floor at 10:30 a.m. On 4/27/21 at 12:18 p.m., PCA 2 and Custodian 2 were observed to reposition Resident 6 in his geri recliner chair. PCA 2 indicated Resident 6 was an extensive assist with a 2 physical assist for bed mobility and transfers. No CNA or Licensed staff assisted with the repositioning. Interview with PCA 2 on 4/27/21 at 10:45 a.m., indicated 3 residents required hoyer lift for transfers, 2 residents need extensive assist with 2 person physical assist for transfers and toileting, 4 residents needed extensive assist with 1 person physical assist for eating and 4 residents needed extensive assist with 2 person physical assist for bathing. The COVID-19 Personal Care Attendant simulation/ Competency check off sheets for PCA's 1, 2, and 3 indicated LPN 2 and CNA 2 had checked off their skills for return demonstration, not a certified CNA instructor. The Director of Nursing (DON) was made aware on 4/23/21 at 10:45 a.m., the PCA's could not transfer any resident by themselves with the hoyer lift or transfer any resident who was a 2		Addendum 4 residents affected, 2 residents require use a hoyer lift and 2 require 2 person assist. Nurse will be present for all hoyer and 2 person assist transfers. The Therapy department will also be available for transfers and assistance with the residents. The facility has to continue to use the P.C.A.'s for staffing C.N.A. class was suppose to start June 21 2021 but it has been delayed. Facility is asking since we have a RN dedicated to training if we can do our own CAN program. The facility has 2 C.N.A. employed at this time. P.C.A.'s do have prior health background training so they have to be used to provide care to the residents.	

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	assist for transfers. There were no changes in the schedule after she was informed. She was also notified a certified CNA instructor had to teach a PCA class. On 4/27/21 at 10:00 a.m., the DON and the Administrator were not available for further interview. 3.1-17(b)			
F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.			
	Based on record review and interview, the facility failed to ensure a Registered Nurse (RN) worked 8 consecutive hours in the facility on any given day. This had the potential to affect 22 of 22 residents who resided in the facility. Finding includes: The staffing schedules for 3/1-4/26/21 were reviewed on 4/26/21 at 3:30 p.m.	F 0727	F727 Refer to F725 and remove tag we have RN coverage 8 hours/7days a week. See attached logs. Points of clarification. 12:00am begins the start of a new day. 4/13/21 RN worked 6:45pm-4/14/21 7:45am clarification RN worked on 4/13/21 RN 1 worked 5.25 hours of 4/13/21 D.O.N. worked prior to her and	05/28/2021

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	There was 1 RN who worked in the facility as a floor nurse. The other RN's who were employed at the facility were the Director of Nursing (DON) and the MDS Coordinator. The DON was scheduled to work on 3/13, 3/14, 3/23, 3/27, 3/28, 4/10, 4/11, and 4/25/21. There was no evidence she worked those days as she does not punch in or out to document 8 consecutive hours of RN coverage. No other RN was scheduled to work those days. RN 1's time card was reviewed on 4/27/21 at 9:00 a.m., and the following was noted: On 4/13 she punched in at 6:45 p.m., and punched out on 4/14 at 7:45 a.m. No RN worked on 4/13/21. On 4/17 she punched in at 6:45 p.m., and punched out on 4/18 at 7:45 a.m. No RN worked on 4/17/21. On 4/18 she punched in at 6:30 p.m. No other RN worked on 4/18/21. On 4/24 she punched in at 6:45 p.m. and punched out on 4/25/21 at 7:30 a.m. No other RN worked on 4/24 or 4/25 for 8 consecutive hours. Interview with LPN 2 on 4/26/21 at 8:30 a.m., indicated the DON came into the facility on 4/25/21 and stayed for 45 minutes. Interview with the MDS Coordinator on 4/26/21 at 5:00 p.m., indicated she had not worked or covered for the RN coverage requirement since February 2021. The DON does not punch in and out using the time clock to document 8 consecutive hours of RN coverage. She was aware there needed to be RN coverage every day for 8 consecutive hours.		was still present when she arrived. D.O.N. only needed to work 2.75 hours on 4/13/21 in which D.O.N. worked 12 hours that day. 4/17/21 RN worked 6:45pm-4/18/21 7:45am clarification RN1 worked 4/17/21 5.25 hours all that was required for the D.O.N. to work was 2.75 hours, however D.O.N. worked 7 hours. 4/18/21 RN worked 6:30pm-4/19/21 8:15am clarification RN1 worked 4/18/21 5.5 hours all that was required for the D.O.N. to work was 2.5 hours, however D.O.N. worked 10 hours. 4/24/21 RN1 worked 5.25 hours all that was required was 2.75 hours. D.O.N. did come to the facility on 4/24/21 at 4:30pm to see how the day went. Unit Manager told me the surveyors had left for the day. D.O.N. was present from 4:30pm-7:00pm. Please let the record state facility lacked RN coverage for ½ hour on 4/24/21, it was really like 15 minutes I was detained in front of the building talking to staff before entering inside of the building. 4/24/21 RN worked 6:45pm-4/25/21 7:30am clarification RN worked 4/25/21 7.5 hours since a new day begins at 12:00a.m. All that was required for D.O.N. to work was .5 hours to cover 4/25/21 however she worked from 7am-5pm. Nurse statement	

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	On 4/27/21 at 10:00 a.m., the DON and the Administrator were not available for interview regarding RN coverage. 3.1-17(b)(3)		stating I was only there 45 minutes which was not true would have still covered the time requirement. RN waiver is still requested, and that the facility does provide 8 consecutive hours of RN coverage. The time schedule has been changed to 12pm-8pm and 8pm-8am so that it will not be so confusing to the surveyors to figure out the time until waiver is granted. 1. The facility provides 8 consecutive hours of RN coverage provided by night RN and D.O.N. of the facility. Facility has requested waiver for this requirement due to inability to hire new RN to serve as a charge nurse. 2. Facility has changed nursing hours to 12pm-8am and 8pm-8am so that the night nurse fulfills the 8-hour requirement. D.O.N. will also be included in the RN coverage hours. Facility has an ongoing need to hire additional licensed and unlicensed staff and will continue to pursue new employees, ongoing. F727: Please note, no waiver had been requested from CMS or IDOH at any time prior to survey and was not discussed at all with survey supervisor during her full day visit on survey. IDOH is not	

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			currently approving any waiver requests, so please ensure the POC does not rely on any assumption of future waiver. Please indicate how DON as RN hours will be documented and monitored and who will be responsible for monitoring DON as RN hours (presumably for resident care). DON had discussed it with the surveyor team leader who she thought would communicate it with her supervisor, but this did not occur. Point of Clarification: DON always puts the residents first and provides care when needed, however due to her vast and overwhelming responsibilities she does require the charge nurse to do her task. We have 21 residents and with a charge nurse LPN being in the building it is unnecessary for me to pass medications or do the nurses documentation when I am doing the 8 hour RN coverage. Since the pandemic and employee shortages the DON has worked in every capacity of the facility which directly or indirectly affects the care of the resident. DON coverage for RN hours will be documented on a schedule and time log which is always reviewed by the Administrator.	

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F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			

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	Based on observation and interview, the facility failed to post and provide daily staffing for all licensed staff working in the facility. This had the potential to affect 22 of 22 residents who resided in the facility. Finding includes: On 4/27/21 at 8:45 a.m., the nurse staffing sign was not posted. On 4/27/21 at 10:50 a.m., Unit Manager 1 was asked for the staffing information. At that time, she was unsure where it was and she would notify the Director of Nursing (who was not present in the facility at the time). Interview with Unit Manager 1 on 4/27/21 at 1:55 p.m., indicated the DON and Administrator had boarded a plane and were unavailable for interview and she did not know where the staffing sheet was for the day. Interview with the MDS Coordinator on 4/27/21 at 2:30 p.m., indicated she did not know where the staffing information was kept nor did she have access to it.	F 0732	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? In-service held with unit manager about Staffing form will indicate the number of staff members, title actual hours worked. The form will be completed by the unit manager each day and posted in the lobby area. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No resident affected. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. D.O.N. held in-service with Unit Manager on staffing form documentation. D.O.N. will review form weekly. D.O.N. will review form with Administrator weekly. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the	05/28/2021

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			regulations. D.O.N. responsible for in-servicing staff on completion of staffing form. Unit Manager is responsible for completion of staffing form each shift every day. D.O.N. will review form with Administrator weekly. D.O.N. will maintain all staffing sheets for 18 months. D.O.N. will maintain staffing sheets in binder next to screening forms and back up copy available on computer. Q.A. Committee will review staffing needs and form and determine monitoring needs and form revision quarterly.	
F 0741 SS=E Bldg. 00	483.40(a)(1)(2) Sufficient/Competent Staff-Behav Health Needs §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:			

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	§483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. Based on observation, record review and interview, the facility failed to ensure staff were trained to care for residents with mental and psychosocial disorders for 3 of 5 employee records reviewed and 2 random staff observations of dementia care. (Dietary Manager, LPN 2, LPN 3, PCA 1 and Custodian 2) Findings includes: 1. The employee records were reviewed on 4/27/21 at 9:15 a.m. and indicated the following: a. Dietary Manager, hired on 2/27/2018, had no annual dementia training completed in 2020. b. LPN 2, hired on 12/9/2019, had no annual dementia training completed in 2020. c. LPN 3, hired on 3/9/2004, had no annual dementia training completed in 2020. 2. Cross reference F744 related to Dementia Care and lack of successful redirection. Interview with PCA 1 on 4/27/21 at 1:30 p.m., indicated she had only received minimal dementia training during her PCA training.	F 0741	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; D.O.N. will provide Dementia Training for all current employees. Social Services will provide Dementia Training to newly hired staff. Unit Manager will maintain Dementia Training in employees file. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No resident affected. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Custodian 2 terminated himself did	05/28/2021

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	Interview with Custodian 2, indicated he had not had a recent inservice related to dementia care.		not show up for work. Annual Dementia Training will be provided by Social Services and Unit Manager is responsible for maintain records. D.O.N. will review Dementia Training Log upon new hires and quarterly, thereafter. Q.A. Committee will review Dementia Training Log semi-annually. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Annual Dementia Training will be provided by Social Services and Unit Manager is responsible for maintain records. D.O.N. will review Dementia Training Log upon new hires and quarterly, thereafter. Q.A. Committee will review Dementia Training Log semi-annually. F741: Please indicate what the facility did to determine no other residents were affected. Please indicate if any observation monitoring of actual dementia care will occur to determine if additional training may be needed. All staff has been trained in how to deal with the elderly and signs of aging which includes dementia. In	

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			the future we will only use Dementia Training, I think it was more so terminology with the older employee. DON consistently refers to Resident's Rights, Caring for the Elderly and Abuse weekly, however the Dementia Training was previously done by the Social Designee who is no longer employed at the facility. In reviewing the old Dementia training, we found a need to update our materiel and training. We have hired a RN Supervisor/Trainer who will hold this duty. In a discussion with the DON and RN Supervisor it has been determined that a new educational program is needed to include life skills. We are in development of great changes to have a great impact on the values and ethics of employees. Nursing is very dear to our hearts and we have to make changes because this future generation will be the ones caring for us one day as we continue to age. Dementia Training was provided to be in compliance, but a more detailed Dementia Course is in the works. Residents Rights Reviewed also. Monitoring of all skills including but not limited to Dementia Training will be monitored by DON	

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	155845	A. BUILDING 00 B. WING	04/27/2021

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			and RN supervisor to determine all educational needs that are needed by staff, ongoing. This will remain ongoing due to hiring of new staff members.	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.			
	Based on observation, record review, and interview, the facility failed to ensure a resident's plan of care was implemented related to residents with dementia who were observed wandering and/or exhibiting behaviors for 2 of 3 residents reviewed for dementia. (Residents 9 and 15) Findings include: 1. On 4/22/21 at 11:27 a.m., PCA 1 brought Resident 9 into the dining room. The resident was told she could sit at the table and watch television. The resident sat at the table for a little bit and then she propelled herself out of the dining room and wandered down the hallway. On 4/23/21 at 9:00 a.m., the resident propelled herself out of the dining room. At 10:00 a.m., she was seated in her wheelchair in the hallway. No activities were taking place. At 11:50 a.m., the resident continued to propel herself up and down the hallway. On 4/24/21 at 11:27 a.m., the resident was seated in her wheelchair in the dining room. Another resident was playing the piano at that time. The	F 0744	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Activity Staff new hire did not show up after first day of orientation. Social Worker has been hired and scheduled to start early part of June 2021. Social Services will complete social history of the residents and interview family members on activity preferences and lifestyle patterns. Staffing of the Activity and Social Services will be combined, and Social services will perform both duties for the two departments. Social Worker will develop activity plan according to resident's preferences and will consult with Resident Council President.	05/28/2021

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resident was tapping her foot and nodding her head along with the music.

On 4/26/21 at 9:02 a.m., 9:15 a.m., 11:30 a.m., and 12:10 p.m., the resident continued to wander in and out of the dining room as well as wander up and down the hallway.

Observations on all days of the survey, indicated no large or small group activities were scheduled. There was no current activity calendar posted.

The record for Resident 9 was reviewed on 4/23/21 at 12:03 p.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, major depressive disorder, anxiety, insomnia, hallucinations, and delusional disorder.

The Annual Minimum Data Set (MDS) assessment, dated 3/10/21, indicated the resident was moderately impaired for daily decision making, had delusions, and behaviors not directed towards others. It was also somewhat important for the resident to listen to music and do favorite activities. It was very important for the resident to participate in religious services.

The Care Plan, dated 9/16/20 and reviewed on 3/11/21, indicated the resident had impaired cognitive function/dementia or impaired thought processes related to diagnoses of dementia, hallucinations, and delusional disorder. Interventions included, but were not limited to, cue, reorient and supervise as needed, keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion and engage the resident in simple, structured activities that avoid overly demanding tasks.

Unit Managers will provide activities until Social Worker can be orientated.

Psychiatric N.P. has been fully vaccinated and will resume visits to facility to monthly evaluate residents receiving psychoactive medications and those with psychiatric and dementia diagnosis. N.P. will evaluate and treat our residents with behavioral issues.
Newly hired MDS Coordinator will make updates to plan of care as they occur.
- how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;

Every resident has been affected by the pandemic which caused their change in life-style and lack of people seeking employment.
- what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;

Residents with behaviors are discussed at morning meetings to indicate if treatment plan is effective or if changes are needed to decrease episodes of unacceptable behavior.
Charge nurses are required to

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	The last documented activity progress note was dated 10/27/20. Interview with the Director of Nursing on 4/26/21 at 5:00 p.m., indicated the resident needed a different type of structured programming. She also indicated a new Activity/Social Service Director would be starting next week. 2. On 4/22/21 at 9:50 a.m. Resident 15 was seated in his wheelchair in his room in front of his sink sleeping. At 12:45 p.m., the resident was served his lunch in the dining room. The resident was picking up his food with his fingers and walking around the dining room. The resident was observed moving chairs in the dining room at that time. At 3:13 p.m., the resident was again in the dining room, he was moving tables and chairs. PCA 1 attempted to redirect the resident. On 4/23/21 at 8:50 a.m., 10:10 a.m., 11:30 a.m., and 1:40 p.m., the resident was observed in his room in bed sleeping. On 4/24/21 at 9:40 a.m., the resident was in his room in bed sleeping. At 11:00 a.m., he was seated in his wheelchair in the dining room feeding himself breakfast with his fingers. No staff were in the dining room. On 4/26/21 at 9:35 a.m., the resident was in his room in bed. He did not come to the dining room for breakfast. At 2:30 p.m., the resident was observed in the dining room moving chairs and tables. Staff tried to redirect the resident with no success. The record for Resident 15 was reviewed on 4/24/21 at 11:41 a.m. Diagnoses included, but were not limited to, dementia with behavior		record resident's behavior in the progress notes for review by Nurse Practitioner. D.O.N./Designee will review behavior notes with N.P. so that effective plan can be implemented for residents with behavior issues. MDS Coordinator will update plan of care to indicate changes prescribed by N.P. Social Service Department will document behavior changes of residents as they occur and provide activity plan for the residents until Activity Staff can be hired. All residents with mental health diagnosis and/or receiving an antipsychotic medication will be seen by psychiatric services at least on a monthly basis. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Facility is actively seeking Activity Staff ongoing. Charge Nurse will correspond with N.P. about residents behavior ongoing. MDS Coordinator will update plan of care ongoing. Social Service Staff and Nursing Staff will meet weekly and review care plan, notes assess the effectiveness of treatment and refer all questions to N.P. Administrator and /or designee will	

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	disturbance, psychotic disorder with hallucinations, insomnia, major depressive disorder, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 4/4/21, indicated the resident was severely impaired for daily decision making, had hallucinations, delusions, physical and verbal behaviors and wandered. The Care Plan, dated 10/7/20 and reviewed on 3/4/21, indicated the resident did show a history and signs of combative behaviors related to psychotic disorder with hallucinations. Interventions included, but were not limited to, caregivers provided opportunity for positive interaction, attention. Stop and talk with him as passing by and intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. A Physician's Order, dated 4/7/21, indicated the resident was to receive Seroquel (an antipsychotic) 25 milligrams (mg) give 12.5 mg daily for agitation and Seroquel 50 mg at bedtime for agitation. Nurses' Notes, dated 4/26/21 at 4:22 a.m., indicated the resident remained up pacing the hallway until 12:00 a.m. He was assisted to bed by staff, incontinence care was provided. The resident went to sleep after finally exhausting himself and remained asleep at the time. Nurses' Notes, dated 4/24/21 at 10:40 p.m., indicated the resident was still awake wandering the hallway and room moving furniture. Nurses' Notes, dated 4/24/21 at 3:47 a.m., indicated		monitor activities provided for dependent residents with behaviors assess diversional efforts to redirect behaviors weekly. Q.A. Committee will review behavior documentation monitored by NP and DON reporting quarterly, ongoing. Q.A. committee will be informed of hiring needs monthly. by what date 5/28/2021. F744: Please indicate what, if anything, was done for the residents affected by the deficient practice. Please indicate how the facility will review and supplement staff training to assist with resident centered behavior interventions. Addendum F744 New MDS Coordinator reviewed care plans. N.P. reviewed all residents on psy medications. Facility has hired a RN Supervisor/Trainer to continually provide educationally services as they occur. The DON and RN Supervisor make every moment a teachable moment in continuing to develop a strong nursing team. Resident behaviors are discussed at shift to shift report and morning meetings to ensure resident centered behavior interventions.	

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the resident was moving furniture in the dining room and pushing chairs into the hallway. Evening care was provided and he continued moving furniture until approximately 1:00 a.m. He was currently in bed sleeping at this time.

Nurses' Notes, dated 4/23/21 at 6:16 a.m., indicated the resident stayed awake the entire night throwing down tables and chairs in the dinning room. The resident became very aggressive when redirected. He finally got tired this morning and sat on the chair.

Nurses' Notes, dated 4/20/21 at 8:35 a.m., indicate the resident refused to stay in bed last night. He wandered around in his room moving furniture and sitting on his roommate's bed. After several attempts to keep him in his own bed without success, he was placed in a chair at the nurses' station. He did go to sleep and slept most of the night.

Nurses' Notes, dated 4/19/21 at 10:47 p.m., indicated the resident roamed the hallway in and out of other resident rooms.

Nurses' Notes, dated 4/18/21 at 10:46 p.m., indicated the resident was still awake roaming the hallway and entering other resident rooms. He was very agitated and combative when redirected.

Nurses' Notes, dated 4/17/21 at 9:43 a.m., indicated the resident stayed awake all night. The resident was moving chairs and tables in room to hallway which caused him physical exertion. This behavior was not easily redirected. He was encouraged to lay down in bed to rest, but refused to stay in bed. He was combative with staff with redirection. After several attempts he was placed in a recliner at the nurses' station to conserve energy and to

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maintain safety. He remained awake the entire night.

Nurses' Notes, dated 4/10/21 at 7:24 a.m., indicated the resident paced the hallway and other resident rooms. He appeared to be very tired but refused to sit down or go to bed.

Nurses Notes, dated 4/7/21 at 10:42 p.m., indicated the resident was received in a chair in the dinning room. He was wandering and moving furniture and turning over chairs. The resident was not easily redirected and he was combative with staff.

Nurses' Notes, dated 4/7/21 at 12:01 p.m., indicated the resident was up all night per night shift nurse report. New medication orders were made per psych nurse practitioner orders. Will continue to monitor effectiveness .

Nurses' Notes, dated 4/7/21 at 3:37 a.m., indicated the resident refused to stay in bed. He was wandering the hallway and dining room, moving furniture and turning over chairs. He was not easily redirected and combative with staff.

Nurses' Notes, dated 4/4/21 at 9:59 p.m., indicated the resident was up all shift wandering the hallway and going from room to room. He was physically aggressive with staff when redirected.

The Quarterly Activity assessment, dated 10/5/20, indicated the resident worked best in smaller groups but still didn't like to sit for long periods of time. The resident had displayed aggressive behavior toward staff and often refused to participate in activities that were offered. The resident will continue to be monitored for activities that he showed interest in. There were no further activity assessments available for

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	review. The last documented psychiatric progress note was dated 10/13/20. There was also no documentation to indicate the Psychiatric Nurse Practitioner was notified of the resident's ongoing behaviors after his medication adjustments. Interview with the Director of Nursing on 4/26/21 at 5:15 p.m., indicated a new activity staff member was starting next week and she would develop a program for the cognitively impaired residents. 3.1-37(a)			
F 0745 SS=E Bldg. 00	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.			
	Based on observation, record review and interview, the facility failed to provide appropriate social services to meet the residents' needs related to not having a social services designee employed since November 2020 for Findings include: 1. Interview with the Director of Nursing (DON) on 4/21/21 at 11:15 a.m. during the entrance conference, indicated the prior Social Service designee was no longer at the facility. "She had a bad leg/knee and she took some time off to see a doctor and get some type of treatment for it and she never came back after that." There was no current designee name listed on the list of key employees requested at entrance	F 0745	Facility continues to try and seek employees to fill all departments with the needed staff. Refer to F744, F657, F744, F758 F745: Please indicate what, if anything, was done for the residents affected by the deficient practice. Please indicate what the facility did to determine if any other residents were affected. Please submit specifics on how the deficient practice will be corrected and by when, including provisional plan for coverage until full time Social Service Director (or designee overseen by licensed SS) is hired Addendum	05/28/2021

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	conference or on the employee roster. The last social service related note documented by the previous designee was dated 10/30/20. Interview with the DON on 4/23/21 at 11:43 a.m., indicated she did not currently have any Social Service staff, she was in the process on hiring a Social Service Director, who should be starting next week. 2. Cross reference F657 related to Care Plan Conference planning not completed. 3. Cross reference F744 related to lack of dementia care and behavior monitoring. 4. Cross reference F758 related to lack of psychotropic medication review and monitoring. 3.1-34(a)		Administrative staff are interviewing seeking to hire people for the social service department. It is anticipated that the employment situation should change within the next 30 – 60 days. Currently nursing is assuming the roles of the social service department in behavior and psy medication documentation. MDS Coordinator is updating the Care Plans and RN Nurse Supervisor is doing the Dementia training. This will be implemented until a full time Social Designee and Social Worker can be employed. Once employed and orientated we anticipate the process taking a month.	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications			

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	for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.			
	Based on record review and interview, the facility failed to ensure excessive doses of over the counter sleep aides were not given and cardiac medications were held per parameters for 2 of 5 residents reviewed for unnecessary medications. (Residents 9 and E) Findings include: 1. The record for Resident 9 was reviewed on 4/23/21 at 12:03 p.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, major depressive disorder, anxiety, insomnia, hallucinations, delusional disorder, and pain. The Annual Minimum Data Set (MDS) assessment, dated 3/10/21, indicated the resident was moderately impaired for daily decision making, had delusions, and behaviors not directed towards others. The April 2021 Physician's Order Summary (POS), indicated the resident was to receive Melatonin (an herbal sleep aid) 3 mg at bedtime for insomnia and Tylenol PM ES (an over the counter sleep aid) 500-25 mg give 500 mg at bedtime for pain. The April 2021 Medication Administration Record (MAR), indicated both medications were scheduled at 9:00 p.m.	F 0757	F757 D.O.N. was never informed of medications needing to be evaluated for this resident. Conference did not occur with D.O.N. 4/26/21. D.O.N. was in the building on 4/26/2021 and available to all surveyors. - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; D.O.N. identified nurses with deficient practices. In-Service held with licensed nursing staff on MAR documentation, reading and proper medication administration. Physician and N.P. consulted on physician order clarification for the 2 residents indicated. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents had potential to be affected due to lack of good reading and critical thinking skills portrayed by licensed nursing	05/28/2021

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	Interview with the Director of Nursing on 4/26/21 at 5:15 p.m., indicated the resident's medications needed to be evaluated related to the concurrent Melatonin and Tylenol PM use. 2. The record for Resident E was reviewed on 4/22/21 at 2:37 p.m. Diagnoses included, but were not limited to, stroke, hypertension, hypertensive chronic kidney disease, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 2/1/21, indicated the resident was cognitively intact for daily decision making. The April 2021 Physician's Order Summary (POS), indicated the resident was to receive Metoprolol Tartrate (a heart medication) 100 milligrams (mg) twice a day. The medication was to be held if the resident's systolic (top number) blood pressure was less than 110 or heart rate under 60. The April 2021 Medication Administration Record (MAR) indicated the following: - On 4/2/21 at 10:00 a.m. and 6:00 p.m., the resident's blood pressure was 97/56 and the Metoprolol Tartrate was administered. - On 4/23/21 at 10:00 a.m., the resident's heart rate was 56 and the medication was given. The March 2021 MAR indicated the following: - On 3/16/21 at 6:00 p.m., the resident's blood pressure was 90/60 and the medication was given. - On 3/23/21 at 6:00 p.m., the resident's blood pressure was 109/69. The medication was administered. Interview with the Director of Nursing on 4/26/21 at 5:00 p.m., indicated the resident's Metoprolol		staff. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; D.O.N. will monitor medication pass weekly with each nurse on all shifts and discipline deficient practices of licensed nurses. D.O.N. will audit all physician orders monthly and ensure licensed nurses understand all physician orders. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and D.O.N. will monitor medication pass weekly with each nurse on all shifts and discipline deficient practices of licensed nurses. D.O.N. will audit all physician orders monthly 5 residents weekly and ensure licensed nurses understand all physician orders. Q.A. Committee will review D.O.N. report of medication med pass, physician order audit and nurse performance quarterly for the next 6 months. - by what date 5/28/21	

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	should have been held as ordered. 3.1-48(a)(1) 3.1-48(a)(3)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and			

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	155845	A. BUILDING 00 B. WING	04/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

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	§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.			
	Based on record review and interview, the facility failed to ensure there was an indication for the use of psychotropic medications as well as monitoring for side effects, effectiveness, and completing Abnormal Involuntary Movement Scale (AIMS) assessments, and monitoring for duplicate drug therapy related to hypnotics and antidepressants for 3 of 5 residents reviewed for unnecessary medications. (Residents 15, 6, and C) Findings include: 1. The record for Resident 15 was reviewed on 4/24/21 at 11:41 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, psychotic disorder with hallucinations, insomnia, major depressive disorder, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 4/4/21, indicated the resident was severely impaired for daily decision making, had hallucinations, delusions, physical and verbal behaviors and wandered.	F 0758	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; New MDS Coordinator hired to assign MDS Assessments and ensure assessments are done timely and accurately. N.P. contacted to review orders for Resident 15, 6, C Nurse Practitioner has started evaluating all resident receiving antipsychotic medication and updating diagnosis. Psychiatric Nurse Practitioner and Pharmacist Consultant will communicate about resident receiving psychoactive medications. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No other residents affected.	05/28/2021

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	A Physician's Order, dated 12/10/20, indicated the resident was to receive Seroquel (an antipsychotic medication) 50 milligrams (mg) twice a day. A Physician's Order, dated 4/7/21, indicated the resident was to receive 12.5 mg of Seroquel daily at 10:00 a.m. and 50 mg at bedtime. A Physician's Order, dated 12/21/20, indicated the resident was to receive Haldol (an antipsychotic medication) 1 mg by mouth every 24 hours as needed (PRN) for insomnia and anxiety. The April 2021 Physician's Order Summary (POS), indicated the resident was to receive Restoril (a sleeping pill) 7.5 mg at bedtime for insomnia. The resident was also scheduled to receive Tylenol PM ES (an over the counter sleep aid) 500-25 mg 1 tablet at bedtime for insomnia. An AIMS scale (a rating scale to monitor for involuntary movements related to long term use of psychotropic medications), dated 5/10/20, was incomplete. There were no other AIMS scales available for review. There was no documentation to indicate the PRN order for Haldol had been re-evaluated by the Physician after 14 days. Interview with the Director of Nursing on 4/26/21 at 5:00 p.m., indicated the PRN order for the Haldol needed to be reviewed as well as the orders for the Restoril and Tylenol PM ES. Interview with the MDS Coordinator on 4/27/21 at 1:45 p.m., indicated an AIMS scale should have been completed. 2. The record for the Resident 6 was reviewed on 4/22/21 at 1:10 p.m. Diagnoses included, but were not limited to, high blood		- what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; In-Service held with licensed nurses on behavior documentation for Nurse Practitioner and Pharmacist Consultant review. Nurse Practitioner has started evaluating all resident receiving antipsychotic medication and behaviors. Psychiatric Nurse Practitioner and Pharmacist Consultant will communicate about resident receiving psychoactive medications and review 14 day psychotropic orders. MDS Nurse and Charge Nurse will update care plans according to behavior and order changes. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and D.O.N. will monitor documentation of changes in medication indications and resident outcome. D.O.N. will monitor communication board weekly and assess documentation of nurses. D.O.N. will meet with Nurse Practitioner and Pharmacist monthly to discuss GDR recommendations and resident’s response to treatment. Q.A. Committee will monitor reports from D.O.N. quarterly to	

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	pressure, chronic pain, dysphagia, type 2 diabetes, assault by shotgun, stroke, hemiparesis, major depressive disorder, convulsions, and psychosis. The Quarterly Minimum Data Set (MDS) assessment, dated 1/10/21, indicated the resident was not cognitively intact, and severely impaired for decision making. The resident needed extensive assist with 2 person assist for bed mobility and transfers, and extensive assist with 1 person assist for eating, toileting, and dressing. The resident weighed 155 pounds and had a significant weight loss noted. The resident received a mechanically altered and therapeutic diet. In the last 7 days the resident received insulin, an antidepressant medication, and a hypnotic medication. Bed rails were coded as being used daily. The resident was admitted to the hospital on 1/21/21 and returned on 1/28/21. Physician's Orders, dated 1/28/21 indicated the following: - Quetiapine Fumarate (Seroquel, an antipsychotic medication) 50 milligrams (mg) 1 tablet by mouth two times a day. - Celexa (an antidepressant medication) 20 mg daily - Cymbalta (an antidepressant medication) 30 mg daily - Lexapro (an antidepressant medication) 10 mg daily - Trazodone (an antidepressant medication) 50 mg at night time - Trazodone (an antidepressant medication) 50 mg twice a day The 1/2021 and 2/2021 Medication Administration		assess effectiveness and evaluate compliance of psychiatric evaluations and treatments. - by what date the systemic changes 5/28/2021. F758: Please indicate what the facility did to determine no other residents were affected. Surveyors reviewed all the residents in the facility with the exception of one which would have been included in this report if deficient practice was found. DON is at a disadvantage since she is unaware of what all was said at the exit conference. Surveyors exited with the previous MDS Coordinator which has been unavailable to discuss the survey findings with the DON since the survey process ended. N.P. reviewed all residents on psy medications and pharmacist recommendations. Pharmacist review did not indicate any other findings, therefore no other residents were affected.	

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	Records indicated all of the above medications were administered from 1/28/2021 to 2/16/21. A Psychiatric Progress Note, dated 7/29/20, indicated to continue current medications with a goal to have improved behaviors. There were no other or current psychiatric progress notes available for review. Behavior sheets and psychiatric progress notes were requested on 4/26/21 at 4:00 p.m. Interview with the Director of Nursing (DON) on 4/26/21 at 4:00 p.m., indicated she was unaware the resident was on all of the above antidepressants and the antipsychotic medications at the same time after he had returned from the hospital. Interview with the MDS Coordinator on 4/27/21 at 1:00 p.m., indicated there was no additional information or rationale of the psychotropic medication being administered. The DON was not available for follow up interview on 4/27/21.3. The record for Resident C was reviewed on 4/23/21 at 12:07 p.m. Diagnoses included, but were not limited to, end stage renal disease, dialysis, diabetes, hemiplegia, and dementia with behavior disturbance, and major depression with psychotic symptoms. The Quarterly Minimum Data Set (MDS) assessment, dated 2/14/21, indicated the resident was alert and oriented and totally dependent with bed mobility and transfers. Physician's Orders, dated 2/6/21, indicated Zyprexa (an antipsychotic medication) 7.5 mg (milligrams) every night at bedtime.			

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	A Care Plan, dated 5/30/19, indicated the resident used psychotropic medications related to behavior management. The interventions included, but were not limited to, administer medications as ordered, and monitor for side effects and effectiveness every shift. The 4/2021 Medication and Treatment Administration Records indicated no documentation related to monitoring for signs, symptoms, and effectiveness of the psychotropic medication use every shift. Interview with the Director of Nursing on 4/26/21 at 4:10 a.m., indicated residents who are taking antipsychotic medications should be monitored for side effects and effectiveness every shift. 3.1-48(a)(1) 3.1-48)a)(2) 3.1-38(a)(4)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 6 residents observed during medication pass. Two errors were observed during 25 opportunities for errors during medication administration. This resulted in a medication error rate of 8%. (Residents 11 & 16) Findings include:	F 0759	F759 Surveyor informed D.O.N 4/23/2021 @3:00 was informed about failure of the nurse to take b/p prior to administration of medication. Surveyor never discussed improper disposal of lancet nor glucogan administration. please correct record. D.O.N. was available on 4/26/2021	05/28/2021

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	1. During medication pass on 4/22/21 at 9:30 a.m., LPN 2 was observed pouring and preparing mediation for Resident 11. At that time, she poured Metoprolol 25 milligrams (mg) 1 tablet into the medication cup. She finished pouring the rest of the medication and walked into the resident's room. The LPN administered a total of 3 pills to the resident with water. The LPN did not take the resident's blood pressure or obtain a pulse prior to administration. The record for Resident 11 was reviewed on 4/26/21 at 11:15 a.m., Physician's Orders, dated 3/30/21, indicated Metoprolol 25 mg twice a day on Tuesday, Thursday, Saturday, and Sunday. Hold blood pressure medication if systolic was less than 110 and heart rate under 60. Interview with the LPN 2 on 4/26/21 at 11:30 a.m., indicated she had taken the resident's blood pressure earlier in that morning and not prior to the administration of the blood pressure medication. Interview with the DON on 4/26/21 at 4:00 p.m., indicated the resident's blood pressure should have been taken at the time of medication administration 2. During medication pass observation on 4/22/21 at 12:15 p.m., LPN 2 obtained the resident's blood sugar level with the glucometer. The resident's blood sugar was 35. The LPN indicated she needed to administer Glucagon and then she would notify the resident's physician. She removed the Glucagon kit from the medication cart and took into the resident's room. Inside the kit there was a syringe of normal saline and vial of		the entire day. MDS Coordinator was not in the building on 4/26/2021. MDS Coordinator was present in building on 4/27/2021 since D.O.N. was not available. Please correct record. Med Error Resident 11 Sarah take b/p prior to giving medication Resident 16 Marquis Acccu-Check disposal wasted too much medication when priming Glucagon F760 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Nurse performing deficient practice was in-serviced according to policy on Accu-Check and properly using glucagon emergency kit. All nurses will be in-serviced on the policy and procedure for administering glucagon emergency kit injection and Accu-checks. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No one else affected 3. What measures will be put into place or what systemic changes will be made to ensure that the	

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	powder. She removed cap from the needle and wiped the opening of the vial with an alcohol pad and injected the saline into the vial. She placed the needle back into the cap, and the shook the medication until blended. The LPN inserted the needed and drew back the medication into the syringe. At that time, she primed the needle and wasted the some of the medication. As she pulled back all of the medication, the amount was noted to be just below 0.5 milligrams (mg). The LPN had the intent to administer the Glucagon and was stopped. The LPN then looked at the medication and realized there was not 1 mg of Glucagon to administer due to her priming the needle and wasting the medication. Interview at that time with LPN 2, indicated she was unaware she did not need to prime the syringe and wasted so much of the medication. The record for Resident 16 was reviewed on 4/26/21 at 11:41 a.m. Physician's Orders, dated 2/14/21, indicated Glucagon Emergency Kit 1 mg. Inject 1 mg intramuscularly every 8 hours as needed for hypoglycemia. Interview with the MDS Coordinator on 4/26/21 at 4:00 p.m., indicated the nurse should not have wasted so much of the medication priming the needle. The Director of Nursing was unavailable for interview. 3.1-48(c)(1)		deficient practice does not recur. D.O.N. reviewed Glucagon Emergecy Kit and Accu-Check Policy with all charge nurses and will continue to inservice new hires on policy. Consultant Pharmacy will provide educational training tools as needed. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. D.O.N. will monitor insulin and glucagon administration with every nurse and new hires to ensure insulin is primed properly monthly. Q.A. Committee will review Monitoring tool and nurse training semi-annually. 5. Completion Date: 5/28/2021	
F 0760 SS=D	483.45(f)(2) Residents are Free of Significant Med Errors			

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Bldg. 00	The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on observation, record review, and interview, the facility failed to ensure a resident was free from significant medication errors related to the incorrect administration of Glucagon for a blood sugar of 35 for 1 of 6 residents observed during medication pass. (Resident 16) Finding includes: During medication pass on 4/22/21 at 12:15 p.m., LPN 2 obtained the resident's blood sugar level with the glucometer. The resident's blood sugar was 35. The LPN indicated she needed to administer Glucagon and then she would notify the resident's physician. She removed the Glucagon kit from the medication cart and took into the resident's room. Inside the kit there was a syringe of normal saline and vial of powder. She removed cap from the needle and wiped the opening of the vial with an alcohol pad and injected the saline into the vial. She placed the needle back into the cap, and the shook the medication until blended. The LPN inserted the needed and drew back the medication into the syringe. At that time, she primed the needle and wasted the some of the medication. As she pulled back all of the medication, the amount was noted to be just below 0.5 milligrams (mg). The LPN had the intent to administer the Glucagon and was stopped. The LPN then looked at the medication and realized there was not 1 mg of Glucagon to administer due to her priming the needle and wasting the medication. Interview at that time with LPN 2, indicated she was unaware she did not need to prime the syringe and wasted so much of the medication.	F 0760	F760 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Nurse performing deficient practice was in-serviced according to policy on Accu-Check and properly using glucagon emergency kit. All nurses will be in-serviced on the policy and procedure for administering glucagon emergency kit injection and Accu-checks. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No one else affected 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. D.O.N. reviewed Glucagon Emergecy Kit and Accu-Check Policy with all charge nurses and will continue to inservice new hires on policy. Consultant Pharmacy will provide educational training tools as	05/28/2021

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	The record for Resident 16 was reviewed on 4/26/21 at 11:41 a.m. Physician's Orders, dated 2/14/21, indicated Glucagon Emergency Kit 1 mg. Inject 1 mg intramuscularly every 8 hours as needed for hypoglycemia. Interview with the MDS Coordinator on 4/26/21 at 4:00 p.m., indicated the nurse should not have wasted so much of the medication priming the needle. The Director of Nursing was unavailable for interview. 3.1-48(c)(2)		needed. 4. Describe who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. D.O.N. will monitor insulin and glucagon administration with every nurse and new hires to ensure insulin is primed properly monthly. Q.A. Committee will review Monitoring tool and nurse training semi-annually. 5. Completion Date: 5/28/2021	
F 0761 SS=E 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.			

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	§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 the medication cart and medication room was locked at all times while unattended. The facility also failed to ensure all ointments were labeled and/or discarded after expiration and medication was pulled from the correct medication cart for administration for 1 of 1 medication rooms observed, 1 of 1 treatment carts observed, and 1 of 6 residents observed during medication pass. (Resident H) Findings include: 1. On 4/26/21 at 9:28 a.m., the nurses' station door was unlocked. At that time, the medication room door located in the nurses' station was also unlocked. Inside the medication room, the medication and treatments carts were both also unlocked. There was no nursing staff observed near or around the medication room or carts. At 9:33 a.m., LPN 2 came back into the nurses' station with the tablet and blood pressure cuff. She walked into the medication room and placed both items on top of the medication cart and locked the cart. The treatment cart remained unlocked. She left the medication room and pulled the door closed behind her, however, it was not locked.	F 0761	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A copy the "Medication Storage" policy was given to all licensed nurses and review included medication being stored safely, securely, and properly. The medication supply is accessible only to licensed nursing personnel. All stock ointments will be kept in storage and not on the treatment cart. All treatments will be labeled with resident's name, dated and physician. Medication room doors, medication and treatment cart locking has been reviewed with nurses. Do to the limited staff pool of licensed nurses the facility will implement a fine to the nurse who is no-compliant for each deficient act.	05/28/2021

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	2. During medication pass on 4/26/21 at 10:06 a.m., LPN 1 was observed pouring and preparing medication for Resident H. At that time, she removed a medication card of Carbamazepine (a medication used for seizures) 200 milligrams (mg). The label indicated to administer 600 mg at night time. The LPN poured 2 tablets (400 mg) into the medication cup. The LPN administered the resident's medications. After the pass, the LPN removed the medication card for the Carbamazepine. Interview with LPN 2 at that time, indicated the morning dose was 400 mg and the evening dose was 600 mg. She indicated that was the only medication card they had to administer the medication. There were not 2 medication cards with 2 different doses. The nursing staff were using the same medication card to administer the different doses. There was no label indicating the morning dose, only the evening dose. The Record for Resident H was reviewed on 4/26/21 at 1:10 p.m. Physician's Order, dated 3/29/21, indicated Carbamazepine 200 mg give 600 mg by mouth at bedtime. Physician's Orders, dated 4/9/21, indicated Carbamazepine 200 mg give 2 tablets by mouth one time a day. Interview with the MDS Coordinator on 4/26/21 at 5:00 p.m., indicated there was to be 1 medication card for each Physician's Order. 3. During observation of the treatment cart located inside the medication room on 4/26/21 at		2. No other deficient practice noted. 3. 11-7 Charge Nurse will monitor medication cart and treatment cart weekly to ensure all items are properly labeled. D.O.N. Designee will monitor medication and treatment cart monthly ongoing. D.O.N. will monitor each licensed nurse practice and give corrective in-servicing ongoing. In-Service on the proper Medication Storage will become part of orientation and will be reviewed quarterly. In-Service on the proper Medication Storage will become part of orientation and will be reviewed quarterly. Unit Manager will monitoring medication storage 5 times weekly for 4 weeks, weekly ongoing. Q.A. Committee will review our monitoring evaluation quarterly for the first 3 months and semi-annually. Q.A. Committee will determine the need for increased or decreased monitoring of proper technique for medication storage. Q.A. Committee will review fines given to staff and see if this practice is effective in licensed	

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	10:37 a.m. the following was observed: - 1 bottle of povidine iodine solution dated 2/18/2019 for a resident not even in the facility. - 1 container of zinc oxide ointment, that was opened with no label and had an expiration of 4/2018. - 1 tube of Medihoney ointment that was open and had no label on it and another tube in a sealed box with no label on it. - 1 tube BCPO wound ointment that was opened and had no label. - 1 bottle Dakin solution that was opened with no label. - 3 bottles of hydrogen peroxide that were opened with no label. - 1 container of body powder that was opened with no label. Interview with the MDS Coordinator on 4/26/21 at 5:00 p.m., indicated the tubes of medication should have been labeled and dated when opened. The DON was unavailable for interview. A current and revised 8/2020 "Storage of medications" policy, provided by the MDS Coordinator on 4/27/21 at 2:01 p.m., indicated medication rooms, carts, and medication supplies were to be locked when that were not attended by persons with authorized use. All medications dispensed by the pharmacy were stored in the pharmacy container with the pharmacy label. Outdated, contaminated, or deteriorated medication and those in containers that were cracked, soiled, or without secure closures were immediately removed and disposed of according to procedures for medication disposal.		nurse's accountability for their actions. Philosophy behind this practice is: -The facility governing agencies feel they should fine the facility enormous fines due to staff practices. -There is a staffing shortage and due to the inability to terminate staff and replace. -Paying for more and more supervisors does not help for people being accountable for their actions. -Since staff has been properly trained and still perform deficient acts they will be fined for their actions and if successful it will be an implemented policy throughout facility. 5. 5/28/21 F761: Please indicate what, if anything, was done for the resident (and treatment cart) affected by the deficient practice. Pharmacy was contacted in reference Resident H and due to payment insurance issues the pharmacy cannot send out 2 cards for the same medication with different instructions, however they will send a card including both instructions on the same card. Resident H medication has 1 card with the medication of Carbamazepine 200 mg give 2 tablets 400mg at 9am and give 3 tablets 600 mg by mouth at	

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	3.1-25(j) 3.1-25(m) 3.1-25(o)		bedtime. 1 bottle of povidone iodine solution dated 2/18/2019 for a resident not even in the facility. - 1 container of zinc oxide ointment, that was opened with no label and had an expiration of 4/2018. - 1 tube of Medihoney ointment that was open and had no label on it and another tube in a sealed box with no label on it. - 1 tube BCPO wound ointment that was opened and had no label. - 1 bottle Dakin solution that was opened with no label. - 3 bottles of hydrogen peroxide that were opened with no label. - 1 container of body powder that was opened with no label were all thrown away.	
F 0805 SS=D Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. Based on observation and interview, the facility failed to prepare a pureed (blended smooth) diet designed to meet the needs of the residents for 1 of 1 residents receiving a pureed diet. (Resident B) Findings include: 1. On 4/23/21 at 12:28 PM, pureed food preparation was observed with Cook 1. The Cook indicated she was making a single serve portion of	F 0805	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? D.O.N. and Nurse Consultant held conference with dietary staff on proper diet being served and reading Dietary Cards. Dietician notified of need for	05/28/2021

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	fried fish, spaghetti with meat sauce and garlic toast. The Cook placed 3 pieces of fried fish on the scale which measured out to be 4 ounces. She then placed the fish in the blender and added 3 teaspoons (tsp) of 2% milk. After blending, the Cook added 3 more tsp of milk. The mixture was blended again, and after stirring, the Cook added 2 more tsp of milk. The mixture was again blended and 1 more tsp of milk was added. After blending a final time, the Cook stirred the mixture and emptied it onto a paper plate. The mixture was not totally smooth in appearance. After washing the blender, the Cook measured out 1 1/2 ounces of spaghetti with meat sauce and placed it in the blender. The Cook added 3 tsp of 2% milk and blended the mixture. She stirred the spaghetti and placed it on the steam table. Again, the mixture wasn't completely smooth. After washing the blender, the Cook placed one slice of garlic bread in the blender as well as 3 tsp of 2% milk. She blended the mixture and added 3 more tsp of milk. After stirring, she added another 3 tsp of milk, blended the mixture and added another 2 tsp of milk. The mixture was again blended and 2 additional tsp of milk was added. After blending a final time, the bread was a smooth consistency. The Cook did not use a recipe to prepare the above items. Interview with the Cook at the time indicated she had been trained to make the pureed food and the facility had a recipe book. Interview with Cook 1 on 4/27/21 at 11:56 a.m., indicated the recipe book was locked in the Dietary Food Manager's (DFM) office. The DFM		dietary in-service on diets and pureed diet recipe. Dietary Manager reviewed all tray card and diet orders. Unit Manager will review tray accuracy of each meal. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No one else affected, only one pureed diet served. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Dietary Manager will monitor diet cards monthly and consult with RD twice monthly. Unit Manager will monitor meal 3 times a week to ensure proper diet is served. Dietician will monitor meal pass 2 times monthly during visits and proper blending of pureed diet. Dietician will provide in-service on use of recipe book, puree consistency to be smooth texture. Recipe books will be available in the kitchen at all times. 1. Describe who will be the person(s) responsible for implementing and monitoring the	

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	had been out of the facility since Friday 4/23/21. 2. On 4/27/20 at 9:20 a.m., Resident B was served pureed scrambled eggs, pureed danish, and pureed oatmeal with fruit. The scrambled eggs contained chunks as well as the danish. Neither item was a smooth pudding like consistency. Interview with PCA 1 at that time, indicated the eggs didn't look very smooth nor did the danish. 3.1-21(a)(3)		plan for future compliance with the regulations. Dietary Manager will monitor diet cards monthly and consult with RD twice monthly. Unit Manager will monitor meal 3 times a week to ensure proper diet is served. Dietician will monitor meal pass 2 times monthly during visits. D.O.N. will monitor documentation monthly. Q.A. Committee will monitor tray accuracy logs and diet orders every 3 months and determine additional monitoring or changes, 5. Completion Date: 5/28/21	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents			

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	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 and interview, the facility failed to serve, store, and prepare food under sanitary conditions related to food not dated when opened, meals served uncovered below waist level, old produce, and improper glove use during food handling for 1 of 1 kitchen areas, potentially affecting 21 of 22 residents who received their meals from the kitchen. (The Main Kitchen) Findings include: 1. During observation of the tray line, on 4/21/21 at 8:52 a.m. with the Dietary Food Manager (DFM), the following was observed: a. The DFM was observed using a plastic spoon to place hot cereal on a plate. The food was not measured. b. The DFM had a disposable glove on one of her hands. She was using her gloved hand to touch the utensil handles and then she proceeded to pick up a donut with her gloved hand and place it on a plate. 2. During the full kitchen sanitation tour, on 4/21/21 at 9:40 a.m., with the DFM the following was observed: a. There was no thermometer in the reach in refrigerator. b. A zip lock plastic bag in the walk in refrigerator	F 0812	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1. All food not labeled or dated was thrown away from reach-in refrigerator. 2. Review of using proper measuring scoops and ladles for serving. 3. Thermometer placed in reach in refrigerator. 4. Inservice held on providing cover over food if second tray of cart is used. D.O.N. and Nurse Consultant held in-service with dietary staff on using Dietary Cards, Pureed Diet, and proper handling and labeling of all food. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No other residents affected. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	05/28/2021

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	contained a bone with ham on it. The bag was not dated. c. A zip lock plastic bag in the walk in refrigerator contained a brown liquid substance with food particles. The bag was not dated. The DFM discarded the bag. d. Three limes in the walk in refrigerator were brown and discolored in areas. The DFM indicated the limes needed to be thrown away. 3. On 4/27/21 at 12:17 p.m., a plastic cart was brought out of the kitchen by Custodian 2. The Custodian proceeded to serve the meals. The top two shelves of the cart had plastic trays with lunch plates on them. The 2 trays on the second shelf were below waist level and they were uncovered. 3.1-21(i)(3)		Dietician in-serviced dietary staff on Proper Labeling and Dating of Food and Recording Food. Labels for dietary use indicate date received and dated of use. Dietary Manager in- serviced dietary department on food labeling practice: a. Food labeled applied when food item received, b. Food dated when removed from freezer c. Food dated when cooked. Dietary Manager will monitor food labeling and storage 5 days a week x 3 weeks then 3 days a week ongoing. Administrator/Designee will monitor food labeling and storage practices weekly. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Dietician will review food for proper labeling on each visit. Dietician will perform inservice of dating, labeling, using proper scoop size and proper serving. Dietary Manager will be responsible for ensuring food is labeled: -Upon purchase, Upon defrosting process, After it is cooked Dietary Manager will in-service dietary staff current and newly hired of proper food labeling. Newly hired Dietary Manager will	

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			monitor food items 5 times a week and complete log then 3 times a week depending upon findings. Administrator/Designee will monitor logs weekly for 3 months and assess dietary department practices. Q.A. Committee will monitor dietician reports, logs quarterly. Monitoring will continue for 6 months and Q.A. Committee will determine further monitoring.	
F 0867 SS=G Bldg. 00	483.75(g)(2)(ii) QAPI/QAA Improvement Activities §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; Based on observation, 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 severity and number of deficiencies cited involving quality of care for nutrition, sufficient and competent nursing staff, RN coverage, resident rights for visitation and dignity, labeling and storage of drugs, kitchen sanitation and food safety requirements, infection control and employing a qualified Infection Preventionist. This deficient practice affected 22 of 22 residents residing in the facility and resulted in harm for Resident 9 and Resident 15, who experienced	F 0867	Upon entrance of our annual survey D.O.N. was given a sign to be posted on the entrance stating the survey would be from Wednesday 4/21/21 through Monday 4/26/21. The D.O.N. discussed her availability during the entrance conference with surveyors. The D.O.N. stated to them that she would not be available on Saturday, April 24, 2021 and would be going out of town on Tuesday 4/27/2021 so she wanted to give them all the information they needed. D.O.N. was informed of QAPI/QAA Plan along with other	05/28/2021

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	significant weight loss. Findings include: During the Entrance Conference with the Director of Nursing (DON) on 4/21/21 at 10:15 a.m., she indicated the Quality Assessment and Assurance (QAA) Committee meets virtually at least quarterly and the committee consisted of the Medical Director, DON, the Dietitian, the Pharmacist, Physical Therapy (PT) and Occupational Therapy (OT). The Administrator was not identified by the DON as being an active part of the QAA committee. The DON was made aware on 4/26 at 5:45 p.m. that the survey QAA review had not been completed. She indicated the MDS Coordinator would complete the interview. The DON was asked at the time to be sure to leave any QAA information with the MDS Coordinator for review. The MDS Coordinator is part time, was hired on 6/29/20, and not part of any QAA activities. The DON was unavailable for any follow-up interview related to QAA prior to the Exit Conference, as she had boarded an airplane for an out of town vacation with the family, which included the Administrator. No one else was able to provide information in regards to QAA or if any quality issues had been identified for improvement. No QAA policy was provided for review. The QAA plan requested at Entrance Conference, provided during the survey by the DON, was a general outline of how to set up a QAA committee and what the committee should do, but nothing specific as to how the facility would monitor and correct quality issues.		entrance paperwork wanted by surveyors upon entrance. D.O.N. gave them the QAA Plan Policy and offered to leave all binders and other information normally, including but not limited QAA minutes reviewed by surveyors in their work area. Their response was they would ask me for what they wanted when they needed it. On Wednesday, 4/21/21 D.O.N. asked did they need anything else before leaving for the day. Their response on 4/21/21 was No. On Thursday, 4/22/21 D.O.N. was present and surveyors did not request any additional information from me. Their response on 4/22/21 was No. On Friday, 4/23/21 D.O.N. held a conference with all surveyors from 2:00p.m. until 4:15p.m. All information requested from D.O.N. was left for surveyors in their work area that evening so that it would be present for them on Saturday, since D.O.N. would not be available. Surveyors informed D.O.N. that they would be exiting on Monday. On Saturday, 4/24/21 D.O.N. was reached by phone and did speak to surveyors because they were concerned about the resident's son being able to visit in the building. No other information was requested. On Sunday, 4/25/2021 D.O.N. was in the facility from 7:00a.m. -5:00p.m. surveyors did not come	

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	During this survey, April 21, 22, 23, 24, 26, and 27, 2021, one deficiency was cited at the harm level, F692 Quality of Care for Nutrition. Multiple deficiencies were cited at a pattern or widespread scope of potential for more than minimal harm: F550 Resident Rights-Dignity, F563 Resident Rights-Visitation, F725 Sufficient Nursing Staff, F726 Competent Nursing Staff, F727 RN Staffing, F741 Sufficient/Competent Staff-Behavior Health Needs, F761 Labeling and Storing of Drugs, F812 Food Safety Requirements, F880 Infection Control, and F882 Infection Preventionist. There was no evidence the facility's Quality Assessment and Assurance Committee had identified the quality deficiencies and developed and implemented appropriate and effective measures to prevent these deficiencies as follows: 1. Quality of Care - Nutrition: The facility failed to ensure residents maintained acceptable parameters of nutritional status related to the failure to assistance with meals, meal consumption records not completed, supplements discontinued and/or not provided as ordered and weights not obtained for residents who were nutritionally at risk. This resulted in a significant weight loss for Resident 9 and Resident 15 and potential for weight loss for other residents. Residents 9 and 15 were observed during the survey to not receive adequate assistance and cuing during meals to ensure and encourage adequate food intake. Resident 9 had experienced a 7% weight loss and then continued to lose weight. Resident 15 had experienced a 14% weight loss. Quality of Care - Nutrition was also cited on Recertification surveys dated 11/20/19 & 3/28/19.		to survey the facility. On Monday, 4/26/2021 D.O.N. was present in the facility and awaited exit. She was informed by surveyors at 5:30p.m. that they would not be exiting. All surveyors were aware that D.O.N. would not be available on Tuesday, 4/27/2021. Surveyors did not request any information from the D.O.N. during the day nor prior to leaving for the day. D.O.N. is requesting that the record be corrected to indicate the proper date sequences. D.O.N. also requested information about RN waiver. D.O.N. was told that the information would be provided on Monday but it was not. The pandemic has caused a staffing shortage and although we have enough licensed nurses to cover the shifts 24 hours/7 days/365 year. Facility has been unable to secure additional RN staff so D.O.N. has functioned in that capacity when night RN is scheduled off and if any call-offs occur within the licensed staff she functions as the charge nurse. It has been an overwhelming year and waiver is need because in the short term the employment situation still appears to be grave with not enough RN or other staff seeking employment. D.O.N. needs the waiver for the 8 hour consecutive RN coverage to take care of some medical concerns neglected due to the pandemic.	

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	Cross reference F692. 2. Resident Rights - Dignity: The facility failed to ensure each resident's dignity was maintained related to a resident being pulled backwards down the hallway and lack of dining assistance for a dependent resident and the use of disposable plates and utensils during 11 of 11 meals observed. Resident Rights - Dignity was also cited on Recertification surveys dated 11/20/19 & 3/28/19. Cross reference F550. 3. Resident Rights - Visitation: The facility failed to offer indoor visitation of residents without stipulations, related to requiring all visitors to be COVID-19 tested and fully vaccinated before entering the facility, potentially affecting 22 of 22 residents who resided in the facility. Cross reference F563. 4. Sufficient Nursing Staff and Competent Nursing Staff: The facility failed to ensure there was a sufficient number of competent nursing staff available to provide nursing related services to assure resident safety was maintained during two person transfers and repositioning for residents who required the use of a Hoyer lift and to provide timely and complete hygiene and assistance with eating and activities, affecting 22 of 22 residents who resided in the facility. The staffing schedule from 3/1- 4/26/21 was reviewed on 4/26/21 at 3:30 p.m. There was only		D.O.N. is still requesting information. QAA Minutes are available. Corrections are as follows: D.O.N. was not made aware that surveyors wanted QAA minutes on 4/26/21 @ 5:45p.m. We had no discussion about MDS Coordinator would complete interview. Exit was supposed to be held on 4/26/21 and D.O.N. was not notified of the change until surveyors were exiting the building at 5:45p.m. D.O.N. would like the record to be corrected to include surveyors were aware that she would be unavailable on Tuesday, 4/27/21. The following information that I boarded an airplane for a vacation has no place in this report. Personal information should not be a part of a public record. So was it intentional not to survey on Sunday to extend the survey until Tuesday when D.O.N. would not be available. Residents Rights in regards, to using disposable plates, cups, and utensils should be corrected facility will continue due to resident's request which was discussed during Resident's Council Meeting. Resident Council President will review use of disposable utensils monthly with residents. Visitation will remain the same per resident's request during Resident's Council Meeting please	

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	155845	A. BUILDING 00 B. WING	04/27/2021

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SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN 46407

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	one CNA on the schedule who worked the midnight shift, or from 7:00 p.m., to 7:00 a.m. The rest of the direct care staff were Personal Care Assistants (PCAs). Interview on 4/23/21 at 10:00 a.m., with PCAs 1, 2, and 3 indicated they were not currently enrolled in a CNA class. All three of them knew what their limitations were and what they could and could not do. They all have worked with only two of them and no CNA. They have used the Hoyer lift with just themselves and no other staff. PCA 2 and PCA 3 had worked by themselves on 4/22/21 with no CNA during the day shift, and they both confirmed they did duties (transferring with the Hoyer lift) without a licensed staff member. The CNAs have walked out and quit. The situation with only PCAs working has been going on since March 2021. Interview with the PCA 4 on 4/26/21 at 1:50 p.m., indicated she has worked with PCA 2 or PCA 1, and they were the only direct care staff and had no other CNA work with them. The LPN will help when she can; otherwise, they were left to do the work by themselves. Interview with PCA 2 on 4/27/21 at 10:45 a.m., indicated 3 residents required Hoyer lift for transfers, 2 residents need extensive assist with 2 person physical assist for transfers and toileting, 4 residents needed extensive assist with 1 person physical assist for eating and 4 residents needed extensive assist with 2 person physical assist for bathing. Review of the COVID-19 Personal Care Attendant simulation/Competency check off sheets for PCAs 1, 2, and 3 indicated LPN 2 and CNA 2 had checked off their skills for return demonstration.		update finding. Residents stated, "We do not want any changes made you kept us safe from COVID and it is not over. People can visit through the glass doors and on the patio if they do not want to get a COVID test and not vaccinated." Resident Council President will review visiting practices monthly with residents. Nursing Staff the facility continues to place ads for help in all departments and call people for interviews, but people do not want to work. The state is aware of the shortages and sent temporary help with the National Guard, this was helpful. The facility has not had success in employing C.N.A.'s. The C.N.A's have not been good candidates some have had anger issues, cursing unbelievable, inappropriate sexual behavior, stealing, texting on facebook, drinking of alcohol, you name it they are doing it. D.O.N. spends more time teaching moral values and putting out fires between staff then ever before. The stimulus checks and extension of unemployment has caused additional problems. Employees will start working and quit and try to get unemployment benefits. D.O.N. has been swamped with unemployment hearings and letters of proof of termination. We have not been able to secure additional C.N.A.'s at this time but we are continuing	

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The Director of Nursing (DON) was made aware on 4/23/21 at 10:45 a.m., the PCAs could not transfer any resident by themselves with the Hoyer lift or transfer any resident who required two assist for transfers. There were no changes in the schedule after she was informed. She was also notified a CNA instructor was required to teach a PCA class.

Sufficient staffing was previously cited on a Recertification survey dated 11/20/19 and a complaint survey dated 2/27/18.

Cross reference F725 and F726.

5. RN Staffing:
The facility failed to ensure a Registered Nurse (RN) worked 8 consecutive hours in the facility on any given day, affecting 22 of 22 residents who resided in the facility.

The staffing schedules for 3/1-4/26/21 were reviewed on 4/26/21 at 3:30 p.m.
There was one RN who worked in the facility as a floor nurse. The other RNs who were employed at the facility were the DON and the MDS Coordinator.

The Director of Nursing was scheduled to work on 3/13, 3/14, 3/23, 3/27, 3/28, 4/10, 4/11, and 4/25/21. There was no evidence she worked those days as she does not punch in or out to document 8 consecutive hours of RN coverage. No other RN was scheduled to work those days.

RN 1's timecard was reviewed on 4/27/21 at 9:00 a.m. She did not work for 8 consecutive hours on 4/13/21, 4/17/21, 4/18/21, 4/24/21 and 4/25/21.

Provider's Plan of Correction:

to place ads and call people for interviews.

Month/Year RN LPN
C.N.A. P.C.A. ACTIVITIES
SS L/H/C DIETARY
Feb. 2020 5 7
10 0 2
2 4 5
March 2020 6 5
8 0 1
1 2 4
April 2020 4 6
5 7 1
1 2 3
May 2020 4 7
2 8 0
1 2 2

June 2020 2 5
2 11 0
1 2 3
July 2020 4 7
3 4 1
1 4 3
Aug. 2020 4 6
3 4 0
1 4 2
Sept. 2020 3 6
5 4 1
1 4 3
Oct. 2020 3 7
3 4 1

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	Interview with LPN 2 on 4/26/21 at 8:30 a.m., indicated the DON came into the facility on 4/25/21 and stayed for 45 minutes. Interview with the MDS Coordinator on 4/26/21 at 5:00 p.m., indicated she has not worked or covered for the RN coverage since February 2021. The DON does not punch in and out using the time clock to document 8 consecutive hours of RN coverage. She was aware there needed to be RN coverage every day for 8 consecutive hours. Inadequate RN coverage was also cited on a complaint survey dated 7/3/19. Cross reference F727. 6. Sufficient/Competent Staff-Behavior Health Needs: The facility failed to ensure staff were trained to care for residents with mental and psychosocial disorders for 3 of 5 employee records reviewed and 2 random staff observations of dementia care. Cross reference F741. 7. Labeling and Storing of Drugs: The facility failed to ensure the medication cart and medication room were locked at all times while unattended. The facility also failed to ensure all ointments were labeled and/or discarded after expiration, and medication was pulled from the correct medication cart for administration for 1 of 6 residents observed during medication pass. Labeling and storage of drugs was also cited on Recertification surveys dated 11/20/19, 3/28/19 & 4/12/17. Cross reference F761.		1 4 4 Nov. 2020 3 5 2 5 0 0 4 3 Dec. 2020 4 5 3 6 0 0 3 6 Jan. 2021 4 4 3 7 0 0 3 5 Feb. 2021 3 4 3 6 0 0 3 3 March 2021 4 4 2 4 0 0 4 4 April 2021 3 4 1 5 0 0 2 2 May 2021 2 4 3 4 0 0 2 3 Dementia training was previously performed by social designee this duty will be given to newly hired social worker to begin in 2 weeks. All licensed nurses are aware of the proper practices and will be disciplined by fine for deficient practices since we are unable to find licensed nurses seeking employment. Newly hired dietary manager and dietician will address past deficiencies. Newly hired MDS Coordinator will address all MDS, Care Plan deficiencies. Infection Control In-servicing will be ongoing for hand sanitation.	

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	8. Kitchen Sanitation and Food Safety Requirements: The facility failed to serve, store, and prepare food under sanitary conditions related to food not dated when opened, meals served uncovered below waist level, old produce, and improper glove use during food handling in 1 of 1 kitchen, potentially affecting the 21 of 22 residents who received their meals from the kitchen. Kitchen sanitation was previously cited on Recertification surveys dated 11/20/19, 3/28/19 & 6/15/18 and complaint surveys dated 11/9/18 & 2/27/18. Cross reference F812. 9. Infection Control: The facility failed to ensure infection control guidelines were in place and implemented, including those specific to properly prevent and/or contain COVID-19, related to personal protective equipment (PPE) not worn properly with resident interaction, hand hygiene not completed after direct resident contact and glove removal, and not monitoring for signs and symptoms of COVID-19 for random observations for infection control on 2 of 2 halls and the Main Dining Room. Infection control was previously cited on Infection Control surveys dated 10/23/20 & 9/18/20, Recertification surveys dated 11/20/19, 3/28/19 & 6/15/18, and Complaint surveys dated 7/3/19 & 2/27/18. Cross reference F880. 10. Infection Preventionist: The facility failed to ensure the designated		Despite infection control surveys, the facility has maintained a COVID-FREE Environment since the pandemic. Our staff continues to be tested 2 times a week. The residents have been 99% vaccinated. Entire facility is a Green Zone now if visitors can come off the street without being vaccinated or take a COVID quick test and just need a mask why is it necessary for us to be shielded and goggled to provided care when everyone is Green. We have no one in Yellow Precautions. Surveyors did not request to see our infection control nurse; arrangements would have been made for them to see her or speak to her over the phone. Our Infection Control Nurse has had many personal obstacles in her family during the pandemic. D.O.N. will consult with infection control nurse to see if she can handle taking the Infection Preventionist Course at this time. It is predicted that July will end additional benefits and more people will return to the workplace. All of the issues will be addressed but we are just coming back to some normalcy since the begin of the COVID Pandemic, however people are still acquiring COVID in our community and dying. F867: This citation is strictly related to the overall facility monitoring and management via a	

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	Infection Preventionist (IP) completed specialized training in infection prevention and control. The employee record for LPN 3, the facility designated Infection Preventionist (IP) was reviewed on 4/26/21 at 2:45 p.m. She was hired on 3/9/2004. There was no documentation to indicate she had completed any specialized IP training. LPN 3 was unavailable for interview. During the Infection Control interview with the Director of Nursing on 4/26/21 at 4:10 p.m., she indicated the LPN had not yet completed the IP training. Cross reference F882. 11. In addition to the above deficiencies, the following deficiencies were cited on this survey at an isolated scope with potential for more than minimal harm and had been cited previously as follows: - F657 Care Plan Timing and Revision was previously cited on Recertification surveys dated 11/20/19 & 3/28/19. - F676 Activities of Daily Living (ADLs) was previously cited on Recertification surveys dated 11/20/19 & 3/28/19. - F677 ADLs for Dependent Residents was previously cited on a Recertification survey dated 11/20/19. - F679 Activities was previously cited on Recertification surveys dated 11/20/19, 3/28/19 & 6/15/18 and a Complaint survey dated 9/1/17. - F684 Quality of Care was previously cited on Recertification surveys dated 11/20/19 & 3/28/19. - F686 Pressure Ulcers was previously cited on Recertification surveys dated 11/20/19, 3/28/19 & 6/15/18 and a Complaint survey dated 2/14/19. - F689 Accidents/ hazards was previously cited on		QAPI program involving the Administrator and entire QAA committee on a regular basis. All other citation information should be with those specific citations. Please revise POC to indicate what changes will be made to and by the entire QAA committee and processes to address and correct ongoing recurrent deficient practice, including, but not limited to, frequency & duration of discussion & monitoring, who will be in charge of each area monitoring, and specific areas of expertise on the committee to involve. Please make sure indicated correction date corresponds to when the facility will have this completed. Please also refer to F563 CMS and IDOH visitation REQUIREMENTS not subject to facility interpretation or change. Addendum: Overall facility monitoring and management under the QAPI program. Management of Simmons Loving Care via QAPI program involving Administrator and QAA Committee on a regular basis is Excellent. It is not the management that causes the deficient it's the employees. They are trained, they are monitored, their deficient practices identified. The one key factor is that management can not work 24	

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	Recertification surveys dated 11/20/19 & 6/15/18 and Complaint surveys dated 12/13/19 & 2/27/18. - F698 Dialysis was previously cited on Recertification surveys dated 11/20/19, 3/28/19 & 6/15/18 - F744 Dementia Care was previously cited on Recertification surveys dated 11/20/19, 3/28/19 & 6/15/18, all of which also included the same resident identified as Resident 15 in this current survey. - F758 Unnecessary Psychotropic Medications was previously cited on Recertification surveys dated 11/20/19, 3/28/19 & 6/15/18. - F760 Significant Medication Errors was previously cited on a Recertification survey dated 11/20/19. - F805 Proper Food Form was previously cited on a Recertification survey dated 11/20/19. 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. 3.1-52(b)(2)		hours a day in all departments and currently you cannot replace the employees doing the deficient practices. COVID has caused great staffing shortages and employees are working in several capacities to fulfill the needs of the residents and facility. On every deficient practice the staff knew better such as Medication Errors, Improper Accu-Check, Improper Flushing, Pulling resident backward in chair, Documentation, ADL, showers, nails cut… every charge nurse is aware of the practice. Previous MDS Coordinator knew how to read and knew drug classifications, side rails as enablers, care plan revisions. Dietary knows to label and date, how to do a pureed diet, recipe book, portions, use of tray cards. Management has needed help, but no one has applied for the positions and also our rates were not competitive with big chains who are able to offer benefits. The financial impact that you place on us with fines cripples us from being able to succeed. We have now been able to secure a RN who is just excellent, old school with good work ethic and will be able to train the staff using different techniques to meet the different styles of learning and learning deficiencies displayed by employees since she is able to teach on a Doctorate level.	

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			So, the DON and RN Supervisor are developing a new training method to meet every employee needs. After that they will be terminated if they cannot meet our standard. Management, Administrator and DON have not taken a salary for over 5 years to keep the facility afloat. Instead of fining us listen to us. COVID should be a learning experience and I ask the question who fought COVID better the big chains or small facilities. The small facility gives you a true picture of what is going on in the work environment because they do not have the luxury of calling corporate to send more employees when there is a survey, nor having people to do one thing so that everything looks good on paper but in reality it is a different story. I do not know what the future holds but I know we do a good job with our residents do I know where our faults, YES. Is it discussed in QAA Committee, YES, currently we can do no more than what we are doing due to the employment situation, No One Wants To Work. Why do I say we do a good job. I had 22 residents during the survey 1 a hospice resident. No facility acquired decubitus, the food is good and all meals are homemade, the residents complain but they are happy, we are their family. The	

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			residents are thankful that we kept them safe during the pandemic. So how do I know we do a good job after over a year of living thru a world catastrophe we lost not one resident or employee to COVID-19. The management along with the QAA Committee will have our problems but we will meet the challenge and the repeated issues in this survey will no longer be after we have had time to regroup. We are on the dawn of great things and we hope you will be supportive of our efforts and give us credit for all that we do. New training program for licensed nurses will begin 7/1/21 and ongoing. New training program for P.C.A. while awaiting C.N.A. programs 6/28/21 ongoing. New training program for Dietary Department 7/15/21 Hiring of Social Worker and Social Designee 7/18/21 hopefully we can employee more C.N.A. and a P.C.A. can take the SSD program. Hiring of new Activity Director 7/18/21. We have a Activity Director who is on sick leave but if we can employee more C.N.A. a P.C.A. can take the Activity Director’s course. One huge replacement is being sought and that is to hire a DON so that the DON can transition to Administrator.	

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			New visitation guidelines are out on 6/11/2021 and will be reviewed and discussed with residents, their families and QAA Committee by June 25, 2021 our next QAA Meeting.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, 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			

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	persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and	F 0880	F880 None of these findings were	05/28/2021

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	interview, the facility failed to ensure infection control guidelines were in place and implemented, including those specific to properly prevent and/or contain COVID-19, related to personal protective equipment (PPE) not worn properly with resident interaction, hand hygiene not completed after direct resident contact and glove removal, and not monitoring for signs and symptoms of COVID-19 for random observations for infection control on 2 of 2 halls and the Main Dining Room. (The West and East halls, the Main Dining Room, and Residents B, E, C, 11, 3, F, and 124) Findings include: 1. On 4/22/21 at 12:33 p.m., Unit Manager 2 was observed assisting PCA 1 with repositioning a resident in a geri chair recliner in the Main Dining Room. After assisting the PCA, the Unit Manager did not wash her hands or use hand sanitizer. The Unit Manager remained in the dining room at the time. At 12:36 p.m., Resident B was yelling out and Unit Manager 2 was rubbing his shoulder with her hand. She did not use hand sanitizer when done. She then assisted Resident E with his beverages and did not use hand sanitizer prior to helping the resident. Interview with the Director of Nursing on 4/26/21 at 5:00 p.m., indicated the Unit Manager should have used hand sanitizer after each direct resident contact. 2. During random observations on 4/21/21 the following was observed: At 8:55 a.m., PCA 2 was observed sitting and feeding Resident B. The PCA was within 6 feet of the resident and he was not wearing a face shield.		discussed with D.O.N. on 4/24/21. - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Handwashing and hand sanitation policy reviewed with all staff. Accu-Check Policy and Disposal of Biohazard/Sharps waste policy reviewed with nursing staff. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No one affected but potential present. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; D.O.N. reviewed handwashing policy with all staff and will complete speedy hand and PPE audit evaluations on all nursing staff weekly ongoing, so that tracking and trends can be established, and deficient practices addressed promptly. D.O.N reviewed Accu-Check Policy and Disposal of Biohazard waste policy reviewed with all charge nursing staff this will be ongoing with current staff and newly hired staff monthly. D.O.N. will review	

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	155845	A. BUILDING 00 B. WING	04/27/2021

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	At 9:00 a.m., CNA 1 was observed feeding Resident E. The CNA was within 6 feet of the resident and she was not wearing a face shield. At 12:30 p.m., PCA 1 was observed wearing a face shield over her face, however, her surgical face mask was below her nose and only covering her mouth. At 12:30 p.m., LPN 2 was observed feeding and assisting Resident B with her face shield on top of her head and not covering her face. She was sitting within 6 feet of the resident. At 12:56 p.m., PCA 1 continued to pass trays and assist residents with her face mask below her nose and only over her mouth. 3. During a random observation on 4/23/21 at 8:32 a.m., PCA 2 was observed sitting next to Resident C assisting him with his breakfast meal. The PCA was not wearing a face shield. At that time, PCA 1 was observed passing beverages to the residents in the dining room with her goggles on top of her head and not over her face. 4. On 4/22/21 at 9:30 a.m., during medication pass observation, LPN 2 was observed preparing and pouring medication for Resident 11. She walked into the resident's room and administered her oral medication first and then walked back to the medication cart and donned clean gloves to both hands without performing hand hygiene. She took the basket of lancets, strips and the glucometer into the resident's room. She removed a strip, and placed it into the glucometer. She wiped the resident's finger with a alcohol wipe and pricked her finger with the lancet, and obtained the blood on the strip. The resident's blood sugar		transmission-based precautions (TBP) related to COVID-19 to all licensed nurses again. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Reports from each department will be given to Q.A. Committee for review quarterly. D.O.N. will provide handwashing evaluations on all nursing staff current and new hires monthly ongoing. D.O.N. will evaluate Accu-Check procedures of all current licensed nurses and newly hired licensed nurses monthly. D.O.N. will review all new admission orders for TBP related to COVID-19. D.O.N reviewed Accu-Check Policy and Disposal of Biohazard waste policy reviewed Date 5/28/2021 F880: Please indicate if random observation rounds for infection control practices, including handwashing and proper PPE, will be completed on all shifts including weekends to ensure compliance after inservicing. Addendum Infection control practices including handwashing and proper PPE will be completed by charge	

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	was 65. She removed her gloves and rolled them into a ball with the lancet inside of the gloves and walked out of the room. She threw the gloves and lancet away in the garbage can on the side of the medication cart. She donned a clean pair of gloves, without performing hand hygiene and pulled out a sani wipe and cleaned the glucometer. Interview with the LPN at that time, indicated she was aware she was supposed to throw the lancet away in the sharps container and not the garbage can. Interview with the MDS Coordinator on 4/26/21 at 5:00 p.m., indicated hand hygiene was to be performed after glove removal and the lancet should have been disposed of in the sharps container. The Director of Nursing was not available for interview. There was no policy available for review.5. The COVID-19 infection monitoring was reviewed on 4/26/21 at 3:00 p.m. for Residents 3, C, and F. There was no documented monitoring of signs and symptoms of COVID-19 at least daily. Interview with the Director of Nursing on 4/26/21 at 4:10 p.m., indicated all of the 22 residents residing in the building were free from COVID-19 and should be monitored for signs and symptoms at least daily. 6. The COVID-19 monitoring for Resident 124 was reviewed on 4/26/21 at 3:30 p.m. She was admitted to the facility on 4/5/21. There were no Physician's Orders to indicate the		nurse everyday and every shift. The monitoring will be located on the nurse rounds log.	

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	resident was placed on Transmission Based Precautions (TBP) related to COVID-19 monitoring for newly admitted residents to the facility. The 4/2021 Treatment Administration Record indicated there was no documentation to indicate the resident was monitored every shift for COVID-19 signs and symptoms for 14 days. Interview with the Director of Nursing on 4/26/21 at 4:10 p.m., indicated resident was placed on droplet-contact TBP for 14 days, however, she was not monitored for signs and symptoms every shift. 3.1-18(b)			
F 0882 SS=F Bldg. 00	483.80(b)(1)-(4)(c) Infection Preventionist Qualifications/Role §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality			

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	assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.			
	Based on record review and interview, the facility failed to ensure the designated Infection Preventionist (IP) completed specialized training in infection prevention and control. Finding includes: The employee record for LPN 3 was reviewed on 4/26/21 at 2:45 p.m. She was hired on 3/9/2004. There was no documentation to indicate she had completed any specialized IP training. Interview with the Director of Nursing on 4/26/21 at 4:10 p.m., indicated LPN 3 was identified as the facility's IP, but had not yet completed the IP training.	F 0882	F882 Refer to F867 F882: Please submit a POC specific to this citation regarding IP training and assign compliance date accordingly as to when this correction will be completed. Please include how monitoring will occur and who will be responsible. The employee record for LPN 3 was reviewed on 4/26/21 at 2:45 p.m. She was hired on 3/9/2004. There was no documentation to indicate she had completed any specialized IP training. Interview with the Director of Nursing on 4/26/21 at 4:10 p.m., indicated LPN 3 was identified as the facility's IP, but had not yet completed the IP training. LPN 3 who has been our infectious nurse for several years is currently not willing to take the IP training at this time. This opportunity will still be made available to her and once staffing stabilizes she will reconsider. LPN 3 will continue to perform her infectious documentation and it will be reviewed by the RN	05/28/2021

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			Supervisor and DON. RN Supervisor/Trainer will be responsible for monitoring infection control practices. DON will perform audits with useful internet tools such as speedy audit which is a hand washing audit tool. DON will also check COVID rates for county weekly to determine PPE usage. Facility will determine in a month who will be able to take the IP training, either RN Supervisor or DON until other nursing staff is able to assume this responsibility. 7/18/21 There was no addendum submitted for F882: F882: Please submit a POC specific to this citation regarding IP training and assign compliance date accordingly as to when this correction will be completed. Please include how monitoring will occur and who will be responsible. The RN Nurse Supervisor has had infection prevention training in the past but has started the CDC Infection Prevention Control for LTC modules online. The nurse consultant will evaluate completion of the modules during the week of July 18, 2021, which is our target date for completion of the course.	

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			Infection Control monitoring will be responsible for infection control training and compliance. Current staff has been in-serviced on infection control by the nurse supervisor who has monitored all nursing staff on all shifts 4-5 days a week, ongoing. D.O.N. monitors all staff for infection control compliance practices 5-6 days a week all shifts, ongoing. Unit Manager monitors staff for infection control compliance 5 days a week, ongoing. After completion of all modules the RN Supervisor will be certified as our Infection Preventionist (IP). Q.A. Committee will be informed of the completion of the modules and the ongoing monitoring of infection control practices. This will be discussed monthly until staffing is more stable then quarterly ongoing.	
F 0909 SS=D Bldg. 00	483.90(d)(3) Resident Bed §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. Based on observation, record review, and interview, the facility failed to ensure the resident's side rails were securely attached to their	F 0909	F909 D.O.N. informed of side rails on Friday 4/23/21 not 4/26/21 - What corrective action(s) will	05/28/2021

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	beds for 2 of 2 residents reviewed for accidents. (Residents 6 and 13) Findings include: On 4/21/21 at 2:30 p.m., Resident 6 was observed in bed. At that time the 1/4 side rail was observed in the up position and was loose and pulling away from the bed. The record for the Resident 6 was reviewed on 4/22/21 at 1:10 p.m. Diagnoses included, but were not limited to, high blood pressure, chronic pain, dysphagia, type 2 diabetes, assault by shotgun, stroke, hemiparesis, major depressive disorder, convulsions, and psychosis. The Quarterly Minimum Data Set (MDS) assessment, dated 1/10/21, indicated the resident was not cognitively intact, and severely impaired for decision making. The resident needed extensive assist with 2 person assist for bed mobility and transfers, and extensive assist with 1 person assist for eating, toileting, and dressing. The resident weighed 155 pounds and a significant weight loss noted. The resident received a mechanically altered and therapeutic diet. In the last 7 days the resident received insulin, an antidepressant medication, and a hypnotic medication. Bed rails were coded as being a restraint and used daily. A Care Plan, dated 3/10/21, indicated the resident used (1/2 bed rails) to enable repositioning. The resident utilized side rails for turning and repositioning purposes. Interview with the Director of Nursing on 4/26/21 at 4:00 p.m., indicated the side rail should be tightened on the resident's bed and were not a		be accomplished for those residents found to have been affected by the deficient practice; Maintenance Supervisor replaced the side rail and continues to check proper use of side rails weekly. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No other resident affected. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Supervisor will continue to monitor side rails weekly for proper use and use log sheet for replacements. In-Service with nursing department on reporting repairs reviewed. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Maintenance Supervisor will report to Administrator all repairs performed weekly. Q.A. Committee will review repair logs semi-annually. - by what date the systemic changes 5/28/2021	

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	restraint. 2. Observation on 4/21/21 at 11:10 a.m. the 1/4 side rail on Resident 13's bed was loose and was pulling away from the side of the bed. The resident indicated the side rails moved when she tried to get out of bed. The record for Resident 13 was reviewed on 4/24/21 at 9:40 a.m. Diagnoses included but were not limited to, sciatica, hallucinations, bipolar disorder, high blood pressure, carpal tunnel, and osteoarthritis. The Quarterly Minimum Data Set (MDS) assessment, dated 3/9/21, indicated the resident was cognitively intact. She does not receive scheduled or prn pain medication. Bed rails were coded as a restraint and used daily. A Care Plan, dated 3/9/21, indicated the resident used 1/2 bilateral side rails when in bed as an enabler to reposition. Interview with the Director of Nursing on 4/26/21 at 4:00 p.m., indicated the side rail should be tightened on the resident's bed and were not a restraint. The Maintenance Director was unavailable for interview regarding preventative maintenance or repair schedules. 3.1-45(a)(1)		F909: Please indicate what the facility did to determine no other residents were affected All residents beds were checked and no other side rails were loose. The facility would love to purchase new electric beds for every resident, but the fine process prevents us from doing the updates that our residents in our community need and deserve.	
F 9999 Bldg. 00	3.1-14 PERSONNEL	F 9999	**F-9999** PERSONNEL	05/28/2021

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	(k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) moths, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.		- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Administrator reviewed of policy with Unit Manager responsible for employee files. Physical Examination within 1 month prior to employment. Mantoux within 1 month prior to employment. Mantoux 2nd step within 3 weeks on first step Mantoux Mantoux must be repeated annually, and chest x-ray is good for 2 years if employee is allergic to Mantoux. New hires 6-hour Dementia Training Annual 3-hour Dementia Training All employee records reviewed. All employees' resident's rights and abuse policy, dementia training and TB testing was updated. Annual Residents Rights and Abuse Policy Reviewed and will be reviewed every January each year. Annual Dementia Training will be reviewed every January each year. Annual Mantoux will be performed every January of each year. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;	

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	(u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure each employee received a Mantoux tuberculin (TB) skin test at least annually for 3 of 5 employees reviewed. (The Dietary Manager and LPN 2 and 3) Findings include: The employee records were reviewed on 4/27/21 at 9:15 a.m. and indicated the following: a. Dietary Manager, hired on 2/27/18, had no annual resident rights, abuse, TB test, or dementia training completed in 2020. b. LPN 2, hired on 12/9/19, had no annual resident rights, abuse, TB test, or dementia training completed in 2020. c. LPN 3, hired on 3/9/2004, had no annual resident rights, abuse, TB test, or dementia training completed in 2020.		No residents affected. - what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; In-Service held employee annual updates reviewed. In-Service held on proper documentation of new employee checklist form and annual review. Unit Manager designated to do employee files. New Employee Checklist will accompany every employee file. Administrator will review check off list of all new hires and review annual employee records. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Employee who is the custodian of the employee's health records will give copies of the employee checklist to the Administrator and D.O.N. Administrator and/or D.O.N. will review all new hires employee checklist form. Administrator and/or D.O.N. will review annually review employees file for updated health information. Q.A. Committee will review new policy and checklist for new employees semi-annually to ensure compliance. -	

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			by what date 5/28/2021	