STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155799	A. BUILDING 00 B. WING	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE MARION LLC	614 WEST 14TH STREET MARION, IN 46953

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaints IN00432449, IN00435594, and IN00437639. This visit included a State Residential Licensure Survey. Complaint IN00432449 - Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00435594 - No deficiencies related to the allegations are cited. Complaint IN00437639 - No deficiencies related to the allegations are cited. Survey dates: June 24, 25, 26, 27, 28, and July 1, 2024 Facility number: 012809 Provider number: 155799 AIM number: 201136580 Census Bed Type: SNF/NF: 51 SNF: 4 Residential: 13 Total: 68 Census Payor Type: Medicare: 4 Medicaid: 35 Other: 16 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deana Jordan Collins	Regional Nurse Consultant	08/01/2024

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

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	Quality review completed July 12, 2024.			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review the facility failed to obtain physician orders for medications and assess residents for self-administration of medications for 2 of 2 residents with medications stored in their rooms. (Resident 35 and Resident 52) Findings include: 1. During an observation, on 6/24/24 at 11:38 a.m., a mometasone furoate nasal spray (used to treat and prevent symptoms of seasonal and perennial hay fever) was on Resident 52's bedside table. Resident 52 indicated she gave herself a spray in each nostril in the morning and evening. During an observation, on 6/26/24 at 12:41 p.m., the nasal spray remained on the resident's bedside table. During an observation, on 6/27/24 at 2:37 p.m., the nasal spray remained on the resident's bedside table. Resident 52's clinical record was reviewed on 6/25/24 at 2:19 p.m. and lacked a physician's order for mometasone furoate spray and a self-administration of medication assessment. During an interview, on 6/27/24 at 3:57 p.m., LPN 8 indicated the residents were permitted to have medications in their rooms if there was a may keep	F 0554	**Tag number: F554** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ; **Residents 35 and 52 had Self Administration of Medication Assessment Completed on 07/06/2024 for Resident 52 and 07/24/2024 for Resident 35.** II. 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 with the potential to self-administer medications have the potential to be affected by the alleged deficient practice. The Director of Nursing/designee audited all facility residents and found no other resident has the ability to self-administer medications.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to re-educate nursing staff on**	07/24/2024

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	at bedside order (MKABS). The resident must also be assessed to see if they met criteria for a MKABS order. The family had probably brought in the nasal spray for the resident. During an interview, on 6/28/24 at 11:22 a.m., LPN 7 indicated for residents to keep medications in their room, they must have a MKABS order and have an assessment completed that determines they meet criteria to self-administer medications. During an interview, on 6/28/24 at 5:06 p.m., the DON indicated residents should not have medications in their rooms unless they have a MKABS order and a self-administration assessment completed indicating the resident meets criteria for self-administration of medications. 2. During an observation, on 6/25/24 at 10:26 a.m., Resident 35 had a tube of nystatin triamcinolone ointment (for fungal skin infections) setting in a cup holder on her recliner and an albuterol sulfate inhaler placed on her bedside table. Resident 35 indicated the inhaler was her rescue inhaler, and the staff had left the cream in her room for her to apply herself as she needed. During an observation, on 6/27/24 at 9:59 a.m., the resident was assisted back to her room by a staff member. The albuterol inhaler remained on her bedside table. The nystatin cream remained in the cup holder portion of her recliner. Resident 35's clinical record was reviewed on 6/26/24 at 9:23 a.m. She had a current physician's order for albuterol sulfate HFA Aerosol Solution 108 (90 Base) MCG/ACT 2 puff inhale orally every 4 hours as needed for SOB, unsupervised self-administration, may keep at bedside		**evaluation/assessment of residents for Self-Administration of Medications.** IV. 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; **DON/designee will conduct an audit of all new and re-admissions the next business day post admission to determine resident's ability to self-administer medications**. **Audits will be completed during clinical meeting 5x a week x 4 weeks, 3x a week x 4 weeks, then weekly x 4 months.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	(12/13/23). She lacked an order for nystatin triamcinolone cream. The clinical record lacked a self-administration of medication assessment. During an interview, on 6/27/24 at 3:57 p.m., LPN 8 indicated the resident had a MKABS order for her albuterol inhaler. She did not have an order for the nystatin triamcinolone and should not have it in her room. During an interview, on 6/28/24 at 5:06 p.m., the DON indicated the residents should not have medication in their rooms unless they had a MKABS order and a self-administration of medication assessment completed. The nurses were to complete a self-administration of medication assessment to see if a resident met criteria when a MKABS ordered was obtained. She was unable to locate a self-administration of medication assessment for Resident 35. A current, undated facility policy, provided by the Administrator on 7/1/24 at 4:34, titled "Self-Administration of Medication," indicated the following: " ...A resident may not be permitted to administer or retain any medication in his/her room unless so ordered, in writing, by the attending physician ...b. Only medications permitted for self-administration shall be left at the bedside; c. A self-administration of medications assessment will be completed that indicates that the resident is capable of self-administering drugs ...." 3.1-11(a)			
F 0578 SS=D	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv			

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Bldg. 00	Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such			

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	information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on interview and record review, the facility failed to ensure advance directives were developed and signed by the resident, who was cognitively intact and their own representative, for 1 of 2 residents reviewed for advance directive. (Resident 35) Findings include: Resident 35's clinical record was reviewed on 6/26/24 at 9:23 a.m. Diagnoses included unspecified adrenocortical insufficiency (Addison's disease), epilepsy, unspecified, not intractable, without status epilepticus, and cirrhosis of liver. Current physician's orders included full code (9/7/23). An admission Minimum Data Set (MDS) assessment, dated 9/9/23, indicated the resident was cognitively intact. An Indiana Physician Orders for Scope of Treatment (POST) form was completed on 9/7/23. Section E indicated in order for the POST form to be effective the patient or legally appointed representative must sign and date the form. Under the signature of patient or legally appointed representative section, the resident's representative had signed the form on 9/7/23. The resident's profile indicated the resident was the responsible party and the health care decision maker. The resident's record lacked documentation of a	F 0578	**Tag number: 578** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident 35 signed a POST form on 07/23/2024** II. 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 have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure all POST forms were signed by the appropriate person** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to educate nursing staff/social services on the policy Advanced Directives to include when a resident is capable of signed the form** IV. 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**; DON/designee will audit all new admissions/re-admission to ensure the POST form has been signed by the correct**	07/24/2024

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	guardian, a health care representative, or a power of attorney. During an interview, on 7/1/24 at 2:28 p.m., the DON indicated when the resident came into the facility, her family accompanied her and signed some of the paperwork. She was uncertain why the POST would have been signed by her representative instead of the resident. She indicated Social Services should know about it. During an interview, on 7/1/24 at 3:09 p.m., the Social Services Director indicated she did not go over advance directives with the residents and their families. The nursing department was responsible for ensuring the advance directives were completed. During an interview, on 7/1/24 at 3:42 p.m., the Administrator indicated she was uncertain who completed the advance directives with the residents and their representatives. During the same interview, the Business Office Manager (BOM) indicated the nursing department assisted the residents and their representatives with advance directives, then the ADON reviewed the advance directives. During an interview, on 7/1/24 at 3:45 p.m., the BOM indicated the resident lacked documentation on file for a guardian, healthcare representative, or power of attorney. During an interview, on 7/1/24 at 4:30 p.m., the ADON indicated she collected the advance directives and made sure the orders matched the signed advance directives. The resident cried a lot when she was admitted to the facility, so the resident representative may have signed for her.		**person. Audits will be completed during clinical meeting 5x a week x 4 weeks, 3x a week x 4 weeks, then weekly x 4 months.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated	

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	A current facility policy, revised 8/14/18, provided by the Administrator on 7/1/24 at 4:34 p.m., titled "Advance Directives" indicated the following: " ...If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. 5. The facility will provide this information to the individual once he or she is able to receive such information. This will be determined by Social Service and/or attending physician assessment of the resident to determine if the resident is capable of understanding and is able to make a decision regarding advance directives ...7. A resident who has not been declared legally incompetent or found by their attending physician to be capable of making a decision may exercise the right to participate in decision making concerning their health care and medical treatment ...." 3.1-4(f)(7)			
F 0582 SS=A Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and			

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

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	requirements of these regulations. Based on interview and record review, the facility failed to provide notification of Medicare non-coverage for 1 of 3 residents reviewed for beneficiary protection notifications. (Resident 11) Finding includes: On 6/27/24 at 4:00 p.m., the SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review Forms were reviewed, and indicated the following: Resident 11 was admitted to Medicare Part A Skilled Services on 4/19/24. The last covered day of Part A services was 5/31/24. The clinical record lacked Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN). During an interview, on 6/28/24 at 3:56 p.m., the Administrator indicated the Resident 11 had remained in the facility and an SNF ABN was not completed for Resident 11. During an interview, on 7/1/24 at 3:58 p.m., the Vice President of Operations indicated the facility did not have a policy on the SNF ABN. The facility followed the Centers for Medicare and Medicaid Services (CMS) regulations. 3.1-4(f)(3)	F 0582	**Tag number: F582 – Medicaid/Medicare Coverage Liability Notice** I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident 11 is no longer on a skilled level of service at the facility.** II 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 with skilled level of service ceasing and going to a non-skilled level of service have the potential to be affected by the alleged deficient practice. The Administrator/designee audited all facility residents and found no further issues as of current – 7-23-2024.** III What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administrator/designee to re-educate Social Services and Business Office Manager on the requirement of needing to provide residents/responsible**	07/24/2024

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			parties ABN notices when skilled level of services cease and resident moves to a long-term care non-skilled level of service. IV 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. **Administrator/designee will conduct an audit of all residents receiving skilled level of service to ensure ABN notices are given when residents cease skilled level of service and transfer to long-term care non-skilled level of service. The audit will be done weekly for 12 weeks** or until an average of 90% compliance or greater is achieved x4 consecutive weeks. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility	F 0641	**Tag number: F641**	07/24/2024

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	failed to accurately code medications on the Minimum Data Set (MDS) assessments for 1 of 3 residents reviewed for medication use. (Resident D) Finding includes: Resident D's clinical record was reviewed on 6/25/24 at 4:12 p.m. Diagnoses included depression, delusional disorders, hallucinations, unspecified, vascular dementia, moderate, with agitation, and atherosclerotic heart disease of native coronary artery (a build-up of fats, cholesterol, and other substances in and on the artery walls causing obstruction of blood flow) without angina pectoris (chest pain). Current physician orders included the following: clopidogrel bisulfate (antiplatelet - used to inhibit blood clot formation) 75 mg daily (11/20/23), mirtazapine (antidepressant) 7.5 mg daily at bedtime (2/16/24), risperidone (antipsychotic) 0.5 mg daily in the morning (3/2/24), risperidone 1 mg daily at bedtime (3/1/24), and sertraline (antidepressant) 100 mg daily (1/24/24). A quarterly MDS assessment, dated 2/20/24, indicated the resident received insulin. The assessment did not indicate the resident received an antidepressant or an antiplatelet. The resident's medication administration record (MAR) for February 2024 indicated the resident received an antiplatelet medication (clopidogrel bisulfate) on 2/16/24, 2/17/24, 2/18/24, and 2/19/24. The resident received an antidepressant at bedtime (mirtazapine) on 2/16/24, 2/17/24, 2/18/24, 2/19/24, and 2/20/24 and an antidepressant (sertraline) in the morning on 2/16/24, 2/17/24, 2/18/24, and 2/19/24.		I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident D's MDS will be modified and transmitted.** II. 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 have the potential to be affected by the alleged deficient practice. The MDS coordinator was educated on the RAI manual procedure for coding medications** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; MDS coordinator will be re-educated on the MDS process and accuracy of MDS.**="" b="">** IV. 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; DON/designee will review 5 MDS/week for4 weeks, then 3 MDS/week for 4 weeks, then 1 MDS/week for 4 weeks, then 1 MDS/month for 3 months for accuracy and modifications will be made as indicated.="" b="">
The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90%	

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	A quarterly MDS assessment, dated 5/5/24, indicated the resident received insulin and did not receive an antipsychotic. The assessment did not indicate the resident received an antidepressant or an antiplatelet. The resident's MAR for May 2024 indicated the resident received an antiplatelet (clopidogrel bisulfate) on 5/2/24, 5/3/24, and 5/4/24. The resident received an antidepressant (mirtazapine) at bedtime on 5/3/24 and 5/4/24 and an antidepressant (sertraline) in the morning on 5/2/24, 5/3/24, and 5/4/24. She received an antipsychotic (risperidone) in the morning on 5/2/24, 5/3/24, and 5/4/24 and at bedtime on 5/3/24 and 5/4/24. During an interview, on 6/28/24 at 2:19 p.m., the MDS coordinator indicated she had reviewed the MAR prior to completing the MDS. She had seen where the resident had often refused medications and had thought the resident had refused the medications during the assessment windows. The resident had received an antidepressant, an antiplatelet, and an antipsychotic medication during the May assessment window. The resident did not receive an antipsychotic in the February assessment window, as it had not been ordered at that time. During an interview, on 7/1/24 at 3:58 p.m., the Vice President of Operations indicated the facility utilized the Resident Assessment Instrument (RAI) manual for the MDS policy. The RAI manual, version 1.18.11, October 2023, indicated " ...High-Risk Drug Classes: Use and Indication ...Coding Instructions ...Code all high-risk drug class medications according to		compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	their pharmacological classification, not how they are being used ...Antipsychotic: Check if an antipsychotic medication was taken by the resident any time during the 7-day look-back period ...Antidepressant: Check if an antidepressant medication was taken by the resident any time during the 7-day look-back period ...Antiplatelet: Check if there is an indication noted for all antiplatelet medications taken by the resident any time during the observation period ...."			
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 provide grooming assistance (Resident C and D) and provide scheduled showers (Resident D) for 2 of 4 residents reviewed for activities of daily living (ADLs). Findings include: 1. During an interview, on 6/25/24 at 11:43 a.m., Resident D's representative indicated the resident's fingernails were always dirty. During an observation, on 6/25/24 at 4:26 p.m., Resident D was lying in bed. Her fingernails had a brown substance under the tips. During an observation, on 6/26/24 at 9:44 a.m., the resident was lying in bed. A brown substance was under her fingernail tips. The resident indicated she wanted a sponge bath.	F 0677	**Tag number: F677** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident D had nails cleaned and trimmed on 07/06/2024 and shower/bed bath 2x week or documented refusals. Resident C had his fingernails cleaned and trimmed on 07/02/2024 and facial hair was shaven on 07/02/2024 and as needed. Refusals documented.** II. 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 have the potential to be affected by the alleged**	07/24/2024

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	Resident D's clinical record was reviewed on 6/25/24 at 4:12 p.m. Diagnoses included depression, delusional disorders, hallucinations, unspecified, vascular dementia, moderate, with agitation, and need for assistance with personal care. A quarterly Minimum Data Set (MDS) assessment, dated 5/5/24, indicated the resident was moderately cognitively impaired. No behaviors were identified. She required substantial/maximal assistance of staff for showering/bathing self, toileting hygiene, upper and lower body dressing, and personal hygiene. Rejection of care was not present during the assessment period. A care plan focus, initiated and revised on 11/22/23, indicated the resident had an ADL self-care/mobility performance deficit related to impaired balance. Interventions included the following: if resident resists with ADLs, reassure resident, leave and return in five to ten minutes later and try again and the resident's usual performance with showers/baths required assistance. A care plan focus, initiated and revised on 11/22/23, indicated the resident required assistance or was dependent for the following ADLs: oral/dental care, bed mobility, transfers, walking, locomotion, dressing, eating, toilet use, personal hygiene, and bathing. Interventions included assist with personal hygiene as needed including oral/dental care. A care plan focus, initiated 12/1/23 and revised on 2/1/24, indicated the resident was noncompliant/resistive with care interventions		**deficient practice. A 100% audit of residents nail care and shaving was completed.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to educate nursing staff on the policies "Shower and Tub Bath, Nail Care and Shaving Male and Female Residents."** IV. 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; **DON/designee will conduct an ADL audit to ensure ADL care, including nail care and shaving of residents facial hair are being rendered per residents POC. Audits will be completed for 5 residents a week for 4 weeks, 3 residents week for 4 weeks then 3 residents monthly for 4 months.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	refusing medications. Interventions included the following: Encourage the resident to bathe for the health and safety of others, Encourage the resident to be compliant with care, Have staff that is most compatible provide care, Leave resident alone and re-approach as needed, and Reorient and cue resident as needed. Each of the interventions was initiated on 12/1/23. The documentation notes for bathing/showers indicated baths/showers were provided on 5/28/24, 6/1/24, 6/4/24, 6/7/24, 6/11/24, 6/18/24, and 6/21/24. No shower/bath was documented between 6/11/24 and 6/18/24. The documentation notes for behaviors indicated the resident had no behaviors listed including rejection of care from 5/27/24 through 6/24/24. The progress notes lacked refusals of fingernail care or showers from 5/28/24 through 6/24/24. During an interview, on 6/27/24 at 11:13 a.m., CNA 4 indicated showers were usually given twice a week. When a resident refused a shower, a bed bath was attempted. The CNA was supposed to attempt to shower a resident three times. If the resident continued to refuse the shower, then the CNA notified the nurse. If a resident was diabetic, the CNA was not permitted to trim the resident's fingernails but was permitted to clean the resident's fingernails. Behaviors were documented in the electronic medical record. During an interview, on 6/27/24 at 3:49 p.m., CNA 18 indicated when a resident refused a shower three times the nurse was notified. A shower sheet was signed by the nurse and the resident. Nail care was completed with showers and when soiled. If the resident was diabetic, the CNA was			

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	not permitted to trim their nails. The nurse had to trim their nails. If the resident refused care, then the CNA reported it to the nurse. The nurse was supposed to chart the refusals. During an interview, on 6/28/24 at 10:05 a.m., CNA 4 indicated Resident D was diabetic, so the aides did not clip her fingernails but could clean her fingernails. She tried to do nailcare at least one day a week on everyone. During an interview, on 6/28/24 at 10:25 a.m., CNA 19 indicated Resident D wanted showers a lot. Sometimes, the resident's family performed fingernail care for the resident. The resident often scratched at herself. The resident would clean her own fingernails if she was given the orange stick by using the flat side of it. During an interview, on 6/28/24 at 10:40 a.m., LPN 8 indicated the aides could clean under the resident's fingernails. The aides needed to do a better job of charting. When there was one aide on the floor, it was difficult to complete the little things. During an interview, on 7/1/24 at 2:42 p.m., the DON indicated showers should be given twice a week. Fingernail care should be given with showers and as needed. Resident D sometimes refused care. The resident often ate chocolate donuts provided by the family, and she questioned if the brown substance under her nails was chocolate pudding. She would look to see if the resident had any documentation of refusals and would check the shower sheets. 2. During an observation, on 6/24/24 at 12:36 p.m., Resident C sat in his recliner in his room, he was unshaven.			

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	During an observation, on 6/25/24 at 8:44 a.m., the resident propelled himself in his wheelchair backwards down the hallway. He was unshaven. During an observation, on 6/25/24 at 10:43 a.m., the resident was in his room and was unshaven. His facial hair was slightly longer than the diameter of a pencil eraser. His fingernails extended over his fingertips. At the same time, the resident indicated he needed to have help with shaving, as he had very limited mobility on his dominant side from a stroke and could not do his own shaving. He had been trying to get someone to cut his nails for two days. During an observation, on 6/26/24 at 9:36 a.m., the resident's chin and cheeks were partially shaven with patches of remaining facial hair. During an observation, on 6/27/24 at 9:51 a.m., the resident was partially shaven with patches of remaining facial hair. His fingernails extended over his fingertips. At the same time, the resident indicated the aide that shaved him did one swipe down each side of his face. He was going to keep asking the staff about getting his fingernails trimmed until he got them cut today. He indicated his fingernails looked like "claws." Resident C's clinical record was reviewed on 6/25/24 at 3:20 p.m. Diagnoses included hemiplegia and hemiparesis following cerebral infarction (stroke) affecting right dominant side, generalized anxiety disorder, major depressive disorder, recurrent severe without psychotic features, chronic pain syndrome, need for assistance with personal care, abnormal posture, and contracture, right wrist.			

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	A quarterly MDS assessment, dated 5/17/24, indicated the resident was cognitively intact. No behaviors were identified. His upper and lower extremities were impaired on one side. He required substantial/maximal assistance of staff for showering/bathing, upper and lower body dressing, and personal hygiene. Rejection of care was not present during the assessment period. A care plan focus, initiated and revised on 1/30/24, indicated the resident had an ADL self-care deficit and required assistance or was dependent for the following ADLs: oral/dental care, bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. Interventions included assist with personal hygiene as needed including oral/dental care initiated 1/30/24. A care plan focus, initiated and revised on 1/30/24, indicated the resident had an ADL self-care/mobility performance deficit that may fluctuate with activity throughout the day related to impaired balance. Interventions included the following: If the resident resists with ADLS, reassure resident, leave and return five to ten minutes later and try again, Monitor/document resident's abilities for ADLs and assist the resident as needed, Encourage the resident to do what they are capable of doing for self, and Provide the resident with opportunities for choice during care. All interventions were initiated on 1/30/24. The documentation notes for behaviors indicated the resident had no behaviors listed including rejection of care from 5/27/24 through 6/24/24. The progress notes lacked refusals of fingernail care or shaving from 5/28/24 through 6/24/24.			

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	During an interview, on 6/27/24 at 11:13 a.m., CNA 4 indicated shaving was typically done on shower days. If a resident would not allow a CNA to perform care, then sometimes a second aide would do the care as the resident allowed. Behaviors like yelling out or refusing care were documented in the electronic medical record. During an interview, on 6/27/24 at 3:49 p.m., CNA 18 indicated she shaved the resident with every shower and as needed. Men were to be shaved daily. During an interview, on 6/28/24 at 10:05 a.m., CNA 4 indicated she was uncertain if the resident had shaving cream or razors. The aides should have checked with him about shaving. Men were shaved twice a week. Nailcare and shaving were done on shower days. Whether nailcare or shaving were done often depended on who was working and how much help was available. During an interview, on 6/28/24 at 10:25 a.m., CNA 19 indicated the resident did most of his own care. He generally asked on Saturday for assistance. If he was not in the mood, he told the staff to go away. During an interview, on 6/28/24 at 10:40 a.m., LPN 8 indicated the resident had asked her today about fingernail care, which she observed he needed. He allowed the staff to shave him. She had never heard of him refusing care. During an interview, on 7/1/24 at 2:42 p.m., the DON indicated fingernail care should be given with showers twice a week and as needed. The resident sometimes refused to allow staff to shave him. She would look to see if the resident had any documentation of refusals.			

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	A current facility policy, revised 1/31/18 and provided by the Administrator on 7/1/24 at 4:34 p.m., titled "Shower and Tub Bath," indicated the following: " ... a shower or tub bath or bed/sponge bath will be offered according to the resident's preference two times per week or according to the resident's preferred frequency and as needed or requested ...." A current facility policy, revised 1/25/18 and provided by the Administrator on 7/1/24 at 4:34 p.m., titled "Nail Care," indicated the following: " ...Observe condition of resident nails during each time of bathing. Note cleanliness, length, uneven edges, hypertrophied nails ...Licensed Nurse is to trim diabetic resident's nails ...." A current undated facility policy, provided by the Administrator on 7/1/24 at 4:34 p.m., titled "Shaving Male & Female Residents," indicated " ...Male residents will be assessed for daily shaving need and assisted as his functional needs indicate ...." 3.1-38(a)(3)(D) 3.1-38(a)(3)(E) 3.1-38(b)(2)			
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			

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	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, interview and record review, the facility failed to implement interventions to prevent the development of a pressure injury for 1 of 3 residents reviewed for pressure injuries. (Resident 31) Finding includes: During an observation, on 6/24/24 at 12:15 p.m., Resident 31 was lying on his back in bed with heel boots on. During an observation, on 6/25/24 at 2:19 p.m., the resident was lying on his back in bed with heel boots on. During an observation, on 6/26/24 at 12:42 p.m., the resident was lying on his back in bed with heel boots on. Resident 31's clinical record was reviewed on 6/26/24 at 2:25 p.m. Diagnoses included methicillin susceptible staphylococcus aureus infection as the cause of diseases classified elsewhere, nontraumatic hematoma of soft tissue, other mechanical complication of surgically created arteriovenous fistula, dependence on renal dialysis, type 2 diabetes mellitus with diabetic neuropathy, peripheral vascular disease, diastolic (congestive) heart failure, and need for assistance with personal care. Current physician orders included the following:	F 0686	**Tag number: F686** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident 31's plan of care updated to include individualized interventions to prevent shearing and skin breakdown, and preference to stay in bed.** II. 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 have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure any resident at risk for skin breakdown has the proper individualized interventions in place.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to educate nursing staff on the policy "Pressure Ulcer Prevention" to include individualizing interventions.**	07/24/2024

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	Wash wound to the right heel with wound cleanser, pat dry, apply hydrogel (gel composed usually of one or more polymers suspended in water) to the wound bed, cover with an abdominal pad, and wrap with a prewashed, fluff-dried 100% woven gauze with crinkle pattern every day shift for wound care (5/2/24) and Proheal Sugar Free Critical Care AWC (advanced wound care) 30 ml two times a day for wound healing (5/6/24). A quarterly Minimum Data Set (MDS) assessment, dated 9/14/23, indicated the resident was cognitively intact. The resident required substantial/maximal assistance of staff for toileting hygiene, upper body and lower body dressing, rolling left and right, moving from lying position to sitting and sitting to lying position, and for transfers. A quarterly MDS assessment, dated 4/16/24, indicated the resident was cognitively intact. No behaviors were exhibited. The resident required substantial/maximal assistance of staff for toileting hygiene, upper body and lower body dressing, rolling left and right, moving from lying position to sitting and sitting to lying position, and for transfers. A care plan focus, initiated and revised on 6/20/23, indicated the resident had an ADL (activities of daily living) self-care performance deficit including bed mobility, eating, transfers, and toileting related to end stage renal disease requiring hemodialysis, falls, peripheral vascular disease, anemia, congestive heart failure, impaired mobility, cardiomyopathy, left lower extremity hematoma, and diabetes mellitus with neuropathy. Interventions included the following: Bed mobility: the resident requires extensive staff assistance to turn and reposition in bed with care		IV. 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; **DON/designee will audit all new admissions/re-admission to ensure anyone at risk for skin breakdown or actual breakdown have individualized interventions in place to include shearing/skin to skin and preference to stay in bed. Audits will be completed during clinical meeting 5x a week x 4 weeks, 3x a week x 4 weeks, then weekly x 4 months.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	155799	A. BUILDING 00 B. WING	07/01/2024

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	and as necessary (6/20/23), Skin observation: the resident requires skin observation with are and as needed. Observe the redness, open areas, scratches, cuts, bruises, and report changes to the nurse (6/20/23), and Encourage the resident to participate to the fullest extent possible with each interaction (6/20/23). A care plan focus, initiated and revised on 6/20/23, indicated the resident had a potential for impairment to skin integrity. Interventions included avoid shearing: use lift sheet for repositioning (6/20/23), assess/record changes in skin status (6/20/23), avoid skin-to-skin contact (6/20/23), and use caution in transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. A care plan focus, initiated on 11/30/23 and revised on 12/12/23, indicated the resident had an unstageable (unable to visualize the wound bed due to dead tissue in order to determine stage) wound to the right heel related to the disease process and immobility. Interventions included the following: administer treatments as ordered and monitor for effectiveness (11/30/23), float heels (11/30/23), pressure relief boots when in bed (11/30/23), Proheal supplement twice a day (11/30/23), and turn and reposition every 2 hours (11/30/23). A care plan focus, initiated and revised on 3/6/24, indicated the resident was non-compliant/resistive to care with care interventions including medication refusal, Diet Restrictions (diabetic diet), showers/baths. Interventions included educated the resident/family/caregiver of possible negative outcomes related to noncompliance (3/6/24), encourage resident to bathe for the health and safety of others (3/6/24), encourage the			

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	resident to be compliant with care (3/6/24), have staff that is most compatible provide care (3/6/24), leave resident alone and re-approach later as needed (3/6/24) and reorient and cue resident as needed (3/6/24). The care plan lacked individualized interventions specific to avoiding shearing or skin to skin contact for Resident 31. The nurses' notes lacked documentation of refusal of care from 9/30/23 through 11/30/23. A weekly skin observation note, dated 11/30/23 at 3:40 p.m., indicated the resident had a deep tissue injury (purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) measuring 2 centimeters (cm) length (L) by 4 cm width (W) to the right heel. A nurses note, dated on 12/28/23 at 2:56 a.m., indicated the resident was transferred to the hospital due to a burst artery in his left leg. A nurses note, dated 1/19/24 at 9:32 a.m., indicated the resident was readmitted to the facility with an unstageable pressure injury to his right heel. A wound summary for Resident 31, provided by the DON on 6/26/24 at 3:30 p.m., indicated the resident had an unstageable pressure injury to the right heel. On 1/22/24, the pressure injury measured 3.0 cm L by 4.0 cm W. The wound bed was 10% pink or red non-granulating (surface smooth and red) tissue, 30% slough (yellow/white dead tissue), and 60% necrotic (nonviable tissue), hard, firmly adherent tissue. On 6/18/24, the pressure injury measured 1.4 cm L by 2.0 cm W.			

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The wound bed was 100 % pink or red non-granulating tissue.

During a wound observation, on 6/27/24 at 3:28 p.m., accompanied by LPN 8, Resident 31's pressure injury to the right heel had a beefy red wound bed and approximately the size of a quarter.

During an interview, on 6/28/24 at 10:05 a.m., CNA 4 indicated the resident did not want to get out of bed. He got out of bed only to go to dialysis and for showers.

During an interview, on 6/28/24 at 10:25 a.m., CNA 19 indicated the resident did not want to get up at all. He got angry when he was asked if he would like to get up. He wore heel protectors.

During an interview, on 7/1/24 at 2:42 p.m., the DON indicated the resident liked to stay in bed. She was unable to provide documentation of resident refusals of care prior to the development of the pressure injury to his right heel.

Resident 31's plan of care lacked individualized interventions related to the resident's condition and preference to stay in bed/immobility.

A current facility policy, revised on 1/15/18, titled "Pressure Ulcer Prevention," provided by the Administrator on 7/1/24 at 4:34 p.m., indicated the following: " ...Turn dependent residents approximately every two hours or as needed ...whenever possible, encourage resident to change position at regular interval as able to promote circulation as indicated ...."

3.1-40(a)

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F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to address the dietary needs for a dialysis resident related to impaired nutrition for 1 of 1 resident reviewed for dialysis. (Resident 28) Finding includes: During an observation, on 6/25/24 at 2:32 p.m., Resident 28 was sitting in a wheelchair in his room. His lunch tray was sitting on his table in front of him with meatloaf, mixed vegetables, a dessert, coffee and an empty cup with remnants of a brown liquid. He ate less than 25% of his meatloaf and nothing else. He indicated the food lacked "something" but could not verbalize what.	F 0692	**Tag number: F692** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident 28 had no adverse outcomes related to the alleged deficient practice** II. 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; **Any resident receiving dialysis has the potential to be affected by the alleged deficient practice.**	07/24/2024

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	There were no condiments on his tray. He stated, "It's just too hard with these teeth." He was wearing dentures. During an observation, on 6/26/24 at 9:19 a.m., the resident was eating his breakfast while watching TV. His breakfast plate was empty and he indicated his food was actually warm today. He did not eat any of the oatmeal. He drank his coffee and there was a milk carton on his tray. He indicated that he did not get lunch prior to or during dialysis that he attended every Monday, Wednesday, and Friday. The resident indicated he got food upon returning to facility "at times" but it was usually not warm. Several salt shakers, pepper, and another seasoning were on the table. During an observation, on 6/26/24 at 1:05 p.m., facility staff delivered trays from the meal cart while Resident 28 was in dialysis. Certified Nurse Aide (CNA) 4 indicated that the resident would be offered food when he returned from dialysis because he was normally gone until 3:30 or 4:00 p.m. on dialysis days. On the same date at 4:32 p.m., the resident was escorted back from dialysis to his room by the ambulance staff. During an interview on the same date at 5:12 p.m., the resident indicated no one had checked on him since he had returned from dialysis and he was hungry. The resident activated his call light at that time and CNA 5 responded. The resident indicated that he was hungry and she responded dinner would be delivered soon. The resident stated, "That may be two hours." CNA 5 indicated it should not take that long, turned off the call light and left the room. She did not offer him anything to eat until dinner arrived. During an interview on 6/27/24 at 10:36 a.m., CNA 6 indicated she had worked at the facility for		III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Administrator/designee to educate dietary staff on providing a sack lunch to any resident prior to leaving for dialysis.** IV. 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; **Administrator/designee to observe residents prior to leaving the facility for dialysis to ensure they have received a sack lunch. Audits will be conducted on 2 residents a day x 8 weeks, then 2 residents a week x 4 weeks, then 2 residents a month x 3 months** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	about 90 days. She had never noticed the resident's dentures dropping down in his mouth and had not offered any denture adhesive during his care. During an interview on 6/27/24 11:10 a.m., the DON indicated that an early lunch tray was sometimes offered prior to the resident leaving for dialysis or upon his return. The DON indicated the dialysis center did not provide food or drinks to residents. During an observation on 6/28/24 at 9:18 a.m., the resident was eating breakfast, started talking, and his upper dentures dropped down into his mouth. He grabbed his dentures, cursed, and threw his upper dentures onto his recliner. During an interview on 6/28/24 at 9:04 a.m., LPN 7 indicated she worked on an as needed basis (PRN). She indicated that at times, when ambulance staff transported the resident back to his room from dialysis, they did not always notify facility staff that the resident had returned. She indicated the facility staff offered food when the resident returned from dialysis. When the resident returned from dialysis, snacks should be offered even if it was close to dinner time. During an observation on 7/01/24 at 9:09 a.m., the resident was sitting in his wheelchair in his room. His breakfast tray had not been delivered yet. He was scheduled to go to dialysis at 11:30 a.m. On the same date at 10:49 a.m., the resident was sitting at the front desk. The business office manager (BOM) gave the resident cash. During an interview at the time of the observation, the resident indicated he was unsure if he had eaten breakfast. He was unable to recall whether he was offered a snack prior to being brought to the front			

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	of facility and was unable to state whether he was hungry or not. He indicated the facility gave him five dollars to be used to buy food in case the driver stopped to pick up food before or after dialysis. The resident's clinical record was reviewed on 6/25/24 at 2:39 p.m. Diagnoses included but were not limited to: chronic kidney disease stage 4 (severe), dependence on renal dialysis, unspecified protein-calorie malnutrition, and cognitive communication deficit. Current physician orders included regular diet with thin consistency and no tomatoes, bananas, orange juice or potatoes (5/20/24), Nepro supplement one time daily for nutrition support, lunch at 1030 prior to leaving for dialysis at 1130 every Monday, Wednesday, Friday (5/22/24), and Nephro-Vite 1 tablet daily (5/11/24). The 5/13/24 annual Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired. He weighed 224 pounds with no or unknown weight loss or gain. A care plan initiated on 9/26/21 indicated the following: I have a nutritional problem or potential nutritional problem related to risk for weight fluctuations...which may affect weight/ appetite. Interventions included: I will maintain current body weight +/- 3% through next review"(10/2/21), encourage PO (by mouth) intake of meals/snacks/fluids (11/30/21), monitor PO intake and record every meal (11/30/21), provide diet as ordered (9/26/2021), weigh at same time of day and record as ordered (9/26/21). Additional focus indicated the following: "I am at risk for complications related to protein calorie malnutrition." Interventions included: I will eat			

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	75% or more of most meals" (5/20/24), offer substitutes if 50% or less is consumed (9/27/21), provide diet as ordered and fluids at consistency ordered (9/27/21), and provide/observe intake of diet/fluids/ snacks (9/27/21). The resident's weight history, in pounds, was as follows: 202.4 on 12/22/23 211.3 on 3/1/24 223.6 on 5/10/24 192.2 on 6/14/24 The nutritional intake form, dated from 5/30/24 through 6/27/24, demonstrated documentation for one meal consumed on 6/19/24 and 6/24/24. For all other included dates, when resident was at dialysis, meal percentages were documented for three meals daily. The "Long Term Care Facility Outpatient Dialysis Services Coordination Agreement", provided during the entrance conference, indicated the long term care facility shall ensure that ESRD residents are prepared to spend an extended length of time at the ESRD dialysis unit and have received proper nourishment...before coming to the ESRD dialysis unit.... 3.1-46(a)(1)			
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,			

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	and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to provide pain medications as ordered for 2 of 3 residents reviewed for pain management. (Resident 22 and Resident 108) Findings include: 1. During an observation, on 6/25/24 at 8:44 a.m., Resident C groaned and grimaced as he propelled himself in his wheelchair down the hall. At the same time, he indicated he had requested to see the physician about his hand and leg. He had been on painkillers for quite a while. He thought his body had gotten used to them and wanted to see if the physician could order him something different Resident C's clinical record was reviewed on 6/25/24 at 3:20 p.m. Diagnoses included hemiplegia and hemiparesis following cerebral infarction (stroke) affecting right dominant side, generalized anxiety disorder, major depressive disorder, recurrent severe without psychotic features, chronic pain syndrome, abnormal posture, contracture, right wrist, varicose veins of right lower extremity with pain, unilateral primary osteoarthritis, right hip, arthropathy, unspecified, opioid dependence, uncomplicated, and other psychoactive substance dependence, uncomplicated. Physician orders included the following: escitalopram (antidepressant) 10 mg daily started 1/30/24, mirtazapine (antidepressant)15 mg daily started 1/30/24, olanzapine (antipsychotic) 7.5 mg daily started 1/30/24, buspirone (antianxiety) 10 mg three times a day started 1/30/24, oxycodone (opioid for pain management) 20 mg three times a	F 0697	**Tag number: F697** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Residents 6 and 108 had no adverse outcomes related to alleged deficient practice**. II. 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; **Any resident receiving pain medication has the potential to be affected by the alleged deficient practice.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to educate nursing staff on the policies "Pain Management and Physicians Orders" to include obtaining pain medication from the EDK** IV. 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; **DON/designee will audit new orders/re-orders to ensure any resident with a pain medication receives the medication timely. Audits will be completed on 5 residents**	07/24/2024

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	day started 1/30/24, fentanyl (opioid for pain management) transdermal patch 100 mcg/hr apply 1 patch transdermally every 72 hours for pain started 4/19/24 and discontinued 6/6/24, tizanidine (muscle relaxant) 2 mg daily every 24 hours as needed for muscle spasms started 6/6/24, and pain assessment every shift started 1/29/24. A quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. He complained of frequent pain which interfered frequently with therapy activities and day to day activities. The resident rated the pain as 7 on a 0 - 10 pain scale with 0 being no pain and 10 being the worst pain ever felt. A care plan focus, initiated and revised on 1/30/24, indicated the resident was on pain medication therapy. Interventions included administer analgesic medications as ordered by the physician and monitor/document side effects and effectiveness every shift. The interventions were initiated on 1/30/24. A care plan focus, initiated and revised on 1/30/24, indicated the resident had pain. Interventions included the following: Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Notify the physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. The interventions were initiated on 1/30/24. The May 2024 medication administration record (MAR) indicated the fentanyl patch was not applied on 5/28/24 or on 5/31/24 as ordered due to unavailability of the medication. The pain assessment indicated the resident rated his pain as 10 on the 0-10 pain scale on 5/28/24 during the		**5x/week for 4 weeks, 4 residents 3x/week for 4 weeks then 5 residents weekly for 4 months.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated	

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night and 8 on 5/31/24 during the night.

A progress note, dated 5/29/24 at 1:59 p.m., indicated the resident's fentanyl patch that was due to be removed on night shift at 5/28/24 was removed at that time. The facility was waiting for a supply of the fentanyl patches to arrive at the facility. The nurse practitioner (NP) was notified, and no new orders were received.

The June 2024 MAR indicated the fentanyl patch was not applied as ordered on 6/3/24 due to the unavailability of the medication. The pain assessment indicated the resident rated his pain as 8 on the 0-10 pain scale on 6/1/24 during the night and 8 on 6/6/24 during the night. The pain assessment completed prior to the administration of oxycodone indicated the resident rated his pain as 6 on 6/1/24 at 8:00 a.m., 8 on 6/1/24 at 8:00 p.m., 8 on 6/2/24 at 8:00 p.m., 8 on 6/3/24 at 8:00 p.m., and 8 on 6/6/24 at 8:00 p.m.

An NP progress note, dated 6/3/24 at 11:21 a.m., indicated the NP assessed the resident. The fentanyl patch order was listed as active. The assessment lacked mention of the resident's fentanyl patch being unavailable.

A progress note, dated 6/3/24 at 11:54 p.m., indicated the fentanyl patch was not available. The pharmacy was aware. The facility was awaiting delivery of the patch from pharmacy.

A progress note, dated 6/6/24 at 12:11 p.m., indicated the resident had been seen by the NP. The fentanyl patch was discontinued and tizanidine was ordered as needed.

The progress notes lacked notification of the medical provider of the unavailability of the

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	fentanyl patch from 5/30/24 through 6/5/24. During an interview, on 6/28/24 at 10:40 a.m., LPN 8, indicated if a resident did not have a medication, she would check the overflow medication cart, the medication room, and the other medication cart to ensure it was not put in the wrong cart. Then, she would notify the physician of the medication's unavailability and await further instruction. She indicated the resident's patch had been reordered and did not know much more about it. In the event a resident's patch was unavailable, she would notify the physician about not having the patch, see if the patch could be put on hold, and check if the resident could be given something else until the patch arrived. During an interview, on 6/28/24 at 11:22 a.m., LPN 7, indicated if a medication was unavailable, she would check the Emergency Drug Kit (EDK). If the medication was a narcotic, she would have to call the pharmacy and get a code to be able to pull it out of the EDK. She thought the EDK contained fentanyl patches. She would also call the pharmacy to have the patch sent immediately and call the DON who would call the physician/NP who could give a one time order for the missing medication. If the fentanyl patch dosage was higher than what was available in the EDK, she would ask the physician/NP if a lower dosage patch or two lower dosage patches would be appropriate. During an interview, on 6/28/24 at 5:06 p.m., the DON indicated she had tried to get a preauthorization from the physician for the patch. The insurance company would not pay for the fentanyl patches. She had contacted the physician several times about the resident not			

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receiving the patch and had received no new orders, but had not documented the notifications. During the time the resident had not received his patch, she had seen and talked to the resident in the hall. He did not appear to be in any distress. She did not document her encounters with the resident. The NP had prescribed the resident tizanidine on 6/6/24 (nine days after the fentanyl patch was due to be applied, but was unavailable).

The National Institute of Health's National Library of Medicine website, https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=2a2238e9-4b5d-c56d-8663-dd354ff9ae0c#section-2.9, accessed on 7/2/24 at 4:01 p.m., indicated the following: " ...2.9 Safe Reduction or Discontinuation of Fentanyl Transdermal System. Do not abruptly discontinue fentanyl transdermal system in patients who may be physically dependent on opioids. Rapid discontinuation of opioid analgesics in patients who are physically dependent on opioids has resulted in serious withdrawal symptoms, uncontrolled pain, and suicide ...."

2. Resident 108's clinical record was completed on 6/26/24 at 9:36 a.m. Diagnoses included Chronic Obstructive Pulmonary Disease (COPD), abnormalities of gait and mobility, unsteadiness on feet, and a need for assistance with personal care.

An admission MDS assessment, dated 6/22/24, indicated the resident was cognitively intact.

A physician's order, dated 6/20/24 at 6:00 p.m., indicated the resident should be assessed for pain every shift.

A physician's order, dated 6/19/24 at 5:00 p.m.,

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	included Hydrocodone-Acetaminophen (a narcotic pain reliever) 5-325 mg, 1 tablet by mouth, every 4 hours, as needed, for moderate pain. A current care plan, dated 6/20/24, indicated to give medications as ordered by physician and to monitor and document side effects and effectiveness of medications. A review of routine shift pain assessments indicated a zero (0) pain rating, on a scale from 0 to 10, with 0 being "no pain" and 10 being "the worst pain imaginable", was documented by nursing on 6/20/24, 6/21/24, 6/22/24, 6/23/24, 6/25/24, and 6/26/24. On 6/20/2024 at 9:30 a.m., the resident had rated his pain at 4/10 and was given a hydrocodone-acetaminophen 5-325 mg at that time. On 6/20/2024 at 3:30 p.m., the resident rated his pain at 7/10 and was given a hydrocodone-acetaminophen 5-325 mg at that time. On 6/20/2024 at 7:39 p.m., the resident rated his pain at 6/10 and was given a hydrocodone-acetaminophen 5-325 mg at that time. On 6/21/2024 08:35 a.m., the resident rated his pain at 6/10 and was given a hydrocodone-acetaminophen 5-325 mg at that time. On 6/21/2024 7:01 p.m., the resident rated his pain at 7/10 and was given a hydrocodone-acetaminophen 5-325 mg at that time.			

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On 6/22/2024 9:22 a.m., the resident rated his pain at 8/10 and was given a hydrocodone-acetaminophen 5-325 mg at that time.

On 6/22/2024 at 2:48 p.m., the resident rated his pain at 9/10 and was given a hydrocodone-acetaminophen 5-325 mg at that time.

On 6/22/2024 9:05 p.m., the resident rated his pain at 8/10 and was given a hydrocodone-acetaminophen 5-325 mg at that time.

During an interview with Resident 108 on 6/26/24, at 1:43 p.m., the resident indicated he had not received his pain medication for the last 3 to 4 days. Nursing told him that his medication was not available. No other medications were offered to help relieve his pain. On the same date, at 3:08 p.m., the resident indicated he was not being assessed for pain every shift. The only time pain levels were addressed was when he would ask for a pain pill. He would tell the staff his pain level at that time. His last pain pill was given on 6/22/24 at 9:05 p.m. At the time of the interview, the resident indicated his pain had not been assessed that day.

On 6/26/24 at 3:00 p.m., two narcotic logs for the D hallway were reviewed . Neither log contained any information or narcotic medication for Resident 108.

During an interview, on 6/26/24 at 3:14 p.m., LPN 8 indicated the resident had admitted to the facility with five (5) hydrocodone-acetaminophen 5-325 mg tablets. Since the depletion of the narcotic

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	pain medication, the facility had been waiting on a prescription from the prescriber. She had sent a text message on 6/23/24 to the Director of Nursing (DON), asking her to contact the provider for a new prescription because the resident had only two tablets remaining. In regards to the inconsistency of the pain assessments in the electronic health record, LPN 8 was not aware of the discrepancies and could not give an explanation as to why the assessments would have conflicting information. Review of the medication administration record indicated on 6/27/24, at 10:52 p.m., the resident rated his pain at an 8/10 and received hydrocodone-acetaminophen 5-325 mg. The last administration was on 6/22/24 at 9:05 p.m. During an interview with LPN 8, on 6/28/24 at 3:25 p.m., she indicated the resident's hydrocodone-acetaminophen 5-325 mg was not delivered until 6/26/24. During an interview on 6/28/24 at 4:57 p.m., the ADON indicated a floor nurse had contacted her about Resident 108's pain medication being unavailable. She had previously educated the staff about their responsibility to contact the provider when an order was needed. There was also a phone number on the medication storage room door, which staff could use to contact the pharmacy when a medication ran out. Staff could get an authorization code from the pharmacy to pull the medication from the emergency drug kit (EDK). The DON contacted the provider on 6/26/24 and received an order for the medication. The clinical record lacked indication of pain assessments between 6/23/24 through 6/25/24.			

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	A current facility policy titled "Pain Management Program", was provided by the Administrator on 7/1/24 at 4:34 p.m. The policy indicated the following: "...Purpose: To establish a program which can effectively manage pain in order to remove adverse physiologic and physiological effects of unrelieved pain and to develop an optimal pain management plan to enhance healing and promote physiological and psychological wellness...Standards: 1) Pain assessment protocol will be initiated under any of the following situations - a) Any indication of pain based on the pain assessment performed for each resident at the time of admission and with any condition change and/or incident associated with the potential of pain...c) Resident receives routine pain medication and/or pain is not controlled. 2) As soon as possible identify the best rating scale for the resident and use the same rating scale to determine the level of pain...10) Documentation of assessments and the resident's response to the pain management plan will be made with each assessment. 11) The resident's physician will be notified of the resident's complaints of pain which are not relieved by comfort measures, including pain medications. 12) Pain control will be assessed during routine medication passes.... A current facility policy, revised 1/31/18 and provided by the Administrator at 4:34 p.m., titled "Physician's Orders - Entering and Processing," indicated the following: " ...Fax or call the orders to the appropriate pharmacy as needed ...If a medication is needed immediately, it will be removed from the Emergency Drug Kit (EDK) ...." 3.1-37(a)			
F 0756 SS=D	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act			

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Bldg. 00	On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the			

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	pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on observation, interview, and record review, the facility failed to follow pharmacy recommendations for 1 of 5 residents reviewed for unnecessary medications. (Resident 1) Findings include: Resident 1's clinical record was reviewed on 6/26/24 at 2:39 p.m.. Diagnoses included schizophrenia, major depressive disorder, unspecified intellectual abilities, and anxiety disorder. A quarterly Minimum Data Set evaluation, dated 5/20/24, indicated the resident was cognitively intact and required substantial to maximal assistance from staff for activities of daily living. A gradual dose reduction recommendation from the pharmacist, dated 11/22/23, indicated the resident was receiving the antipsychotic medication Risperdal (antipsychotic) 2 mg by mouth twice a day. Residents taking Risperdal required an AIMS (abnormal involuntary movement scale) assessment to be performed every 6 months. The last assessment, noted by the pharmacist, was performed on 5/22/23. The resident was due for an AIMS assessment at the time of the recommendation. On 12/18/23, a second request from the pharmacist indicated the resident was receiving Risperdal 2 mg by mouth twice a day and needed an AIMS assessment. The last AIMS assessment was 5/22/23. A care plan, with a revision date of 5/19/23,	F 0756	**Tag number: F756** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident 1 had an AIMS completed on 07/24/2024. DON educated on completing pharmacy recommendations timely.** II. 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; **Any resident receiving an antipsychotic medication has the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure any resident receiving an antipsychotic had an AIMS completed timely.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **RNC to educate DON on timely completion of pharmacy recommendations.** IV. 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; **DON/designee will review pharmacy recommendations**	07/24/2024

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	indicated the resident was receiving psychotropic medications. The goal of the plan was the resident would remain free of psychotropic drug related complications, including movement disorder...or cognitive/behavioral impairment through the review date. The clinical record lacked indication of a completed AIMS assessment after 5/22/23. During an interview with the Director of Nursing (DON), she indicated she was aware of the two pharmacist requests for an AIMS assessment to be completed. She knew the last assessment was completed on 5/22/23. She was unable to provide a reason for the missed assessments. 3.1-48(3)		**and ensure they are completed timely to include AIMS assessments. Audits will be completed monthly x 6 months.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from			

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	the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. Based on observation, interview, and record review, the facility failed to provide prompt dental services for ill-fitting dentures to 1 of 2 residents reviewed for dental services (Resident 28). Finding includes: The resident's record review was completed on 6/25/24 at 2:39 p.m. Medical diagnoses included, but were not limited to: unspecified protein-calorie malnutrition; anemia in Chronic Kidney Disease (CKD); and unspecified dementia with unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety.	F 0791	**Tag number: F791** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident 28 has a dentist appt scheduled for August 5th** II. 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; **Any resident with dental issues has the potential to be affected by the alleged deficient practice.**	07/24/2024

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	Current physician orders included regular diet,thin consistency with no tomatoes, bananas, orange juice or potatoes (5/20/2024). The annual Minimum Data Set (MDS) assessment completed on 5/13/24 indicated the resident did not have broken or loosely fitting full or partial dentures (chipped, cracked, uncleanable, or loose). A current care plan, initiated on 9/12/21, included: "I exhibit dental/mouth problems: I have no natural teeth" (9/12/21), I will not develop oral/dental complications (5/20/24), report changes in oral status to MD (9/26/21), report to nurse changes in oral status...dentures (broken, loose...)(9/27/21). A social services note, dated 11/17/23 at 3:20 p.m., indicated the resident was referred to the attending dentist per the request of the resident's daughter. A social services note, dated 1/26/2024 at 3:11 p.m., indicated the writer scheduled the resident a dental appointment for 2/19/24 at 9:20 a.m. and staff was made aware. A social services note, dated 3/28/2024 at 3:11 p.m., indicated the writer contacted the resident's daughter and notified her that the resident would be seen for an adjustment for his dentures on April 5, 2024. A nurse's note, dated 5/29/2024 at 11:03 a.m., indicated a Certified Nursing Assistant (CNA) attempted to put the resident's dentures in and he refused, stating they did not fit and had not fit for over three months.		**A full house audit was completed to ensure no other residents had dental issues that needed addressed.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Social Services Director educated on importance of obtaining timely dental care for residents.** IV. 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: **Social Services will inquire about any dental issues during the admission and quarterly care plan reviews. Any issues identified will be referred to the dentist.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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A nurse's note, dated 5/29/2024 at 11:10 a.m., indicated the resident was at the front of the facility talking with staff and other residents about throwing his dentures in the trash. A nurse spoke with resident and reminded him that he had refused to put the dentures in his mouth because they had not fit him for over three months.

A social services note, dated 5/29/2024 at 11:14 a.m., indicated the writer spoke with the resident's daughter yesterday and informed her that the resident was scheduled to see the dentist and the resident was at dialysis when the dentist visited. The daughter stated that she wanted the resident seen by another dentist instead.

An appointment departure note, dated 6/11/2024 at 12:00 p.m., indicated the resident LOA (leave of absence) to a dentist appointment.

During an observation, on 6/25/24 at 2:32 p.m., the resident indicated it was too hard to eat "with these teeth." He had upper and lower dentures in his mouth.

During an interview, on 6/28/24 at 9:04 a.m., LPN 7 indicated it could take a long time for dentures to be fixed or replaced as dental services only came to facility about once a month.

During an observation, on 6/28/24 at 9:18 a.m., the resident started talking and his upper dentures dropped down into his mouth. He grabbed his upper denture, cursed and threw the denture on to the recliner.

During an interview, on 7/1/24 at 11:01 a.m., the MDS Coordinator indicated that there was an Interdisciplinary Team (IDT) meeting every

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	morning and she was not aware of any issues with the resident's dentures not fitting because it had not been mentioned in the meetings. During a telephone interview, on 7/1/24 at 2:04 p.m., the resident's representative stated Resident 28's dentures had been ill-fitting since October 2023 and the facility had been aware since that time. The resident had not been seen by a dentist until 6/11/2024 and had impressions made for new dentures and was scheduled the following day for an appointment. The representative was unaware of any adjustments that had previously been made to the resident's dentures. A current facility policy, dated 11/28/17, provided by the Administrator on 6/27/24 at 11:25 a.m., titled "Dental Services and Loss or Damage of Dentures" indicated "The facility will, if necessary or requested by the resident...arranging...promptly refer residents with lost or damaged dentures for dental services..."Prompt referral" means, within reason, as soon as the dentures...damaged...this referral should occur within 3 business days...." 3.1-24(a)(3)			
F 0801 SS=E Bldg. 00	483.60(a)(1)(2) Qualified Dietary Staff §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e)			

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	This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services			

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	must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.			
	Based on interview and record review, the facility failed to ensure a qualified dietary manager supervised the kitchen staff and operations. This deficiency had the potential to affect 54 of 55 residents who received meals from the facility kitchen. Finding includes: During an interview, on 6/24/24 at 10:13 a.m., the Head Cook indicated the kitchen had been	F 0801	**Tag number: F801** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; No residents were affected by this alleged deficient practice** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	07/24/2024

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	without a manager for six to seven months. During an interview, on 6/24/24 at 4:14 p.m., the Administrator indicated the facility did not currently have a dietary manager. She was filling in as the dietary manager. The employee records, provided by the Administrator on 6/25/24 at 9:50 a.m., did not include a dietary manager. During an interview, on 6/27/24 at 9:24 a.m., the Head Cook indicated she was not certified as a dietary manager, but she and the Administrator had been discussing getting her into a certification class. She indicated the dietician came in about three times a month. During an interview, on 6/28/24 at 11:55 a.m., the Administrator indicated a new dietary manager had started on 6/24/24. The prior dietary manager had been terminated in the past couple of weeks. She was unable to provide a dietary manager certification for the prior dietary manager. During an interview, on 6/28/24 at 3:56 p.m., the Administrator indicated the new dietary manager was being trained this week. She indicated the facility had not had a dietary manager for several months. The newly hired dietary manager's employee record, provided by the Administrator on 6/28/24 at 4:02 p.m., was reviewed. The newly hired dietary manager had a physical on 6/25/24 and had signed a "Cook" job description. She had a ServSafe food production manager certification that would expire on 8/18/2025. During an interview, on 7/1/24 at 4:29 p.m., the		action(s) will be taken; **All residents have the potential to be affected by this alleged deficient practice.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **The facility will maintain a qualified dietary manager at all times. A qualified dietary manager was hired on 6/20/2024 .** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **The administrator or designee will audit the dietary managers employee file weekly to ensure the facility maintains a qualified dietary manager at all times**. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	Administrator indicated the dietician came in once a month. One resident received nutrition only through a feeding tube, the remaining 54 residents received their meals and/or snacks from the kitchen. A Time Card Report, provided by the Administrator on 7/1/24 at 4:33 p.m., indicated the dietician had been in the facility on 6/19/24 for 8 hours. The Indiana Department of Health Long-term Care Newsletter, dated 10/26/23, retrieved from https://www.in.gov/health/ltc/files/2023-23.pdf on 7/3/24 at 12:02 p.m., indicated the following " ...Dietary Manager Qualifications: Effective Oct. 1, the Centers for Medicare and Medicaid Services requires the following qualifications for the director of food and nutrition services under F801 of the State Operations Manual, §483.60(a)(2). 'If a qualified dietitian or other clinically qualified nutrition professional is not employed fulltime, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or (D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations			

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	including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving" Certification from ServSafe, or similar national certification for food service management and safety from a national certifying body, meets the requirement for option C, §483.60(a)(2(i)(C). Successful completion of the ServSafe food manager program (or other nationally recognized course of study in food safety and management) by Oct. 1 AND two or more years of experience as a director of food and nutrition services in a nursing facility setting, meets the regulatory requirement of the option E, described in §483.60(a)(2(i)(E) ....' 3.1-20(c)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement			

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	based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.			

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	§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, interview, and record review, the facility failed to implement infection prevention strategies related to enhanced barrier precautions (EBP) for 2 of 4 residents reviewed for transmission-based precautions. (Resident 44 and Resident 53) Findings include: 1. During an observation, on 6/24/24 at 12:15 p.m., Resident 53 was lying in his bed. The resident's door and room had no posted signage. During an observation, on 6/25/24 at 2:19 p.m., the resident was lying on his back in bed with his eyes closed. The resident's door had no posted signage. Resident 53's clinical record was reviewed on 6/26/24 at 2:25 p.m. Diagnoses included methicillin susceptible staphylococcus aureus infection as the cause of diseases classified elsewhere, nontraumatic hematoma of soft tissue, other mechanical complication of surgically created arteriovenous fistula, and dependence on renal dialysis. The physician orders lacked an order for enhanced barrier precautions. A progress note, dated 1/19/24 at 1:24 p.m.,	F 0880	**Tag number: F880** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Residents 44 and 53 had no adverse outcomes related to the alleged deficient practice** II. 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 have the potential to be affected by the alleged deficient practice. Regional Nurse conducted 1:1 education with the facility IP on EBP and placing signage on doors. DON completed 1:1 education with the wound nurse on proper donning/doffing of PPE when a resident is in EBP. A full house audit was completed to ensure any resident who should be in EBP had an order and signage on the door.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	07/24/2024

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	indicated the resident readmitted to the facility with a wound to the left lower leg with an attached wound vacuum. A wound summary, provided by the DON on 6/26/24 at 3:30 p.m., indicated the resident had a surgical wound to the left outer calf. On 1/22/24, the surgical wound measured 14 cm long by 13 cm wide. The wound bed was 60 % bright beefy red tissue, 15% slough, and 25% necrotic tissue. On, 6/18/24, the surgical wound measured 4.0 cm wide by 2.4 cm wide. The wound bed was 100 % bright pink or red tissue. A wound summary, provided by the DON on 6/26/24 at 3:30 p.m., indicated the resident had an unstageable pressure injury to the right heel. On 1/22/24, the pressure injury measured 3.0 cm long by 4.0 cm wide. The wound bed was 10% pink or red non-granulating (surface smooth and red) tissue, 30% slough (yellow/white dead tissue), and 60% necrotic (nonviable tissue), hard, firmly adherent tissue. On 6/18/24, the pressure injury measured 1.4 cm long by 2.0 cm wide. The wound bed was 100 % pink or red non-granulating tissue. During an interview, on 6/26/24 at 10:09 a.m., CNA 23 indicated if a person was on EBP it would be on the door and the PPE would be inside the room. If the PPE chest was outside the room, then it was some other type of isolation precautions. She indicated there were two residents on the D Hall that were on precautions. She did not include Resident 53. During a wound observation, on 6/27/24 at 3:28 p.m., LPN 8 washed her hands, applied gloves and proceeded to perform pressure injury wound care and surgical wound care. The pressure injury wound bed was beefy red, and quarter sized on		DON/designee to re-educate nursing staff on the proper donning and doffing of PPE when a resident is in EBP. IV. 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; DON/designee will conduct an audit on nursing staff donning/doffing of PPE. Audits will be completed on 5 employees a week x 3 months, then 1 employee a week x 3 months. DON/designee will all residents with an admitted with or new wounds to see if EBP is indicated. If indicated, DON/designee will audit for a physicians order and EBP signage on residents doors. Audits will be completed 5x week for 4 weeks, 3x a week for 4 weeks, weekly x 4 weeks, then monthly x 3 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	the right heel. The surgical wound bed was beefy red on the left lower leg. LPN 8 did not apply a gown prior to the dressing change. The door and room lacked signage and PPE for EBP. During an interview, on 6/28/24 at 10:40 a.m., LPN 8 indicated Resident 53 was not on EBP because one of his wounds was surgical. During an interview, on 6/28/24 at 2:35 p.m., the DON indicated Resident 53 should have been placed on EBP. During an interview, on 6/28/24 at 5:06 p.m., the DON indicated she had spoken to her corporate infection preventionist about the resident and EBP. The resident's wounds were considered chronic and had existed greater than 28 days. He required EBP. 2. Resident 44's clinical record was reviewed on 6/26/24 at 9:28 a.m. Diagnoses included: other abnormalities of gait and mobility and Type 2 diabetes mellitus without complications. During an observation on 6/24/24 at 10:20 a.m., Resident 44's door was open and an Enhanced Barrier Precautions (EBP) sign was located on the door. A personal protective equipment (PPE) cart was located outside of her room. A wound summary, provided by the DON, on 6/26/24 at 3:35 p.m., indicated the resident had an active pressure wound to her coccyx, present on admission. On 6/18/24 at 11:45 a.m., the assessment indicated the pressure ulcer measured 0.4 cm wide, 0.4 cm long and 0.4 cm deep, 100% bright pink or red with no undermining, no tunneling and no exudate (drainage). On a prior assessment, dated 4/9/24 at 2:49 p.m., the pressure ulcer measured 1.0 cm wide, 0.5 cm long, and 0.5			

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	cm deep. During a wound observation on 6/27/24 at 3:34 p.m. the ADON performed wound care for Resident 44. During an interview at the same time, the ADON indicated that she did not wear a gown and should have worn a gown during the dressing change as the resident has an EBP sign on the door and a gown should be worn during pressure ulcer dressing changes. A current facility policy, revised 5/7/24, provided by the Administrator on 7/1/24 at 4:34 p.m., titled "Enhanced Barrier Precautions," indicated the following: " ...EBP are indicated for residents with any of the following: ...Chronic Wounds ...Examples of chronic wounds include, but are not limited to: Pressure ulcers, Diabetic foot ulcers, Unhealed surgical wounds, Venous stasis ulcers ...For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident activities ...Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting ...Wound care: any chronic skin opening requiring a dressing ...." 3.1-18(b)(2)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (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	F 9999	**Tag number: F9999** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **CNA 6, CNA 12, LPN 10 and Dietary 13 received TST tests on 07/02/24** II. How other residents having the	07/24/2024

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	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. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to accurately document the administration and results of mandatory tuberculin skin tests (TST) performed on 4 of 5 new employee files reviewed. (CNA 6, LPN 10, CNA 12, and Dietary Aide 13) Findings include: Employee records were provided by the Administrator on 6/25/24 at 9:50 a.m. and reviewed on 6/28/24 at 4:02 p.m. An Employee Physical form for CNA 6 indicated a first step TST was performed on 2/22/24 and read on 2/24/24. A second step test was performed on 3/2/24 and read on 3/4/24. The tests administered did not include the times administered or read. An Employee Physical form for LPN 10 indicated a first step TST was performed on 11/8/23 and read on 11/10/23. A second step test was performed on 11/17/23 and read on 11/19/23. The tests administered did not include the times administered or read. An Employee Physical form for CNA 12 indicated a first step TST was performed on 4/18/24 and read on 4/20/24. A second step test was		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice.** III. 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 educated on putting the times administered and read on all TST tests.** IV. 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; **DON/designee to audit 3 new employee records to ensure the TST had the times administered and read. Audits will be completed 3x week x 3 months, then monthly x 3 months.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	performed on 4/27/24 and read on 4/29/24. The tests administered did not include the times administered or read. An Employee Physical form for CNA 6 indicated a first step TST was performed on 1/10/24 and read on 1/12/24. A second step test was performed on 1/19/24 and read on 1/21/24. The tests administered did not include the times administered or read. During an interview, on 6/28/24 at 5:06 p.m., the DON, who also served as the facility's Infection Preventionist, indicated TSTs should be read two days after given, specifically 48-72 hours after given. A current facility policy, dated 4/22/22, provided by the Administrator on 7/1/24 at 5:09 p.m., indicated the following: " ...Two-Step PPD: The first dose given and read at 48-72 hours ...Procedure: Give 0.1 cc PPD [purified protein derivative] of 5 U.S. tuberculin units, intradermally on forearm; read area for induration size at 48 to 72 hours ...." The Mantoux Tuberculin Skin Testing Fact Sheet from the Centers for Disease Control and Prevention (CDC) website at https://www.cdc.gov/tb/publications/factsheets/testing/Tuberculin_Skin_Testing_Information_for_Health_Care_Providers.pdf accessed on 7/2/24 at 1:46 p.m., guidance included: "...The skin test reaction should be read between 48 and 72 hours after administration by a health care worker trained to read TST results. A patient who does not return within 72 hours will need to be rescheduled for another skin test...."			

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaints IN00432449, IN00435594, and IN00437639. Survey dates: June 24, 25, 26, 27, 28, and July 1, 2024 Facility number: 012809 Residential Census: 13 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed July 12, 2024.	R 0000	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
R 0026 Bldg. 00	410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and			

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	responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands. Based on observation, interview, and record review, the facility failed to procure signed and dated Resident's Rights for 1 of 7 residents reviewed for Resident Rights and did not provide a copy of Resident's Rights in a publicly accessible area. (Resident 2) A clinical record review for Resident 2 was performed on 6/28/24 at 9:37 a.m. The resident's record contained no signed and dated Resident Rights document. During an observation of the facility, on 7/1/24 at 3:54 p.m., there were no Resident Rights available in a publicly accessible area. During an interview with the Administrator on 7/1/24 at 4:22 p.m., she indicated she was unaware the facility did not have the Resident Rights posted anywhere. She was unable to provide a signed and dated copy of Resident Rights for Resident 2.	R 0026	**Tag number: R026** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Residents Rights were posted in a publicly accessible area on 07/23/2024. Resident 2 received and signed a copy of resident rights on 07/01/2024** II. 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 have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure all residents received and signed/dated a copy of residents rights.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Admissions/nursing staff will be educated on obtaining a signature and date on residents rights for all new admissions** IV. 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;	07/24/2024

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			DON/designee will audit all new AL admissions to ensure the resident has received/signed and dated residents rights. Audits will be completed daily x 3 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for			

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	every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on observation, interview, and record review, the facility failed to provide at least one staff person with a current cardiopulmonary resuscitation (CPR) certification and first aid certification for four (4) shifts during a one (1) week look-back. On 7/1/24 at 9:42 a.m., a review of staffing for the facility was performed. CPR and first aid certifications were provided during the residential entrance conference on 6/28/24 at 9:02 a.m. On 6/17/24, 6/18/24, 6/21/24, and 6/22/24, the facility did not have a CPR/first aid certified staff member available during third shift for each of those days. During an interview with the Administrator on 7/1/24 at 4:38 p.m., she indicated her staff had looked for more certifications but had not found anything to add to the previously provided documents.	R 0117	**Tag number: R117** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **No residents were affected by the alleged deficient practice. Scheduler educated on scheduling at least 1 staff member with a current CPR/First Aid certification each shift.** II. 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 have the potential to be affected by the alleged deficient practice. An audit was completed on employee files to compile a list of staff who need their CPR/First Aid certification.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Human Resource Manager will provide the scheduler with a list of staff with a current CPR/First Aid certification to ensure one certified person is scheduled each shift.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance	07/24/2024

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			program will be put into place; Human Resource Manager/designee will audit first aid binder weekly to notify all staff when their re-certification is due. Audits will be completed weekly x 3 months.="" b=""> The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on observation, interview, and record review, the facility failed to perform a pre-admission evaluation for 2 of 7 residents reviewed and failed to perform a semi-annual evaluation for 2 of 7 residents reviewed for evaluation(s). (Residents 2, 3, 4, and 7) On 6/28/24, at 9:37 a.m., a clinical record review was performed for Resident 2. His record did not contain a pre-admission evaluation. On 6/28/24, at 10:12 a.m., a clinical record review	R 0214	**Tag number: R214** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; Resident 4 had a semiannual assessment completed on 07/06/2024. Resident 7 no longer resides at the facility.** II. How other residents having the potential to be affected by the same deficient practice will be	07/24/2024

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	was performed for Resident 3. His record did not contain a pre-admission evaluation. On 6/28/24, at 10:35 a.m., a clinical record review was performed for Resident 4. Her record did not contain a semi-annual evaluation. Her last semi-annual evaluation was dated 5/22/22. On 6/28/24, at 3:30 p.m., a closed record review was performed for Resident 7. His record did not contain a semi-annual evaluation. His last evaluation was performed on 9/17/22. During an interview on 7/1/24 at 4:26 p.m., the Administrator indicated she was unable to locate or provide the abovementioned information. Whatever had been found in the clinical record review was all that was available. A policy, titled "Evaluation of Resident's Needs", was provided by the Administrator on 7/1/24 at 12:00 p.m. The policy indicated the following: "An evaluation of the Resident's needs will be completed at admission and at least every six (6) months thereafter; every three (3) months for Medicaid Waiver."		identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure all residents had a semiannual assessment completed timely. DON educated on obtaining a pre admission assessment on all potential admissions.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **RNC/designee to educate DON/nursing staff on when assessments should be completed.** IV. 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; **DON/designee to audit all resident assessments quarterly to ensure they are completed timely.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on observation, interview, and record review, the facility failed to ensure pharmaceutical services performed a drug regimen review for 6 of 7 residents reviewed for pharmaceutical services. (Residents 3, 4, 5, 6, 7, and 8) A clinical record review for Resident 3 was performed on 6/28/24 at 10:14 a.m. The record did not contain any pharmacist's drug regimen reviews. The resident admitted on 3/27/24. A clinical record review for Resident 4 was performed on 6/28/24 at 10:35 a.m. The record did not contain any pharmacist's drug regimen reviews. The resident admitted on 7/29/22. A clinical record review for Resident 5 was performed on 6/28/24 at 11:36 a.m. The record did not contain any pharmacist's drug regimen reviews. The resident admitted on 1/20/23. A clinical record review for Resident 6 was	R 0298	**Tag number: R298** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; The Pharmacist completed a record review on residents 3,4,5,6,7 and 8 on 06/30/2024** II. 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 have the potential to be affected by the alleged deficient practice. Pharmacy educated on completing a pharmaceutical drug regimen review on all residents timely. A full house audit was completed to ensure any resident needing a pharmacy**	07/24/2024

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	performed on 6/28/24 at 11:57 a.m. The record did not contain any pharmacist's drug regimen reviews. The resident admitted on 3/18/24. A closed record review for Resident 7 was performed on 6/28/24 at 3:30 p.m. The record did not contain any pharmacist's drug regimen reviews. The resident admitted on 9/17/22 and discharged on 5/1/24. A closed record review for Resident 8 was performed on 6/28/24 at 12:23 p.m. The record did not contain any pharmacist's drug regimen reviews. The resident admitted on 5/2/16 and discharged on 6/1/24. During an interview with the Administrator on 7/1/24, at 9:38 a.m., she indicated no pharmacist's drug regimen reviews were available.		**drug review obtained one.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Pharmacist/DON educated on regulations regarding pharmacy drug reviews. IV. 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; **DON/designee to audit pharmacy recommendations to ensure residents receive pharmacy reviews timely. Audits will be completed monthly x 3 months.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.			

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	(f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on observation, interview, and record review, the facility failed to complete the 2-step tuberculin skin testing (TST) required prior to or upon admission for 2 of 7 residents reviewed for infection control. (Residents 2 and 3) A clinical record review for Resident 2 was performed on 6/28/24 at 9:37 a.m. The record lacked documentation of TST for Resident 2. On 6/28/24, at 10:12 a.m., a clinical record review was performed for Resident 3. The record lacked documentation of TST for Resident 3. During an interview on 7/1/24 at 4:36 p.m., the Administrator indicated she could not locate or provide any tuberculin skin testing results for either Resident 2 or Resident 3.	R 0410	**Tag number: R410** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Residents 2 and 3 received a TST test on 07/24/2024** II. 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 have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure all residents have received a TST.** III. 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 educated on administering a TST to residents upon admission**	07/24/2024

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			IV. 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; **DON/designee will audit all new admission to ensure they have received a TST .Audits will be completed 5x a week x 3 months.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	