STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	04/24/2024

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VALLEY VIEW HEALTHCARE CENTER	333 W MISHAWAKA RD ELKHART, IN 46517

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00429126, IN00430346, IN00431942, IN00433033 and IN00433034. Complaint IN00429126 - No deficiencies related to the allegations are cited. Complaint IN00430346 - Federal/state deficiencies related to the allegations are cited at F812 & F921. Complaint IN00431942 - Federal/state deficiencies related to the allegations are cited at F656 & F677. Complaint IN00433033 - No deficiencies related to the allegations are cited. Complaint IN00433034 - No deficiencies related to the allegations are cited. Survey dates: April 17, 18, 19, 22, 23 and April 24, 2024 Facility number: 000523 Provider number: 155496 AIM number: 100266930 Census Bed Type: SNF/NF: 84 Total: 84 Census Payor Type: Medicare: 1 Medicaid: 79 Other: 4 Total: 84	F 0000	**/b> /p> Preparation and execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts or alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of non-compliance cited during the survey process. Please accept this plan of correction as the provider's credible allegation of compliance. The facility is respectfully requesting a desk review**	

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

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

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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/30/24.			
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on record review and interview, the facility failed to ensure 1 of 1 resident's Level One PASARR (Preadmission Screening and Resident Review) assessment was completed accurately and failed to complete an updated Level 1 review. (Resident 66) Finding includes: A record review was completed on 4/18/2024. Resident 66 was admitted on 3/23/2023.	F 0644	Resident #66 was not harmed by the alleged deficient practice. Social Services Designee updated PASARR to match resident diagnosis and medications. SSD will complete an audit to validate all PASRRs are accurate by 5/10/2024. Executive Director/Designee educated SSD on the facility PASSAR policy/procedure with emphasis on completing	05/15/2024

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	The resident's March and April 2023 medication orders included the medication Quetiapine (antipsychotic) 50 mg (milligrams) 1 tablet by mouth nightly for psychosis. The Medication Administration Records (MARs), dated March and April 2023, indicated the resident had received the antipsychotic medication daily. A Preadmission Screening and Resident Review form, dated 4/7/2023, indicated Resident 66's diagnoses included major depressive disorder and dementia. There were no known mental health behaviors that affect interpersonal interactions. There were no known or suspected developmental conditions or diagnoses that affects intellectual and /or adaptive functioning. Mental Health Medications- List any antidepressants, mood stabilizers, antipsychotics, or other mental health medications prescribed currently or other mental health medications prescribed currently or within the past 6 months. No medications were listed on the form. A Notice of PASARR Level 1 Screen Outcome form, dated 4/7/2023, indicated Resident 66's Level 1 PASARR showed no Level II was required to be completed. The Algorithm outcome indicated: Rationale: The Level 1 screen indicates that a PASARR disability is not present because of the following reason: There is no evidence of a PASARR condition of an intellectual /developmental disability or a serious behavioral health condition. If changes occur or new information refutes these findings, a new screen must be completed. During an interview on 4/24/2024 at 11:29 A.M., the Corporate Nurse indicated the Level 1 was not		accurately. Exhibit A Executive Director/designee will complete an audit to validate PASSARs are being completed accurately. These audits will be completed 3x weekly for two (2) weeks; once weekly for two (2) weeks and then monthly for three (3) months. All new admissions are audited by the intake team and Business Office. Any needed correction will be immediately addressed by the Social Service Manager. The results of these audits/observations will be reported, reviewed and trended for compliance and further follow up through the facility QAPI Committee. Exhibit B	

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	completed accurately and a new Level 1 should have been completed. On 4/24/2024 at 8:37 A.M., the Corporate Nurse provided the policy titled, "PASRR- Pre-admission screening and resident review", dated 8/14/2020, and indicated the policy was the one currently used by the facility. The policy indicated, "... PASRR regulation requires resident reviews when there is a significant change in a NF residents's physical or mental condition...."			
F 0656 SS=E Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR			

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	recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on record review, observation and interview, the facility failed to develop comprehensive/person centered care plans for residents with behaviors and dementia care, for 6 of 23 residents whose care plans were reviewed. (Residents 66, 17, 77, 5, E & F) Findings include: 1. A record review was completed on 4/22/2024 at 10:27 A. M. Resident 66's diagnoses included, but were not limited to, dementia, depression anxiety, mood disorder and psychosis. A Quarterly MDS (Minimum Data Set) assessment, dated 3/18/2024, indicated the resident was moderately cognitively impaired.	F 0656	Desk Review Requested Resident #66,17 ,77, and 5 were not harmed by the alleged deficient practice. Residents #66,17and 77 had their care plans updated to be person centered. Resident #5 no longer resides in the facility. MDS, SSD and DON/Designee completed an audit on all resident's care plans with behaviors and Dementia care to validate they are person centered. Any issues were corrected. Exhibit C Regional Director Clinical Operations educated	05/15/2024

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	A current Care Plan, dated 3/27/2023, indicated the resident was at risk for Psychosocial well-being related to: Adjustment to new admission, Anxiety, Loss of Independence, dementia with behavioral disturbances, paranoia, auditory hallucinations, anxiety, and depression. A current Care Plan, dated 4/2/2023, indicated the resident had a behavior problem related to Psychosocial issues, dementia with behavioral disturbances, auditory hallucinations, agitation, anxiety, depression, paranoia, adjustment to new facility, history of saying she is here to work; now ready to go home; history of layering her clothing; history of disorganized thoughts; history of putting clothing in room trash can; history of expressions of frustrations to others. Packs personal belongings and repeatedly asks to leave. Exit seeking behavior, asking for the door codes and a history of repeating questions. At times redirection is unsuccessful. She prefers to wear make up and likes to put it on herself. History of pulling peers hair and pushing peer. Interventions included, but were not limited to: Administer medications as ordered. Observe and document signs/symptoms, and effectiveness and side effects. Educate resident / resident representative to medication effectiveness and side effects. Approach, speak in calm manor. Behavioral health consults as needed. Communicate with resident / resident representative regarding behaviors, and treatment. Encourage active support by family / resident representatives. Encourage Resident to express feelings. Encourage resident to participate in activities of choice. Encourage to maintain as much independence and control / decision making as possible. Intervene as necessary to protect the rights and safety of others. Minimize potential for		Interdisciplinary Team on the facility Plan of Care Overview policy with emphasis on person centered care plans. DON educated all licensed nurses on the facility Plan of Care Overview policy with emphasis on person centered care plans. Exhibit D DON/Designee will complete an audit to validate care plans are person centered. These audits will be completed 3x weekly for two (2) weeks; once weekly for two (2) weeks and then monthly for three (3) months. Care Plans are reviewed by the IDT group weekly and provided to the resident, POA and or Guardian per clinical change or as requested but no less than quarterly per resident. Care plans are monitored for date compliance per Point Click Care dashboard, the facility EMR system. The results of these audits/observations will be reported, reviewed and trended for compliance and further follow up through the facility QAPI Committee. Exhibit E	

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	disruptive behaviors by offering tasks that divert attention. Monitor behavioral episodes, and attempt to determine underlying causes. Observe and anticipate resident's needs: thirst, food, body positioning, pain, toileting needs. Offer resident activities of books, magazines, and if applicable with time and weather out side walks. Praise any indication of progress in behaviors. During an interview, on 4/22/2024 at 2:02 P.M., the Corporate Nurse indicated the care plan was not person centered and should have been.2. A clinical record review was completed on 4/19/2024, at 11:51 A.M. Resident 17's diagnoses included, but were not limited to: Cerebral palsy, Type 2 diabetes, depression, anxiety, hallucinations, and dementia. A current Care Plan, dated 8/30/2021, indicated the resident had a behavior problem related to dementia as evidence by, repetitively packing her belongings and staying in her room, sitting on the floor, believing there were bugs in her toes, picking her toenails off, yelling at people who were not there, talking to and carrying a doll. Interventions included, but were not limited to, administer medications as ordered, observe and document signs and symptoms of effectiveness and side effects of medications, educate resident and resident representative on medication, speak in a calm manor, communicate with resident regarding behaviors and treatment, encourage active support, encourage resident to express feelings, encourage resident to participate in activities, and encourage resident to maintain as much decision making as possible. During an interview, on 4/22/2024 at 1:59 P.M., the Corporate Infection Prevention Nurse indicated the care plans were not person centered and they			

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	should have been. 3. A clinical record review was completed on 4/18/2024 at 3:08 P.M. Resident 77's diagnoses included, but were not limited to: Alzheimer's, dementia, major depressive disorder, psychosis, hallucinations, and psychotic disorder with delusions. A Care Plan, dated 10/27/2023, indicated the resident had the potential to urinate and defecate on floors, become aggressive with care, a history of becoming physically and verbally aggressive, and a history of inappropriate boundaries. Interventions included but were not limited to 1:1 at all times with a staff, speak in a calm manner, intervene as necessary, minimize potential for disruptive behaviors by offering tasks that divert attention, observe and anticipate resident's needs, observe behavioral episodes and attempt to determine the underlying cause. During an interview, on 4/22/2024 at 1:59 P.M., the Corporate Infection Prevention Nurse indicated the care plans were not person centered and they should have been. 4. During an interview on 4/18/2024 at 10:05 A.M., Resident 5 became frustrated when she could not remember what she had eaten for breakfast. Resident 5's frustration was eased when asked about her child. A record review was completed on 4/19/2024 at 3:15 P.M. Resident 5's diagnoses included, but were not limited to: dementia, anxiety disorder, major depressive disorder, post traumatic stress disorder, chronic pain, and delusional disorders. A current Care Plan, dated 3/14/2024, indicated Resident 5 had a behavior problem related to			

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	disease process, family dynamic, loss of independence, nursing home admission, pain and psychosocial issues. The interventions were: observe and anticipate resident's needs: thirst, food, body positioning, pain and toileting needs, and praise any indication of progress in behaviors. A current Care Plan, dated 3/21/2024, indicated Resident 5 had impaired cognitive function related to dementia. The interventions were: encourage resident to be involved in daily decision making and keep routine as consistent as possible in order to decrease confusion. During an interview on 4/22/2024 at 10:05 A.M., Qualified Medication Aide (QMA) 12 indicated Resident 5 did exhibit frustration over being confused sometimes and the staff used the resident's Care Plan to identify interventions to help her. QMA 12 was not able to identify interventions in Resident 5's Care Plan that were person-centered. An interview with the Corporate Nurse was completed on 4/22/2024 at 10:30 A.M. The Corporate Nurse indicated Resident 5 did not have person-centered interventions for the Care Plans. 5. During an observation on 4/18/2024 at 10:07 A.M., Resident E's hair was oily and she had long fingernails on both of her hands. Resident E's finger nails were dirty on her right hand. An observation of Resident E was completed on 4/19/2024 at 9:45 A.M. Resident E's hair was oily and she had long fingernails on both of her hands. Resident E's finger nails were dirty on her right hand.			

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	Resident E's record review was completed on 4/22/2024 at 9:00 A.M. Resident E's diagnoses included, but were not limited to: vascular dementia, major depressive disorder, mood disorder, anxiety disorder, cerebral vascular accident, contracture of left wrist and left hand, and contracture of muscle of left lower leg and left lower hand. A Quarterly Minimum Data Set (MDS) assessment, dated 2/17/2024, indicated Resident E had severe cognitive impairment, had rejected care 1-3 days and was dependent on staff for bathing and personal hygiene. Resident E's record included documentation she had received bed baths on 4/1/2024, 4/4/2024, 4/8/2024, 4/15/2024, and 4/18/2024, but lacked the documentation that she had refused hair or nail care during any bed baths. A current Care Plan, dated 12/1/2023, indicated Resident E had an Activities of Daily Living self care performance deficit, required assistance with Activities of Daily Living and had a history of refusing nail care from staff. The interventions included, but were not limited to: Resident E is dependent for shower or bath and helper does all of the effort, and Resident E is dependent for personal hygiene care and helper does all of the effort. During an interview on 4/19/2024 at 10:44 A.M., CNA 6 indicated hair and nail care were performed during showers and bed baths. Residents were allowed to refuse care, but staff would make three attempts to complete showers, baths, hair and nail care. CNA 6 indicated the third attempt was done with a nurse, and if the resident still rejected care,			

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	the number of attempts and refusal for care was documented on the shower sheets. During an interview on 4/19/2024 at 10:50 A.M., the Director of Nursing indicated there were no shower sheets in the shower book for Resident E. An interview with the Corporate Nurse was completed on 4/22/2024 at 10:34 A.M. The Corporate Nurse indicated Resident E did not have person-centered interventions for the Care Plan to address rejection of care. 6. During an interview on 4/19/2024 at 10:20 A.M., Resident F indicated she did not always receive two showers a week. Resident F's hair appeared dirty and a strong smell of body odor was observed during the interview. Resident F's record review was completed on 4/19/2024 at 11:23 A.M. Her diagnoses included, but were not limited to: chronic obstructive pulmonary disease, major depressive disorder, asthma, chronic respiratory failure with hypoxia, vertigo, bipolar disorder, congestive heart failure and chronic pain. An Admission Minimum Data Set (MDS) assessment, dated 3/9/2024, indicated Resident F had intact cognition and required maximal assistance for showering and personal hygiene. Documentation indicated Resident E received a shower on 4/3/2024 and 4/10/2024, but refused a shower on 4/6/2024, 4/13/2024 and 4/17/2024. A current Care Plan, dated 2/20/2024, indicated Resident F had impaired skin integrity or is at risk of altered skin integrity related to congestive heart failure, body size, and morbid obesity, and often			

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	refuses showers. The interventions included, but were not limited to: complete akin at risk assessment upon admission, readmission, quarterly, and as needed and complete weekly skin checks. During an interview on 4/19/2024 at 10:44 A.M., CNA 6 indicated hair and nail care were performed during showers and bed baths. Residents were allowed to refuse care, but staff would make three attempts to complete showers, baths, hair and nail care. CNA 6 indicated the third attempt was done with a nurse, and if the resident still rejected care, the number of attempts and refusal for care was documented on the shower sheets. The shower sheets for Resident F were requested from the Director of Nursing on 4/19/2024 at 10:50 A.M., but none were provided prior to exiting the survey. An interview with the Corporate Nurse was completed on 4/22/2024 at 10:36 A.M. The Corporate Nurse indicated Resident F did not have person-centered interventions for the Care Plan to address rejection of care. On 4/22/2024 at 1:57 P.M., an undated policy was received from the Corporate Nurse, titled, "Plan of Care Overview", and identified as the policy currently used by the facility. The policy indicated, "...the Plan of Care, also Care Plan is written treatment provided for a resident that is resident-focused and provides for optimal personalized care... planning includes the provision of services to enable the resident to live with dignity and supports the resident's goals, choices, and preferences including, but not limited to, goals related to their daily routines...."			

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	This citation relates to Complaint IN00431942. 3.1-35(a)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review and interview, the facility failed to ensure residents requiring assistance with Activities of Daily Living (ADL) receive adequate assistance with hair and nail care and bathing for 2 of 5 residents reviewed for ADLs. (Residents E and M) Findings include: 1. During an observation on 4/18/2024 at 10:07 A.M. Resident E's hair was oily and she had long fingernails on both her hands. Resident E's finger nails were dirty on her right hand. An observation of Resident E was completed on 4/19/2024 at 9:45 A.M. Resident E's hair was oily and she had long fingernails on both her hands. Resident E's finger nails were dirty on her right hand. Resident E's record review was completed, on 4/22/2024 at 9:00 A.M. Resident E's diagnoses included, but were not limited to: vascular dementia, major depressive disorder, mood disorder, anxiety disorder, cerebral vascular accident, contracture of left wrist and left hand, and contracture of muscle of left lower leg and left lower hand.	F 0677	Desk Review is Requested Residents could not be identified related to confidential complaint survey. N DON/Designee completed an observation audit on all residents requiring assistance with Activities of Daily Living to ensure they have received adequate assistance with bath or shower per their preference and nail care. Exhibit F DON/Designee educated all nursing staff on the facility Routine Nursing Care and Nail and Hair Service policy with emphasis on giving adequate assistance to residents who require assistance and bathing or showering residents per their preference. Exhibit G DON/Designee will complete observation audits to validate adequate assistance is given to residents who require assistance with nail care and bathing or showering per their preference. These audits will be completed 3x weekly for two (2) weeks; once weekly for two (2) weeks and then	05/15/2024

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	155496	A. BUILDING 00 B. WING	04/24/2024

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VALLEY VIEW HEALTHCARE CENTER	333 W MISHAWAKA RD ELKHART, IN 46517

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	A Quarterly Minimum Data Set (MDS) assessment , dated 2/17/2024, indicated Resident E was dependent on staff for bathing and personal hygiene. Resident E's record included documentation she had received bed baths on 4/1/2024, 4/4/2024, 4/8/2024, 4/15/2024, and 4/18/2024. Resident E's record lacked the documentation to indicate she had refused hair or nail care. A current Care Plan, dated 10/6/2020, indicated Resident E had contractures and impaired functional range of motion of left side related to cerebral vascular accident. The interventions included, but were not limited to: daily hand washing, and weekly nail care. A current Care Plan, dated 12/1/2023, indicated Resident E had an ADL self care performance deficit, required assistance with ADL's and had a history of refusing nail care from staff. The interventions included, but were not limited to: Resident E is dependent for shower or bath and helper does all of the effort, and Resident E is dependent for personal hygiene care and helper does all of the effort. During an interview on 4/19/2024 at 10:44 A.M., CNA 6 indicated hair and nail care were performed when a shower or bed bath was given. If a resident refused a bed bath, shower, hair or nail care, CNA 6 would try again at a later time. If the resident still refused care, CNA 6 would have the nurse try to convince the resident to accept care. If the resident still refused care on the third attempt, the refusal and number of attempts would be documented on the residents shower sheets. CNA 6 indicated Resident E's hair was dirty and		monthly for three (3) months. Ongoing, the angel round manager assigned to residents will ask the resident about facility compliance. The DON/designee will also monitor regarding their preferences as well as monitoring the shower sheets for trends of refusals and compliance. The Resident Council is also an opportunity for residents to voice resident concerns regarding care. Any concerns voiced in Resident Council will be reduced to writing and forwarded to the DON/designee. The results of these audits/observations will be reported, reviewed and trended for compliance and further follow up through the facility QAPI Committee. Exhibit H	

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	her fingernails were long on both hands and finger nails were dirty on the right hand. During an interview, on 4/19/2024 at 10:50 A.M., The Director of Nursing indicated there were no shower sheets in the shower book for Resident E.2. During an observation on 4/18/2024 at 10:53 A.M., Resident M had a large growth of whiskers and needed to be shaved. A record review for Resident M was completed on 4/22/2024 at 2:38 P.M. Diagnoses included, but were not limited to dementia, protein malnutrition and Wernicke's encephalopathy. A Significant Change MDS (Minimum Data Set) assessment, dated 3/15/2024, indicated the resident required staff assist for all ADLs (activities of daily living) and it was very important to choose between a tub bath, shower or bed baths. A current Care Plan, dated 3/27/2024, indicated the resident had an ADL self care performance deficit related to requires assistance with ADLs, disease process due to weakness, and encephalopathy. Resident M's shower documentation, from 3/1/2024 to 4/21/2024, indicated the resident had received a shower on 3/2, 3/9, 3/16, 4/3 and 4/6/2024. A bed bath on 4/13 and refused on 4/20/2024. On dates: 3/6, 3/13, 3/20, 3/27, and 3/30/2023, NA (not applicable) was documented. During an interview on 4/19/2024 at 11:18 A.M., CNA 3 indicated staff had to attempt care 3 times, then tell the nurse, and it should be documented on the sheet when residents refuse care. During an interview on 4/22/2024 at 10:02 A.M.,			

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	QMA 4 indicated the Resident M would refuse care at times. During an interview on 4/24/2024 at 9:03 A.M., the Corporate Nurse indicated the resident should have received 2 showers per week. On 4/24/2024 at 9:15 A.M., the Corporate Nurse provided the policy titled, "Routine Nursing Care", undated, and indicated the policy was the one currently used by the facility. The policy indicated"...Routine Resident Care: care that is not necessarily medically or clinically based but necessary for quality of life promoting dignity and independence, as appropriate... 3. Routine care by a nursing assistant included but is not limited to the following: i. Assisting or provides personal care. 1. bathing...." On 4/24/2024 at 11:30 A.M., the Corporate Nurse provided the policy titled, "Nail and Hair Service", and indicated the policy was the one currently used by the facility. The policy indicated..."This facility will provide routine care for resident hygiene and for the psychosocial well being of the resident...routine care also includes nail hygiene services including routing trimming, cleaning and filing...a. Residents will have routine nail hygiene and hair hygiene as part of the bath or shower.... This citation relates to Complaint IN00431942. 3.1-38(a)(3) 3.1-38(b)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including			

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	tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review and interview, the facility failed to maintain oxygen equipment in a sanitary manner related to a dirty air filter on an oxygen concentrator for 1 of 2 residents who were reviewed for the use of oxygen. (Resident 21) Finding includes: An observation of Resident 21 was completed on 4/17/2024 at 02:52 P.M. Resident 21 was wearing a nasal cannula connected to an oxygen concentrator. The oxygen concentrator's filter had a thick layer of dust. During an observation on 4/19/2024 at 1:30 P. M., Resident 21 was wearing a nasal cannula connected to an oxygen concentrator. The oxygen concentrator's filter had a thick layer of dust. During an observation of Resident on 4/22/2024 at 2:14 P.M., Resident 21 was wearing a nasal cannula connected to an oxygen concentrator. The oxygen concentrator's filter had a thick layer of dust. A record review for Resident 21 was completed on 4/22/2024 at 2:45 P.M. His diagnoses included, but were not limited to: chronic respiratory failure with hypoxia, congestive heart failure, and chronic obstructive pulmonary disease.	F 0695		

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	A Physician's Order, dated 11/6/2023, indicated to administer oxygen at 2 to 4 liters for shortness of breath. A Physician's Order, dated 11/12/2023, indicated to clean the oxygen concentrator filter with soap and water weekly and as needed, at bedtime every Sunday. During an interview on 04/24/2024 at 9:37 A.M., LPN 5 indicated the oxygen concentrator's filter was dirty. During an interview on 04/24/2024 at 10:30 A.M., the Corporate Nurse indicated the filter on oxygen concentrator should have been cleaned weekly. On 4/24/2024 at 10:27 A.M., an undated policy was received from the Corporate Nurse, titled, "Oxygen Therapy Using Concentrators", and identified as the policy currently used by the facility. The policy indicated "... III. Care and Maintenance a. Filters and machines are to be cleaned once a week: i. Perform hand hygiene and done gloves ii. Remove filter iii. Rinse with running water until clean iv. Squeeze water from filter v. Dry with towel (cloth or paper)...." 3.1-18(b)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.			

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	Based on interview and record review the facility failed to assess a resident upon return from dialysis procedures for 1 of 1 resident reviewed for dialysis. (Resident 34) Finding includes: A record review for Resident 34 was completed on 4/19/2024 at 2:08 P.M. Diagnoses included, but were not limited to, end stage renal dialysis and dependence on dialysis. The Quarterly Minimum Data Set (MDS) assessment, dated 2/26/2024, indicated Resident 34's cognition was intact and she received dialysis services. Physician orders included, but were not limited to: - 4/29/2022 Obtain pre-dialysis weight, and post dialysis weights on every Monday, Wednesday, and Friday, related to end stage renal disease. - 8/25/2022 Dialysis Monday, Wednesday, and Friday at [name of] Dialysis Center. A Care Plan problem, initiated on 10/6/2020 and revised on 6/21/2023, indicated Resident 34 had end stage renal disease and required hemodialysis with the potential for complications. Interventions included, but were not limited to: -If the resident refuses to go to dialysis, provide education as to the risks of skipping treatment i.e., hyperkalemia, cardiac arrhythmias, risk for cardiac failure, hyperphosphatemia, weakening of bones, increased risk for heart disease. -Monitor vital signs and report abnormal findings to medical provider, nephrologist, dialysis center, resident and/or resident representative. Post-dialysis evaluations were not completed on	F 0698	Desk Review is Requested Resident #34 was not harmed by this alleged deficient practice. Resident #34 was assessed by nursing staff. DON/Designee completed an audit for the last 2 weeks on all residents who have hemodialysis to validate that a post dialysis assessment had been completed. Exhibit I DON/Designee educated all licensed nurses on the facility Hemodialysis Care and Monitoring policy with emphasis on completing an assessment on resident when returning from dialysis. Exhibit J DON/Designee will an audit to validate post assessments are completed on dialysis residents. These audits will be completed on each resident receiving dialysis weekly for two (2) weeks; then weekly for two (2) weeks and then monthly for three (3) months. The clinical team will monitor pre and post dialysis assessments no less than monthly for all residents receiving dialysis. The results of these audits/observations will be reported, reviewed and trended for compliance and further follow up through the facility QAPI Committee. Exhibit K	05/15/2024

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	the following dates: 1/3/24 1/5/24 1/8/24 1/10/24 1/15/24 1/19/24 1/22/24 1/24/24 1/26/24 1/29/24 2/2/24 2/5/24 2/7/24 2/9/24 2/12/24 2/16/24 2/19/24 2/26/24 During an interview on 4/23/2024 at 2:35 P.M., LPN 5 indicated a post-dialysis assessment should be done each time a resident returned from dialysis. During an interview on 4/23/2024 at 2:38 P.M., LPN 13 indicated he looked at dialysis paperwork and documented on the post-dialysis assessment each time a resident returned from dialysis. During an interview on 4/24/2024 at 9:35 A.M., the Corporate Nurse indicated that post-dialysis assessments were not completed upon return to the facility on the dates listed above. A current policy titled "Hemodialysis Care and Monitoring" provided by the Corporate Nurse, on 4/24/2024 at 8:45 A.M., included, but was not limited to, "37b. Nurse to complete the post-dialysis evaluation upon return from dialysis			

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	center ...." 3.1-37(a)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure a medication cart was kept locked when unattended during a random observation of the medication cart. This had the potential to affect the 22 residents residing on the memory care unit. (400 Hall Medication Cart)	F 0761	Desk Review Requested No residents were harmed by this alleged deficient practice. Nurse was immediately educated on locking cart when unattended. DON/Designee immediately completed an observation audit to	05/15/2024

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	Finding includes: During a random observation on 4/18/2024 at 11:10 A.M., the 400 hall medication cart on the memory care unit was unlocked with no staff in the vicinity. During an interview on 4/18/2024 at 11:12 A.M., LPN 14 indicated the cart should have been locked. On 4/24/2024 at 8:37 A.M., the Corporate Nurse provided the policy titled, "Storage of Medications", dated 8/2020, and indicated the policy was the one currently used by the facility. The policy indicated..."Medications and biologicals are stored safely, securely, and properly... 2. Medication rooms, carts and medication supplies are locked when they are not attended by persons with authorized access...." 3.1-25(m)		validate all carts were locked when unattended. Exhibit L DON/Designee educated all licensed nurses and QMA's on the facility Storage of Medication policy with emphasis on ensuring medication cart is locked when unattended. Exhibit M DON/Designee will an audit to validate medication carts are locked when unattended. These audits will be completed 3x weekly for two (2) weeks; 2x weekly for two (2) weeks and then no less than monthly thereafter. The results of these audits/observations will be reported, reviewed and trended for compliance and further follow up through the facility QAPI Committee. Exhibit N	
F 0800 SS=D Bldg. 00	483.60 Provided Diet Meets Needs of Each Resident §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Based on observation, interview, and record review, the facility failed to provide residents with appropriate serving sizes for 1 of 4 residents reviewed for pureed meals. Finding includes: During an observation of the dining room on	F 0800	Desk Review Requested As indicated on the 2567, the inappropriate serving size was replaced with the correct serving size at the time of survey observation. All residents receiving pureed servings could have been affected.	05/15/2024

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	4/17/2024 at 12:55 P.M., there were four residents who received pureed meals. When the last resident received their meal, QMA 4 removed the lid of the bowl and there was approximately one tablespoon of green beans in the resident's bowl. During an interview, on 4/17/2024 at 12:56 P.M., QMA 4 indicated there was not ½ cup of pureed green beans in the bowl. During an interview on 4/17/2024 at 1:25 P.M., the Dietary Manager (DM) indicated the portion of green beans that was served was not a full serving of ½ cup. After telling the cook to remove what was in the bowl and then scoop out a full amount of the green beans, the DM indicated the amount did not meet the dietary requirements. On 4/18/2024 at 8:50 A.M., the Corporate Infection Prevention Nurse provided the pureed menu for week four, which indicated the lunch meal was for pureed cheese ravioli and pureed green bean salad using a #10 scoop which equaled ½ cup. She indicated they did not have a policy for specific portion sizes, they went by the menu. 1.3-20(a)		All kitchen staff were inserviced on 5/6/24 and 5/8/24 on the correct serving scoop size. (inservice and post-test attached) Adding instructional sheets were handed out depicting the color coding of the scoops. Scoops are to be fill to the top to meet the desired caloric intake of each resident. The Dining Services Manager will monitor pureed scoop serving for 5 meals per week for 3 weeks, then no less than 2 times per week for four weeks to ensure the scoop is filled to the top as required. Any failure of this area will be remedied with re-education of the affected staff member or discipline as required by company policy. Audits will continue as a part of the kitchen manager duties no less than weekly. The audits will be added to the monthly reporting of the QAPI committee.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or			

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	regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to store food and maintain equipment in a sanitary manner related to foods not sealed tightly, mold in a refrigerator, cookware with chipped Teflon and a resident's personal water container with mold (Resident G). This deficient practice had the potential to affect 84 of 84 residents who received meals out of the kitchen. Findings include: 1. During an interview on 4/18/2024 at 11:32 A.M., Resident G indicated he had a plastic water container that he used to use, but the water from the bathroom where the staff would get the water from turned his straw black. Resident G indicated staff had never washed it. He had stopped them from using it and had a water pitcher staff would put ice in now. A plastic clear water jug with a plastic ringed straw sitting in the container was observed on the resident's night stand. The straw was noted to have black around the rings of the straw. A record review was completed on 4/23/2024 at	F 0812	Desk Review Requested The plastic water container for resident G was replaced. The suspected mold in a cooler was cleaned the same day as identified. The unsealed food container was sealed during the inspection. Three scratched Teflon skillets were removed from service and new skillets were received the day the deficiency was discovered. All residents had the potential to be affected. The dietary staff were inserviced on the correct storage and cleaning operations as indicated on /6/24 and 5/8/24. The inservice material covered and post-test are attached. The dietary manager will inspect skillets monthly to ensure any scratched surface skillets are removed from service and replaced. The dining services manager will provide routine sanitation rounds to ensure all	05/15/2024

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	5:00 P.M. Resident G was cognitively intact. During an observation on 4/24/2024 at 9:57 A.M. the Corporate Nurse, the container was on the resident's night stand. During an interview on 4/24/2024 at 9:58 A.M., the Corporate Nurse indicated the container was dirty and should have been sanitized, and it was not dirty due to the water, but was moldy. 2. On 4/17/2024 at 9:37 A.M., a kitchen tour was conducted with the Dietary Manager (DM). The following was observed: a buildup of ice on the floor of a freezer, mold on a refrigerator shelf, one dented can of pumpkin, and a bag of whipped topping and parmesan cheese not sealed appropriately. During an interview on 4/22/2024 at 10:14 A.M., the DM indicated areas should be clean and food stored and sealed properly, 3. During a follow-up tour of the kitchen on 4/22/2024 at 10:11 A.M., the following was observed: two skillets with a buildup of grease on the inside and four skillets missing Teflon. During an interview on 4/22/2024 at 10:14 A.M., the DM indicated he understood that chipped Teflon could get into the food and the skillets should be removed. On 4/18/2024 at 8:47 A.M., the Corporate Infection Prevention Nurse provided the policy titled, "Environment", dated 9/2017, and indicated the policy was the one currently used by the facility. The policy indicated ... "Procedures: 1. The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and		stored foods are sealed for storage. And coolers do not have suspected mold growth. All residents are provided a 16 oz. disposable water cup with straw and lid. These items are replaced and dated by staff every 24 hours. The dining services manger's inspection and audit reports are added as a part of the reports provided through the QAPI committee. The dining manager will continue to these audits on a ongoing basis and be no less than three times weekly. Any education needed will be provided as a follow up. The angel round managers will provide an audit of drinking cups ensuring that the cups are replaced every 24 hours as indicated by the date on the cup.	

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	155496	A. BUILDING 00 B. WING	04/24/2024

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	ventilation. 4. The Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas and surfaces ...." On 4/18/2024 at 8:47 A.M., the Corporate Infection Prevention Nurse provided the policy titled, "Food Storage: Dry Goods," dated 9/2017, and indicated it was the one currently used by the facility. The policy indicated ... "Procedures: 5. All packaged and canned food items will be kept clean, dry, and properly sealed ..." On 4/18/2024 at 8:47 A.M., the Corporate Infection Prevention Nurse provided the policy titled, "Food Storage: Cold Foods," dated 4/2018, and indicated it was the one currently used by the facility. The policy indicated ... "Procedures: 5. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination ..." This citation relates to Complaint IN00430346. 3.1.21(i)(3)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a safe, clean and comfortable environment was maintained related to missing dresser drawer handles, a missing bathroom door knob, broken window blinds, and mold in a closet, as well as dirty microwaves, drawers, an oven, and cabinets/drawers for 2 of 4 halls observed. (200 &	F 0921	Desk Review Requested The missing handles were replaced prior to the completion of the survey. The window blinds were replaced within 24 hours. The microwave on 400 unit was replaced and the activities microwave was cleaned prior to	05/15/2024

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	400 halls) Findings include: An environmental tour was conducted on 4/24/2024 at 11:16 A.M. with the Maintenance Director, Administrator and the (AIT) Administrator in training. 1. The following was observed on the 400 hall: - Room 404: there was a broken window blind. - Room 405: the dresser was missing 8 handles. - Room 407: the bathroom door had no handle. - Room 415: there was a window blind setting on the floor and not covering the window. - The 400 unit dining room had 4 broken blinds, an oven that was not plugged in with dried food particles in the oven and the oven door had dried grease stains, and kitchenette drawers and cabinets had various different items stored along with non-food items that were dirty. - A storage closet holding activity items and other items had no lock, had a hole in the ceiling where insulation and water had leaked onto the floor and where mold had grown on the wall. 2. The following was observed on the 200 hall: - The Activity room had a microwave that was dirty with dried food substance and rust along the bottom and inside on the ceiling of the unit. During an interview, on 4/24/2024 at 11:40 A.M., the Administrator indicated the blinds/doors were being replaced, the kitchenette items (microwaves/drawers/cabinets) should be clean, and the storage room should be locked. On 4/24/2024 at 12:16 P.M., the Corporate Nurse indicated they had no specific policy regarding the environment and it would fall under resident		the completion of the survey. The suspected mold in the storage closet was cleaned and sealed/painted within 24 hours. The 400 dining cupboards and oven were cleaned by housekeeping on 5/6/24. The identified faulty doors were repaired. The facility does have a door replacement program for doors identified as hardly operable. The identified doors have been bid out for replacement as they are manufactured. All residents had the possibility to be affected. Some residents do remove handles and break blinds as a busy hands or curiosity on the 400 unit. They blinds will be inspected no less weekly and needed repairs will be routed through the TELs maintenance management system for timely repair. The oven and microwaves will be wiped after each use. They will be inspected aby the Memory Care Manager no less than 3 times weekly. The storage area will be inspected as a part of the normal room audit no less than weekly. Any water leaks found will be reported on the TELS maintenance management system. The inspections and audits are ongoing. The door will be replaced as quickly as they can be manufactured. The facility has an ongoing door replacement process replacing identified broken or malfunctioning doors as a	

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	rights. This citation relates to Complaint IN00430346. 3.1-19(f)		priority. All TELS maintenance management reports show the time the needed repair was logged to the time of correction. The TELS report is audited monthly for completion on an ongoing basis. The doors were identified and requests for bid prior to the survey process. Some prior identified doors have already been replaced. Approximately 12 doors have already been replaced in this process.	