STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155845	A. BUILDING 00 B. WING	04/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00404632 and IN00404731. This visit resulted in an Extended Survey - Substandard Quality of Care. Complaint IN00404632 - Federal/State deficiencies related to the allegations are cited at F677, F684, F686, F692. Complaint IN00404731 - Federal/State deficiencies related to the allegations are cited at F684 and F692. Survey dates: April 2, 3, 4, and 5, 2023 Extended Survey Date: April 5, 2023 Facility number: 000368 Provider number: 155845 AIM number: 100275220 Census Bed Type: SNF/NF: 22 Total: 22 Census Payor Type: Medicaid: 19 Other: 3 Total: 22 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/11/23.	F 0000		
F 0550 SS=E	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights			

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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Bldg. 00	§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as			

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	required under this subpart. Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to dining assistance for dependent residents and staff talking about residents for 4 of 6 residents reviewed for dignity and 2 of 3 meals observed. (Residents K, E, 23, and 6) Findings include: 1. On 4/2/23 at 10:15 a.m., Resident K was in his geri recliner in the dining room. The resident's tablemate was served at that time and proceeded to eat his breakfast. The resident was served at 10:21 a.m. and he didn't receive any assistance from staff until 10:27 a.m. On 4/3/23 at 9:50 a.m., the resident was in the geri recliner in the dining room. The resident's tablemate was served oatmeal. Resident K did not receive his breakfast tray until 10:12 a.m. and he didn't receive assistance with his meal until 10:30 a.m. Both of his tablemates were eating in front of him during that time. The record for Resident K was reviewed on 4/3/23 at 2:23 p.m. Diagnoses included, but were not limited to, hemiparesis (muscle weakness) following a stroke, Vitamin C and D deficiencies, and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 1/8/23, indicated the resident was cognitively impaired for daily decision making and was totally dependent on staff for eating. Interview with the Nurse Consultant on 4/5/23 at 10:40 a.m., indicated the residents should have been served a table at a time and assistance with	F 0550	Corrective Action(s) for Residents Affected by the Deficient Practice Resident K – The resident has been discharged per family request. Resident E - Meals are served at the same time other residents at his table are served. Meal assistance is provided timely. Resident 23 – SW interviewed the resident regarding the staff conversation she thinks she overheard. The resident requested the conversation to remain private. Resident 6 – Staff are monitoring the resident's dignity and responding by providing tissues if her nose is observed running while in the dining room. Corrective Action(s) for Other Residents Potentially Affected All residents have the potential to be affected by this deficient practice. All staff are responsible for ensuring the Resident's Right to a dignified existence. Staff education has been provided, and monitoring for dignity practices is in place. Measures to Ensure the Deficient Practice Does Not Recur All staff have been re-educated on Resident Rights with a focus on each resident's right to a dignified existence. Charge nurses are responsible for monitoring dignity issues through Daily Rounds and are required to	06/15/2023

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	their meals should have been more timely. 2. On 4/3/23 at 9:50 a.m., Resident E was observed in the dining room in his adaptive wheelchair. His tablemate was served oatmeal at that time. Resident E received his breakfast tray at 10:12 a.m. He did not receive assistance with his meal until 10:22 a.m. The record for Resident E was reviewed on 4/4/23 at 1:30 p.m. Diagnoses included, but were not limited to, cerebral palsy, intellectual disabilities, and aphasia (difficulty speaking). The Discharge Return Anticipated Minimum Data Set (MDS) assessment, dated 2/23/23, indicated the resident was severely impaired for daily decision making and was totally dependent on staff for eating. Interview with the Nurse Consultant on 4/5/23 at 10:40 a.m., indicated the residents should have been served a table at a time and assistance with their meals should have been more timely. 3. During the Resident Council Meeting on 4/4/23 at 11:42 a.m., Resident 23 indicated she was in her room one day last week and overheard NA 1 talking out loud to another staff member about her personal business. NA 2 was speaking loudly in the hallway so anyone could hear on how the resident's daughters do not want anything to do with her, she has no money, no place to live and she does not have a fiance. The resident was very upset this employee was saying all this to another person as she sat in her room and listened. The resident stated, "The part that really got me was how happy she was to say all of that. It was very upsetting to me." The record for Resident 23 was reviewed on 4/5/23		address and correct any concerns found during their rounds. The Monitoring Process to Ensure the Deficient Practice Does Not Recur The Administrator or designee will complete Dignity / Privacy / Survey Book Rounds three times per week for four weeks, then two times per week for four weeks, then once per week for four weeks or until 100% compliance has been achieved during four consecutive audits. Audit results will be documented and submitted to the QAPI Committee for review with further revisions or actions implemented as deemed necessary. DATE: 6/15/23	

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	at 4:00 p.m. Diagnoses included, but were not limited to, schizophrenia, bipolar disorder, anxiety, high blood pressure and epilepsy. The Admission Minimum Data Set (MDS) assessment, dated 3/13/23 indicated the resident was cognitively intact and had no behaviors. Interview with the Director of Nursing on 4/5/23 at 2:00 p.m., indicated the resident has been talking about employees and calling other resident's family members, so she was not sure if NA 2 really said what was reported.4. On 4/2/23 at 10:23 a.m., Resident 6 was observed seated at a table in the dining room with three other residents. She was served her breakfast at this time. At 10:28 a.m., Resident 6 was observed to start feeding herself her breakfast with her hands. Her nose was dripping into the food as she was eating. The Activity Director and two aides were in the dining room at the time and did not provide any assistance to the resident. Resident 6's record was reviewed on 4/4/23 at 10:45 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, major depressive disorder, and anxiety disorder. The Annual Minimum Data Set (MDS) assessment, dated 2/2/23, indicated the resident was severely cognitively impaired for daily decision making. The resident required extensive assistance with one person physical assist for bed mobility, transfer, and personal hygiene. Interview with the Nurse Consultant on 4/4/23 at 12:40 p.m., indicated she had no further information to provide. 3.1-3(t)			

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F 0577 SS=C Bldg. 00	483.10(g)(10)(11) Right to Survey Results/Advocate Agency Info §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. Based on observation and interview, the facility failed to ensure residents and/or visitors could access the survey inspection results without having to ask. This had the potential to affect 22 of the 22 residents who resided in the facility. Finding includes: During the Resident Council Meeting on 4/4/23 at 11:42 a.m., the President was the only person who was able to indicate where the survey inspection	F 0577	F577 Corrective Action(s) for Residents Affected by the Deficient Practice No specific residents were cited. The sign indicating the location of the survey binder is posted on the glass window in front of the nurses station. The survey binder is located on the shelf under the time clock, which is approximately eight feet from the posted sign.	06/15/2023

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	results were located. There were 7 residents who attended the meeting. After the meeting was adjourned, the President walked over to the employees' time clock and the book was located on a shelf under the clock. There was no sign on the wall or around the area to indicate the survey book was located under the clock. Interview with the Nurse Consultant on 4/5/23 at 10:30 a.m., indicated there was no sign posted by the time clock to let visitors and residents know where the survey book was located. 3.1-3(b)(1)		Corrective Action(s) for Other Residents Potentially Affected All residents have the potential to be affected by this deficient practice. All residents and/or their responsible parties have been notified of the location of the survey binder. Measures to Ensure the Deficient Practice Does Not Recur All staff have been re-educated on the importance of public information regarding the location of the survey binder. Charge nurses will ensure that the posted sign in front of the nursing station does not get covered by any other sign. The Monitoring Process to Ensure the Deficient Practice Does Not Recur The Administrator or designee will complete Dignity / Privacy / Survey Book Rounds three times per week for four weeks, then two times per week for four weeks, then once per week for four weeks or until 100% compliance has been achieved during four consecutive audits. Audit results will be documented and submitted to the QAPI Committee for review with further revisions or actions implemented as deemed necessary. DATE:6/15/23	
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 record review and interview, the facility failed to ensure residents' advance directive information was documented for 1 of 12 residents reviewed for advance directives. (Resident H) Finding includes: Resident H's record was reviewed on 4/3/23 at 2:28 p.m. Diagnoses included, but were not limited to, depression, dementia, and Parkinson's disease. The resident was admitted on 3/8/23. There was no documentation related to advance directives. The was no documentation related to the resident's code status. Interview with the Nurse Consultant on 4/4/23 at 12:40 p.m., indicated the resident did not have an advance directive and her code status should have been documented in his chart. 3.1-4(f)(A)(ii)	F 0578	**F578** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident H – The Health Care Power of Attorney has been requested to discuss the resident's preference regarding Advanced Directives. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. Every resident's electronic record has been reviewed for Advanced Directives. All residents have physician orders regarding the code status as per Advance Directive preference. **Measures to Ensure the Deficient Practice Does Not Recur** Licensed nurses have been re-educated on the need to request an order for code status according to the Advanced Directive preference for all new admissions. They have been instructed to notify the Social Worker if Advanced Directive information is not available with admission documents. The Social Worker will contact the resident if alert and oriented or the responsible party/guardian and request that Advanced Directive	06/15/2023

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			information be provided. The physician will provide the code status order based upon the written Advanced Directive preference. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Director of Nursing or nurse designee will review all new admissions within five business days post-admission to ensure that code status orders are in place and match the Advanced Directive preferences for each resident. The DON will be alerted immediately if code status orders are not located in the electronic record. The new admission reviews will be documented in an audit form and will be on-going. Audit results will be documented and submitted to the QAPI Committee for review with further revisions or actions implemented as deemed necessary. DATE: 6/15/23	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's			

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

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	Based on record review and interview, the facility failed to ensure the Physician was notified of continued medication refusals for 1 of 1 residents reviewed for notification of change. (Resident 5) Finding includes: The record for Resident 5 was reviewed on 4/5/23 at 8:48 a.m. Diagnoses included, but were not limited to, end stage renal disease, dependence on renal dialysis, schizophrenia, and hypertension. The Annual Minimum Data Set (MDS) assessment, dated 1/13/23, indicated the resident was cognitively impaired for daily decision making and rejection of care had occurred 4 to 6 days. A Care Plan, reviewed on 2/2/23, indicated the resident had a history of refusing medications. The goal was for medication refusals to occur less than 2 times per month through the next review. Interventions included, but were not limited to, attempt to administer ordered medications 30 minutes later if he refused at the ordered time. Nurses' Notes, dated 3/23/23 at 3:41 p.m., indicated the resident had bilateral edema to his hands. The dialysis center was contacted and they indicated the edema was observed at dialysis that morning. The Physician was notified and orders were received for Lasix (a diuretic) 20 milligrams daily for 5 days. Nurses' Notes, dated 3/25/23 at 6:57 a.m., indicated the resident had swelling of his bilateral hands and he was complaining of pain. The resident refused to take his medication. A new order for Lasix was received and the medication was available but the resident refused the medication.	F 0580	**F580** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 5 – The Lasix has been discontinued; however, the resident is sporadically refusing other ordered medications. The physician has been notified of the resident's medication refusals. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. Medication Administration Records for the month of April have been reviewed, and the physician notified of any medication refusals. Charges nurses are reporting any accident, significant change in physical, mental, or psychosocial status that may result in the need to alter treatment significantly to the resident's primary care physician and/or the psychiatric nurse practitioner. **Measures to Ensure the Deficient Practice Does Not Recur** 24-hour reports available in Point Click Care are reviewed daily Monday through Friday by the Nurse Supervisor and daily by the Nurse Consultant during visits to the facility. The DON and/or Nurse Consultant review the 24-hour reports daily on weekends. The nursing progress notes of any	06/15/2023

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	The March 2023 Medication Administration Record (MAR) indicated the resident refused all 5 doses of the Lasix. There was no documentation to indicate the Physician was notified of the continued medication refusals. Interview with the Nurse Consultant on 4/5/23 at 10:30 a.m., indicated the resident's Physician should have been notified of the Lasix refusals. 3.1-5(a)(2)		resident with changes are reviewed to ensure timely physician/family notification. Licensed nurses have been re-educated on all circumstances requiring physician and family/guardian notification. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The DON or designee will monitor physician notification of resident changes and or medication refusals through 24-hr report reviews daily on-going. Quality of Care audits for residents with condition changes are being conducted by the Director of Nursing and/or nurse designee on a concurrent basis and will continue on-going. The Quality of Care audit focus has been expanded to include monitoring MD notification of residents who are refusing medications. The DON will be notified upon completion of each audit to ensure immediate corrective actions are implemented. Audit results will be documented with compliance rates determined and submitted to the QAPI Committee for review. Further revisions or actions will be implemented as deemed necessary. DATE: 6/15/23	
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality.			

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	155845	A. BUILDING 00 B. WING	04/05/2023

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	The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation, record review, and interview, the facility failed to ensure privacy was provided during wound and incontinence care for 2 of 2 residents reviewed for privacy. (Residents E and K)	F 0583	**F583** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident E – privacy is provided	06/15/2023

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	Findings include: 1. Wound care for Resident E was observed on 4/5/23 at 11:56 a.m. with Agency LPN 1. CNA 1 was assisting the LPN with positioning the resident. The privacy curtain was pulled due to the resident's roommate being in the room. He was seated on his bed facing Resident E. The resident's pants were pulled down and his brief was removed so the LPN would have access to the dressing on the resident's right buttock. After the dressing was removed, the LPN proceeded to the sink to wash her hands, when she walked past the foot of the bed, the privacy curtain opened. When she returned to the side of the resident's bed to complete the treatment to the right buttock, the curtain was not pulled closed. The resident was visible to his roommate. After the treatment to the resident's buttock was completed, the resident's brief was changed and his pants were left around his knees. The privacy curtain remained open while the LPN proceeded to complete the treatment to the resident's right outer ankle. At the completion of the treatment, the LPN jokingly said to the resident's roommate, "After watching me, you will be able to complete the treatment next time." The record for Resident E was reviewed on 4/4/23 at 1:30 p.m. Diagnoses included, but were not limited to, cerebral palsy, intellectual disabilities, and aphasia (difficulty speaking). The Discharge Return Anticipated Minimum Data Set (MDS) assessment, dated 2/23/23, indicated the resident was severely impaired for daily decision making and he was totally dependent on staff for bed mobility and transfers.		during all personal and wound care. Resident K - The resident has been discharged per family request. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. Privacy during personal care or treatment is provided to all residents. **Measures to Ensure the Deficient Practice Does Not Recur** All staff have been re-educated on the need to provide privacy when personal care is rendered, or while treatments are performed. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Administrator or designee will complete Dignity / Privacy / Survey Book Rounds three times per week for four weeks, then two times per week for four weeks, then once per week for four weeks or until 100% compliance has been achieved during four consecutive audits Audit results will be documented and submitted to the QAPI Committee for review with further revisions or actions implemented as deemed necessary. DATE: 6/15/23	

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	Interview with the Nurse Consultant on 4/5/23 at 1:46 p.m., indicated the privacy curtain should have remained pulled throughout the entire treatment. 2. On 4/3/23 at 3:13 p.m., Resident K was transferred from his geri recliner to his bed. The resident's roommate was in the room at the time seated in his wheelchair. The privacy curtain was not pulled while the resident was being transferred via the hoyer lift. Incontinence care was provided by Agency CNA 1 and CNA 2 after the resident was placed in bed. The privacy curtain was not pulled while incontinence care was being provided and the resident's roommate remained seated in his wheelchair. The record for Resident K was reviewed on 4/3/23 at 2:23 p.m. Diagnoses included, but were not limited to, hemiparesis (muscle weakness) following a stroke, Vitamin C and D deficiencies, and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 1/8/23, indicated the resident was cognitively impaired for daily decision making and was totally dependent on staff for bed mobility and transfers. Interview with the Nurse Consultant on 4/5/23 at 10:40 a.m. indicated the privacy curtain should have been pulled when the CNAs were providing incontinence care. 3.1-3(p)(2) 3.1-3(p)(4)			
F 0585 SS=E Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances.			

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	§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her			

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	grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not			

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	confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.			
	Based on record review, and interview, the facility failed to provide a formal process to address, investigate, and resolve resident council concerns in a timely manner for 1 of 1 resident council groups. This had the potential to affect all residents who attended or participated in the resident council group. Finding includes: During the Resident Council Meeting on 4/4/23 at 11:42 a.m., the Council President, indicated he pretty much handled the meetings by himself without staff involvement. He documented all of the resident's concerns on a legal note pad and after the meetings he would present the council concerns to the Director of Nursing (DON). He did not know of a process to complete a grievance form to formally present the concerns to Administration. All 7 residents in attendance at the meeting indicated they did not know how to file a complaint/grievance. There were no	F 0585	**F585** **Corrective Action(s) for Residents Affected by the Deficient Practice** The Resident Council President and active members of the council have been informed of the formal grievance process and the location of forms that can be completed if a resident wishes to submit a written grievance. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. Residents and/or family members/guardians have been informed of the formal grievance process and the location of forms that can be completed if the person wishes to submit a written grievance. Grievance forms have	06/15/2023

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	complaint forms to complete that were readily accessible to the residents. A resident indicated the DON was not always readily available to talk with them. They indicated they had tried 3 times to speak to the DON and were told to come back later, she was busy. The Council President indicated the DON was not always available to go over the concerns/complaints from the meetings. He has always relied on "Good Faith Effort" for the DON to get back with him regarding the concerns. Interview with the Nurse Consultant on 4/5/23 at 10:30 a.m., indicated she did not think grievance forms were readily available anywhere for residents to submit a complaint. She indicated there should be a formal procedure with the resident council for their grievances to be addressed. Interview with the DON on 4/5/23 at 2:00 p.m., indicated she was unaware she had to complete a formal grievance when the Resident Council President approached her after the meetings with all of the resident's concerns. The SSD (Social Service Director) would usually go around and ask the residents if they had any problems but nothing was formally documented. 3.1-3(l)		been provided to the Resident Council president and have been placed in common areas where they will be easily accessible to residents, family members, and/or visitors. **Measures to Ensure the Deficient Practice Does Not Recur** The Grievance Policy has been reviewed and revised as deemed necessary to ensure there is formal process for discussion and timely response to any written grievance. The administrative team will offer assistance with Resident Council meetings and attend meetings upon invitation. The Administrator or designee will maintain all completed Grievance forms in a central location upon resolution. The Monitoring Process to Ensure the Deficient Practice Does Not Recur The Social Worker or designee will complete audits of the grievance process once per week for four weeks, then once every two weeks for four weeks, then once per month for four weeks or continued until 100% compliance has been achieved during four consecutive audits. Any concerns found during the audits will be reported to the Administrator for immediate correction. Audit results will be documented and submitted to the QAPI Committee for review with further	

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			revisions or actions implemented as deemed necessary. DATE: 6/15/23	
F 0645 SS=D Bldg. 00	483.20(k)(1)-(3) PASARR Screening for MD & ID §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.			

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	§483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.			
	Based on record review and interview, the facility failed to ensure a Level I PASARR (Preadmission Screening and Resident Review) was completed for a resident with a mental illness for 1 of 1	F 0645	**F645** **Corrective Action(s) for Residents Affected by the Deficient Practice**	06/15/2023

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	residents reviewed for PASARR. (Resident 23) Finding includes: The record for Resident 23 was reviewed on 4/5/23 at 11:22 a.m. Diagnoses included, but were not limited, to schizophrenia, bipolar disorder, and anxiety disorder. The Admission Minimum Data Set (MDS) assessment, dated 3/13/23, indicated the resident was cognitively intact for daily decision making. The question regarding the resident being considered by the State Level II PASARR (Preadmission Screening and Resident Review) process to have serious mental illness and/or intellectual disability or a related condition was marked "No." In the last 7 days the resident had received an antipsychotic, anti-anxiety, and antidepressant medication. Interview with the Nurse Consultant on 4/5/23 at 2:17 p.m., indicated the resident should have had a PASARR Level 1 completed prior to admission. 3.1-16(d)(1)(B)		Resident 23 – The PASARR information has been obtained and is available in the electronic record. **Corrective Action(s) for Other Residents Potentially Affected** All newly admitted residents have the potential to be affected by this deficient practice. There have been no new admissions since the survey exit date. The Pre-Admission team members are responsible for ensuring that PASARR information is completed prior to the prospective resident's admission. A Pre-Admission Checklist has been developed and implemented which includes PASARR Level I or II as a pre-requisite for approval to admit. **Measures to Ensure the Deficient Practice Does Not Recur** The Pre-Admission team members have reviewed the Pre-Admission process and checklist that must be completed prior to approving a new admission. The DON and SW now have access to the official PASARR assessment site to enable completion if not provided from the referring facility. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The DON or designee will review the Pre-Admission Checklists	

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			prior to accepting a new admission to ensure all pre-requisite information is available. The Administrator or designee will review all new admissions within five business days post-admission to ensure that PASARR documents are available These audits will be continued on-going. The Director of Nursing will document the PASARR audits with date of completion and determine compliance rates. The audit results will be submitted for review per the QAPI Committee with further revisions or actions implemented as deemed necessary. DATE: 6/15/23	
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure dependent residents received assistance with ADL's (activities of daily living) related to dining assistance, transfers, oral hygiene, incontinence care, and repositioning for 4 of 7 residents reviewed for ADL's. (Residents K, E, F, and D) Findings include: 1. On 4/2/23 at 10:15 a.m., Resident K was in his geri recliner in the dining room. The resident's	F 0677	**F677** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident K – The resident has been discharged per family request. Resident E - Meals are served at the same time other residents at his table are served. Meal assistance is provided timely. Assistance with activities of daily	06/15/2023

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	tablemate was served at that time and proceeded to eat his meal. Resident K was served at 10:21 a.m. He received pureed eggs, meat, bread, and hot cereal with sugar on top. The resident was drinking from a cup but he made no attempt to feed himself. He did not receive assistance from staff until 10:27 a.m. On 4/3/23 at 9:50 a.m., the resident was in his geri recliner in the dining room. The resident's tablemate was served oatmeal. Resident K did not receive his breakfast tray until 10:12 a.m. His geri recliner was positioned next to the table rather than underneath. At 10:20 a.m., the resident's spoon was in his lap and he had his hand in his food. At 10:22 a.m., CNA 2 took the resident's tray back to the kitchen to warm it up. At 10:28 a.m., the resident's tray was brought back out and the Director of Nursing positioned the resident upright in his chair and placed the chair underneath the table. The resident received assistance with his meal at 10:30 a.m. The record for Resident K was reviewed on 4/3/23 at 2:23 p.m. Diagnoses included, but were not limited to, hemiparesis (muscle weakness) following a stroke, Vitamin C and D deficiencies, and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 1/8/23, indicated the resident was cognitively impaired for daily decision making and he was totally dependent on staff for eating. A Care Plan, reviewed 1/22/23, indicated the resident had an ADL self care performance deficit related to assault by shotgun and hemiplegia/hemiparesis (muscle paralysis and weakness). The resident required one staff assistance to eat.		living, including transfer in and out of bed is provided timely to ensure the resident is turned and repositioned as per the care plan and to enable adequate rest periods. Resident F – The resident has expired. Resident D – Assistance with activities of daily living including turning/repositioning and incontinence care is provided every two hours as per the care plan. **Corrective Action(s) for Other Residents Potentially Affected** All residents who require assistance with activities of daily living have the potential to be affected by this deficient practice. The care plans of all applicable residents have been reviewed and the task lists updated as needed to ensure direct care staff are aware of the resident's specific needs. **Measures to Ensure the Deficient Practice Does Not Recur** Licensed and certified staff have been re-educated on the activity of daily living task lists generated through the care planning process and how to document that the tasks were completed timely in the electronic record. Charge nurses are responsible for ensuring the CNAs complete their required documentation prior to the end of their tour of duty.	

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	155845	A. BUILDING 00 B. WING	04/05/2023

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	Interview with the Nurse Consultant on 4/5/23 at 10:40 a.m., indicated the resident should have received assistance with his meals in a more timely manner. 2. On 4/3/23 at 9:50 a.m., Resident E was observed in the dining room in his adaptive wheelchair. His tablemate was served oatmeal at that time. Resident E received his breakfast tray at 10:12 a.m. He made no attempts to feed himself. At 10:22 a.m., Agency CNA 1 sat down next to the resident and started feeding him. The CNA did not warm up the resident's tray prior to assisting him. The resident did not receive his thickened beverage until 10:30 a.m. On 4/4/23 at 11:10 a.m., the resident was observed in his room seated in his wheelchair in front of the television. At 11:51 a.m., the resident remained in his wheelchair in his room and he was yelling intermittently. At 11:56 a.m., the Nurse Consultant went into the resident's room to check on him. She told the resident she would get him some help. At 12:00 p.m., Nursing Assistant 2 entered the resident's room to check on him. She asked the resident if he wanted something to drink and he shook his head no, when asked if he would like to lie down, the resident pointed towards his bed. The Nursing Assistant told the resident she was going to get some help and she would come back. At 12:07 p.m. and 12:18 p.m., the resident remained in his wheelchair in his room and continued to yell off and on. No staff members had returned to his room. At 12:19 p.m., the Nurse Consultant asked LPN 1 what could be done to help the resident and she asked her to approach the aides. At 12:30 p.m., LPN 1 remained at the nurses' station, she had not approached any staff to assist the resident. The resident continued to		**The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The DON or designee will monitor that activities of daily living tasks are completed and documented in the electronic record through audits conducted three times per week for four weeks, two times per week for four weeks, then once per week for four weeks or until 100% compliance is achieved for four consecutive weeks. The Director of Nursing or designee will monitor that residents who require meal assistance receive assistance timely through meal observation audits conducted during morning, noon, and evening meals at least once per week for four weeks, then once every two weeks for four weeks, then once per month for four weeks or until 100% compliance is achieved. Audit results will be reviewed per the QAPI Committee with further revisions or actions implemented as deemed necessary. DATE: 6/15/23	

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	call out. At 12:36 p.m., Agency CNA 2 approached the resident and asked him if he needed any help, he pointed to the bed and she told him she would get the other aide and left the room. At 12:46 p.m., the Agency CNA 1 and CNA 2 entered the resident's room with the hoyer lift. There were no gloves in the resident's room so CNA 2 left the room to get some. At 12:50 p.m., the CNA returned to the room and the resident was transferred to bed. The record for Resident E was reviewed on 4/4/23 at 1:30 p.m. Diagnoses included, but were not limited to, cerebral palsy, intellectual disabilities, and aphasia (difficulty speaking). The Discharge Return Anticipated Minimum Data Set (MDS) assessment, dated 2/23/23, indicated the resident was severely impaired for daily decision making and he was totally dependent on staff for transfers and eating. A Care Plan, reviewed on 1/5/23, indicated the resident had an ADL self care performance deficit related to Cerebral Palsy, intellectual disabilities, aphasia (difficulty speaking), and Down Syndrome. Interview with the Nurse Consultant on 4/5/23 at 10:40 a.m., indicated the resident should have received assistance in a more timely manner with his meals and being transferred back to bed. 3. On 4/4/23 at 8:45 a.m., CNA 3 was observed providing AM care for Resident F. The resident's face was washed, along with his arms, torso and peri area. The CNA then proceeded to dress the resident and he was transferred to his wheelchair via the hoyer lift. Once in the wheelchair, the CNA applied baby oil to the resident's face and			

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	arms. He was then taken out of his room and to the dining room. Oral care was not completed prior to taking the resident out of the room. The record for Resident F was reviewed on 4/5/23 at 9:00 a.m. Diagnoses included, but were not limited to, dementia with psychotic disturbance and anxiety disorder. The Annual Minimum Data Set (MDS) assessment, dated 3/29/23, indicated the resident was cognitively impaired for daily decision making and he was totally dependent on staff for personal hygiene. A Care Plan, reviewed on 1/8/23, indicated the resident had an ADL self care performance deficit related to aggressive behavior, confusion, impaired balance, and limited mobility. Interventions included, but were not limited to, encourage the resident to participate to the fullest extent possible with each interaction. Interview with the Nurse Consultant on 4/5/23 at 10:40 a.m., indicated oral care should have been completed during AM care. 4. On 4/4/23 at 9:05 a.m., Resident D was observed in her bed. She had indicated she had her brief changed around an hour ago, but was unable to tell if her brief was soiled at the time of the interview. A continuous observation of the resident began at that time. On 4/4/23 at 10:15 a.m., a housekeeper went into the Resident D's room to change her roommate's bed linens. On 4/4/23 at 10:59 a.m., a housekeeper went into Resident D's room to empty the garbage. On 4/4/23 at 11:10 a.m., the continuous			

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	observation of the resident concluded. No other staff members had been in to check on the resident for brief changes or repositioning. On 4/5/23 at 9:40 a.m., Resident D indicated she was unsure if she needed her brief changed. She indicated a CNA had been in to check on her this morning, however she did not physically check to see if her brief was soiled and did not change her. The resident again indicated she was unable to tell when her brief was soiled and needed to be changed. Resident D's record was reviewed on 4/3/23 at 2:30 p.m. Diagnoses included, but were not limited to, fibromyalgia (disorder that causes pain and tenderness throughout the body), systemic lupus erythematosus (an autoimmune disease), and schizoaffective disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 2/20/23, indicated the resident was cognitively intact for daily decision making. She required limited assistance with one person physical assist for bed mobility and required total dependence with two persons physical assist for transfers, dressing, toilet use, bathing, and personal hygiene. She was always incontinent of bowel and bladder. A Care Plan, dated 1/5/23, indicated the resident had an activity of daily living (ADL) self-care performance deficit. Interventions included, but were not limited to, the resident required extensive to total assistance with two or more staff for repositioning and turning in bed every two hours and as necessary. The March 2023 ADL - Incontinent Care Check and Change Every 2 Hours/As Needed CNA			

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	Task, indicated the resident received incontinence care on 3/1/23, 3/4/23, 3/15/23, 3/17/23, 3/22/23, 3/27/23, 3/30/23, and 3/31/23. The March 2023 Monitor - Turn and Reposition CNA Task, indicated the resident was turned and repositioned on 3/1/23, 3/4/23, 3/15/23, 3/17/23, 3/22/23, 3/27/23, 3/30/23, and 3/31/23. The April 2023 ADL - Incontinent Care Check and Change Every 2 Hours/As Needed CNA Task, indicated the resident received incontinence care on 4/1/23, and 4/2/23. The April 2023 Monitor - Turn and Reposition CNA Task, indicated the resident was turned and repositioned on 4/1/23 and 4/2/23. Interview with the Nurse Consultant on 4/5/23 at 12:40 p.m., indicated the resident was supposed to be repositioned and have incontinence care at least every two hours but the CNA Task sheets were not completed every two hours. This Federal tag relates to Complaint IN00404632. 3.1-38(a)(2)(B) 3.1-38(a)(2)(C) 3.1-38(a)(2)(D) 3.1-38(b)(1) 3.1-38(b)(6)			
F 0679 SS=E Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored			

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	group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review, and interview, the facility failed to ensure an ongoing activity program was implemented for alert and oriented, cognitively impaired, and dependent residents for 1 of 1 residents reviewed (Resident B) and random observations for activities. Findings include: 1. On 4/2/23 at 8:58 a.m., 9 residents were observed in the dining room. The television was on and the activity calendar posted on the bulletin board was dated February 2023. On 4/3/23 at 9:25 a.m., 16 residents were in the dining room. The television was on, some residents had beverages and some didn't. The February 2023 activity calendar had been removed from the bulletin board, but it was not replaced with an April 2023 calendar. A current activity calendar was not present in the hallway either. The Activity Director was seated in the dining room writing things down on a clip board at that time. The first breakfast tray was served at 9:54 a.m. After breakfast was completed, the television remained on in the dining room. No group activity took place between breakfast and lunch. At 3:00 p.m., the television remained on in the dining room and again, no group activity was taking place. The same was observed on 4/4/23. 2. On 4/2/23 at 1:38 p.m., Resident B was observed sitting in the dining room. There were no activities	F 0679	**F679** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident B (4) – The resident has advanced cognitive impairment and shows no interest in watching television. The care plan identifies her lack of interest in group activities and states she will participate in one on one activities three times weekly. The individual activities have been resumed for this resident, and documentation of her participation and response is available. The resident prefers to sleep when in bed in her room. The facility-wide activity program has been revised based upon feedback from alert and oriented residents. The current activity calendar is posted in the dining room. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. Planned group and individual activities occur as per the schedule unless there is an emergency situation. Residents are informed of changes concurrently so they can adjust	06/15/2023

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	happening. The television was out of view of the resident. On 4/2/23 at 2:50 p.m., Resident B was observed sitting in the dining room. There were no activities happening. The television was out of view of the resident. On 4/3/23 at 9:57 a.m., Resident B was observed sitting in the dining room. There were no activities happening. The television was out of view of the resident. On 4/4/23 at 9:15 a.m., Resident B was observed sitting in the dining room. There were no activities happening. The television was out of view of the resident. On 4/5/23 at 9:30 a.m., Resident B was observed sitting in the dining room. There were no activities happening. The television was out of view of the resident. On 4/5/23 at 11:53 a.m., Resident B was observed in bed with no activity in the room. Resident 4's record was reviewed on 4/4/23 at 8:45 a.m. Diagnoses included, but were not limited to, dementia and major depressive disorder. The Annual Minimum Data Set (MDS) assessment, dated 3/12/23, indicated the resident was severely cognitively impaired for daily decision making. A Care Plan, dated 1/7/23, indicated the resident had little activity in group activities and enjoyed one on one activities due to cognitive defect. Interventions included, but were not limited to, the resident would participate in one on one		their planned daily activities. **Measures to Ensure the Deficient Practice Does Not Recur** The facility is recruiting and screening staff who are interested in providing activity programming for the residents. Once candidates are selected, they will receive orientation to the position. The Social Worker and the Interim Administrator have developed activity calendars that meet the interests of current residents and include individualized activities for residents who are unable to participate in group activities. In-room activities will be provided to residents who prefer this. Activity calendars will be posted timely so residents can plan their daily activity routine in advance. The Monitoring Process to Ensure the Deficient Practice Does Not Recur The social worker or designee will be responsible for ensuring that planned activities occur on a daily basis Monday through Friday. Charge nurse will be responsible for ensuring that planned activities occur on weekends. Activity audits will be conducted by the Administrator or designee once weekly for two months, then once every two weeks for a month or continued until 100% compliance has been achieved during four consecutive audits. Audit results will be reviewed per the QAPI	

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	activities three times weekly and participate in group activities that were modified for cognitive defect at least once weekly. A Quarterly Activities Participation Review, dated 9/11/22 at 11:15 a.m., indicated the resident participated in news/coffee, patio outings, music/meditation, and snacks/movie. Interview with the Nurse Consultant on 4/4/23 at 12:40 p.m., indicated she was aware of the lack of activities provided throughout the survey timeframe observations. 3. On 4/4/23 at 11:42 a.m. during a resident council meeting, the residents in attendance all stated there were no activities on a day to day basis. (Residents 10, 7, 13, 14, 12, 17, and 23) There was no posted current activity calendar in the facility. Interview with the Nurse Consultant on 4/4/23 at 12:40 p.m., indicated she was aware of the lack of activities provided throughout the survey timeframe observations. 3.1-33(a)		Committee with further revisions or actions implemented as deemed necessary. DATE: 6/15/23	
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan,			

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	and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure abrasions, blisters, and areas of bruising were assessed, monitored, and treatment orders were obtained for 3 of 4 residents reviewed for skin conditions non-pressure related. The facility also failed to ensure neurological checks were initiated following a fall for 2 of 2 residents reviewed for falls and laboratory tests were obtained timely for 1 of 1 residents reviewed for hospitalization. (Residents K, J, G, B, and H) Findings include: 1. On 4/3/23 at 3:13 p.m., Resident K was transferred to bed via the hoyer lift by Agency CNA 1 and CNA 2. The resident's pants were removed and incontinence care was provided. A foam dressing was observed on the resident's right knee. The dressing was dated 3/27/23. At 3:50 p.m., LPN 1 and the Nurse Consultant were in the resident's room. The right knee dressing had been removed and the Nurse Consultant confirmed the dressing was dated 3/27/23. She also indicated there was no order for any treatment and there was no documentation on 3/27/23 in the nurses' notes related to the right knee. LPN 1 was cleansing the areas to the knee, they were pink in color and circular in shape. There was also dark areas of dried skin being wiped away. The Nurse Consultant indicated the areas to the knee looked like abrasions and she would investigate further. The record for Resident K was reviewed on 4/3/23 at 2:23 p.m. Diagnoses included, but were not limited to, hemiparesis (muscle weakness) following a stroke, Vitamin C and D deficiencies,	F 0684	**F684** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident K – The resident has been discharged per family request. Physician orders for treatment of the right knee abrasions were obtained and executed on 4/03/23. Resident J – Unable to correct the previous occurrence. The resident has had no further falls. Neurological checks will be completed in accordance with the revised policy when indicated. Resident G – Unable to correct the previous occurrence. Labs are drawn in accordance with physician orders. Any evidence of new non-pressure related skin impairment will be addressed in accordance with facility policy. Resident B – Unable to correct the previous occurrence. The resident has had no further falls. Neurological checks will be completed in accordance with the revised policy when indicated. Resident H – The electronic record includes progress notes entered on 4/02/23 at 0836 stating the resident was observed in her room “at the sink hitting side of walls with arms and hands…” The nurse who observed these actions requested the resident not to hit the walls because she would injure her hands and arms. The	06/15/2023

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	and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 1/8/23, indicated the resident was cognitively impaired for daily decision making and was totally dependent on staff for bed mobility and transfers. A Care Plan, dated 1/8/23, indicated the resident was at further risk for impairment to his skin integrity related to decreased mobility, diabetes mellitus, stroke, left hemiplegia, and multiple other comorbidities. Interventions included, but were not limited to, monitor/document location, size, and treatment of skin injury, report abnormalities, failure to heal, signs and symptoms of infection, and maceration to the Physician. The March and April 2023 Physician's Order Summaries, indicated the resident had no order for a treatment to his right knee. There was no documentation in the Nurses' Notes for the month of March 2023 related to the resident's knee. The Skin Observation Tool, dated 3/21/23, indicated there was no documentation related to the resident's knee. There were no other skin observation tools available for review. Physician's Orders, dated 4/3/23, indicated skin prep was to be applied daily to the resident's right lateral knee, right lateral lower knee, and right medial knee for superficial abrasions. The Wound Observation Tool, dated 4/3/23, indicated the following: - Right lateral lower knee, superficial abrasion 5 millimeters (mm) x 10 mm		progress note further states the resident has a history of self-inflicting injuries. An entry on 4/02/23 at 1451 indicates the physician was notified of the resident's behavior and the start of bruising due to rubbing and hitting the wall. The physician ordered protective arm sleeves day and night to prevent injury. The resident has not been observed hitting her hands or arms on walls and has no new areas of bruising. **Corrective Action(s) for Other Residents Potentially Affected** All residents with falls and/ non-pressure related skin impairment have the potential to be affected by this deficient practice. There have been no resident falls. Weekly skin assessments are completed on all residents who allow the licensed staff to complete a head-to-toe skin observation, and no new areas of non-pressure related skin impairment have been identified. Resident behaviors are monitored on every shift with planned interventions when self-inflicted harm caused by behaviors are observed in the resident's care plan. **Measures to Ensure the Deficient Practice Does Not Recur** Facility policy related to neurological assessment has been revised to reflect specific frequency and time frames for	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- Right lateral upper knee, superficial abrasion 10 mm x 10 mm - Right medial knee, superficial abrasion 20 mm x 13 mm Interview with the Nurse Consultant on 4/5/23 at 10:40 a.m., indicated the resident's Physician should have been notified when the area was first noted and treatment orders obtained. She indicated documentation should also have been completed in the resident's record. 2. On 4/3/23 at 2:15 p.m., Resident J was observed in the dining room. The resident had fading discoloration beneath his eyes and a cut was observed to the bridge of his nose. The record for Resident J was reviewed on 4/4/23 at 3:14 p.m. Diagnoses included, but were not limited to, schizophrenia and psychosis. The Quarterly Minimum Data Set (MDS) assessment, dated 2/20/23, indicated the resident was cognitively impaired for daily decision making and he was independent in ambulation. A Care Plan, dated 1/7/23, indicated the resident was at risk for falls related to decreased strength and endurance, unsteady gait and balance, he required assistance with activities of daily living, use of psychotropics, and diagnosis of osteoarthritis. Interventions included, but were not limited to, anticipate and meet the resident's needs and follow the facility fall protocol. A Fall Risk assessment, dated 2/13/23, indicated the resident scored a "30", a moderate risk for falling.		neurological assessments to be completed. Weekly Skin Observation assessments have been re-assigned to ensure timely completion. Licensed nurses have been in-serviced on facility policy related to fall follow-up including neurological assessments and documentation, as well as assigned Weekly Skin Observation Tools. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The DON or designee will be responsible for auditing falls and follow-up assessment documentation once weekly for two months, then once every two weeks for a month. Weekly Skin Observation Tool audits are completed by the DON or designee three times per week for four weeks, two times per week for four weeks, then once per week for four weeks or until 100% compliance is achieved for four consecutive weeks. Audit results will be reviewed per the QAPI Committee with further revisions or actions implemented as deemed necessary. DATE: 6/15/23	

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	Nurses' Notes, dated 3/31/23 at 2:10 p.m., indicated the resident was observed on the floor lying on his left side. His nose had two tiny lacerations and was swollen and bleeding from the nares. The resident was assisted back to bed. He indicated he lost his balance and fell. At 2:19 p.m., the resident's Physician was notified and orders were received for an x-ray of the facial bones status post fall and injury to the nose. The resident was transported to the emergency room for evaluation. The Hospital After Visit Summary, dated 3/31/23, indicated the resident had an open fracture of the nasal bone, a laceration to the nose, and a sinus infection. The resident was to have his sutures to the nose removed in 5-7 days. The resident's Care Plan had not been updated to reflect the resident's fall, nasal fracture, or sutures. A neurological checklist was completed on 3/31/23 at 11:52 p.m. No other neurological checklists or assessments were available for review. Interview with the Nurse Consultant on 4/5/23 at 2:20 p.m., indicated the neuro check policy did not specify how often neuro checks were to be completed, but she would expect the standard of practice to be followed and neuro checks completed every 15 minutes x 1 hour, every 30 minutes x 1 hour, every hour x 4 hours, and every 4 hours x 24 hours. She indicated more neuro checks should have been completed rather than just on 3/31/23. 3. The closed record for Resident G was reviewed on 4/4/23 at 9:02 a.m. Diagnoses included, but were not limited to, type 2 diabetes, vascular dementia, high blood pressure, paranoid			

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	schizophrenia, major depressive disorder, hallucinations, anxiety disorder, stroke, and acute kidney failure. The Annual Minimum Data Set (MDS) assessment completed on 2/11/23, indicated the resident was cognitively intact. The resident was independent with most ADLs. Nurses' Notes, recorded as a late entry for 3/21/23 at 4:00 a.m. and documented on 4/1/23 at 8:37 a.m., indicated the resident removed his socks and a dark fluid filled blister was on the 2nd left toe. At that time, the resident denied any injury to his foot. The Physician was notified and no new orders were obtained. Nursing would contact the doctor once the blister ruptured. Nurses' Notes, dated 3/23/23 at 2:57 p.m., indicated the resident was observed to have an open area to the left foot on the middle toe. The Physician was notified and received an order to cleanse with normal saline, apply triple antibiotic ointment, and cover with dry gauze. The Wound Doctor would be notified. Nurses' Notes, dated 3/24/23 at 5:11 p.m., indicated the Wound Doctor was in the facility and was informed of the new wounds to the resident's left foot toes. The first documented measurements of the ulcers were on 3/24/23 as follows: - Left Second toe: first observed on 3/23/23. Classified as a diabetic ulcer with 50% necrotic tissue. The wound measured 35 millimeters (mm) by 20 mm - Left Third toe: first observed on 3/23/23. Classified as a diabetic ulcer with 100% necrotic tissue. The wound measured 1 mm by 0.5 mm			

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Physician's Orders, dated 3/24/23 at 11:45 a.m., indicated Triple Antibiotic Plus External Ointment 1 %. Apply to left foot, second and third toes topically one time a day for wound healing. Cleanse with normal saline cover with dry gauze and secure with tape.

Nurses' Notes, dated 3/26/23 at 3:30 a.m., indicated the resident was observed in the hallway without clothes around 1:45 a.m. The resident was adamant that his family was coming to pick him up. The resident was redirected multiple times, but he did not respond well. The resident was given a shower, and afterwards he put on his jacket and walked out the front door. He agreed to come back inside, but would not go further into the facility. The Director of Nursing was called and the writer was instructed to call the police and paramedics. EMS arrived and the resident agreed to go to the hospital.

Nurses' Notes, dated 3/26/23 at 10:06 a.m., indicated the resident was admitted with acute kidney injury.

Physician's Orders, dated 2/1/23, indicated labs to be drawn every 3 months March, June, September, and December. The labs were a comprehensive metabolic 14 panel, complete blood count, thyroid hormone, urinalysis, and glycohemoglobin.

The labs for March 2023 were not completed.

The hospital labs obtained in the emergency room on 3/26/23 indicated the resident's blood urea nitrogen (BUN) was 33 (a high value) and the creatinine was 2.2 (a high value).

Interview with the Nurse Consultant on 4/5/23 at

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	10:30 a.m., indicated the resident did not have his labs drawn in the month of March 2023. The resident was admitted to the hospital on 3/26/23 with the diagnoses of acute kidney injury and his labs were not within normal limits. Interview with the Nurse Consultant on 4/5/23 at 3:00 p.m., indicated she had spoken to the Director of Nursing about the entry in the nursing progress notes on 3/21/23 and there was no documentation of the measurement of the fluid filled blister.4. Resident B's record was reviewed on 4/4/23 at 8:45 a.m. Diagnoses included, but were not limited to, dementia, stroke, atrial fibrillation, and anemia. The Annual Minimum Data Set (MDS) assessment, dated 3/12/23, indicated the resident was severely cognitively impaired for daily decision making. She required extensive assistance with one person physical assist for bed mobility, dressing, and personal hygiene. She required total dependence with two persons physical assist with transfer and bathing, and total dependence with one person physical assist with toilet use. She had an impairment on both sides with range of motion to the lower extremities. A Nurses' Note, dated 3/18/23 at 4:20 p.m., indicated the resident had a fall while CNAs were transferring her from the wheelchair to the bed with a gait belt. The resident began to be aggressive during the transfer and leaned forward, causing her to fall on to the bed's side rail. The resident sustained an open area 2 centimeters (cm) by 3 cm over her left eyebrow. Vital signs were assessed and pressure applied to the open area. A Nurses' Note, dated 3/18/23 at 4:22 p.m.,			

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	indicated a head to toe assessment was performed and no new areas of discoloration, redness, or swelling were noted. There were no other open areas besides to the forehead. A Nurses' Note, dated 3/18/23 at 4:34 p.m., indicated the resident was transferred via ambulance to the hospital. A Nurses' Note, dated 3/18/23 at 8:15 p.m., the resident returned to the facility. A Care Plan, updated on 4/2/23, indicated the resident was at increased risk for falls related to impaired cognition, unsteady gait and balance, incontinence, behaviors, use of psychotropic medication, and resistive to care. Interventions included, but were not limited to, 2 staff assist for all transfers with gait belt, ensure that the resident is wearing appropriate footwear non-skid socks/shoes when ambulating or mobilizing in wheelchair, and inform resident what will be done prior to all transfers in a calm voice assuring her that she will be safe. A Care Plan, dated 4/3/23, indicated the resident had an actual fall with minor injury. Interventions included, but were not limited to, monitor suture line for bleeding or signs or symptoms of infection, monitor/document/report as needed for 72 hours for signs or symptoms of pain, bruises, change in mental status, new onset confusion, sleepiness, inability to maintain posture, and agitation. Interview with the Nurse Consultant on 4/5/23 2:50 p.m., indicated there were no neurocheck assessments started for the resident before she went to the hospital or when she returned.			

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	5. During an interview with Resident H on 4/2/23 at 11:05 a.m., there were dark purple discolorations noted to both the right and left lower arms. The resident was unable to indicate how or when she acquired the bruises. Resident H's record was reviewed on 4/3/23 at 2:28 p.m. Diagnoses included, but were not limited to, depression, dementia with behavioral disturbance, and Parkinson's disease. The Admission Minimum Data Set (MDS), dated 3/21/23, indicated the resident was cognitively intact for daily decision making. She was independent for bed mobility, transfer, and toilet use and required supervision for dressing, eating, personal hygiene, and bathing. A Skin Observation Tool, dated 3/30/23 at 1:37 p.m., indicated the resident had four bruises noted to the left arm. A Skin Observation Tool, dated 4/2/23 at 12:27 p.m., indicated the resident had four new bruises noted to the right arm. A Physician's Order, dated 4/2/23 at 11:00 p.m., indicated protective arm sleeves were to be worn day and night to prevent skin injury. Interview with the Nurse Consultant on 4/4/23 at 12:40 p.m., indicated she had no further information to provide. This Federal tag relates to Complaints IN00404632 and IN00404731. 3.1-37(a)			

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F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure a resident with a history of pressure ulcers was assessed and monitored for the development of pressure ulcers which resulted in the development of a suspected deep tissue injury (DTI). (Resident K) The facility also failed to ensure a resident with pressure ulcers received the treatment and services necessary to promote healing related to turning and repositioning and treatments in place for 1 of 2 residents reviewed for pressure ulcers. (Resident E) Findings include: 1. On 4/3/23 at 9:50 a.m., Resident K was observed in the dining room in a geri recliner. The resident had bilateral heel boots in place. At 2:17 p.m., the resident remained in the dining room and he was being fed by staff. At 3:13 p.m., the resident was transferred from his	F 0686	**F686** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident K – The resident has been discharged per family request. Resident E – Agency LPN 1 is no longer assigned to active shifts at the facility. The resident continues to receive treatments to all skin wounds in accordance with physician orders. The care plan has been updated to reflect current skin impairment. Turning, repositioning, and tissue off-loading is provided in accordance with MD orders and the care plan. **Corrective Action(s) for Other Residents Potentially Affected** All residents at risk for pressure	06/15/2023

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	geri recliner to his bed. Incontinence care was provided and the resident's bilateral heel boots remained in place. The heels were not offloaded (raised off of the bed surface to decrease pressure contact) in bed. At that time, Agency CNA 1 was asked to remove the resident's heel boots as well as his socks. A large area of dark purplish/black discoloration was observed to the resident's right inner ankle. Interview with Agency CNA 1 at that time, indicated this was her first day at the facility and she was not told the resident had any pressure areas. CNA 2, who was also in the room, indicated she normally worked the other hall and she was not aware the resident had any pressure ulcers. At 3:35 p.m., the Nurse Consultant was brought into the room to visualize the area to the right inner ankle. The Nurse Consultant indicated she was told the area had healed and she would inform the Director of Nursing. At 3:50 p.m., LPN 1 and the Nurse Consultant were in the resident's room. The LPN indicated the area to the resident's inner ankle had recently healed. She also indicated she had not been told the resident had any areas to his feet. The Nurse Consultant indicated she would stage the area to the resident's right inner ankle as a suspected 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). At that time, the area to the right inner ankle measured 4.5 centimeters (cm) by 7.0 cm. The record for Resident K was reviewed on 4/3/23 at 2:23 p.m. Diagnoses included, but were not limited to, hemiparesis (muscle weakness) following a stroke, Vitamin C and D deficiencies,		injury developments have the potential to be affected by this deficient practice. All at-risk residents have had head-to-toe skin assessments completed with results documented in Skin Observation Tools in the electronic record. Braden Scale scores have been reviewed and risk assessments updated as deemed necessary. Care plan interventions for all applicable residents have been reviewed and revised as deemed necessary. Turning and repositioning is provided as per care plans. **Measures to Ensure the Deficient Practice Does Not Recur** Licensed and certified staff have been re-educated on the activity of daily living task lists generated through the care planning process and how to document that the tasks were completed timely in the electronic record. Charge nurses are responsible for ensuring the CNAs complete their required documentation prior to the end of their tour of duty. Licensed staff have been re-educated on completing thorough head-to-toe skin assessments as per assigned schedules in the electronic record, and reporting any new areas immediately to the physician, the resident's family/guardian, and the DON. The education included the proper execution of treatment	

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	and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 1/8/23, indicated the resident was cognitively impaired for daily decision making and was totally dependent on staff for bed mobility, transfers, and eating. The resident was identified as having one Stage 3 pressure ulcer and two deep tissue injuries. A Care Plan, dated 1/8/23, indicated the resident was at further risk for impairment to his skin integrity related to decreased mobility, diabetes mellitus, stroke, left hemiplegia, and multiple other comorbidities. Interventions included, but were not limited to, monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, and maceration to Physician, prevent pressure to bilateral heels by floating heels on a pillow when in bed, and protect heels from friction by applying bilateral heel boots when up in the chair. A Braden scale, dated 2/15/23, indicated the resident scored a "12" and was at high risk for developing pressure ulcers. A Weekly Wound Observation sheet, dated 3/17/23, indicated the resident had a Stage 1 pressure ulcer to the right medial heel which measured 15 millimeters (mm) x 12 mm. The area was improving, epithelial (body tissue) tissue was present and pink. No necrosis and/or slough to the wound bed was noted and the wound edges were well defined. The treatment of medihoney (a debriding ointment) was discontinued and Vaseline was to be applied daily to the area and it was to be left open to air. The area was first observed on 11/17/22 as a Stage 3 pressure ulcer (full thickness skin loss potentially extending into		orders for skin wounds. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** Weekly Skin Observation Tool audits are completed by the DON or designee three times per week for four weeks, two times per week for four weeks, then once per week for four weeks or until 100% compliance is achieved for four consecutive weeks. The DON or designee will observe treatment administration once weekly times eight weeks, then once every two weeks times four weeks. Results will be documented on an audit form and immediate corrective actions taken if infractions are found. Audits will be discontinued when 100% compliance rates are consistently noted. Audit results will be submitted to the QAPI Committee for review with further revisions or actions implemented as deemed necessary. DATE: 6/15/23	

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	the subcutaneous tissue layer). A Skin Observation tool, dated 3/21/23, indicated the treatment to the resident's right heel continued. No other information was on the sheet. A Weekly Wound Observation sheet, dated 3/24/23, indicated the resident's right medial heel was healed and his treatment was discontinued. There were no skin observation tools completed after 3/21/23 and no weekly wound observation sheets after 3/24/23. There was no documentation related to turning and repositioning the resident for the dates of 3/1 - 4/4/23. A Skin and Wound Note, dated 3/23/23 at 8:05 p.m., indicated the wound to the resident's right heel was greatly improved. Vaseline was applied and left open to air. The resident's skin was warm and dry. No open areas were observed and pressure relieving devices were in place. A Skin and Wound Note, dated 3/24/23 at 10:09 a.m., indicated the Wound Physician was in the facility. The wound to the resident's right heel was evaluated and it was healed. No further orders were given at that time. The heel boots were to be continued for off loading. The Wound Observation tool, dated 4/3/23, indicated the resident had a suspected deep tissue injury (DTI) to the right inner heel. This was the first observation of the area which was fluid filled with no drainage. The area measured 45 mm x 70 mm.			

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	A Physician's Order, dated 4/3/23, indicated a foam dressing was to be applied to the right inner heel daily. A Skin/Wound Note, dated 4/3/23 at 4:33 p.m., indicated the resident was observed to have a suspected DTI to his right heel. The Wound Physician was notified and orders were received to cover the right heel with a dry bordered gauze. He indicated he would be in the facility on Friday to assess the area and give further treatment as needed. Interview with the Nurse Consultant on 4/5/23 at 2:55 p.m., indicated the resident's feet should have been monitored and assessed, weekly skin assessments should have been completed, and documentation related to turning and repositioning should also have been completed. She indicated she had no additional documentation she could provide. 2. On 4/2/23 at 10:29 a.m., Resident E was brought into the dining room. The resident was seated in his adaptive wheel chair and he had bilateral heel boots in place. At 2:44 p.m., the resident was observed in his room in bed. The heels were not offloaded (raised off of the bed surface) in bed. On 4/3/23 at 9:50 a.m., 10:22 a.m., and 2:19 p.m., the resident was observed in his wheelchair in the dining room. The resident had bilateral heel boots in place. On 4/4/23 at 8:42 a.m., the resident was observed in his room seated in his wheelchair. His bilateral heel boots were in use. At 10:00 a.m., the resident was observed in the dining room. On 4/4/23 at 11:00 a.m., 11:51 a.m., and 12:40 p.m.,			

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	the resident was seated in his wheelchair in his room. The resident was intermittently yelling out during the above time frame. At 12:50 p.m., the resident was transferred to bed. The heels were not offloaded (raised off of the bed surface) in bed. The record for Resident E was reviewed on 4/4/23 at 1:30 p.m. Diagnoses included, but were not limited to, cerebral palsy, intellectual disabilities, and aphasia (difficulty speaking). The Discharge Return Anticipated Minimum Data Set (MDS) assessment, dated 2/23/23, indicated the resident was severely impaired for daily decision making and was totally dependent on staff for bed mobility, transfers, eating, and toilet use. The resident was always incontinent of bowel and bladder and he had no pressure ulcers. A Care Plan, revised on 1/5/23, indicated the resident had potential for impairment to his skin integrity related to incontinence and limited mobility. The goal was for the resident to be free from pressure injury and moisture associated dermatitis through the next review. A Braden Scale, dated 12/26/22, indicated the resident scored a "10" a high risk for pressure ulcers. A Braden Scale, dated 3/27/23, indicated the resident scored an "11" a high risk for pressure ulcers. A Skin Observation Tool, dated 3/22/23, indicated the resident's skin was warm, dry, and intact. No open areas or redness were noted. Barrier creams were applied to prevent skin breakdown.			

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	155845	A. BUILDING 00 B. WING	04/05/2023

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	A Physician's Order, dated 9/17/21 and listed as current on the April 2023 Physician's Order Summary (POS), indicated the resident was to receive A & D ointment to the buttocks topically every shift for a skin barrier. The March 2023 Treatment Administration Record (TAR) indicated the treatment had been signed out as being completed for each shift the entire month. Nurses' Notes, dated 3/27/23 at 7:43 p.m., indicated the CNA reported the resident had wounds to both feet and his right buttock. Bordered foam dressings were in place. Upon assessment, wounds were observed to the right outer ankle, left lateral foot, and right buttock. The Wound Physician was informed. Orders were received to cleanse all wounds with normal saline, apply Medihoney (a debriding agent) to the wound beds, and cover with a bordered gauze every day. The Wound Physician would be in the facility on Friday, 3/31/23, to assess the wounds and evaluate treatment for any change in orders if needed. Wound Observation Tools, dated 3/27/23, indicated the following: - Right buttock Stage 3 which measured 40 millimeters (mm) x 47 mm - Right outer ankle Stage 3 which measured 29 mm x 27 mm. Slough was present as well as a moderate amount of serosanguineous drainage. - Left lateral distal foot suspected deep tissue injury (DTI) 35 mm x 20 mm Physician's Orders, dated 3/27/23, indicated the resident was to have an air mattress to his bed and both feet were to be off loaded (raised off of the bed). Physician's Orders, dated 3/28/23, indicated the			

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	resident was to be turned and repositioned every 2 hours and heel booties were to be applied to both feet every shift. The incontinence care, check and change every 2 hours sheet for the dates of 3/1 - 4/4/23, indicated the only documentation was completed on 3/15/23 at 7:30 a.m., 9:30 a.m., 11:30 a.m., and 1:30 p.m. The turn and reposition sheet for the dates of 3/1 - 4/4/23, indicated the only documentation was completed on 3/15/23 at 7:30 a.m., 9:30 a.m., 11:30 a.m., and 1:30 p.m. Wound Physician progress notes, dated 3/31/23, indicated the following: - Right buttock Stage 3, 4 centimeters (cm) x 4.7 cm x 0.2 cm. Recommendations were to off load the wound, limit sitting to 60 minutes, and turn side to side in bed every 1-2 hours if able. - Right proximal dorsal lateral foot Stage 3, 2.9 cm x 2.7 cm x 0.2 cm - Right distal medial foot Unstageable Deep Tissue Injury (DTI), 0.7 cm x 1.0 cm - Left proximal lateral foot Unstageable DTI, 1.5 cm x 1.4 cm - Left distal lateral foot Unstageable DTI, 3.5 cm x 2 cm - Left dorsal 4th toe Unstageable DTI, 1.5 cm x 0.5 cm Physician's Orders, dated 4/1/23, indicated the resident was to receive medihoney to the right buttock and right outer ankle daily. The areas were to be cleansed with normal saline and covered with a border gauze dressing. After being cleansed with normal saline, skin prep was to be applied to the right medial distal foot, left foot 4th toe, and left foot distal lateral.			

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	The resident's Care Plan had not been updated to reflect the new wounds. Interview with CNA 3 on 4/4/23 at 9:00 a.m., indicated the resident had open areas to his butt cheek on the right side and his foot, she indicated they had a lot of new staff and she wasn't sure if they were repositioning him like they should. Wound care for the resident was observed on 4/5/23 at 11:56 a.m., with Agency LPN 1. CNA 1 was assisting the LPN with positioning the resident. Both staff members washed their hands and donned gloves. The dressing to the resident's right buttock was dated 4/4, the LPN indicated that was the dressing she had changed yesterday. After the dressing was removed, the LPN removed her gloves and washed her hands. The LPN donned new gloves and the wound was cleansed with normal saline. Some slough was noted to the wound bed and the outer edges of the wound started to bleed after cleansing. After washing her hands and applying new gloves, the LPN applied skin prep to the edge of the wound, she also used the skin prep pad to wipe up the blood from the wound bed. She removed her gloves, washed her hands, and donned new gloves. The LPN proceeded to apply the medihoney directly to the dressing, she indicated she didn't have a "stick" to spread the medihoney so she would do it when she applied the dressing. The dressing was applied to the right buttock and not dated. The LPN removed her gloves and washed her hands. While the LPN was washing her hands, CNA 1 removed the heel protector to the resident's right foot and removed his non-skid sock. There was no dressing in place to the right outer ankle. The CNA indicated she provided incontinence care for the resident before he got up for breakfast but he was already dressed when			

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	she came on duty. She indicated she did not know how long the dressing had been off. No slough was noted to the right outer ankle wound. The wound bed was pink with no drainage. The LPN donned gloves and cleansed the area to the ankle with normal saline, she washed her hands, donned new gloves, and applied skin prep to the edge of the wound. She washed her hands, donned new gloves, and applied the medihoney to the foam dressing and then applied it to the right outer ankle. The dressing was not dated. The LPN then asked if all of the wound treatments had to be completed, she had the CNA remove the heel boot and sock on the resident's left foot, she looked at the foot and indicated everything looked good. She did not complete any treatments to the resident's left foot. Interview with the Nurse Consultant on 4/5/23 at 1:46 p.m., indicated the resident's dressing to the right outer ankle should have been in place and the treatments should have been completed to the left foot. She also indicated the turn and reposition and incontinence care flow sheets should have been completed. This Federal tag relates to Complaint IN00404632. 3.1-40(a)(1) 3.1-40(a)(2)			
F 0688 SS=G Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates			

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	that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to ensure an ongoing assessment was completed related to monitoring for contractures and no treatment was in place for a contracture after being identified by therapy which resulted in a decline in range of motion for 1 of 1 residents reviewed for limited range of motion (ROM). (Resident F) Finding includes: On 4/3/23 at 3:05 p.m., Resident F was observed in his room seated in his wheelchair. The resident's left middle, ring, and pinky fingers were closed in a fist. When asked if he could extend those fingers, the resident was not able to do so. He had no anti-contracture device in use. On 4/4/23 at 8:45 a.m., CNA 3 was observed completing morning care for the resident. She wiped his left hand with a wash cloth but she made no attempts to extend the fingers on his left hand. Interview with the CNA at that time, indicated she didn't try to open the resident's hand because it hurt him and then he would get mad. She couldn't remember how long his hand	F 0688	**F688** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident F has expired. **Corrective Action(s) for Other Residents Potentially Affected** All residents at risk for decline in range of motion and mobility have the potential to be affected by this deficient practice. All applicable residents have been screened per Occupational Therapy with no new evidence on contractures identified. OT screening results have been compared to Section GG of current MDS assessments for all residents screened. Mobility Assessments and care plans have been reviewed and revised as deemed necessary. **Measures to Ensure the Deficient Practice Does Not Recur** Mobility Assessments are completed on admission and	06/15/2023

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	had been that way, but she knew it had been awhile. The resident had no anti-contracture device in use. The record for Resident F was reviewed on 4/5/23 at 9:00 a.m. Diagnoses included, but were not limited to, dementia with psychotic disturbance and anxiety disorder. The Annual Minimum Data Set (MDS) assessment, dated 3/29/23, indicated the resident was cognitively impaired for daily decision making and he had no limitation in ROM to the upper extremities. The Quarterly MDS assessments, dated 12/22, 9/22, and 6/22/22, indicated the resident had no limitation in ROM to the upper extremities. The Admission MDS assessment, dated 3/28/22, indicated the resident had no limitation in ROM to the upper extremities. The resident had no care plan related to the left hand contracture. A Mobility Assessment, dated 6/21/22, indicated the resident had full ROM to his left wrist and fingers. The Admission Mobility Assessment, dated 3/21/22, indicated the same. There were no other Mobility Assessments available for review after 6/21/22. Nurses' Notes from 10/2022 thru 4/2023 indicated there was no documentation related to the left hand contracture. Nurses' Notes, dated 2/20/23 at 1:45 p.m., indicated the resident's ROM to his upper and lower bilateral extremities were within normal limits		quarterly. These assessments have been re-assigned to ensure timely completion. Licensed staff have been educated on the importance of completing accurate and timely Mobility Assessments and the need to inform the DON if decline in mobility is observed. CNAs have been educated on the need to perform active and passive range of motion during routine care and to report to the charge nurse when a decline in mobility is observed. The DON will review Mobility Assessments while completing Section GG during scheduled MDS assessments. Significant Change MDS assessments will be completed as indicated. Therapy service providers will be requested to screen any resident with a decline in mobility and determine the appropriate treatment plan. The Monitoring Process to Ensure the Deficient Practice Does Not Recur The DON or designee will monitor that Mobility Assessments are completed as scheduled through audits three times per week for four weeks, two times per week for four weeks, then once per week for four weeks or until 100% compliance is achieved for four consecutive weeks. The audits will include monitoring of any recommended mobility devices to ensure the proper device is utilized as per therapy	

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	(WNL). A Physician's Order, dated 2/24/23, indicated the resident had a decline in dressing and transfers. Refer to Occupational Therapy (OT). An OT Progress Note, dated 2/25/23, indicated OT had facilitated passive range of motion (PROM) to the left fingers due to contractures to determine the most appropriate orthosis. An OT Progress Note, dated 3/24/23, indicated PROM was completed to the fingers of the left hand to determine if there were any changes to the resident's tolerance to the movement of his fingers. The resident was educated on the importance of PROM to the left hand/fingers to reduce the potential for skin breakdown. The OT Evaluation and Plan of Treatment, dated 2/25/23, indicated the resident was certified for therapy thru 3/23/23. The resident had a goal of being able to tolerate the use of a palm protector in the left hand for up to 2 hours to reduce potential for skin breakdown. The target date was 3/9/23. The OT Evaluation also indicated prior to the onset of care, the resident did not have any orthosis for the left hand. Documentation indicated the resident's baseline on 2/25/23 was that he was currently able to tolerate the use of a rolled washed cloth for up to 2 hours. The April 2023 Physician's Order Summary (POS), indicated there was no order for an anti-contracture device. Interview with the Nurse Consultant on 4/5/23 at 3:30 p.m., indicated a Mobility Assessment should		recommendations and MD orders. Audit results will be documented and submitted to the QAPI Committee for review with further revisions or actions implemented as deemed necessary. DATE: 6/15/23	

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	have been completed quarterly and the resident should have been monitored for contracture development. She was not aware when the contracture developed. 3.1-42(a)(1)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure half side rails were securely fastened to the bed for 3 of 3 residents reviewed for accident hazards. (Residents E, K & D) Findings include: 1. On 4/3/23 at 11:43 a.m., the half side rail to the left side of Resident E's bed was observed to be loose. The record for Resident E was reviewed on 4/4/23 at 1:30 p.m. Diagnoses included, but were not limited to, cerebral palsy, intellectual disabilities, and aphasia (difficulty speaking). The Discharge Return Anticipated Minimum Data Set (MDS) assessment, dated 2/23/23, indicated the resident was severely impaired for daily decision making and was totally dependent on	F 0689	**F689** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident E – A side rail assessment has been completed. Resident K – The resident has been discharged per family request. Resident D – A side rail assessment has been completed and the side rails have been secured. **Corrective Action(s) for Other Residents Potentially Affected** All residents who benefit from the use of side rails have the potential to be affected. Residents are assessed upon admission, quarterly and with significant change to determine whether there	06/15/2023

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	staff for bed mobility and transfers. The April 2023 Physician's Order Summary (POS), indicated the resident was to have bilateral half side rails as an enabler for repositioning when in bed. Interview with the Nurse Consultant on 4/4/23 at 2:00 p.m., indicated she would tell the Custodian the half side rail needed to be tightened. 2. On 4/3/23 at 11:47 a.m., the half side rail on the left side of Resident K's bed was observed to be loose. The record for Resident K was reviewed on 4/3/23 at 2:23 p.m. Diagnoses included, but were not limited to, hemiparesis (muscle weakness) following a stroke, Vitamin C and D deficiencies, and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 1/8/23, indicated the resident was cognitively impaired for daily decision making and was totally dependent on staff for bed mobility and transfers. The April 2023 Physician's Order Summary (POS), indicated the resident was to have bilateral half side rails as an enabler for repositioning when in bed. Interview with the Nurse Consultant on 4/4/23 at 2:00 p.m., indicated she would tell the Custodian the half side rail needed to be tightened. 3. On 4/2/23 at 10:51 a.m., Resident D was observed in bed. There were full length side rails to both sides of the bed. On 4/3/23 at 3:49 p.m., Resident D was observed in		is a need/benefit for side rails. MD orders have been obtained when indicated and reflect the reason for side rail use. Care plans have been updated when indicated. **Measures to Ensure the Deficient Practice Does Not Recur** Staff have been in-serviced on facility policy related to side rail assessments and use. Custodial staff have been provided with a bed rail safety checklist and are responsible for ensuring the side rails are properly installed and secure. This has been added to the preventive maintenance plan. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Administrator or designee will monitor the security of bed rails during environmental rounds and document the results in audits completed once per week for eight weeks then once every two weeks for four weeks or until 100% compliance is achieved. The DON or designee will monitor the completion of side rail assessments per policy through audits completed once per week for eight weeks then once every two weeks for four weeks or until 100% compliance is achieved. The audit results will be documented and will be reviewed per the QAPI Committee with further revisions or actions implemented as deemed necessary.	

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	bed. There were full length side rails to both sides of the bed Interview with Resident D on 4/4/23 at 9:10 a.m., indicated she couldn't use the side rails because they were broken and if she pulled on them they would fall off. The resident laughed and said "this is my new broken bed." At that time, the resident shook the rails and they were observed to be loose. Resident D's record was reviewed on 4/3/23 at 2:30 p.m. Diagnoses included, but were not limited to, fibromyalgia (disorder that causes pain and tenderness throughout the body), systemic lupus erythematosus (an autoimmune disease), and schizoaffective disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 2/20/23, indicated the resident was cognitively intact for daily decision making. She required limited assistance with one person physical assist for bed mobility and required total dependence with two persons physical assist for transfers, dressing, toilet use, bathing, and personal hygiene. She did not use a bed rail. A Physician's Order, dated 10/12/21, indicated half side rails when in bed for turning and repositioning. A Care Plan, updated on 1/5/23, indicated the resident had an activity of daily living (ADL) self-care performance deficit. Interventions included, but were not limited to quarter side rails up as per Physician's orders for safety during care provision to assist with bed mobility, observe for injury or entrapment related to side rail use and reposition every two hours and as necessary to avoid injury.		DATE: 6/15/23	

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	Interview with the Nurse Consultant on 4/4/23 at 2:00 p.m., indicated she had maintenance looking for half side rails that fit appropriately on her current bed. 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's			

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	comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on record review and interview, the facility failed to ensure residents with urinary tract infections received the necessary treatment and services related to prompt treatment and Physician notification for 2 of 2 residents reviewed for urinary tract infections. (Residents 13 and 15) Findings include: 1. The record for Resident 13 was reviewed on 4/4/23 at 2:35 p.m. Diagnoses included, but were not limited to, type 2 diabetes, atrial fibrillation, high blood pressure, and vascular dementia. The Annual Minimum Data Set (MDS) assessment, dated 3/18/23, indicated the resident was cognitively intact, and always continent of urine. Nurses' Notes, dated 1/12/23 at 12:23 p.m., indicated received labs for urinalysis. The results were negative and faxed to the doctor. The final urine culture, was dated 1/13/23 and reported to the facility at 6:08 p.m. The resident had greater than 100,000 staphylococcus aureus. There was no documentation the Physician was notified of the culture results indicating a urinary tract infection on 1/13/23. Nurses' Notes, dated 1/14/23 at 3:26 p.m., indicated the facility received a call from the doctor regarding the urine culture results. New	F 0690	**F690** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 13 – Unable to correct the previous occurrence. The resident has not required antibiotic therapy for treatment of a urinary tract infection since 1/21/23. Resident 15 - Unable to correct the previous occurrence. The resident has not required antibiotic therapy for treatment of a urinary tract infection since 1/6/23. **Corrective Action(s) for Other Residents Potentially Affected** All residents with new urinary tract infections per laboratory cultures have the potential to be affected by this deficient practice. All current laboratory urinalysis with culture and sensitivity results have been reviewed and the physician notified of any positive results. **Measures to Ensure the Deficient Practice Does Not Recur** Licensed nurses have been re-educated on the need to notify the physician immediately upon receipt of laboratory cultures that are positive for urinary tract infection. They have been instructed on communication to subsequent shifts per the written	06/15/2023

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	155845	A. BUILDING 00 B. WING	04/05/2023

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	orders were received for Bactrim DS twice a day times 7 days. The order was faxed to the pharmacy. Physician's Orders, dated 1/14/23 at 2:07 p.m., indicated Bactrim DS twice a day times 7 days for urinary tract infection. Nurses' Notes, dated 1/15/23 at 7:58 p.m., indicated the antibiotic for the urinary tract infection was initiated. The Medication Administration Record (MAR) for 1/2023 indicated the resident received the Bactrim 1/15-1/21/23 at 9 a.m. and 9 p.m. Interview with the Nurse Consultant on 4/5/23 at 10:30 a.m., indicated there was a delay in communication with the Physician and the initiation of the antibiotic for the urinary tract infection. 2. During a random observation on 4/2/23 at 10:15 a.m., Resident 15 was observed reaching down his pants then licking his hands afterwards. During a random observation on 4/3/23 at 9:54 a.m., the resident was observed with both of his hands inside his pants and then he ate his oatmeal. The record for Resident 15 was reviewed on 4/4/23 at 2:30 p.m. Diagnoses included, but were not limited to Down Syndrome, anxiety disorder, and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 2/20/23, indicated has short and long term memory problem and was moderately impaired for decision making. The		24-hour report when follow-up to a new urinary tract infection is required. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The DON or designee will monitor that timely treatments are implemented for urinary tract infections per MD orders through audits completed once per week for eight weeks then once every two weeks for four weeks or until 100% compliance is achieved. Audit results will be reviewed per the QAPI Committee with further revisions or actions implemented as deemed necessary. DATE: 6/15/23	

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	resident was on urinary toileting program and was occasionally incontinent of urine. A Care Plan, updated 2/23/23, indicated the resident had a psychosocial well-being problem and was unable to make good judgements regarding care and exhibits repetitive behavior. For example, he licked his hands then rubs his penis and buttock. An urinalysis, dated 12/21/22 had indications the resident had an urinary tract infection. The urine culture, dated 12/24/22, indicated the resident had greater than 100,000 staphylococcus epidermidis organism in his urine. A Nurses' Note, dated 12/29/22 at 1:47 p.m., indicated the Physician was in the facility and labs were reviewed. A new order was received for Bactrim DS twice a day times 5 days for urinary tract infection. Physician's Orders, dated 12/30/23, indicated Bactrim DS Oral Tablet 800-160 milligrams (mg). Give 1 tablet by mouth two times a day for UTI for 7 days. There was no documentation the Physician was notified on 12/24/22 of the final urine culture results. The Medication Administration Record (MAR) for 12/2022 indicated the resident did not receive the first dose of the antibiotic until 12/31/22 at 9:00 a.m. Interview with the Nurse Consultant on 4/5/23 at 10:30 a.m., indicated the Physician should have been notified in a more timely manner and the antibiotic should have been initiated on 12/29/22.			

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	3.1-41(a)(2)			
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, record review, and interview, the facility failed to ensure residents maintained acceptable parameters of nutritional status related to meal consumption records not completed for residents with a history of weight loss, diets not provided as ordered, and Registered Dietitian visits not completed following readmission to the facility for 3 of 4 residents reviewed for nutrition. (Residents E, K, and C) Findings include:	F 0692	**F692** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident E – The registered dietitian reviewed the resident's weights and discussed his eating and fluids preferences with nursing staff on 4/19/23. A mini-nutritional assessment was completed on this date and weekly weights for four weeks ordered. The resident receives Resource 2.0 1 carton	06/15/2023

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	1. The record for Resident E was reviewed on 4/4/23 at 1:30 p.m. Diagnoses included, but were not limited to, cerebral palsy, intellectual disabilities, and aphasia (difficulty speaking). The Discharge Return Anticipated Minimum Data Set (MDS) assessment, dated 2/23/23, indicated the resident was severely impaired for daily decision making and he was totally dependent on staff for eating. The resident was identified as having no weight issues. The resident did not have a nutritional care plan. The resident was hospitalized for pneumonia 2/23-2/28/23. A Registered Dietitian (RD) progress note, dated 3/11/23 at 3:50 p.m., indicated the resident was being seen for readmission and a significant weight change. On 3/6/23, the resident weighed 120 pounds and on 2/1/23 the resident weighed 129.6 pounds, a 7.3% decrease in 30 days. The weight loss was secondary to his hospitalization. Continue diet as ordered, monitor weight, intake, and follow up as needed. The Food Consumption Log, dated 2/1-3/31/23, indicated the only food consumption documented during that time frame was on 3/15/23 at 9:00 a.m. Interview with the Nurse Consultant on 4/5/23 at 10:40 a.m., indicated the resident's food consumption should have been documented for each meal. 2. On 4/3/23 at 10:12 a.m., Resident K was served his breakfast meal. He was served a single scoop of pureed eggs and meat.		three times daily and consumes this well. Meal consumption is being monitored. Resident K – The resident has been discharged per family request. Resident C – The resident has expired. **Corrective Action(s) for Other Residents Potentially Affected** All residents at nutritional risk have the potential to be affected by this deficient practice. The current Mini Nutritional Assessments of all applicable residents have been reviewed per the registered dietitian and recommendations for nutritional support implemented as deemed necessary. Food consumption is being documented at each meal. **Measures to Ensure the Deficient Practice Does Not Recur** Licensed and certified staff have been re-educated on the importance of maintaining accurate weight and food consumption records. Charge nurses and CNAs have been reminded of their responsibility to report weight changes and decrease in food consumption at meals to the DON. The DON will request the registered dietitian review any resident with potential nutritional needs. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur**	

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	Pureed food preparation was observed on 4/5/23 at 10:05 a.m. with the Dietary Food Manager (DFM). She was observed to puree scrambled eggs and sausage. Two residents received a pureed diet. The DFM was observed to place one 2 ounce scoop of eggs and sausage on each plate. The record for Resident K was reviewed on 4/3/23 at 2:23 p.m. Diagnoses included, but were not limited to, hemiparesis (muscle weakness) following a stroke, Vitamin C and D deficiencies, and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 1/8/23, indicated the resident was cognitively impaired for daily decision making and was totally dependent on staff for eating. The resident was identified as having one Stage 3 pressure ulcer and two deep tissue injuries. The resident had no weight issues and he received a mechanically altered/therapeutic diet. A Care Plan, reviewed on 1/22/23, indicated the resident received a pureed diet, low concentrated sweets and no added salt related to diabetes, hypertension, and dysphagia (difficulty swallowing). Interventions included, but were not limited to, provide and serve diet as ordered and RD to evaluate and make diet change recommendations as needed (PRN). On 9/7/22, the resident weighed 173 pounds. On 2/16/23, the resident weighed 148 pounds and on 3/9/23, he weighed 151 pounds. The resident had a 12.7% weight loss in 6 months. The resident was hospitalized 12/6-12/16/22 and 1/28-2/14/23. A Physician's Order, dated 1/23/23, indicated the		The DON or designee will monitor weight and food consumption records through audits completed three times per week for four weeks, two times per week for four weeks, then once per week for four weeks or until 100% compliance is achieved for four consecutive weeks. Audit results will be reviewed per the QAPI Committee with further revisions or actions implemented as deemed necessary. DATE: 6/15/23	

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	resident received a modified diabetic (low concentrated sweet) diet, puree texture. The resident was to receive double protein with breakfast and dinner. An RD progress note, dated 1/18/23 at 9:22 a.m., indicated the resident was being seen due to his readmission. The resident was showing a 10.7% weight loss since November and a 11.4% weight loss since August. The weight loss was secondary to his hospitalization. Per meal records, the resident's intake was good and was expected to return to his usual weight as he is fed/assisted by staff for meals. Continue diet as ordered, monitor weight, intake, and follow up as needed. The resident did not have an RD progress note related to his readmission on 2/14/23. The last RD note was dated 1/18/23. The resident returned to the facility with a Stage 2 pressure ulcer to the right medial heel and suspected deep tissue injuries (DTI) to the left heel and left distal foot. The Food Consumption log, dated 2/1-3/31/23, indicated the following: - No dinner was documented on 2/16, 2/20, 2/21, and 2/27/23. - No lunch was documented on 2/20/23 - No food consumption was documented on 2/17-2/19, 2/22-2/26, and 2/28/23. There was no documentation for the month of March 2023. Interview with the Nurse Consultant on 4/5/23 at 10:40 a.m., indicated the resident should have been seen by the RD after his February readmission, he should have received double protein at breakfast as ordered, and his food consumption should have been documented for each meal. 2. The closed record for Resident C			

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	was reviewed on 4/3/23 at 2:16 p.m. Diagnoses included, but were not limited to, chronic kidney disease, dementia with behavioral disturbance, anemia, anxiety, major depressive, psychotic disorder with hallucinations, and anorexia. The Significant Change Minimum Data Set (MDS) assessment, dated 1/22/23, indicated the resident had a short and long term memory problem and was moderately impaired for decision making. The resident had no oral problems, weighed 117 pounds, had no significant weight loss and received a mechanically altered diet. A Care Plan, updated on 1/25/23, indicated the resident had an unplanned/unexpected weight loss related to fluctuating food intake and refusing to eat with assistance. The approaches were to monitor and record food intake at each meal. The weight record indicated the following recorded weights: - 2/5/23 115.8 pounds - 1/31/23 116 pounds - 1/24/23 117 pounds - 1/17/23 117.9 pounds - 1/9/23 118.8 pounds - 12/10/22 118.2 pounds - 11/7/22 121.4 pounds - 10/26/22 122.8 pounds A Registered Dietitian's (RD) note, dated 2/11/23 at 3:11 p.m., indicated the resident had a Body Mass Index (BMI) of 18.7. The resident received diet and medication supplements. The plan was to continue the same diet and supplements as ordered, monitor weight, intake and follow up as needed.			

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	The Meal Consumption Logs indicated there was no documentation of the breakfast meal on 1/19/23, 1/29/23, 1/30/23, 2/7/23, 2/8/23, 2/14/23, and 2/15/23. There was no documentation of the lunch meal on 1/19/23, 1/29/23, 1/30/23, 2/7/23, 2/8/23, 2/14/23, 2/15/23. There was no documentation of the dinner meal on 1/17/23, 1/18/23, 1/19/23, 1/20/23, 1/21/23, 1/22/23, 1/23/23, 1/24/23, 1/25/23, 1/26/23, 1/27/23,1/28/23, 1/29/23, 1/30/23, 1/31/23, and 2/1/23-2/16/23. A late entry for 2/2/23 at 7:40 a.m., indicated the resident continued to decline related to his Alzheimer's disease and had been hospitalized and readmitted and showed no improvement. Discussed with the Physician this morning regarding a PEG (a tube inserted directly into the stomach for nutrition) tube for hydration and nutrition as the resident continued to lose weight and was not eating. Nursing will discuss with the resident's spouse regarding the PEG tube. The resident expired on 2/17/23 at the facility. Interview with the Director of Nursing on 4/5/23 at 2:45 p.m., indicated the meal consumption logs were incomplete. They were waiting on an answer from the resident's spouse regarding the PEG tube, however, the resident passed away. This Federal tag relates to Complaints IN00404632 and IN00404731. 3.1-46(a)(1)			
F 0700 SS=D Bldg. 00	483.25(n)(1)-(4) Bedrails §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed			

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	rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. Based on observation, record review and interview, the facility failed to attempt alternative measures and assess the necessity for bed rails quarterly as required for 1 of 1 residents reviewed for bed rails. (Resident D) Finding includes: On 4/2/23 at 10:51 a.m., Resident D was observed in bed. There were full length side rails to both sides of the bed. On 4/3/23 at 3:49 p.m., Resident D was observed in bed. There were full length side rails to both sides of the bed. Interview with Resident D on 4/4/23 at 9:10 a.m., indicated she couldn't use the side rails because they were broken and if she pulled on them they would fall off. The resident laughed and said "this	F 0700	**F700** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident D – A side rail assessment has been completed. **Corrective Action(s) for Other Residents Potentially Affected** All residents who benefit from the use of side rails have the potential to be affected. Residents are assessed upon admission, quarterly and with significant change to determine whether there is a need/benefit for side rails. MD orders have been obtained when indicated and reflect the reason for side rail use. **Measures to Ensure the Deficient Practice Does Not**	06/15/2023

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	is my new broken bed." At that time, the resident shook the rails and they were observed to be loose. Resident D's record was reviewed on 4/3/23 at 2:30 p.m. Diagnoses included, but were not limited to, fibromyalgia (disorder that causes pain and tenderness throughout the body), systemic lupus erythematosus (an autoimmune disease), and schizoaffective disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 2/20/23, indicated the resident was cognitively intact for daily decision making. She required limited assistance with one person physical assist for bed mobility and required total dependence with two persons physical assist for transfers, dressing, toilet use, bathing, and personal hygiene. She did not use a bed rail. A Physician's Order, dated 10/12/21, indicated half side rails when in bed for turning and repositioning. A Care Plan, updated on 1/5/23, indicated the resident had an activity of daily living (ADL) self-care performance deficit. Interventions included, but were not limited to quarter side rails up as per Physician's orders for safety during care provision to assist with bed mobility, observe for injury or entrapment related to side rail use and reposition every two hours and as necessary to avoid injury. There were no assessments completed for the use of full side rails. There were no orders for the use of full side rails. Interview with the Nurse Consultant on 4/4/23 at		**Recur** Staff have been in-serviced on facility policy related to side rail assessments and use. Custodial staff have been provided with a bed rail safety checklist and are responsible for ensuring the side rails are properly installed and secure. This has been added to the preventive maintenance plan. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Administrator or designee will monitor the security of bed rails during environmental rounds and document the results in audits completed once per week for eight weeks then once every two weeks for four weeks or until 100% compliance is achieved. The DON or designee will monitor the completion of side rail assessments per policy through audits completed once per week for eight weeks then once every two weeks for four weeks or until 100% compliance is achieved. Audit results will be reviewed per the QAPI Committee with further revisions or actions implemented as deemed necessary. DATE: 06/15/23	

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	2:00 p.m., indicated she was unable to find documentation related to assessments completed on the use of side rails and she had maintenance looking for half side rails that fit appropriately on her current bed. 3.1-45(a)(2)			
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents'			

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	needs, as identified through resident assessments, and described in the plan of care. Based on observation, record review, and interview, the facility failed to assure resident safety was maintained related to two person transfers for 2 of 3 residents who were observed being transferred with the hoyer lift. (Residents K and B)(CNA 2) Findings includes: 1. On 4/3/23 at 3:13 p.m., Agency CNA 1 and CNA 2 entered Resident K's room with the hoyer lift. The resident was seated in his geri recliner with the hoyer pad underneath him. The CNA's proceeded to place the loops of the hoyer pad onto the cradle. CNA 2 was having difficulty adjusting the base of the hoyer to fit underneath the geri recliner and the Agency CNA was instructing the CNA where to position the base. CNA 2 then proceeded to crank the hoyer lift, the resident's geri recliner was moved out of the way, and the base of the hoyer lift was next to the resident's bed instead of underneath. Instead of locking the hoyer lift, CNA 2 hit the release lever and the resident started lowering to the floor. The Agency CNA grabbed the hoyer pad to prevent the resident from landing on the floor. She told CNA 2 to lock the lift and position the base of the hoyer underneath the resident's bed instead of next to it. CNA 2 indicated it was hard to get the base underneath the bed due to the half side rail being in the way. The half side rail was raised so the base would fit underneath and the resident was placed in bed. The record for Resident K was reviewed on 4/3/23 at 2:23 p.m. Diagnoses included, but were not limited to, hemiparesis (muscle weakness)	F 0726	**F726** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident K – The resident has been discharged per family request. Resident E - Direct care staff have been in-serviced on the proper use of the hoyer lift. **Corrective Action(s) for Other Residents Potentially Affected** All residents requiring transfer per hoyer lift have the potential to be affected by this deficient practice. Direct care staff have been in-serviced on the proper use of the hoyer lift. **Measures to Ensure the Deficient Practice Does Not Recur** All licensed and certified staff have been in-serviced on the proper use of the hoyer lift. Charge nurses were informed of their responsibility to monitor hoyer lift safety during their tour of duty. The custodial staff is responsible for testing the hoyer lift for function and safety as scheduled per the preventive maintenance plan. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The DON or designee will monitor the proficiency of staff by observing hoyer lift transfers	06/15/2023

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	155845	A. BUILDING 00 B. WING	04/05/2023

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	following a stroke, Vitamin C and D deficiencies, and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 1/8/23, indicated the resident was cognitively impaired for daily decision making and was totally dependent on staff for bed mobility and transfers. The April 2023 Physician's Order Summary (POS), indicated the resident was to be transferred with the hoyer lift. 2. On 4/4/23 at 12:46 p.m., Agency CNA 2 and CNA 2 entered Resident E's room with the hoyer lift. The resident was seated in his adaptive wheelchair with a hoyer pad underneath him. CNA 2 left the room to get gloves and returned at 12:50 p.m. When the CNA returned to the room, the hoyer pad was connected to the cradle and the base of the hoyer was placed underneath the wheelchair. CNA 2 proceeded to crank the hoyer lift while the Agency CNA spotted her. While moving the resident towards the bed, CNA 2 hit the release lever and the resident started to lower towards the floor. The CNA stated, "Oh no, I did it again." She then proceed to move the lever into the locked position and the resident was placed in bed. The record for Resident E was reviewed on 4/4/23 at 1:30 p.m. Diagnoses included, but were not limited to, cerebral palsy, intellectual disabilities, and aphasia (difficulty speaking). The Discharge Return Anticipated Minimum Data Set (MDS) assessment, dated 2/23/23, indicated the resident was severely impaired for daily decision making and was totally dependent on staff for bed mobility and transfers.		through audits completed three times per week for four weeks, two times per week for four weeks, then once per week for four weeks or until 100% compliance is achieved for four consecutive weeks. The audits will be completed on random shifts to ensure all staff are proficient. Audit results will be reviewed per the QAPI Committee with further revisions or actions implemented as deemed necessary. DATE: 6/15/23	

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	The April 2023 Physician's Order Summary (POS), indicated the resident was to be transferred with the hoyer lift. Interview with the Nurse Consultant on 4/4/23 at 3:00 p.m., indicated the CNA needed to be inserviced on the use of the hoyer. On 4/5/23 at 2:20 p.m., the Administrative Assistant indicated the resident's employee file was not available for review. She had seen it earlier but she didn't know what happened to it. 3.1-17(b)			
F 0757 SS=E Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the			

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	reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure therapeutic drug levels were monitored as ordered for 4 of 5 residents reviewed for unnecessary medications. (Residents K, J, 6, and 21) Findings include: 1. The record for Resident K was reviewed on 4/3/23 at 2:23 p.m. Diagnoses included, but were not limited to, hemiparesis (muscle weakness) following a stroke, Vitamin C and D deficiencies, and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 1/8/23, indicated the resident was cognitively impaired for daily decision making. Physician's Orders, dated 3/4/23, indicated the resident was to receive 25 units of Glargine Insulin every evening and Atorvastatin (a cholesterol medication) 10 milligrams (mg) in the evening. A Physician's Order, dated 2/16/23, indicated the resident was to receive Levothyroxine Sodium (a thyroid medication) 50 micrograms (mcg) daily. The April 2023 Physician's Order Summary (POS), indicated the following laboratory tests were to be completed in March: T4 (thyroid function), Lipid panel (a test to monitor cholesterol levels), and a Hemoglobin A1C (a test that measures average blood sugar levels). None of the laboratory tests had been completed for the month of March 2023.	F 0757	**F757** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident K – The resident has been discharged per family request. Resident J – Unable to correct previous occurrence. Laboratory tests have been completed in accordance with MD orders and the MD notified of results. Resident 6 - Unable to correct previous occurrence. Laboratory tests have been completed in accordance with MD orders and the MD notified of results. Resident 21 - Unable to correct previous occurrence. Laboratory tests have been completed in accordance with MD orders and the MD notified of results. **Corrective Action(s) for Other Residents Potentially Affected** All residents with orders for laboratory testing have the potential to be affected by this deficient practice. Laboratory orders have been reviewed, and all ordered tests have been drawn or collected and results received. The ordering MD has been notified of results. **Measures to Ensure the Deficient Practice Does Not Recur** All laboratory orders have been reviewed and a new schedule	06/15/2023

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	Interview with the Nurse Consultant on 4/5/23 at 10:40 a.m., indicated the resident's March 2023 labs were not drawn as ordered. 2. The record for Resident J was reviewed on 4/4/23 at 3:14 p.m. Diagnoses included, but were not limited to, schizophrenia and psychosis. The Quarterly Minimum Data Set (MDS) assessment, dated 2/20/23, indicated the resident was cognitively impaired for daily decision making. A Physician's Order, dated 2/3/23, indicated the resident was to receive Valproic Acid (a medication used to treat seizures and bipolar disorder) 250 milligrams (mg), 2 capsules twice a day. A Physician's Order, dated 1/15/23, indicated the resident was to have a Valproic Acid test every 3 months. The last test was due in March 2023. The results were not available for review. Interview with the Nurse Consultant on 4/5/23 at 10:40 a.m., indicated the resident's March 2023 labs were not drawn as ordered. 3. Resident 6's record was reviewed on 4/4/23 at 10:45 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, major depressive disorder, psychotic disorder with delusions, and anxiety disorder. The Annual Minimum Data Set (MDS) assessment, dated 2/2/23, indicated the resident was severely cognitively impaired for daily decision making. In the last 7 days, the resident received an antipsychotic, antidepressant, hypnotic, anticoagulant, and diuretic each day.		established with the contracted phlebotomist to ensure laboratory draws are completed as per MD orders. Urinalysis tests will be collected and submitted to the laboratory as per MD orders. Laboratory orders will be entered into the electronic medication administration record according to the new schedule, and licensed staff will be responsible for documenting that the tests have been drawn or collected. Licensed nurses have been re-educated on the new process for entering laboratory orders and documenting that these have been completed. They have also been reminded of their responsibility to monitor that results are received, and the MD is notified in a timely manner of results. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The DON or designee will monitor timely completion of laboratory orders through audits completed once per week for eight weeks then once every two weeks for four weeks or until 100% compliance is achieved. Audit results will be reviewed per the QAPI Committee with further revisions or actions implemented as deemed necessary. DATE: 6/15/23	

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	The April 2023 Physician's Order Summary (POS) indicated the following: - metoprolol 25 milligram (mg), half tablet (12.5 mg) twice a day; hold if systolic blood pressure (BP) is less than 100, diastolic bp is less than 60, or heart rate is less than 60 - eliquis (anticoagulant medication) tablet 5 mg 1 tablet twice daily - depakote 250 (a seizure medication) mg 1 tablet twice daily - depakote 500 mg 1 tablet at bedtime - furosemide (a diuretic medication) 20 mg 1 tablet once daily - potassium 10 mg 1 tablet once daily - zyprexa (antipsychotic medication) 10 mg 1 tablet twice a day - vitamin D 50 mcg one time a day - lipitor (cholesterol medication) 20 mg 1 tablet at bedtime - quarterly lipid panel every 3 months starting on the 1st for September, December, March, and June - valproic acid levels every 3 months starting in September, December, March, and June - complete metabolic 14 panel every day shift every 3 months starting on the 19th (9/19/22) - complete blood count with differential every day shift every 3 months starting on the 19th (9/19/22) There was no documentation of the March 2023 quarterly lipid panel, valproic acid level, complete metabolic panel, or complete blood count with differential laboratory results. Interview with the Nurse Consultant on 4/4/23 at 3:54 p.m., indicated the lab work was not completed in March 2023. 4. Resident 21's record was reviewed on 4/4/23 at 9:34 a.m. Diagnoses included, but were not limited			

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	to, dementia with behavioral disturbance, fracture of right patella, depression, anemia, and bipolar disorder. A Significant Change Minimum Data Set (MDS) assessment, dated 1/4/23, indicated the resident was severely cognitively impaired for daily decision making. In the last 7 days, the resident had received an antipsychotic medication, anti-anxiety medication, antidepressant medication, and hypnotic medication each day. The April 2023 Physician's Order Summary (POS) indicated the following: - trazodone (antidepressant medication) 50 milligram (mg) 1 tablet at bedtime - seroquel (antipsychotic medication) 100 mg 1 tablet twice daily - depakote (seizure medication) 500 mg 1 tablet twice daily - ferrous sulfate (iron supplement) 325 mg 1 tablet twice daily - folic acid (vitamin supplement) 1 mg tablet twice daily - valproic acid test every day shift every 3 months starting on the 1st for September, December, March, and June - Iron/IBC test every day shift every 3 months starting on the 1st for September, December, March and June - Complete metabolic 14 panel every day shift every 3 months starting on the 1st for September, December, March, and June - Complete blood count with differential every 3 months on the 1st for September, December, March, and June There was no documentation of the March 2023 quarterly lipid panel, valproic acid level, complete metabolic panel, or complete blood count with			

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	differential laboratory results. Interview with the Nurse Consultant on 4/4/23 at 3:54 p.m., indicated the lab work was not completed in March 2023. 3.1-48(a)(3)			
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 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;			

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	§483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. Based on observation, record review, and interview, the facility failed to ensure a resident received routine and/ or emergency dental services related to heavy debris build up, discolored and painful teeth for 1 of 1 residents reviewed for dental services. (Resident D) Finding includes: Interview with Resident D on 4/2/23 at 10:51 a.m., indicated she needed some teeth pulled as her teeth were very painful. She had not seen a dentist for a very long time. Upon observation at that time, the residents teeth were discolored and had a noted build up on them. Resident D's record was reviewed on 4/3/23 at 2:30 p.m. Diagnoses included, but were not limited to, fibromyalgia (disorder that causes pain and tenderness throughout the body), systemic lupus erythematosus (an autoimmune disease), and schizoaffective disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 2/20/23, indicated the resident was cognitively intact for daily decision making.	F 0791	**F791** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident D – The Social Worker has contacted the contracted dental provider as well as other providers to find one that will accept this resident's payment source. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. All residents have been reviewed for dental service preferences. Residents who need on-site dental services have been scheduled to be seen during the next visit. The facility will continue to search for other dental providers if the current contracted provider cannot accept a resident's payment source. **Measures to Ensure the Deficient Practice Does Not**	06/15/2023

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	She required total dependence with two persons physical assist for transfers, dressing, toilet use, bathing, and personal hygiene. A Physician's Order, dated 3/29/21, indicated the resident could see dentist, podiatrist, optometrist, dermatologist, or the psychologist. The last scheduled session for routine hygiene visits was on 2/7/23 and Resident D was not on the list to be seen. There was no documentation related to the resident seeing a dentist. Interview with the Nurse Consultant on 4/4/23 at 2:00 p.m., indicated the resident was not on the list to be seen by dental services and she was not aware if the resident had been seen in the past as she could not find any further documentation. 3.1-24(a)(2)		**Recur** The facility will maintain a list of all dental service providers who are willing to come on-site, and a list of payment sources accepted by the providers. Residents will be notified of the next scheduled on-site visit per a dental provider and given opportunity to be seen. The Social Worker will prepare a list of residents who wish to be seen when dental services will be on site. Residents will be questioned regarding their dental needs during the MDS observation period. Any residents with new complaints of tooth pain or signs of bleeding gums, tooth decay, broken tooth, infection, or other dental problems will be referred to the appropriate provider for evaluation. The resident's MD will be notified as well. Licensed staff have been educated on the process for evaluating and reporting dental needs. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The DON or designee will be responsible for monitoring that residents receive appropriate dental services through completion of the MDS on-going. The Social Worker will include questions regarding dental services during routine Resident Rights interviews on-going and will document results. Results will be reviewed per the QAPI Committee with	

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			further revisions or actions implemented as deemed necessary. DATE: 6/15/23	
F 0806 SS=D Bldg. 00	483.60(d)(4)(5) Resident Allergies, Preferences, Substitutes §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; Based on observation, record review, and interview, the facility failed to ensure resident's food preferences were honored and food substitutes were offered to 1 of 2 residents observed during 1 of 3 meal observations. (Resident 21) Finding includes: On 4/03/23 at 10:03 a.m., Resident 21 was served a breakfast plate which included eggs, fruit, bacon, and a donut. At 10:16 a.m., Resident 21 was observed picking at the fruit on her plate, but still had not eaten anything on her breakfast plate. At 10:31 a.m., the Activity Director asked Resident 21 why she was not eating her breakfast. Resident 21 replied that she didn't want that for breakfast.	F 0806	**F806** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 21 – The resident receives food preferences at each meal. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. The list of resident food preferences has been updated and is available for dietary staff to reference. **Measures to Ensure the Deficient Practice Does Not Recur** All staff involved in dining services have been re-educated on the	06/15/2023

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	The Activity Director did not reply or offer anything else for the resident to eat. Resident 21's record was reviewed on 4/4/23 at 9:34 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, depression, anemia, and bipolar disorder. A Significant Change Minimum Data Set (MDS) assessment, dated 1/4/23, indicated the resident was severely cognitively impaired for daily decision making. She was totally dependent with one person physical assist for bed mobility, transfer, dressing, eating, toilet use, personal hygiene, and bathing. Interview with the Nurse Consultant on 4/4/23 at 12:40 p.m., indicated she had no further information to provide.		need to monitor residents during meals and the proper procedure to follow when a resident states they do not want the food that has been served. Dietary staff have been educated on the individual food preference lists and the importance of serving food preferences or providing planned menu substitutions upon resident request. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Director of Nursing or designee will monitor that residents receive food preferences or planned substitutions through meal observation audits conducted during morning, noon, and evening meals at least once per week for four weeks, then once every two weeks for four weeks, then once per month for four weeks or until 100% compliance is achieved. Audit results will be reviewed per the QAPI Committee with further revisions or actions implemented as deemed necessary. DATE: 6/15/23	
F 0825 SS=D Bldg. 00	483.65(a)(1)(2) Provide/Obtain Specialized Rehab Services §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual			

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	disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. Based on interview and record review, the facility failed to ensure specialized rehabilitation services were provided to a resident per the Physician's Orders for 1 of 1 residents reviewed for rehabilitation services. (Resident 23) Finding includes: Interview with Resident 23 on 4/3/23 at 10:58 a.m., indicated she was in the facility for therapy services however she was not receiving services as often as she should. Resident 23's record was reviewed on 4/5/23 at 11:22 a.m. Diagnoses included, but were not limited to, schizophrenia, bipolar disorder, and anxiety disorder. The Admission Minimum Data Set (MDS) assessment, dated 3/13/23, indicated the resident was cognitively intact for daily decision making. She required total dependence with one person physical assist for transfer and toilet use. She required limited assistance with one person physical assist for dressing, personal hygiene,	F 0825	**F825** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 23 – PT services have been provided per MD order. **Corrective Action(s) for Other Residents Potentially Affected** All residents with orders for rehabilitative services have the potential to be affected by this deficient practice. All current therapy orders have been reviewed and therapy providers have provided validation that services are rendered in accordance with MD orders. **Measures to Ensure the Deficient Practice Does Not Recur** The Administrator met with therapy service providers to review the agreement for service provision. Therapy staff are aware of their responsibility to provide	06/15/2023

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	and bathing. She had a functional limitation in range of motion to both lower extremities. A Physician's Order, dated 3/23/23, indicated the resident was to received skilled physical therapy (PT) 3-5 times per week for 4 weeks, effective 3/2/23. A completed PT Evaluation and Plan of Treatment was completed on 3/2/23. Resident 23 had two PT Treatment Encounter Notes completed on 3/24/23 and 4/3/23. Interview with the Nurse Consultant on 4/5/23 at 2:30 p.m., indicated the initial evaluation was completed on 3/2/23. The next visit was not until 3/24/23. 3.1-23(a)(1)		timely services in accordance with the physician plan of care and orders. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Administrator or designee will monitor that therapy services are provided through validation of service provision audits at least once per week for four weeks, then once every two weeks for four weeks, then once per month for four weeks or until 100% compliance is achieved. Audit results will be reviewed per the QAPI Committee with further revisions or actions implemented as deemed necessary. DATE: 6/15/23	
F 0835 SS=F Bldg. 00	483.70 Administration §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review, and interview, key members of the facility's Administrative staff failed to use resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident related to the development of an unstageable pressure sore (Residents K and E) not prevented or found due to lack of QAPI monitoring, and a contracture that was not treated (Resident F) as well as lack of onsite management. This inaction in	F 0835	**F835** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident K – The resident has been discharged per family request. Resident E - Agency LPN 1 is no longer assigned to active shifts at the facility. The resident continues to receive treatments to all skin	06/15/2023

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	administering the facility had the potential to affect all residents residing in the facility. Findings include: 1. On 4/3/23 at 9:50 a.m., Resident K was observed in the dining room in a geri recliner. The resident had bilateral heel boots in place. At 2:17 p.m., the resident remained in the dining room and he was being fed by staff. At 3:13 p.m., the resident was transferred from his geri recliner to his bed. Incontinence care was provided and the resident's bilateral heel boots remained in place. At that time, Agency CNA 1 was asked to remove the resident's heel boots as well as his socks. A large area of dark purplish/black discoloration was observed to the resident's right inner ankle. Interview with Agency CNA 1 at that time, indicated this was her first day at the facility and she was not told the resident had any pressure areas. CNA 2, who was also in the room, indicated she normally worked the other hall and she was not aware the resident had any pressure ulcers. At 3:35 p.m., the Nurse Consultant was brought into the room to visualize the area to the right inner ankle. The Nurse Consultant indicated she was told the area had healed and she would inform the Director of Nursing. At 3:50 p.m., LPN 1 and the Nurse Consultant were in the resident's room. The LPN indicated the area to the resident's inner ankle had recently healed. She also indicated she had not been told the resident had any areas to his feet. The Nurse Consultant indicated she would stage the area to the resident's right inner ankle as a suspected deep tissue injury (purple or maroon localized area		wounds in accordance with physician orders. The care plan has been updated to reflect current skin impairment. Turning, repositioning, and tissue off-loading is provided in accordance with MD orders and the care plan. Resident F – The resident has expired. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. See the corrective action plans submitted in this report for F550, F645, F677, F679, F684, F686, F689, F692, F757, F867, and F880. **Measures to Ensure the Deficient Practice Does Not Recur** An Interim Administrator has been contracted to provide additional oversight and support to the administrative team. The Interim Administrator will be present at the facility Monday through Friday except for illness or an emergency situation. An Interim DON is scheduled to begin on 5/8/23 and will be present at the facility Monday through Friday except for illness or an emergency situation. The licensee will continue to provide on-site and remote clinical oversight and support. The licensee will provide additional support as deemed necessary.	

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	of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear). The area to the right inner ankle measured 4.5 centimeters (cm) by 7.0 cm. The record for Resident K was reviewed on 4/3/23 at 2:23 p.m. Diagnoses included, but were not limited to, hemiparesis (muscle weakness) following a stroke, Vitamin C and D deficiencies, and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 1/8/23, indicated the resident was cognitively impaired for daily decision making and was totally dependent on staff for bed mobility, transfers, and eating. The resident was identified as having one Stage 3 pressure ulcer and two deep tissue injuries. 2. Wound care for Resident E was observed on 4/5/23 at 11:56 a.m., with Agency LPN 1. CNA 1 was assisting the LPN with positioning the resident. Both staff members washed their hands and donned gloves. While the LPN was washing her hands, CNA 1 removed the heel protector to the resident's right foot and removed his non-skid sock, there was no dressing in place to the right outer ankle. The CNA indicated she provided incontinence care for the resident before he got up for breakfast but he was already dressed when she came on duty. She indicated she did not know how long the dressing had been off. No slough was noted to the right outer ankle wound. The wound bed was pink with no drainage. The LPN donned gloves and cleansed the area to the ankle with normal saline, she washed her hands, donned new gloves, and applied skin prep to the edge of the wound. She washed her hands, donned new gloves, and applied the medihoney to the foam dressing and then applied it to the right outer		**The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The licensee will require weekly compliance reports from the administrative team to ensure the effectiveness of daily onsite management. These reports will be in writing and submitted to the Vice President of Strategic Partnering and Compliance weekly on-going. Please refer to the monitoring processes for all deficient practices identified at F550, F645, F677, F679, F684, F686. F689, F692, F757. F867, and F880. Audit results will be documented and submitted to the QAPI Committee for review with further revisions or actions implemented as deemed necessary. DATE: 6/15/23	

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	ankle. The dressing was not dated. The LPN then asked if all of the wound treatments had to be completed, she had the CNA remove the heel boot and sock on the resident's left foot, she looked at the foot and indicated everything looked good. She did not complete any treatments to the resident's left foot. The record for Resident E was reviewed on 4/4/23 at 1:30 p.m. Diagnoses included, but were not limited to, cerebral palsy, intellectual disabilities, and aphasia (difficulty speaking). The Discharge Return Anticipated Minimum Data Set (MDS) assessment, dated 2/23/23, indicated the resident was severely impaired for daily decision making and was totally dependent on staff for bed mobility, transfers, eating, and toilet use. The resident was always incontinent of bowel and bladder and he had no pressure ulcers. 3. On 4/3/23 at 3:05 p.m., Resident F was observed in his room seated in his wheelchair. The resident's left middle, ring, and pinky fingers were closed in a fist. When asked if he could extend those fingers, the resident was not able to. He had no anti-contracture device in use. The record for Resident F was reviewed on 4/5/23 at 9:00 a.m. Diagnoses included, but were not limited to, dementia with psychotic disturbance and anxiety disorder. The Annual Minimum Data Set (MDS) assessment, dated 3/29/23, indicated the resident was cognitively impaired for daily decision making and he had no limitation in ROM to the upper extremities. The Quarterly MDS assessments, dated 12/22,			

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	9/22, and 6/22/22, indicated the resident had no limitation in ROM to the upper extremities. The Admission MDS assessment, dated 3/28/22, indicated the resident had no limitation in ROM to the upper extremities. A mobility assessment, dated 6/21/22, indicated the resident had full ROM to his left wrist and fingers. The admission mobility assessment, dated 3/21/22, indicated the same. There were no other mobility assessments available for review after 6/21/22. An OT progress note, dated 2/25/23, indicated OT had facilitated passive range of motion (PROM) to the left fingers due to contractures to determine the most appropriate orthosis. The OT evaluation and plan of treatment, dated 2/25/23, indicated the resident was certified for therapy thru 3/23/23. The resident had a goal of being able to tolerate the use of a palm protector in the left hand for up to 2 hours to reduce potential for skin breakdown. The target date was 3/9/23. The OT evaluation also indicated prior to the onset of care, the resident did not have any orthosis for the left hand. Documentation indicated the resident's baseline on 2/25/23 was that he was currently able to tolerate the use of a rolled washed cloth for up to 2 hours. 4. The facility continues to have multiple recited deficiencies survey to survey, including the following on this current survey, some of which resulted in harm: - F550 Resident Rights/Exercise of Rights was previously cited on Recertification surveys dated 10/6/22, 10/29/21, and 4/27/21.			

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	- F645 PASARR Screening for MD and ID was previously cited on a Recertification survey dated 10/6/22. - F677 ADL Care Provided for Dependent Residents was previously cited on Recertification surveys dated 10/6/22 and 4/27/21, and Complaint survey dated 3/3/22. - F679 Activities Meet Interest/Needs Each Resident was previously cited on Recertification surveys dated, 10/6/22 and 4/27/21. - F684 Quality of Care was previously cited on Recertification surveys dated 10/6/22, 4/21/22, 10/29/21, and 4/27/21, and Complaint survey dated 3/3/22 - F686 Pressure Ulcers was previously cited on Recertification surveys dated 4/21/22, 10/29/21, and 4/27/21, and Complaint survey dated 3/3/22. - F689 Free of Accident Hazards/Supervision/Devices was previously cited on Recertification surveys dated 10/6/22, 10/29/21, and 4/27/21, Complaint survey dated 8/25/22 at IJ (Immediate Jeopardy) level and subsequent complaint PSR on 10/6/22. - F692 Nutrition/Hydration/Status Maintenance was previously cited on Recertification surveys dated 4/21/22, 10/29/21, and 4/27/21. - F757 Unnecessary Medications was previously cited on Recertification surveys dated 10/6/22, 4/21/22, 10/29/21, and 4/27/21. - F867 QAPI/QAA Improvement Activities was previously cited on Recertification surveys dated 10/6/22 and 4/27/21. - F880 Infection Control was previously cited on Recertification surveys dated 10/6/22, 4/21/22, 10/29/21, and 4/27/21. Interview with the Risk Management Specialist on 4/5/23 at 3:04 p.m., indicated she was brought into the facility to help with their QAPI Program. Her job was to compile data gathered from the facility			

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	staff and use that information to improve care and prevent recurrence. She indicated her system introduced root cause analysis to determine how and why recurrences were occurring in the facility, however the facility staff were having a difficult time with this process. She was having trouble implementing the QAPI Program effectively because the facility staff were not always documenting and providing the surveillance data she needed in order to implement new procedures to improve care and prevent recurrence. 5. On 4/2/23 at 8:30 a.m., the survey team entered the building. The Director of Nursing (DON) indicated she needed to leave and would be back "later on." The DON returned at 9:45 a.m. and completed the entrance conference. - The DON worked the night shift on 4/2/23 and stayed throughout the day on 4/3/23. - On 4/4/23, the DON was not present at any point during the day, as she had worked part of the night shift on 4/3/23. The Nurse Consultant was present for the length of the day and was the only point of contact for information from the facility. The Administrator was in the building in the afternoon but had no information related to anything involving nursing. - On 4/5/23 at 12:30 p.m., the DON was interviewing a potential staff member approximately 2 hours. The Nurse Consultant was present and was the only point of contact for information from the facility. The Administrator was in the building in the afternoon but had no information related to anything involving nursing. . - On 4/5/23 at 6:15 p.m., the Exit Conference began			

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	with the Administrator, the Risk Management Specialist, and the Nurse Consultant in attendance. The DON had left before the Exit Conference began. - The DON never provided a working schedule for the survey team to review after being asked at entrance and twice more during the survey time period. Cross reference F686, F688, and F867. 3.1-13(q)			
F 0842 SS=F Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of			

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	the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;			

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	(v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on observation and interview, the facility failed to ensure clinical records were complete related providing information to identify residents for Agency Staff for 1 of 7 residents observed during medication pass. This had the potential to affect all residents residing in the facility. Finding includes: On 4/3/23 at 9:50 a.m., Agency RN 1 was observed preparing medication for Resident 17. At that time, he was standing by the medication cart outside of the dining room where all of the residents were seated and eating breakfast. After the resident's medications were poured, he indicated he did not know who the resident was due to there was no picture of the resident in her electronic clinical record. The RN indicated he was going to have to ask LPN 1 (who was an employee at the facility) to identify and point out Resident 17. Interview with Agency RN 1 at that time, indicated he had only worked at the facility a couple of times and did not remember who the residents were. There was no picture of the residents in the computer and he was not aware of any book where pictures were kept. Interview with Agency LPN 1 on 4/5/23 at 9:00 a.m., indicated she had worked at the facility about 7 times before. During her shift (the midnight shift), agency staff were frequently the only employees who had worked. She indicated there were no pictures of the residents in the computer so they could be identified.	F 0842	**F842** **Corrective Action(s) for Residents Affected by the Deficient Practice** Resident 17 and all current residents have had photos taken and uploaded into the electronic record. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. All current residents have had photos taken and uploaded into the electronic record. **Measures to Ensure the Deficient Practice Does Not Recur** The Interim Director of Nursing will be responsible for obtaining and uploading photos of new admissions within five business days after the admission. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Administrator will review all new admissions within five business days post-admission to ensure that a photo is available. The Director of Nursing or designee will document the new admission audits with date of completion and determine compliance rates. These audits will be continued on- going.	06/15/2023

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	Interview with the Nurse Consultant on 4/5/23 at 10:30 a.m., indicated as far as she knew, there were no photos of the residents in the computer nor was there was a book of pictures to identify residents. Interview with the Director of Nursing on 4/5/23 at 2:45 p.m., indicated they had recently taken photos of the residents on an Ipad, however, none of them had been uploaded to the resident's electronic clinical record. 3.1-50(a)(1)		Audit results will be documented and submitted to the QAPI Committee for review with further revisions or actions implemented as deemed necessary. DATE: 6/15/23	
F 0851 SS=C Bldg. 00	483.70(q)(1)-(5) Payroll Based Journal §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).			

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	§483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. Based on record review and interview, the facility failed to ensure the mandatory submission of staffing information, based on payroll data, was electronically submitted to CMS. This had the	F 0851	**F851** **Corrective Action(s) for Residents Affected by the Deficient Practice**	06/15/2023

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	potential to effect 22 residents who resided in the facility. Finding includes: Staffing information was reviewed on 4/5/23 at 10:02 a.m. Interview with the Director of Nursing (DON) on 4/5/23 at 2:45 p.m., indicated she had not been submitting the required Payroll Based Journal (PBJ) to CMS "for awhile now." She had no rationale on why it had not been completed.		No specific residents were cited. The DON or designee will attempt to submit data for the first quarter. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. The DON or designee will submit data concurrently as required. **Measures to Ensure the Deficient Practice Does Not Recur** The DON or designee has reviewed the requirements related to PBJ submission and is aware of the responsibility to submit the data timely. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Administrator or designee will monitor that PBJ submission is completed concurrently by requesting validation of submission each month. A record of PBJ submission will be maintained and submitted as these audits will be continued on-going to the QAPI Committee for review with further revisions or actions implemented as deemed necessary. DATE: 6/15/23	
F 0867 SS=G Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement			

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	written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.			

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

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	learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. Based on observation, record review, and interview, the facility failed to identify unresolved quality deficiencies, some of which had been cited	F 0867	**F867** **Corrective Action(s) for Residents Affected by the**	06/15/2023

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	on previous surveys, and ensure actions were developed and implemented to attempt to correct the deficiencies through the quality assessment and assurance (QAA) process as evidenced by the number of repeated deficiencies cited involving quality of care, pressure ulcers, unnecessary medications, and infection control. This deficient practice affected 22 of 22 residents residing in the facility. Findings include: Interview with the Director of Nursing on 4/2/23 at 9:45 a.m., indicated the Quality Assessment and Assurance (QAA) Committee met at least quarterly and the committee consisted of the Medical Director, the Administrator, the DON, Infection Control Nurse, the Minimum Data Set (MDS) Nurse, the Dietitian, the Food Sanitation Supervisor, the Pharmacist, and Maintenance. The Quality Assurance and Performance Improvement (QAPI) plan requested at the Entrance Conference was provided during the survey by the DON. The plan was a general outline of how to set up a QAPI committee and what the committee should do. Chapters Four and Five of the plan indicated how to implement performance improvement projects (PIP) as part of the QAPI program and implementing the QAPI program planning and processes. 1. The following deficiencies were cited on this survey at an isolated, pattern or widespread scope with potential for more than minimal harm and had been cited previously: - F550 Resident Rights/Exercise of Rights was previously cited on Recertification surveys dated 10/6/22, 10/29/21, and 4/27/21. - F645 PASARR Screening for MD and ID was		**Deficient Practice** No specific residents were cited. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. See the corrective action plans submitted in this report for F550, F645, F677, F679, F684, F686, F689, F692, F757, F867, and F880. Measures to Ensure the Deficient Practice Does Not Recur An Interim Administrator has been contracted to provide additional oversight and support to the administrative team. The Interim Administrator will be present at the facility Monday through Friday except for illness or an emergency situation. An Interim DON is scheduled to begin on 5/8/23 and will be present at the facility Monday through Friday except for illness or an emergency situation. The Nurse Consultant will continue to provide on-site and remote clinical oversight and support. The Nurse Consultant is working closely with the Risk Management Specialist and the new administrative team to ensure all components of the QAPI program are executed and meaningful data is collected and analyzed, and facility practices are in compliance. The Vice President of Strategic	

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	previously cited on a Recertification survey dated 10/6/22. - F677 ADL Care Provided for Dependent Residents was previously cited on Recertification surveys dated 10/6/22 and 4/27/21, and Complaint survey dated 3/3/22. - F679 Activities Meet Interest/Needs Each Resident was previously cited on Recertification surveys dated, 10/6/22 and 4/27/21. - F684 Quality of Care was previously cited on Recertification surveys dated 10/6/22, 4/21/22, 10/29/21, and 4/27/21, and Complaint survey dated 3/3/22 - F689 Free of Accident Hazards/Supervision/Devices was previously cited on Recertification surveys dated 10/6/22, 10/29/21, and 4/27/21, Complaint survey dated 8/25/22 at IJ (Immediate Jeopardy) level and subsequent complaint PSR on 10/6/22. - F692 Nutrition/Hydration/Status Maintenance was previously cited on Recertification surveys dated 4/21/22, 10/29/21, and 4/27/21. - F757 Unnecessary Medications was previously cited on Recertification surveys dated 10/6/22, 4/21/22, 10/29/21, and 4/27/21. - F880 Infection Control was previously cited on Recertification surveys dated 10/6/22, 4/21/22, 10/29/21, and 4/27/21. 2. The following deficiencies were cited on this survey at an isolated scope with actual harm that is not immediate jeopardy and had been cited previously: - F686 Pressure Ulcers was previously cited on Recertification surveys dated 4/21/22, 10/29/21, and 4/27/21, and Complaint survey dated 3/3/22. - F867 QAPI/QAA Improvement Activities was previously cited on Recertification surveys dated 10/6/22 and 4/27/21.		Partnering and Compliance is employed by the licensee and participates in QAPI meetings. The licensee will provide additional support as deemed necessary. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The effectiveness of the QAPI program will be determined through on-going communication between the Interim licensed leadership, the Risk Management Specialist, the administrative team, and the licensee. The Interim leadership and the Risk Management Specialist communicate electronically or by phone at least weekly and discuss the progress of corrective action plans. This will be continued on-going. Program revisions will be made as deemed necessary. The necessary audits for monitoring of all corrective actions have been delegated and will be completed as defined in this report. Audit results will be documented and submitted to the QAPI Committee for review with further revisions or actions implemented as deemed necessary. DATE: 6/15/23	

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	There was no evidence the facility had identified, developed, or implemented action plans and/or continued to monitor any corrective actions taken when these deficiencies were cited previously. Interview with the Risk Management Specialist on 4/5/23 at 3:04 p.m., indicated she was brought into the facility to help with their QAPI Program. Her job was to compile data gathered from the facility staff and use that information to improve care and prevent recurrence. She indicated her system introduced root cause analysis to determine how and why recurrences were occurring in the facility, however the facility staff were having a difficult time with this process. She was having a difficult time implementing the QAPI Program effectively because the facility staff were not always documenting and providing the data she needed in order to implement new procedures to improve care and prevent recurrence. 3.1-52(b)(2)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:			

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	§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility 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.			

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	§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented related to hand hygiene prior to meals and bathing during random observations of infection control, 3 of 3 meals observed, and 1 of 1 observations of morning care. (Resident F) Findings include: 1. On 4/2/23 at 9:37 a.m., staff came out of the kitchen and asked the residents who wanted cold cereal and/or oatmeal. Sixteen residents were in the dining room. At 9:42 a.m., cereal and/or oatmeal was being served. The residents were not offered hand sanitizer prior to being served. 2. On 4/3/23 at 9:25 a.m., 16 residents were in the dining room. At 9:54 a.m., the breakfast trays were served. The residents were not offered hand sanitizer prior to being served. The same was observed during lunch. Interview with the Nurse Consultant on 4/5/23 at 10:40 a.m., indicated the residents should have	F 0880	**F880** **Corrective Action(s) for Residents Affected by the Deficient Practice** Hand hygiene is being offered to all residents prior to their meals. Resident F has expired. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. Hand hygiene is being offered to all residents prior to their meals. **Measures to Ensure the Deficient Practice Does Not Recur** Licensed and certified staff have been in-serviced on the need to offer hand hygiene for residents prior to meals. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Administrator or designee will	06/15/2023

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	been offered hand sanitizer prior to their meals. 3. On 4/4/23 at 8:45 a.m., CNA 3 was observed completing morning care for Resident F. The CNA had water running in the sink and a wash cloth was submerged in the water. The CNA donned a pair of gloves and retrieved the wash cloth from the sink. She wiped the resident's face with the wash cloth, along with his arm pits, arms, and chest area. The CNA then went back to the sink and rinsed off the wash cloth, body wash was applied to the same wash cloth, and she walked back to the side of the resident's bed. The resident's brief was removed and his peri area was washed. The CNA then went back to the sink and rinsed off the wash cloth, the resident was positioned on his left side and his back was wiped down and then his buttock area. The CNA continued to use the same wash cloth. The CNA then placed a clean brief on the resident, dressed him, and then placed him in the wheelchair. Interview with the Nurse Consultant on 4/5/23 at 10:40 a.m., indicated the CNA should not have used the same wash cloth throughout the resident's bed bath. 4. On 4/2/23 at 10:15 a.m., Resident 15 was observed reaching his right hand into his pants and then bringing his hand to his mouth and licking his hand. The resident's breakfast tray was delivered to him at 10:26 a.m., no staff member offered hand sanitizer to the resident. On 4/3/23 at 10:10 a.m., Resident 15 was observed reaching his hand into his pants. Agency CNA 1 told the resident to remove his hand from his pants and continued to serve his breakfast plate. She did not offer hand sanitizer to the resident prior to breakfast.		monitor that residents are offered hand hygiene before meals through meal observation audits conducted during morning, noon, and evening meals at least once per week for four weeks, then once every two weeks for four weeks, then once per month for four weeks or until 100% compliance is achieved. Audit results will be reviewed per the QAPI Committee with further revisions or actions implemented as deemed necessary. DATE: 6/15/23	

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	5. On 4/2/23 at 10:15 a.m., residents' breakfast trays were being passed to each resident individually. No staff member offered hand sanitizer to any resident in the dining room. 6. On 4/3/23 at 10:10 a.m., residents' breakfast trays were being passed to each resident individually. No staff member was observed to offer hand sanitizer to any resident in the dining room. Interview with the Nurse Consultant on 4/5/23 at 10:38 a.m., indicated she had no further information to provide. 3.1-18(b)			
F 0883 SS=F Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:			

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	(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.			
	Based on record review and interview, the facility failed to ensure infection control guidelines were in place and implemented, related to offering and providing the Influenza and Pneumococcal vaccines for 6 of 6 residents reviewed for	F 0883	**F883** **Corrective Action(s) for Residents Affected by the Deficient Practice** Residents 9, 17, 20, 21, 22, and	06/15/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	vaccinations. (Residents 9, 17, 20, 21, 22, and 23) Findings include: The Influenza and Pneumococcal vaccine records were reviewed on 4/4/23 at 1:20 p.m. a. Resident 9 had no documentation of a signed consent or refusal of the Influenza or Pneumococcal vaccines. A Care Conference Note, dated 3/3/23 at 10:30 a.m., indicated the resident was alert & oriented and did not attend. His daughter/ POA (Power of Attorney) attended and gave a verbal consent for the resident to receive any Covid, Flu and Pneumonia vaccination shots "but resident refuses." There was no further documentation in any progress notes related to when the resident was offered and refused vaccinations and no signed written refusal. b. Resident 17 had no documentation of a signed consent or refusal of the Influenza or Pneumococcal vaccines. c. Resident 20 had no documentation of a signed consent or refusal of the Influenza or Pneumococcal vaccines. d. Resident 21 had no documentation of a signed consent or refusal of the Influenza or Pneumococcal vaccines. e. Resident 22 had no documentation of a signed consent or refusal of the Influenza or Pneumococcal vaccines.		23 – The resident or responsible party/guardian has been contacted and written consent or refusal obtained for Covid, Flu and Pneumonia vaccination shots. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. The resident or his/her responsible party/guardian has been requested to provide written consent or refusal for Covid, Flu and Pneumonia vaccination shots. Documentation is available in the electronic record. Influenza vaccinations will be offered during the 2023-2024 influenza season. Pneumococcal vaccinations will be provided to all residents who have written consent. **Measures to Ensure the Deficient Practice Does Not Recur** Facility policy and procedure regarding influenza vaccination consent and administration of vaccines has been reviewed and will be followed to ensure written consent is available in the electronic record and vaccines are administered during the time frame recommended per the CDC. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The DON or designee will be responsible for ensuring that flu and COVID consents or refusals	

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	155845	A. BUILDING 00 B. WING	04/05/2023

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	f. Resident 23 had no documentation of a signed consent or refusal of the Influenza or Pneumococcal vaccines. Interview with LPN 1 (the Infection Preventionist) on 4/4/23 at 2:45 p.m., indicated they did not administer the Influenza or Pneumococcal vaccine to any resident last fall. Interview with the Nurse Consultant on 4/4/23 at 3:30 p.m., indicated the Influenza and Pneumococcal vaccine consent or refusal forms were not completed in writing. Interview with the Director of Nursing on 4/5/23 at 11:15 a.m., indicated there were no Influenza or Pneumococcal vaccine consent forms completed by the residents and/or their families. The Social Service Director (SSD) was in charge of obtaining the consent forms for both vaccines and was supposed to contact the families. The SSD had since left her position at the facility. 3.1-18(b)		are in writing for all current residents through audits completed once per month on-going. Audit results will be documented and submitted to the QAPI Committee for review with further revisions or actions implemented as deemed necessary. DATE: 6/15/23	
F 0887 SS=E Bldg. 00	483.80(d)(3)(i)-(vii) COVID-19 Immunization §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential			

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	side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19			

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	vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). Based on record review, and interview, the facility failed to ensure COVID-19 infection control guidelines were in place and implemented related to ensuring a continued ongoing effort was in place to vaccinate and obtain consents for the COVID-19 vaccine for 5 of 6 residents reviewed for vaccinations. (Residents 9, 20, 21, 22, and 23) Findings include: The COVID-19 vaccine records were reviewed on 4/4/23 at 1:20 p.m. All of the residents reviewed were identified on the facility list as unvaccinated for COVID-19. a. Resident 9 had no documentation of a signed consent or refusal of the COVID-19 vaccine. A Care Conference Note, dated 3/3/23 at 10:30 a.m., indicated the resident was alert & oriented and did not attend. His daughter/ POA (Power of Attorney) attended and gave a verbal consent for the resident to receive any Covid, Flu and Pneumonia vaccination shots "but resident refuses." There was no further documentation in any progress notes related to when the resident was offered and refused vaccinations and no signed written refusal. b. Resident 20 had no documentation of a signed consent or refusal of the COVID-19 vaccine. c. Resident 21 had no documentation of a signed	F 0887	**F887** **Corrective Action(s) for Residents Affected by the Deficient Practice** Residents 9, 20, 21, 22, and 23 – The resident or responsible party/guardian has been contacted and written consent or refusal obtained for Covid, Flu and Pneumonia vaccination shots. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. The resident or his/her responsible party/guardian has been requested to provide written consent or refusal for Covid, Flu and Pneumonia vaccination shots. Documentation is available in the electronic record. A Covid vaccination clinic has been scheduled for any residents who request the vaccine. **Measures to Ensure the Deficient Practice Does Not Recur** Facility policy and procedure regarding COVID vaccination consent and administration of vaccines has been reviewed and will be followed to ensure written consent is available in the electronic record and vaccines are	06/15/2023

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	consent or refusal of the COVID-19 vaccine. d. Resident 22 had no documentation of a signed consent or refusal of the COVID-19 vaccine. e. Resident 23 had no documentation of a signed consent or refusal of the COVID-19 vaccine. Interview with LPN 1 (the Infection Preventionist) on 4/4/23 at 2:45 p.m., indicated they had not had a COVID-19 vaccine clinic since last year. Interview with the Director of Nursing on 4/5/23 at 11:15 a.m., indicated there were no COVID-19 vaccine consent or refusal forms completed since 3/2022. The Social Service Director (SSD) was in charge of obtaining the consent forms for the COVID-19 vaccine and recently called the families on the phone in regards to all the vaccines, however, written consents were not obtained. The SSD had since left her position at the facility. 3.1-18(b)		administered when requested by a resident or his/her responsible party. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The DON or designee will be responsible for ensuring that flu and COVID consents or refusals are in writing for all current residents through audits completed once per month on-going. Audit results will be documented and submitted to the QAPI Committee for review with further revisions or actions implemented as deemed necessary. DATE: 6/15/23	
F 9999 Bldg. 00	3.1-14 PERSONNEL (q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (6) Position in the facility and job description. (7) Documentation of orientation to the facility and to the specific job skills. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment.	F 9999	**State Only** **3.1-14 Personnel** **Corrective Action(s) for Residents Affected by the Deficient Practice** No specific residents were cited. Cook 1 – The physical exam, job description, and job specific orientation are now in the employee file. OT 1 – The job description and job specific orientation are now in the employee file.	06/15/2023

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	This rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure each new employee had a signed job description as well as job specific orientation. The facility also failed to ensure every new hire had a completed physical exam for 4 of 4 new employees reviewed hired in the last 120 days. Findings include: The Employee files were reviewed on 4/5/23 at 1:30 p.m. a. Cook 1, hired on 3/29/23, had no physical exam. There was no job description or job specific orientation in his file. b. OT 1, hired on 2/11/23, had no job description or job specific orientation in his file. c. NA 2, hired on 2/23/23, had a physical exam, however, it was not signed by the Physician. There was no job description or job specific orientation in her file. d. CNA 1, hired on 3/30/23, had no job description or job specific orientation in her file. Interview with the Secretary on 4/5/23 at 4:05 p.m., indicated there was no job description or job specific orientation in the above employee files. She was unaware the 1 physical exam was not signed and the other employee did not have one.		NA 2 – A physical exam signed per an MD, the job description and job specific orientation are now in the employee file. CNA 1 – The job description and job specific orientation are now in the employee file. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice. All employee files have been thoroughly reviewed, and any missing documents have been obtained. Job specific orientation has been completed for all new hires. **Measures to Ensure the Deficient Practice Does Not Recur** The Executive Secretary has been re-educated on all employment documents she is responsible for. Employment checklists and packets have been reviewed and revised to ensure all required documents are listed and available. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The DON or designee will monitor that all new hire documents related to clinical staff hiring and orientation are completed, and the Administrator or designee will monitor that all new hire documents related to non-clinical staff hiring and orientation are	

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			completed. Audits of employee files will be completed once per month by the Administrator or designee on-going. Audit results will be documented and submitted to the QAPI Committee for review with further revisions or actions implemented as deemed necessary. DATE: 6/15/23	