STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 00 B. WING	11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISON POINTE HEALTHCARE CENTER	5226 E 82ND STREET INDIANAPOLIS, IN 46250

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included Investigation of Complaint IN00420188, IN00420302, IN00420370, IN00420233, IN00419854, and IN00419574. This visit resulted in an Extended Survey - Substandard Quality of Care - Immediate Jeopardy. This visit was in conjunction with complaint survey for complaint IN00420629. Complaint IN00419854- Federal/State deficiencies related to the allegations are cited at F0550, F0584, and F0677. Complaint IN00420370- Federal/State deficiencies related to the allegations are cited at F0558, F0584 and F0585. Complaint IN00420188 - Federal/State deficiencies related to the allegations are cited at F0684 Complaint IN00420302 - Federal/State deficiencies related to the allegations are cited at F0684 Complaint IN00420233- No deficiencies related to the allegations are cited. Complaint IN00419574 - No deficiencies related to the allegations are cited. Complaint IN00420629- Federal/State deficiencies related to the allegations are cited at F0684 and F0584 Survey dates: October 26, 27, 30, 31 and November 1, 2, and 3, 2023. Facility number: 000172 Provider number: 155272 AIM number: 100267130 Census Bed Type: SNF/NF: 108	F 0000	Preparation execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts or alleged or conclusions set forth on the State of Deficiencies. The plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The plan of correction is submitted in order to respond to the allegation of non-compliance cited during survey process. Please accept this plan of correction as the provider's credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lenore Williams	RN	11/30/2023

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

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	Total: 108 Census Payor Type: Medicare: 4 Medicaid: 89 Other: 15 Total: 108 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 15, 2023			
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §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.			

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	§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation and interview, the facility failed to protect and value a resident's private space by not knocking on doors and requesting permission before entering a resident's room for 2 residents during a random observation (Resident 52 and 38) and not taking into account the physical limitations of a resident by not clearly explaining to a resident who is blind what she had placed on his bedside tray table nor where it was placed so that he may find it for 1 of 1 residents observed during a random observation (Resident 52). Findings include: 1. A random observation made on 10/30/23 at 3:14 p.m. observed CNA (Certified Nursing Assistant) 20 passing out lunch trays. CNA 20 failed to knock and wait for permission to enter Resident 52's room when delivering his lunch tray. After exiting his room, she grabbed another tray from the dining cart and proceed to Resident 38's room where she failed again to knock and wait for permission to enter prior to entering the room.	F 0550	**1. Residents 52 and 38 were not harmed by the deficient practice.** **2. All residents have the potential to be affected. CNA 20 and 22 were educated on resident rights.** **3. All staff was educated on the Resident Rights Policy with emphasis on knocking on resident doors and waiting on permission to enter prior to entering and proper set up for visually impaired residents.** **4. Unit Manager/Designee will audit and observe 10 staff per week x1 month, then 5 staff per week x 1 month, then 3 staff per week x 1 month to ensure staff is knocking on resident doors and waiting on**	12/05/2023

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	An interview with CNA 20 conducted on 10/30/23 at 3:16 p.m. indicated, she was aware she should have knocked first then asked for the residents' permission to enter their rooms but failed to do so. 2. The clinical record for Resident 52 was reviewed on 10/27/23. Resident 52's diagnoses included, but not limited to, blindness. A random observation was made on 10/27/23 at 1:48 p.m. of CNA 22. CNA 22 had walked into Resident 52's room and without saying anything to the resident, she placed an ice cream cup on the edge of his bedside table furthest away from the resident then mumbled something as she left the room. Immediately following CNA 22's exit, Resident 52 was asked if he heard what she said and he replied, "something about ice cream". The surveyor then explained to Resident 52 that the aide had just brought him an ice cream cup and placed it near the edge of his bedside table. When asked if he had a spoon to eat the ice cream with he replied with a "no". CNA 22 was asked to bring Resident 22 a spoon. When CNA 22 arrived with the spoon, she entered the room without knocking and placed the spoon on top of the ice cream cup but, hadn't said anything to the resident. The surveyor then had to again explain to Resident 52 the arrival of the spoon and where it was located. A Resident Rights policy received on 10/30/23 at 4:05 p.m. from DON (Director of Nursing) indicated, it is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents... The purpose of this policy is to guide employees in the general principles of dignity and respect of caring for		**permission to enter prior to entering resident rooms.** **Unit Manager/Designee will audit and observe 10 residents per week x 1 month, then 5 residents per week x 1 month, then 3 residents per week x 1 month to ensure visually impaired residents have proper meal tray set up and communication as to where items are located.** **The results of the audit or observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months, then randomly thereafter for further recommendations.**	

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	residents...Care for residents will be provided in a safe and respectful manner...Residents will be treated with dignity and respect including but no limited to...b. When providing care, staff will...Knock before entering resident room..." This citation relates to Complaint IN00419854. 3.1-3(a) 3.1-3(t) 3.1-3(v)(1)			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview and review, record the facility failed to have the Interdisciplinary team (IDT) determine and document a self medication assessment was clinically appropriate for 2 of 2 residents randomly observed with medications at the bedside. (Resident 12 and 83) Findings include: 1. The clinical record for Resident 83 was reviewed on 10/26/23. Resident 83's diagnoses included, but not limited to, bipolar, dysphagia (difficulty swallowing), and anxiety. A random observation conducted on 10/26/23 at 2 p.m. of Resident 83's room found on his bed side table a small white pill. When Resident 83 was asked about the pill, he stated he didn't know what the medication was but, then indicated to give it to him and he would take the pill now. It was explained to Resident 83 that if he was	F 0554	1) Resident 83 and 12 were not harmed by the deficient practice. The medications were immediately removed from the resident bedside. **2) All residents have the potential to be affected. An audit was conducted to identify any other residents that have medications at bedside to ensure a self-administration of medication has been completed or if not appropriate the medication was removed from the bedside. Any findings were immediately corrected.** **3) Nurses and QMAs were educated on facility policies "Medication Administration**	12/05/2023

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	unaware of what the medication was, he probably shouldn't just take it but rather ask his nurse about it. An interview with Resident 83's QMA (Qualified Medication Assistant) 22 was conducted immediately following the random observation. QMA 22 indicated, she was unable to identify the medication left on his bedside table and when asked if medications should be left at bedside, she replied "no". 2. The clinical record for Resident 12 was reviewed on 10/27/23 at 9:26 a.m. The Resident's diagnosis included, but were not limited to, epilepsy. On 10/27/23 at 9:26 a.m., Resident 12 was observed sitting in bed. On his overbed table was a plastic medication cup with 3 yellow tables and 1 oblong white table. Resident 12 indicated the pills in the plastic medication cup were his morning medications. He was going to take them after he ate breakfast. During an interview on 10/27/23 at 9:30 a.m., LPN (Licensed Practical Nurse) 6 indicated she had administered Resident 12's medications to him earlier in the shift and had thought he had taken them. During an interview on 10/31/23 at 9:28 a.m., the DON (Director of Nursing) indicated that Resident 12 did not have a self administration of medication assessments present in his clinical record. A Medication Administration policy received on 11/1/23 at 2:24 p.m. from ED (Executive Director) indicated, "Procedure...a. Administer medication only as prescribed by the provider...m. Do not administer medications prepared by others...w. Never leave medications unattended...bb. Remain		**policy" with an emphasis on ensuring all medications have been administered appropriately.** **4) Unit Manager or Designee will audit 10 resident rooms per week x 1 month, then 5 resident rooms per week x 1 month, then 3 resident rooms per week x 1 months to ensure medication is not being left at the bedside.** **The results of the audit or observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months, then randomly thereafter for further recommendations.**	

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	with resident until the medication is swallowed cc. Do not leave medication at bedside..."			
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation,interview, and record review, the facility failed to ensure continued provision of a wheel chair and to ensure a resident's television was positioned for viewing for 1 of 4 residents reviewed for personal property and 1 of 2 residents reviewed for accommodation of needs. (Resident E and Resident 50) . Findings include: 1. The clinical record for Resident E was reviewed on 10/30/23 at 10:46 a.m. His diagnoses included, but were not limited to: type 2 diabetes, hypertension, major depressive disorder. He was discharged from the facility to the hospital on 4/30/23, readmitted to the facility on 5/2/23, discharged to the hospital on 8/11/23, readmitted to the facility on 8/20/23, discharged to the hospital on 8/31/23, readmitted to the facility on 9/5/23, and discharged to the hospital on 9/13/23. Resident E discharged to another facility when he left the hospital. The ADL (activities of daily living) self care performance deficit care plan, initiated 10/19/23, indicated he required assistance with ADL functional deficit. An intervention was that he required extensive assistance with transfers.	F 0558	Resident E and Resident 50 were not harmed by the facility's alleged deficient practice. Resident 50 had his television mounted appropriately for viewing. All residents have the potential to be affected. An audit was conducted on all residents that require the use of a wheelchair or assistive device to ensure all residents had their mobility needs met. The facility conducted an audit of all resident rooms to ensure the television was placed in a manner that the resident was able to view. Education was provided to all staff on the importance of ensuring that resident wheelchairs remain available for residents after LOA or discharge to hospital and to notify DON/Unit Manager if residents assistive device was not available. Education was provided to Maintenance to ensure that when televisions are mounted or positioned in the residents' room it is positioned appropriately for	12/05/2023

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	The impaired cognitive function care plan, initiated 10/19/22, indicated an intervention was to communicate with resident/family/caregivers regarding resident's capabilities and needs. An interview was conducted with Guardian 35 on 10/30/23 at 10:59 a.m. She indicated she became Resident E's guardian a few weeks prior to his final hospital discharge. She visited Resident E on 9/5/23 and noticed he did not have a wheel chair. She sent an email to SS (Social Services)referencing this. Guardian 35 provided a copy of this email via email. The 9/12/23 care plan note, written as a late entry by SS (Social Services) 26, read, "Care Plan Meeting held with [Name of Resident E,] Also present is His Volunteer Patient Advocate [Name of Guardian 35,] DNS [Director of Nursing Services,] Therapy Dept. [Department] and Social Services. Therapy continues working with resident on upper body strength, AROM [Active range of motion] Upper and Lower body. Resident is unable to stand. Is max. [maximum] to Mod. [moderate] assist with bed mobility. [Name of Guardian 35] asked where residents w/c [wheel chair] was. Therapy states that they will get him a w/c that his has been used for someone else d/t [due to] recent hospitalization. [Name of Resident E] does enjoy getting up in wheelchair and watching tv....Therapy and writer assured [Name of Guardian 35] that a wheelchair will be given to [Name of Resident E] and he will resume his getting out of bed routine." An interview was conducted with SS 26 on 10/30/23 at 2:31 p.m. He indicated Resident E was without a wheel chair for "maybe a month." He went to the hospital, and therapy borrowed it		resident viewing. The ED/Designee will conduct random audits of 10 rooms per week for 1 month, then 5 rooms a week for 1 month, then 3 rooms a week for 1 month to ensure televisions are positioned appropriately for resident viewing. The ED/Designee will conduct an audit of all residents that return from the hospital to ensure that they have the required mobility device upon return to the facility for 1 month, then 10 residents that return from the hospital x 1 month, then 5 residents that return from the hospital x 1 month. /b>	

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	while he was gone. Then came back from hospital. He thought he'd been without the wheel chair since he was readmitted to the facility from the hospital on 8/20/23, and no one recognized he didn't have one. Before he went to the hospital, he was getting up a few times a week. He would sit in his wheel chair by his bed and watch television. When he came back from the hospital, he didn't have one. Resident E never was provided with a wheel chair prior to his final 9/13/23 discharge. An interview was conducted with the TD (Therapy Director) on 11/1/23 at 2:29 p.m. He indicated if it was brought to therapy's attention that Resident E did not have a wheel chair and needed one, therapy would pick him up for wheel chair management. Nursing did not refer him for wheel chair management until around 9/13/23, when they did an evaluation. Therapy notes dating back to 7/11/23 were reviewed with the TD at this time, and none of them referenced use of a wheel chair. The 7/11/23 Physical Therapy Evaluation and Plan of Treatment indicated he was bed ridden at this time. 2. The clinical record for Resident 50 was reviewed on 10/26/23 at 2:00 p.m. The diagnosis included but was not limited to: Chronic Obstructive Pulmonary Disease (COPD). An activities care plan dated 4/10/23 indicated the resident's activity preference was watching television. A mood care plan dated 10/23/23 indicated the resident was to be encouraged to participate in activities as preferenced.			

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	An observation was made of Resident 50 on 10/26/23 at 2:15 p.m. The resident was observed in bed with a television mounted to the wall above resident's head. The television was not on. An interview was conducted with Resident 50 on 10/26/23 at 2:17 p.m. He indicated he just lays here in bed. An observation was made of Resident 50 on 11/2/23 at 11:34 a.m. The resident was observed lying in bed in the dark eating eggs staring at the wall. The resident's television was observed mounted on the wall above his head and not on. An observation was made of Resident 50 on 11/2/23 at 3:06 p.m. The resident was observed in his bed staring at the wall. The resident indicated he would like to watch television, but unable to see it. He had told several staff about it a couple weeks. The television was observed mounted on a wall above his head and not on. An observation was made of Resident 50 on 11/2/23 at 3:11 p.m., with the Unit Manager (UM) 24, License Practical Nurse (LPN) 27, and Certified Nursing Assistant (CNA) 28. CNA 28 indicated the resident's television use to be on an extension arm and pointed with his finger the wall the extension arm was previously located. The extension arm was removed, and the television was mounted to the wall above the resident's head. The resident's television had been like that for approximately a couple of weeks. The resident indicated he also was needing a remote control, because he did not have one to turn the television on. UM 24 indicated she would address and have maintenance move the television; so it could be visible for the resident.			

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	A resident rights policy was provided by the Director of Nursing on 11/3/23 at 9:38 a.m. It indicated "...Procedure: I. Resident will be treated with dignity and respect including but not limited to:..II. Resident Rights in Nursing home protected under Federal and State Law..ii. Participate in activities..." This citation relates to Complaint IN00420370.			
F 0584 SS=E Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;			

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	§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview, and record review, the facility failed to ensure a safe, comfortable, and homelike environment for 7 of 12 resident rooms observed. (Residents 7, 32, 43, 62, 228, 226, and 69) Findings include: 1. An observation conducted of Resident 7's room on 10/26/23 at 3:39 p.m., noted the wall by the window with missing paint approximately the size of a ruler. The roommate of Resident 7 indicated the area of missing paint has been there "for a while". The area of missing paint was still noted on 11/2/23 at 10:31 a.m. 2. An observation conducted of Resident 32's room, on 10/27/23 at 10:17 a.m., noted crumbs on wheelchair and built up dirt located on the legs of the bedside table. The crumbs were still located to the foot rests of the wheelchair along with built up of dirt to the	F 0584	No resident was harmed by the facility's alleged deficient practice. All residents have the potential to be affected. The facility ensured that rooms were painted, lights were functioning correctly, window boards were in good repair, wheelchairs, and bedside table legs were clean. Education was provided to all staff on the importance of ensuring a safe, clean, comfortable, homelike environment and how to report observances to Maintenance through TELS. The ED/Designee will conduct random audits of 10 rooms per week for 1 month, then 5 rooms a week for 1 month, then 3 rooms a week for 1 month to ensure that rooms were painted, lights are functioning correctly, window boards are in good repair, wheelchairs, and bedside table legs are clean. /b>	12/05/2023

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	155272	A. BUILDING 00 B. WING	11/03/2023

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	legs of the bedside table on 11/2/23 at 10:33 a.m. 3. An observation conducted of Resident 43's room, on 10/26/23 at 11:33 a.m., noted an area of plastered dry wall beside the bed that was not painted. There was missing paint on the walls by both beds located in the room. The area of plastered dry wall and areas with missing paint were still still noted on 11/2/23 at 10:36 a.m. 4. An observation conducted of Resident 62's room, on 10/26/23 at 11:57 a.m., noted a dim light when the bathroom light was turned on that made it difficult to see. The dim light was still noted on 11/2/23 at 10:41 a.m. 5. An observation conducted of Resident 228's room, on 10/26/23 at 2:04 p.m., noted the overhead light on. When attempted to be turned off the light continued to stay on. 6. An observation conducted of Resident 226's room, on 10/26/23 at 11:39 a.m., noted a chip in the board located underneath the window. Resident 226 indicated that chip had been there since he came to the facility. The chip to the board underneath Resident 226's window was still present on 11/2/23 at 10:47 a.m. 7. An observation conducted of Resident 69's room, on 10/26/23 at 1:53 p.m., noted paint peeling along with missing paint along the wall that was closest to the door. The peeling paint along with missing paint was			

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	still present on 11/2/23 at 10:50 a.m. Resident 69 indicated it's been like that for over a month. This citation relates to Complaints IN00419854, IN00420370, and IN00420629. 3.1-19(f) 3.1-19(bb)			
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §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:			

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	(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 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			

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	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 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 interview and record review, the facility failed to timely address a resident's guardian's grievances and to promptly resolve an oral grievance from a resident regarding missing clothing items for 2 of 4 residents reviewed for personal property. (Resident E and Resident 32) Findings include: 1. The clinical record for Resident E was reviewed on 10/30/23 at 10:46 a.m. His diagnoses included,	F 0585	Resident E and resident 32 were not harmed by the facility's alleged deficient practice. Resident E no longer resides in the facility. Resident 32 grievance was resolved and resident was satisfied with resolution. All residents have the potential to be affected. An audit was conducted of the grievances for the last 30 days to ensure all	12/05/2023

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	but were not limited to: type 2 diabetes, hypertension, major depressive disorder. He was discharged to the hospital on 8/11/23, readmitted to the facility on 8/20/23, discharged to the hospital on 8/31/23, readmitted to the facility on 9/5/23, and discharged to the hospital on 9/13/23. Resident E discharged to another facility when he left the hospital. The ADL (activities of daily living) self care performance deficit care plan, initiated 10/19/23, indicated he required assistance with ADLs. An intervention was that he required extensive assistance with transfers, bed mobility, and toileting. The impaired cognitive function care plan, initiated 10/19/22, indicated an intervention was to communicate with resident/family/caregivers regarding resident's capabilities and needs. An interview was conducted with Guardian 35 on 10/30/23 at 10:59 a.m. She indicated she became Resident E's guardian a few weeks prior to his final 9/13/23 hospital discharge from the facility. She visited Resident E on 9/5/23 and noticed some issues with room cleanliness, food or something smeared on the privacy curtain, bed frame, and wall. Used gloves and a feeding tube syringe on the bedside table. Dirty laundry, a sheet on floor, and jeans with a strong urine smell. Another resident's mail was in his drawer. She questioned use of a communication board with speech therapy, whether he'd been getting up since there was no wheel chair in the room, and a lack of comfortable clothing like sweats. This information was communicated to SS (Social Services) 26 via email through CARE (Centers for At Risk Elders) that same evening of 9/5/23, along with a copy of the invoice for clothing ordered for him that would		grievances had resolution. Education was provided to all staff on the facility's policy "Residence Grievance Indiana" with emphasis on addressing residents, guardian, and family grievances received orally or written- in a timely manner. ED/Designee will review all grievances in a reasonable time frame consistent with the type of grievance but not to exceed 30 days. This is a facility ongoing practice. The ED/Designee will conduct on audit of 10 grievances weekly for 1 month, then 5 grievances weekly x 1 month, then 3 grievances weekly for 1 month to validate resolution. /b>	

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	be arriving at the facility. Guardian 5 returned to the facility on 9/11/23 for a follow-up visit and several of the issues had not been addressed. The same food was still on the wall and privacy curtain next to his bed. The urine soaked jeans were thrown in the closet, unwashed. Several of the clothing items ordered for him that should have arrived on 9/6/23 could not be located. The nurse that day told her Resident E did not get dressed and out of bed. Resident E informed Guardian 35 he would like to start getting dressed. She also questioned how much therapy he was receiving. This information was communicated to SS 26 via email on 9/11/23. A copy of this email was provided by Guardian 35. The 9/12/23 care plan note, written as a late entry by SS (Social Services) 26, read, "Care Plan Meeting held with [Name of Resident E,] Also present is His Volunteer Patient Advocate [Name of Guardian 35,] DNS [Director of Nursing Services,] Therapy Dept. [Department] and Social Services. Therapy continues working with resident on upper body strength, AROM [Active range of motion] Upper and Lower body. Resident is unable to stand. Is max. [maximum] to Mod. [moderate] assist with bed mobility...OT states that [name of Resident E]s dependent on Dressing of upper and lower body. Advocate pointed out that there was tube feeding on [Name of Resident E's] Hospital gown. Cna [certified nursing assistant] was notified and will change gown as soon as the care plan meeting is over. Advocate Pointed out a stain on the privacy curtain in room. Housekeeping notified and curtain changed. Advocate also pointed out a quarter sized (pink) spot on the walls, Writer personally Cleaned spot off the wall..." An interview was conducted with SS 26 on			

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	10/30/23 at 2:31 p.m. He indicated Guardian 35 came to the facility the week prior to Resident E's final discharge and was upset. He was first informed of Guardian 35's concerns via email, so he suggested a care plan meeting. They met that same day. SS 26 saw the jeans referenced in the email, but they were not the right size for him, so they weren't his. He straightened up the rest of the closet. Guardian 35 pointed out food on the wall. He scrubbed it, maybe the size of quarter. Guardian 35 informed the day after the care plan meeting that Resident E would be leaving the facility. SS 26 did not fill out a grievance form after Guardian 35's 9/5/23 email referencing her concerns. He stated, "I guess I should have." SS 26 never found the clothing that was sent to the facility for Resident E, and they had not yet reimbursed for the missing clothing. An interview was conducted with SS 26 on 11/1/23 at 4:08 p.m. He indicated he went back into Resident E's room and found 2 boxes of clothing with the tags still on them, unworn. The only things they couldn't find were socks and some t-shirts which came to $39 and he was going to contact CARE about getting a check sent out. 2. The clinical record for Resident 32 was reviewed on 10/31/23 at 2 p.m. Resident 32's diagnoses included, but not limited to, idiopathic peripheral autonomic neuropathy (damage of peripheral nerves where cause can not be determined, affecting the feet) and paraplegia (paralysis of the legs). A quarterly MDS (Minimum Data Set) assessment completed on 9/19/23 indicated, Resident 32 was cognitively intact. An interview with Resident 32 conducted on			

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	10/27/23 at 10:25 a.m. indicated, he was missing some personal items from the laundry department for over 3 months. He indicated, he had told the laundry aide he was missing a pair of gray sweatpants and three white T-shirts but nothing had been done about it. In an interview with laundry aide (LA) 23, conducted on 10/30/23 at 11:05 a.m., she indicated, if a resident says they are missing items from laundry, she writes a note to herself with the resident's name, room number, and a description of the missing items. Then she will look for the items on the unlabeled personals rack. If she is unable find the exact items, she will offer the resident a similar item from the unlabeled personals rack. When asked if she ever fills out a grievance form for the missing items, she indicated, she does not. An interview with HSKM (housekeeping manager) conducted on 10/30/23 immediately following LA 23's interview, indicated, no grievance forms are filled out by laundry staff members. He indicated, the grievances are filled out by the "office" such as ED (Executive Director) DON (Director of nursing) or unit managers. HSKM indicated, he does not keep a record of items the residents are missing in the laundry area. An interview with ED conducted on 10/30/23 at approximately 3 p.m. indicated, she did not have a grievance form for Resident 32 concerning his missing sweatpants and/or T-shirts. The Resident Grievance policy was provided by the DON (Director of Nursing) on 10/30/23 at 4:05 p.m. It read, "Upon receipt of an oral, written or anonymous grievance submitted by a resident,			

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	the Grievance Official will take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated, if indicated....the Grievance Official shall complete an investigation of the resident's grievance....The grievance review will be completed in a reasonable time frame consistent with thee type of grievance but not to exceed 30 days." This citation relates to Complaint IN00420370. 3.1-7(a)(2) 3.1-7(b)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview, and record review, the facility failed to ensure accuracy of a resident's MDS (Minimum Data Set) assessment for 1 of 1 resident reviewed for PASRR (Pre Admission Screening Resident Review) and 2 of 3 residents reviewed for MDS accuracy. (Resident 26, 83, and 69) Findings include: 1. The clinical record for Resident 26 was reviewed on 10/26/23 at 3:35 p.m. His diagnoses included, but were not limited to: bipolar disorder, major depressive disorder, anxiety disorder, and mild vascular dementia. Resident 26's 6/25/18 Summary of Preliminary Findings and Recommendations of PASRR/MI [Pre admission screening resident review/mental illness] Level II Mental Health Assessment	F 0641	1. The MDS assessment for residents 26, 83, and 69 were modified and reflect MDS accuracy. **2. All residents have the potential to be affected. An audit was conducted of the most recent MDS submitted to ensure accuracy of the MDS for PASARR and gastrostomy tube on all appropriate residents.** **3. The Regional MDS or designee will educate the facility MDS coordinators and Interdisciplinary Team on MDS coding per the RAI manual for MDS accuracy.**	12/05/2023

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	indicated he was mentally ill and to continue current mental health services, medication monitoring, and medication administration. It indicated diagnoses of bipolar disorder, major depression, and anxiety disorder. Section A1500 of Resident 26's 4/12/23 Annual MDS assessment, completed by SS (Social Services) 26, indicated he was not considered by the state level II PASRR process to have a serious mental illness. An interview was conducted with SS 26 on 11/1/23 at 4:12 p.m. He indicated Section A1500 of Resident 26's 4/12/23 Annual MDS assessment should indicate he was considered to have a serious mental illness by the state level II PASRR process. The facility used the RAI (Resident Assessment Instrument) manual as their MDS policy. 2. The clinical record for Resident 83 was reviewed on 11/1/23 at 10:30 a.m. The diagnoses included, but were not limited to, bipolar disorder, psychosis, and schizophrenia. A preadmission screening and resident review (PASARR), dated 1/19/23, indicated a level 2 without specialized services. The significant change MDS assessment, dated 4/11/23, did not indicate a level 2 PASARR for Resident 83. 3. The clinical record for Resident 69 was reviewed on 11/1/23 at 10:38 a.m. The diagnoses included, but were not limited to, gastrostomy (opening into the stomach from the abdominal wall) status, muscle weakness, and aphasia (language disorder affecting one's ability to communicate) following		**4. The following audits will be conducted by the Regional MDS or designee to ensure compliance with MDS accuracy: An audit of 5 MDS will be completed per week for 4 weeks, then 10 MDS per month for 1 month and then 5 MDS for 1 month.** **The results of the audit or observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months, then randomly thereafter for further recommendations.**	

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	cerebral infarction. An observation conducted of Resident 69, on 11/2/23 at 10:50 a.m., noted a feeding tube to her abdomen. The physicians' orders for Resident 69 indicated the use of the gastrostomy tube (feeding tube) for flushes and medication administration. The admission MDS assessment, dated 3/31/23, indicated no feeding tube was marked. The same was noted on the quarterly MDS assessment, dated 6/8/23, and the quarterly MDS assessment, dated 9/27/23. An interview with the Regional Vice President of Risk Management, dated 11/2/23 at 10:55 a.m., indicated the MDS assessments for Resident 83 and Resident 69 were modified.			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be			

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	included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, interview, and record review, the facility failed to timely update an ADL (Activities of Daily Living) care plan to reflect the resident's refusal of care and to ensure a resident's dialysis care plan was updated for 1 of 4 residents reviewed for ADL care and 1 of 2 residents reviewed for Dialysis. (Resident 69 and Resident C) Findings include: 1. The clinical record for Resident 69 was reviewed on 10/26/23 at 12:13 p.m. The Resident's diagnosis included, but was not limited to, hypertension and anemia. A care plan, last revised on 8/1/23, indicated Resident 12 had an ADL self care performance deficit and required assistance with ADL care. The goals were for her to no have further declines in range of motion and to exhibit improved function. The interventions included, but were not limited to, Resident 12 required extensive assistance of 2 staff members for transfers. A Quarterly MDS (Minimum Data Set)	F 0657	**1) Residents 69 and C were not harmed by the deficient practice. Resident 69's care plan was updated with refusals. Resident C's plan of care was updated to reflect the appropriate dialysis site and appropriate dialysis schedule.** **2) All residents who refuse care and have dialysis have the potential to be affected. An audit was conducted on all residents with known refusals and of residents who receive dialysis to ensure an accurate plan of care reflects their refusals and/or dialysis requirements.** **3. MDS and Social Services were educated on the following policies "Plan of Care" and "Hemodialysis care and monitoring policy" with emphasis on care planning known refusals and dialysis requirements including but not limited to schedules and**	12/05/2023

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	Assessment, completed 9/27/23, indicated she was cognitively intact and was dependent on staff for transfers. During an interview on 10/26/23 at 12:13 p.m., Resident 69 indicated that she would like to get out of bed and into her wheelchair every other day. The staff did not get her out of bed as often as she would like. The staff would tell her they would be back to get her up, but then never come back. On 10/31/23 at 10:05 a.m., Resident 69 was observed in her bed wearing a hospital gown. On 11/02/23 at 2:39 p.m., Resident 69 was observed in her bed and dressed in street clothes. Resident 69 indicated that the CNA (Certified Nursing Assistant) had said they would be back after lunch and get her out of bed. The CNA had not come back. During an interview on 11/3/23 at 1:07 p.m., the DON (Director of Nursing) indicated that Resident 69's family member came to see her daily. When the family member was here, Resident 69 would request to get out of bed and then when the family member left, Resident 69 would refuse to get up. The DON spoke with Resident 69's family member often about her care and refusals. The DON was unsure if the care plan had been updated to include refusals of care. 2. The clinical record for Resident C was reviewed on 10/26/23 at 2:00 p.m. The diagnoses included but were not limited to: chronic kidney disease and type 2 diabetes mellitus. The Annual Minimum Data Set (MDS) assessment dated 10/11/23 indicated Resident C was cognitively intact.		**dialysis site location.** **4) DON or Designee will audit 10 residents care plans per week x 1 month, then 5 residents per week x 1 month, then 3 residents per week x 1 month to ensure resident care plans for refusals are update and accurate for refusals and dialysis requirements.** **The results of the audit or observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months, then randomly thereafter for further recommendations.**	

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A care plan dated 10/6/23 indicated Resident C received dialysis services in the facility on Mondays, Wednesdays and Fridays. The resident's access site was in her right chest.

An interview was conducted with Resident C on 10/26/23 at 1:59 p.m. She indicated she received dialysis services in the facility on Tuesdays, Thursdays and Saturdays. The resident's port was located on her left thigh. The nursing staff do not observe the site or ask her if the site was okay.

The Dialysis hand off communication reports dated 10/5/23, 10/7/23, 10/10/23, 10/12/23, 10/14/23, 10/17/23, 10/19/23, 10/24/23, 10/26/23, and 10/28/23 for the resident was provided by the Director of Nursing (DON) on 10/30/23 at 1:27 p.m. The reports indicated Resident C had dialysis Tuesdays, Thursdays, and Saturdays in the facility and her site was located in her left thigh.

An interview was conducted with the Director of Nursing (DON) on 10/31/23 at 10:47 a.m. She indicated Resident C's care plan should be updated.

A hemodialysis care and monitoring policy was provided by the Director of Nursing on 10/30/23 at 1:27 p.m. It indicated "...Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial and emotional needs and concerns of the residents. Safety is a primary concern for our residents, staff and visitors. Residents may require hemodialysis in the event of critically low kidney function, usually 12-15% or less, that allows the buildup of lethal toxins in the blood. Hemodialysis may be required due to renal damage attributable to long term uncontrolled diabetes and/or hypertension or for

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	an acute episode due to physical or chemical injury to the kidney. Residents will be individually evaluated by a nephrologist/physician for hemodialysis and will have a vascular access device or VAD placed specific to their needs. It is important the nurse understand the type of venous access device each resident has, what to expect as normal and what to do an in emergency situation even when dialysis is not being performed...III. General Vascular Access Device...b. The nurse will be aware of the specific type of VAD the resident has, for assessment and monitoring purposes. c. Different types of VAD may be have specific assessment parameters. d. Care plans will be updated to reflect individual VAD care and monitoring...x. Care plan. a. updated to reflect VAD b. Schedule days for dialysis..." A plan of care policy was provided by the DON on 10/31/23 at 12:14 p.m. It indicated "...It is the policy of this facility to provide a resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety is a primary concern for our residents, staff and visitors. The purpose of the policy is to provide guidance to the facility to support the inclusion of the resident or resident representative in all aspects of person-centered care planning and that this planning includes the provision of services to enable the resident to live with dignity and supports the resident's goals, choices and preferences including, but not limited to, goals related to their daily routines and goals to potentially return to a community setting...Procedures:...d. The facility will: i. Provide an RN [Registered Nurse] assessment of the resident as an on-going, periodic review that provides the foundation for resident focused care and the care planning process..iii. Review care plans quarterly and/or with significant changes in			

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	care..." 3.1-35(d)(2)(B)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review the facility failed to provide showers that included shaving and by not ensuring twice weekly showers/complete bed baths were provided for 2 of 4 residents reviewed for Activities of Daily Living. (Resident 225 and Resident F) Findings include: 1. The clinical record for Resident 225 was reviewed on 10/26/23 at 2:30 p.m. The diagnoses included but were not limited to: major depressive disorder, anxiety disorder and blindness. The resident was admitted on 10/11/23. The Annual Minimum Data Set (MDS) assessment dated 10/18/23 indicated Resident 225 was cognitively intact. The resident was needing partial/moderate assistance with bathing and supervision that included verbal cues and touching assistance for personal hygiene and dressing. An ADL care plan for Resident 225 indicated the resident was needing assistance with ADL's due to blindness. An observation was made of Resident 225 on	F 0677	**1) Resident 225 and resident F were not harmed by the alleged deficient practice. Resident 225 was immediately provided a shower per the resident preference. Resident F no longer resides at the facility.** **2) All residents have the potential to be affected. All residents were audited to ensure they had received shower/bath and face shaved per their preferences. Care plans were revised to reflect resident current preference. Any resident found to have not received a shower/bed bath per their preference or shaved was immediately addressed and corrected.** **3) Nursing staff were educated on facility policies "Routine Resident Care" and "Personal Bathing and Shower" with an emphasis on ensuring residents receive showers/bed baths and faces shaved based on resident**	12/05/2023

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	10/26/23 at 2:24 p.m. The resident was observed wearing blue jeans and a black sweatshirt with hair on his face. An interview was conducted with Resident 225 on 10/26/23 at 2:25 p.m. He indicated he hasn't received a shower since he has been here. He would "love" a shower and a shave. Some staff will come in tell him it's shower day, and they would be back to give him one. They never come back to give him one. Observations were made on 10/30/23 at 3:31 p.m., 10/31/23 at 10:00 a.m., and 10/31/23 at 12:37 p.m., of Resident 225 was observed with facial hair on his face wearing blue jeans and a black sweat shirt. The shower binder indicated Resident 225 was to receive showers on Mondays and Thursdays on day shift. The resident's shower sheets were provided by the Director of Nursing on 10/31/23 at 8:54 a.m. The shower sheets indicated Resident 225 was provided a shower or bed bath on the following days: 10/12/23 - shower given by Certified Nursing Assistant (CNA) 29, 10/16/23 - shower given by CNA 38, 10/19/23 - bed bath - given by CNA 29, 10/23/23 - shower - given by CNA 29, 10/26/23 - bed bath - given by CNA 38 An observation was made of Resident 225 with CNA 29 on 10/31/23 at 12:44 p.m. The resident was observed wearing blue jeans and a black sweatshirt with facial hair on his face. The resident indicated he would like to take a shower		**preferences.** **4) Director of Nursing or Designee will audit and observe 10 residents per week x 1 month, then 5 residents per week x 1 month, then 3 residents per week x 1 month to ensure residents have received shower or bed bath per preference and face shaved according to their plan of care.** /b>	

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	and be shaved. CNA 29 indicated she would provide a shower and a shave. An observation was made of CNA 29 at the nurse's station on 10/31/23 at 12:50 p.m. CNA 29 was observed filling out a shower sheet for Resident 225. The shower sheet indicated CNA 29 had provided a shower to Resident 225 on 10/31/23. CNA 29 indicated the resident had agreed to take a shower after lunch. She has not ever provided showers to Resident 225. On admission, the resident had stated he liked to wash up in the sink, so she has never asked him again if he would like to take a shower due to the refusal on admission. 2. The clinical record for Resident F was reviewed on 10/31/23 at 10:18 a.m. Resident F's diagnoses included, but not limited to, hemiplegia (paralysis of one side of the body) affecting the right, dominant side, bipolar disorder, major depressive disorder, and anxiety disorder. Resident F's care plan initiated on 8/10/21 and last revised on 7/17/23 indicated, Resident F has an ADL self care deficit and required extensive assistance with bathing. Resident F's shower sheets were provided by UM (Unit Manager) 24 on 10/31/23. Resident F had a shower/bed bath on the following dates in October 2023: 10/2/23, 10/3/23, 10/5/23, 10/10/23 and 10/17/23. In an interview with UM 24 conducted on 10/31/23 at 1:20 p.m., she indicated, if the resident had refused a shower/bed bath then the aide would have the nurse sign the shower sheet in the section marked 'nurse signature if refused'. When asked if there were more shower sheets for Resident during the month of October 2023, UM 24 indicated, there may be, however, no further shower sheets were provided prior to			

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	exiting the facility. A routine resident care policy was provided by the Director of Nursing on 10/31/23 at 3:15 p.m. It indicated "...Policy: It is the policy of this facility to promote resident centered care by attending to the total medical, nursing, physical, emotional, mental, social, and spirtual needs and honor resident lifestyle preferences while in the care of the this facility...3. Unlicensed staff:..b. Routine care by a nursing assistant includes but is not limited to the following: 1. bathing 2. dressing..." This citation relates to Complaint IN00419854. 3.1-38(a)(2) 3.1-38(a)(3) 3.1-38(b)(2)			
F 0684 SS=J Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to ensure admission orders were entered into the electronic medical record accurately, timely, and that such orders were administered as ordered by the physician for a resident with type 1 diabetes resulting in the resident experiencing a change in condition that included nausea and vomiting that was not	F 0684	**F684-Quality of Care** **Residents B, D, and C no longer reside in the facility. Resident D, C, 11, 24, and 26 were not harmed due to deficient practice.** Resident 11-Prevalon Boots were	12/05/2023

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	documented in the medical record (Resident B); ensure a diabetic resident's sliding scale insulin order was continued upon admission to the facility; administer a resident's pain medication as ordered (Resident D); ensure weekly wound assessments were conducted; administer insulin as ordered (Resident C); provide geri-sleeves and Prevalon boots, as ordered (Resident 11); address a resident's low blood pressure (Resident 24); and apply a resident's Lidocaine patches, as ordered (Resident 26) for 1 of 2 residents reviewed for wounds, 1 of 1 resident reviewed for insulin, 1 of 3 residents reviewed for positioning and mobility, 1 of 2 residents reviewed for pain management, and 3 of 5 residents reviewed for change in condition. (Residents B, C, D, 11, 24, and 26) The deficient practice resulted in Resident B experiencing cardiac arrest and being admitted to an acute care hospital for type 1 diabetes mellitus with ketoacidotic coma (coma due to high blood sugar), metabolic acidosis (accumulation of too much acid in the body), acute respiratory failure, aspiration pneumonia, and cardiac arrest with a blood glucose level of 1,189. The immediate jeopardy began on 10/17/23 when admission orders were not entered into the electronic medical record accurately, timely, and that such orders were administered as ordered by the physician. The Executive Director, Director of Nursing, Executive Director of sister facility, and Registered Nurse were notified of the immediate jeopardy at 11:02 a.m. on 11/01/2023. The immediate jeopardy was removed on 11/3/23, but noncompliance remained at the lower scope and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy .		applied that day but discontinued the next due to resident refusal to wear, resident refused Gerri-Sleeves and the order was discounted for Gerri-Sleeves. Resident 26-was not harmed due to the deficient practice. Resident 24-The medication orders were split into two routine orders to ensure nurses could read correctly on the EMAR/TAR. **All residents have the potential to be affected.** Any residents that reside in the facility with Diabetes Mellitus, change in condition, and new admission orders have the potential to be affected. An audit was completed on all residents with Diabetes Mellitus to ensure the appropriate and accurate orders are in place. Any discrepancies noted were immediately corrected. The MD/NP has signed off that the orders are accurate and administered as ordered. An audit was completed on all new admissions orders for the last 14 days to ensure an accurate medication reconciliation was completed and that all physician orders on the discharge summary were transcribed appropriately and accurately. Any discrepancies or omissions identified were immediately corrected and the appropriate notification to the	

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	Findings include: 1. The clinical record of Resident B was reviewed on 10/26/2023 at 2:26 p.m. The Resident's diagnosis included, but were not limited to, type 1 diabetes mellitus, end stage renal disease, dysphagia (difficulty swallowing), pneumonia due to unspecified infectious organism, tracheostomy, and gastrostomy. She was admitted to the facility on 10/17/23 and discharged to the acute care hospital on 10/19/23 due to cardiac arrest. The clinical record for Resident B contained the Facility to Facility Report provided by the discharging Long Term Care Hospital, dated 10/17/23, which included the discharge medications Resident B was to receive upon admission to the facility. The discharge medication list included, but was not limited to, the following: - Insulin aspart (rapid acting insulin) to be given sq (subcutaneously) per sliding scale dependent on blood sugar levels every 6 hours. For blood sugar of 71 to 150- no units were to be given, blood sugar of 151-200- 3 units were to be given, blood sugar of 201-250- 6 units were to be given, 251-300- 8 units were to be given, blood sugar of 301-350- 12 units were to be given, blood sugar of 351- 400- 16 units were to be given. The physician was to be called if blood sugar results were greater 250 twice in 24 hours. The last dose received at the discharging facility was on 10/17/23 at 1:11 p.m. - Insulin aspart- 4 units sq at 6:00 a.m. daily. The last dose received at the discharging facility was on 10/16/23 at 5:40 a.m. - Insulin aspart- 4 units sq at 12:00 p.m. daily. The last dose received at the discharging facility was on 10/17/23 at 1:11 p.m. - Insulin aspart- 4 units sq at 6:00 p.m. daily. The		MD/NP and family were completed. An audit was completed on all residents in the facility for change in condition in the last 14 days to ensure appropriate follow-up and MD/NP notification was completed. Any changes in condition that did not have appropriate follow-up or MD/NP notification were immediately addressed and corrected per the MD/NP. An audit was conducted of residents with skin preventive orders in place to ensure orders were being followed as indicated. Any findings that resulted in not following physician orders or resident preference were immediately corrected. An audit was conducted of all residents that reside in the facility with wounds to ensure each resident had a weekly wound assessment completed. Any resident identified with wounds that did not have a weekly wound assessment immediately had a head to toe assessment and wounds measured and documented per the facility policy, the family and physician were notified, and the plan of care updated accordingly. An audit was conducted on all residents for the last 14 days for blood pressures that were not within normal limits for that resident. Any blood pressure that was not within normal limits was	

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	last dose received at the discharging facility was on 10/16/23 at 6:03 p.m. - Insulin glargine (long-acting insulin) 18 units sq daily at 6 p.m. The last dose received at the discharging facility was on 10/16/23 at 6:03 p.m. The facility admission order did not include physician's orders for the insulin aspart per sliding scale dependent on blood sugars, orders to notify the physician if blood sugar readings were greater than 250 twice in 24 hours, physician's orders for insulin aspart 4 units scheduled daily at 6:00 a.m., 12:00 p.m., and 6:00 p.m., and there were no physician's order to obtain blood sugars. The Nursing Admission Evaluation, dated 10/17/23 at 7:10 p.m., indicated Resident B was alert and oriented to person, place, and time. She had clear speech and no behaviors. Her lung sounds were clear. A Social Services Note, dated 10/18/23 at 11:30 a.m., indicated Resident B had a BIMS (Brief Interview for Mental Status) score of 14 (cognitively intact). She was able to understand and be understood by others. She was a full code and wanted to discharge to her home with her family. Her family was very involved. A care plan, initiated 10/18/23, indicated Resident B had diabetes and retinopathy (eye disease). The goal was for her to be able to articulate potential complications of not following prescribed regimen and for her to be free from any signs or symptoms of hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar). The interventions, initiated 10/18/23, were to administer insulin injections as ordered, rotating injection sites, Educate resident and resident		retaken, called to the NP/MD, and any orders received with transcribed accordingly. An audit was conducted on all residents that receive patches to ensure orders were being followed as indicated and patches were being applied appropriately. **Licensed nursing staff was educated on the following facility policies:** "Admission Evaluation" policy with emphasis on order verification, transcription, medication reconciliation, confirmation, order clarification and admission order entry process. Education on the admission order entry process included but was not limited to monitoring of communication for clarification of orders via fax, email, and secured conversation. All licensed nurses were educated on the facility's policy, "Notification of Change in Condition" and change in condition with emphasis on identification of change in condition, MD/NP notification of change in condition, and follow-up with change in condition, and complete accurate documentation of change in condition. All licensed nurses were educated on the facilities polices identified	

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	representative on medical management and importance of adherence, to prevent complications of the disease, glucose observation, nutritional requirements, weight management, smoking cessation, insulin administration, signs and symptoms of hypo/ hyperglycemia, close observation of skin integrity/ wound healing and foot care, to observe for signs and symptoms of hyperglycemia such as increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing (deep and labored breathing pattern), acetone breath (fruity breath) stupor, coma. Report any abnormal findings to medical provider, resident and /or resident representative. Observe for signs and symptom of hypoglycemia such as sweating, tremors, increased heart rate, pallor, nervousness, confusion, blurred speech, lack of coordination, staggering gait, Report any abnormal findings to medical provider, resident and/ or resident representative. Obtain blood sugars per orders. Report abnormal findings to medical provider, resident and /or resident representative. Offer bedtime snack, weekly skin checks. A Nurses Note, dated 10/19/23 at 5:55 a.m. read "... arrived in patient room at approximately 5am (sic) 10/19/2023, found patient unresponsive and proceeded to do CPR [cardiopulmonary resuscitation] at 5:05 am (sic). patient was restless most of the night and stated that she felt very sick. got patients pulse back after 10 minutes of doing CPR and medics arrived shortly after and took over CPR and shortly after that took patient to ...hospital." The clinical record did not contain any additional nursing assessment of Resident B's condition		as, “Physician Order” and “Pain Management and Assessment” with emphasis on following physician orders for pain patches as written and contacting physician if medication is unavailable. All licensed nurses were educated on care of the Diabetic resident with emphasis on monitoring blood glucose as orders and signs and symptoms of hyper/hypoglycemia. Nurse managers were educated by the VP of Clinical Operations on the facility’s morning meeting process with emphasis on medication reconciliation on all new admissions. The weekend nursing supervisor was educated on medication reconciliation on all new admissions on Saturday and Sunday. Systematic process changes include the exact medication that requires clarification will be sent via fax, email, and now secured conversation. Secured Conversation can be immediately accessed by the licensed nurse. An additional audit is completed the following morning for all orders received the previous day by the Admissions Order Entry Department Manager to insure all insulin related orders have been transcribed appropriately and accurately. An alert email is sent to the facility and regional team for any errors or omissions that require further follow-up.	

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	from the time of the Admission Evaluation until the Nurses Note which indicated she had been found unresponsive on 10/19/23 at 5:55 a.m. The October 2023 MAR (Medicine Administration Record) did not contain any recorded blood sugar readings or administrations of any insulin aspart. The insulin glargine had been administered once on 10/18/23 at HS (bedtime). The Emergency Department Provider note, dated 10/19/23 at 5:40 a.m., indicated Resident B presented at the emergency department from a long-term care facility. The long-term care facility staff had found resident with vomit around her, not breathing and pulseless. Resident B had received chest compressions for 30 minutes. When medics arrived, they found she had a pulse. She was unresponsive and unable to give any history. The acute care hospital History and Physical exam dated 10/19/23 at 8:14 a.m. read "...History of Present Illness... Assessment/ Plan...1. DKA [Diabetic Ketoacidosis] with Hx of DM type 1: Glucose 1189...2. Severe Metabolic Acidosis: 2/2 [secondary to] DKA and renal disease...4. Cardiac arrest: Unclear rhythm, approximately 20 minutes of CPR performed at facility. Posturing to pain, myoclonic jerking [quick jerking movements that are not controlled] ...concern for anoxic [lack of oxygen] injury...5. Recent HCAP [Health Care Acquired Pneumonia]/ new Aspiration event: + [positive] aspiration at facility..." During an interview on 10/30/23 at 8:41 a.m., FM (Family Member) 20 indicated Resident B was still in the hospital and not responding. FM 20 had last seen Resident B when she was admitted to the facility on 10/17/23, at that time Resident B		All licensed nurses were educated on the facility's policy "Skin Care and Wound Management" with emphasis on weekly wound assessment and following physician orders related to skin breakdown prevention such as but not limited to prevalon boots and geri-sleeves. All licensed nurses were educated on notification to the physician for blood pressures that are obtained and not within normal limits for the resident. **4.** The DON/Unit Manager will complete medication reconciliation audit the following morning Monday through Friday on all new admissions. The weekend supervisor will complete medication reconciliation audit on Saturday and Sunday. This will be an ongoing facility process. The DON/Unit Manager will complete an audit via facility reports for change in condition Monday through Friday and the weekend supervisor Saturday and Sunday to ensure appropriate follow-up, MD/NP notification, and documentation has occurred. This will be an ongoing facility process. The DON/designee will audit 5 Diabetic residents orders weekly x 4 weeks, then 3 Diabetic residents orders weekly x 4 weeks, then 4	

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	had been smiling and interacting with the family and was hoping to be able to go home after her stay at the facility for rehabilitation. FM 20 had been informed by the acute care hospital that it was uncertain if Resident B would regain consciousness again. During an interview on 10/31/23 at 10:24 a.m., NP (Nurse Practitioner) 21 indicated the facility normally used the discharge medication orders sent by the discharging facility as the admission orders until the resident was seen by a physician at the facility. During an interview on 10/31/23 at 12:23 p.m., UM (Unit Manager) 22 indicated that she had assisted the admitting nurse with the physician's orders. Normally, the admission nurse would fax the medication orders received from the discharging facility to the Admission Order Entry service. The admitting nurse admits the patient into the electronic health record system and then faxes the orders so they can be data entered into the system by the Admission Order Entry service. If there are questions about the admission orders, the Admission Order Entry Service would call or fax the facility. UM 22 had no knowledge of the Admission Order Entry service calling or faxing with questions about Resident B's admission orders. When the Admission Order Entry service finished entering the orders, they inform the facility by sending a message on electronic health record to alert the facility that their portion was finished. The admitting nurse should have confirm and check the orders entered against the discharge orders. UM 22 normally would have compare the new resident's orders in the electronic health system with the orders sent from the discharging facility, but somehow there was a miscommunication with Resident B's orders. UM		Diabetic residents monthly x 1 month to ensure orders are followed as written. The wound nurse or designee will audit 5 wound residents weekly x 4 weeks, then 3 resident weekly x 4 weeks, then 4 residents monthly x 1 month to ensure weekly wound assessments are being completed. The wound nurse or designee will audit 5 wound residents weekly x 4 weeks, then 3 resident weekly x 4 weeks, then 4 residents monthly x 1 month to ensure skin prevention orders such as but not limited to prevalon boots and geri-sleeves are being followed. The DON or designee will audit the vital signs tab daily x 4 weeks, then 3 x weekly x 1 month, then 1 time weekly x 1 month to ensure any blood pressure documented that is not within normal limits for the resident have been addressed per facility policy. /b>	

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	22 was aware that Resident B was a diabetic. During an interview on 10/31/23 at 12:51 p.m., LPN (Licensed Practical Nurse) 23 indicated she had worked the night shift which began on 10/17/23 at 11 p.m. and ended the morning of 10/18/23. LPN 23 did not recall any faxes or calls with questions about Resident B's admission orders. During an interview on 10/31/23 at 1:00 p.m., QMA (Qualified Medication Aide) 24 indicated he had been caring for Resident B on 10/19/23 when she was sent to the hospital. QMA 24 had been called to Resident B's room by a CNA (Certified Nursing Assistant) at around 3:00 a.m. because Resident B was sliding out of the bed and vomiting. QMA 24 had informed LPN 25 that Resident B was vomiting and asked if Resident B could have something for nausea. At around 4:00 a.m., QMA 24 had assisted a CNA in placing a mattress on the floor by Resident B's bed because QMA 24 was afraid Resident B was going to fall and hurt herself. At around 5:00 a.m. Resident B had been found unresponsive and LPN 25 had come to assist. CPR had been started and 911 was called. QMA 24 had not been spoken to about his care of Resident B on early morning on 10/19/23 by any of the facility management. On 10/31/23 at 1:45 p.m., the RVPRM (Regional Vice President of Risk Management) provided the Admission Order Entry Communication fax which was time stamped as being received on 10/17/23 at 9:22 p.m., which indicated Resident B had medication issues that needed further attention. Medication not entered was insulin aspart due to clarification being need for the directions and frequency. During an interview on 10/31/23 at 1:45 p.m., the			

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	RVPRM and DON indicated the fax had been sent to the copy room fax machine. The nurses on duty had access to the copy room fax machine. The copy room was located in the middle of the building, between the two units. During an interview on 10/31/23 at 2:21p.m., LPN 26 indicated she had worked on 10/17/23 from 6:00 p.m. until 10/18/23 at 6:00 a.m. To LPN 26's knowledge, Resident B's admission orders had been taken care of by UM 22. LPN 26 was a fairly new employee to the facility. She had not received report from the previous shift. LPN 26 had not received any requests for clarification of Resident B's admission orders. UM 22 had asked the other nurse working the unit with LPN 26 that assist her with completing Resident B's Nursing Admission Assessment, but the other nurse on duty was unable to assist due to being busy with her patients. UM 22 had phoned her around 12:30 a.m. to make sure the admission assessment had been completed. LPN 26 had not been made aware of any concerns with Resident B's admission orders. During an interview on 10/31/23 at 3:07 p.m., LPN 25 indicated she had worked with QMA 24 on 10/19/23 when Resident B was sent to the hospital. QMA 24 had gotten her to look at Resident B around 1:00 a.m. QMA 24 had told LPN 25 that Resident B was vomiting a lot. There was not vomit present when LPN 25 assessed Resident B. Resident B had been restless and was repositioned in bed. LPN 25 had wondered if QMA 24 had mistaken Resident B "spitting up" for vomiting and had looked in the medical record to see if Resident B had any medication for anxiety. LPN 25 had not taken Resident B vital signs or made the physician aware. LPN 25 was not aware that Resident B was a diabetic. LPN 25			

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	indicated that if she had known Resident B was a diabetic, she would have taken her blood sugar. Around 5:00 a.m., a CNA had come up to LPN 25 and told her that Resident B was not responsive. LPN 25 had gone to Resident B's room and started CPR until the ambulance arrived and EMS took over her care. On 10/30/23 at 11:20 a.m., the ED provided the current Admission Evaluation policy which read "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. A systematic evaluation is completed by a licensed nurse upon admission/ readmission to assist in determining the most effective and appropriate care needs of each resident admitted to the center...2. Prioritize resident needs with appropriate interventions to include but not limited to...g. complete medication reconciliation...Communicate Care Plan Need to team..." On 11/1/23 at 2:33 p.m., the DON provided the current Notification of Change of Condition Policy which read "...Compliance Guidelines: The center must inform the resident, consult with the resident's physician and /or notify the residents' representative, authorized family member, or legal power of attorney/ guardian when there is a change requiring such notification...2. Significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental or psychosocial status including but not limited to: a. life-threatening conditions, or b. clinical complications. 3. Circumstances that require a need to alter treatment which may include: a. new treatment b. discontinuation of current treatment..." 2a.. The clinical record for Resident D was			

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	reviewed on 11/1/23 at 9:22 a.m. Resident D's diagnoses included, but not limited to, cancer of the tongue, diabetes mellitus Type II, hydrocephalus (extra fluid in the brain causing pressure) with VP shunt (Ventriculoperitoneal shunt, a tube inserted into a hole in the skull too drain excess fluid and relieve pressure on the brain) and status post laryngectomy (removal of larynx, voice box). A university hospital's discharge instructions for Resident D were provided by ED (Executive Director) on 11/1/23 at 2:24 p.m. The discharge instructions indicated, Resident D had tongue cancer and underwent surgery to remove his larynx (voice box), tongue, the lymph nodes from both sides of his neck and a VP shunt revision. The medication reconciliation indicated Resident D was on the following medications: Folic Acid 1 mg (milligram) once a day via G-tube (Gastrostomy, stomach tube used for medications, hydration, and enteral feeding) Lansoprazole (a stomach ulcer medication) 3 mg/ml (milliliter)- give 10 milliliters once a day via G-tube Multivitamin with minerals -one tablet, once a day via G-tube Oxycodone (a narcotic pain medication) 5 mg- one tablet three time a day via G-tube Apixaban (an anticoagulant) 5 mg - one tablet twice a day via G-tube Glargine insulin (slow acting insulin) 13 units at bed time subcutaneouly (under the skin in subcutaneous fat) Metoprolol (blood pressure medication) 50 mg given twice daily via G-tube Acetaminophen 325 mg - give 2 tablets via G-tube for fever Atorvastatin (cholesterol reducing medication) 20 mg via G-tube at bedtime			

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	Certrizine (anti-allergy medication) 10 mg tablet via G-tube every morning Cholecalciferol (vitamin D3) 1250 mcg (microgram) every Monday via G-tube Fentanyl (narcotic pain reliever) 12 mcg/hr patch -apply once every 3 days Fluoxetine (antidepressant) 20 mg/5 ml - give 5 ml via G-tube every morning Gabapentin 300 mg tablet via G-tube three times a day Guafenesin 100 mg/ 5 ml - give 10 ml via G-tube every four hours as needed for congestion Insulin Lispro 100 units/ml -give per sliding scale subcutaneously as needed for elevated blood glucose levels Loperamide (anti-diarrheal) 1 mg/ 7.5 ml -give 30 ml via feeding tube every 6 hours as needed for loose stool Melatonin 3 mg at bed time to aid with sleeping Metformin (diabetic medication) 500 mg tablet two time a day via G-tube Ondansetron 8 mg via G-tube every 8 hours as needed for nausea and vomiting Polyethylene glycol (stool softener) 17 grams via G-tube every morning Senna 8.8 mg/ 5 ml -give 5 ml via G-tube two times a day and to stop taking Omeprazole (stomach ulcer medication) A physician's progress note dated 8/14/2023 at 1:00 a.m. indicated, Resident D's medications included: the medications listed above except for the Lispro insulin, Folic acid and multivitamin. The lansoprazole was replaced with Omeprazole. An interview with Resident D's NP (Nurse Practitioner) 21 was conducted on 11/1/23 at 1:53 p.m. NP 21 indicated, the medications listed on his discharge paperwork from the hospital were			

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	the medications which should have been continued here at the facility which included the Lispro insulin with the sliding scale. An interview with Resident D's Endocrinologist (a physician who specializes in the Endocrine system) conducted on 11/1/23 at 2:12 p.m. indicated, if Resident D was on Lispro insulin at the hospital, she would have continued him on the same medication and dosage as he had previously been on at hospital until there was more data collected to determine if any changes needed to occur. She also mentioned, in order to give an accurate dose of Lispro insulin the facility should check his blood glucose at least 3 times daily. A review of Resident D's orders from the time of admission to current did not include an order for Lispro insulin three times daily before meals. Resident D's blood glucose readings were provided by ED on 11/1/23 at 2:24 p.m. The blood glucose readings ranged from the lowest reading at 118 to the highest reading of 336. Most of the readings were greater than 200. The review of Resident D's August, September, and October MARs (medication administration record) received from ED on 11/1/23 at 2:24 p.m. indicated, he had not received any Lispro insulin with a sliding scale. The August MAR indicated, 2 b. The review of Resident D's August MAR indicated Resident D did not receive his Fentanyl pain patch on the following dates: 8/12/23, 8/19/23, 8/27/23, 8/30/23. The chart code for the missed Fentanyl applications was "9" which indicated "see nurse notes"			

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	The Medication Administration note dated 8/15/23 indicated, pharmacy notified; 8/16/23 indicated, new order has to be received by pharmacy; 8/27/23 indicated, not available, still waiting for script; and 8/30/23 indicated, on order from pharmacy.3a. The clinical record for Resident C was reviewed on 10/26/23 at 2:00 p.m. The diagnoses included but were not limited to: chronic kidney disease and type 2 diabetes mellitus. The resident was admitted on 10/4/23. The Annual Minimum Data Set (MDS) assessment dated 10/11/23 indicated Resident C was cognitively intact. A care plan dated 10/6/23 indicated Resident C had diabetes. The staff was to administer insulin as ordered. A physician order dated 10/4/23 indicated the resident was to receive 10 units of Glargine (lantus) insulin at bed time. The order was discontinued on 10/20/23. An Endocrinologist visit note dated 10/13/23 indicated Resident C's insulin was going to be changed to 6 units of lantus twice a day. A physician order dated 10/13/23 indicated the resident was to receive 6 units of lantus at bedtime. The order was discontinued on 10/20/23. A physcian order dated 10/14/23 indicated the resident was to receive 6 units of lantus in the morning. The order was discontinued on 10/20/23. A physician order 10/20/23 indicated the resident's 10 units of glargine at bedtime was to be discontinued.			

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	A physician order dated 10/21/23 indicated the resident was to receive 6 units of lantus in the morning and 6 units of lantus at bedtime. The October 2023 Medication Administration Record (MAR) indicated the following days Resident C received 16 units of glargine/lantus insulin at bedtime: 10/14/23, 10/17/23 and 10/18/23 An interview was conducted with Resident C on 10/26/23 at 1:59 p.m. She indicated the staff have not been giving her insulin correctly. An interview was conducted with Endocrinologist Nurse Practitioner (NP) 35 on 10/31/23 at 3:00 p.m. She indicated on 10/13/23, she had changed Resident C's insulin orders due to her chronic kidney disease. The long acting insulin would be more effective if it was split up. The resident would received some insulin in the morning and some insulin at night. On 10/20/23, she had noticed the resident was receiving 16 units of lantus at bedtime instead of 6 units. NP 35 had spoken with the nursing staff to claify the orders. The 10 units of glargine insulin to be given at bedtime that was originally ordered was to be discontinued on 10/13/23. 3b. An at risk for altered skin integrity care plan with an initial date of 10/6/23 and a revision date of 10/18/23, indicated Resident C had impaired skin integrity. Weekly skin assessments dated 10/11/23 and 10/18/23 indicated the resident had no skin areas. A wound specialist visit note dated 10/17/23 indicated Resident C had an arterial ulcer to right lateral leg. The wound status assessment indicated the wound was full thickness measuring			

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	10 centimeters in length and 2.5 centimeters in width. The periwound was intact, fragile and dry. The treatment plan was for staff to apply skin prep to the wound base daily; leave open to air. The staff was to monitor the wound and notify provider with changes to the skin. A physician order dated 10/18/23 indicated the staff was to apply skin prep to right lateral ankle once a day. The resident's clinical record did not include any additional weekly wound measurements completed for the resident's arterial ulcer on her right leg after 10/17/23. An observation was made of Resident C on 10/26/23 at 1:59 p.m. Resident C's right outer leg was observed with a round area that was white, flakey and dry the size of a half dollar. An interview was conducted at that time with Resident C. She indicated the wound doctor came in and looked at her wound on her leg. He then took photos and ordered a treatment a few weeks ago. The staff nor the wound doctor has observed the wound since. An interview was conducted with the Wound Nurse 36 on 10/31/23 at 9:20 a.m. She indicated the wound doctor comes in weekly to do the wound assessments. The wound doctor sees all residents on admission and weekly with wounds. Resident C's initial visit with the wound doctor was on 10/17/23. He had observed an arterial ulcer on the resident's right leg at that time. It was difficult for the wound doctor to see her due to the resident goes to dialysis and leaves LOA (leave of absence) a lot. The resident's wound was not assessed with measurements last week.			

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ALLISON POINTE HEALTHCARE CENTER	5226 E 82ND STREET INDIANAPOLIS, IN 46250

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	A skin care and wound management policy was provided by the Director of Nursing on 10/31/23 at 12:14 p.m. It indicated "...Policy: The facility staff strives to prevent resident/patient skin impairment and to promote the healing of existing wounds. The interdisciplinary team works with the resident/patient and/or family/responsible party to identify and implement interventions to prevent and treat potential skin integrity issues. The interdisciplinary team evaluates and documents identified skin impairments and pre-existing signs to determine the type of impairment, underlying condition(s) contributing to it and description of impairment to determine appropriate treatment. Each resident/patient is evaluated upon admission and weekly thereafter for changes in skin condition...Treatment 6. monitor and document progress..." 4. The clinical record for Resident 11 was reviewed on 10/26/23 at 2:30 p.m. His diagnoses included, but were not limited to: right hand contracture, left hand contracture, convulsions, and hypertension. The impaired skin integrity/at risk for altered skin integrity care plan, revised 12/18/22, indicated the goal was for him to be without impaired skin integrity through the next review date. An intervention was to administer treatments as ordered by medical provider. The ADL (activities of daily living) care plan, revised 12/18/22, indicated he required total assistance with ADLs related to limited physical mobility and impaired functional range of motion to extremities. The goal was for him to remain free of complications related to immobility, including contractures, thrombus formation, skin breakdown and fall related injury through the next review date.			

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	The physician's orders read, "1) Staff to use: bilateral leg rest with foot buddy to support BLE [bilateral lower extremities,] when up in the wheelchair. 2)Staff to flip foot rest parts of both elevating leg rest away to prevent foot injury when up in wheelchair. 3) staff to put provolone [sic] boots [boots with a cushioned bottom that float the heel off the surface, helping to reduce pressure] on BLE to protect both feet when up in wheelchair. every shift for positioning," starting 4/22/21 and "Geri-Sleeves [stocking sleeves to protect the arms from friction and shearing] for protection. every shift for protection," starting 4/22/21. An observation of Resident 11 was made in the common area of the Brookshire Unit on 10/26/23 at 2:46 p.m. He was sitting in his chair in front of the television with his eyes closed. He was not wearing Prevalon boots or Geri-sleeves. The October, 2023 MAR (medication administration record) indicated Resident 11's Prevalon boots were on every shift on 10/26/23. An observation of Resident 11 was made with UM (Unit Manager) 24 in the common area of the Brookshire Unit on 11/1/23 at 3:24 p.m. He was not wearing Prevalon boots or Geri-sleeves. An interview was conducted with UM 24 on 11/1/23 at 3:24 p.m. during the above observation. She indicated, if the order said Geri-sleeves, he should have them. An interview was conducted with the Wound Nurse on 11/2/23 at 11:15 p.m. She indicated Prevalon boots were a preventative measure and he should be wearing them.			

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An observation of Resident 11 was made with the Wound Nurse in the common area of the Brookshire Unit on 11/2/23 at 11:17 p.m. He was sitting in his chair. He was not wearing Prevalon boots.

An interview was conducted with the Wound Nurse on 11/2/23 at 11:25 a.m. She indicated she went ahead and applied Resident 11's Prevalon boots.

The Skin Care and Wound Management policy was provided by the DON (Director of Nursing) on 10/31/23 at 12:14 p.m. It read, "Procedure: Prevention...4. Develop a care plan with individualized interventions to address risk factors. 5. Communicate risk factors and interventions to the care giving team. 6. Evaluate for consistent implementation of interventions and effectiveness at clinical meeting."

5. The clinical record for Resident 26 was reviewed on 10/26/23 at 3:35 p.m. His diagnoses included, but were not limited to: hypotension, mild vascular dementia, alcoholic cirrhosis the of liver, and end stage renal disease.

The orthostaatic hypotension care plan, revised 4/24/21, indicated interventions were vital signs as ordered/per facility protocol and to follow up as indicated.

The Vitals section of the electronic health record indicated the following blood pressures on the following dates and times, taken by LPN (Licensed Practical Nurse) 37: 10/27/23 at 10:43 p.m. -64/45 mmHg taken while standing in his right arm and 10/27/23 at 10:40 p.m. - 64/45 mmHg taken while sitting in his right arm.

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There was no information in the clinical record, including the progress notes or assessments, to indicate how the above blood pressures were addressed on 10/27/23.

There were no blood pressures in the clinical record after the 10/27/23, 10:43 a.m. blood pressure of 64/45 until 11/1/23 at 11:25 a.m. It was a reading of 102/58.

The 11/1/23, 1:08 p.m. nurse's note read, "Res. [Resident's] Nephrologist Called Stated Res HGB [hemoglobin] 6.5 Gave Order For Res To Go To [name of local hospital emergency room] for Blood Transfusion, Staes [sic] He Had Notified Someone Via Text Last Evening, Res. Stated He Received A Text Last Evening, But Didn't See Text Until This Am [morning,] Res Denies SOB [shortness of breath,] No CP [complaints,] No Dizziness, Sister [name of sister] Notified, 911 Called, Report Given, Res. Transferred To [name of hospital emergency room] NP Notified."

An interview was conducted with NP (Nurse Practitioner) 21 on 11/1/23 at 1:57 p.m. She indicated she did not recall being notified of the 10/27/23 low blood pressures. Since it was after hours, another service provider would have received notification. This was her first time hearing about these blood pressures. She thought with blood pressures that low, he would have been lethargic and nursing would have seen a change in condition. She stated, "That's really low." If the blood pressures were legit, she would like to know. Her treatment would depend on how symptomatic he was.

An interview was conducted with the RVPRM (Regional Vice President of Risk Management) on

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	11/2/23 at 10:07 a.m. She indicated she couldn't' find any verification Resident 11's 10/27/23 low blood pressures were addressed. An interview was conduted with LPN 37 on 11/3/23 at 12:00 p.m. She indicated she did not notify anyone of Resident 11's blood pressure of 64/45. She took his blood pressure again later and it was 110/62, she thought. She used another blood pressure cuff machine to recheck it. She should have crossed out the low blood pressure. She retook his blood pressure because the reading was strange. She did not document the new blood pressure reading in the clinical record. 6. The clinical record for Resident 24 was reviewed on 10/27/23 at 11:45 a.m. Her diagnoses included, but were not limited to, pelvic and perineal pain, morbid obesity, hypertension, pain in right hip, and pain in left hip. The complaints of chronic pain care plan, revised 9/5/23, indicated interventions were to provide mediation per orders; observe for signs and s ymptoms of side effects; and to evaluate effectiveness of medication. The physician's orders indicated to apply a Lidocaine External Patch 5% to her right hip and left knee topically one time a day for pain and remove per schedule, starting 8/30/23.An interview was conducted with Resident 24 on 10/27/23 at 11:56 a.m. She indicated she was not getting her pain patches changed daily.The October, 2023 MAR (medication administration record) indicated the Lidocaine External Patch 5% was applied at 8:00 a.m. and removed at 9:59 p.m. daily to			

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	her right hip and left knee, as ordered, every day in October, 2023.An interview was conducted with Resident 24 on 11/2/23 at 2:24 p.m. She indicated she had Lidocaine patches on currently, but they had been on for over 3 days. An observation and interview was conducted with UM (Unit Manager) 24 and Resident 24 in Resident 24's room on 11/2/23 at 2:40 p.m. Resident 24 was lying in bed. UM 24 lifted Resident 24's blanket. There was a Lidocaine patch on the front of her right thigh, not over her right hip. Resident 24 indicated, while rubbing her hand up and down her right hip, that she liked for the patch to be applied higher up, because it made the whole area feel better. There was a Lidocaine patch on her left knee.An interview was conducted with LPN (Licensed Practical Nurse) 36 on 11/2/23 at 2:58 p.m. She indicated she changed Resident 24's Lidocaine patches yesterday, 11/1/23. She did not change the patch to her right knee, because the right knee didn't show up for her on the MAR. She did apply the right hip patch yesterday.An observation of the medication cart was made with UM 24 on 11/2/23 at 3:22 p.m. There was one 30 count box of Lidocaine patches in the cart for Resident 24, dated 8/30/23, with 23 patches remaining in the box.The Lidocaine patch pharmacy requisitions from 8/2/23 to			

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	present were provided by the DON (Director of Nursing) on 11/3/23 at 9:38 a.m. They indicated a 30 count box (15 day supply) was delivered to the facility on 8/2/23; a 30 count box (15 day supply) was delivered to the facility on 8/30/23; and a 30 count box (15 day supply) was delivered to the facility on 10/21/23.The Pain Management and Assessment policy was provided by the DON on 11/3/23 at 9:38 a.m. It read, "...the facility must ensure that residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan and the resident's choices related to pain management."The immediate jeopardy that began on 10/17/23 was removed on 11/3/23 when the facility completed an audit of all residents with Diabetes Mellitus to ensure the appropriate and accurate orders were in place and the physician/ nurse practicioner signed off that the orders were accurate and administered as ordered. Audits were completed on all new admissions orders for residents admitted 14 days prior to 10/17/23 to ensure an accurate medication reconciliation had been completed and that all physician orders on the discharge summary were transcribed appropriately and accurately. Audits were completed for all residents in the facility for change in condition in the 14 days prior to			

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	10/17/23 to ensure appropriate follow-up and physician/ nurse practitioner notification was completed. Education was provided to all licensed nurses on the facility's policy identified as, "Admission Evaluation" policy with an emphasis on order verification, transcription, medication reconciliation, confirmation, order clarification and admission order entry process. Education on the admission order entry process included but was not limited to monitoring of communication for clarification of orders via fax, email, and secured conversation. All licensed nurses were educated on the facility's policy, "Notification of Change in Condition" and change in condition with emphasis on identification of change in condition, physician/ nurse practitioner notification of change in condition, and follow-up with change in condition, and completely and accuratately documenting the change in condition. All licensed nurses were educated on the facility's policy identified as, "Physician Order" with emphasis on following physician orders as written. All licensed nurses were educated on care of the Diabetic resident with emphasis on monitoring blood glucose as orders and signs and symptoms of hyper/hypoglycemia. Nurse managers were educated on the facility's morning meeting process with emphasis on medication			

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	reconciliation for all new admissions. The weekend nursing supervisor was educated on medication reconciliation for all new admissions on Saturday and Sunday. A systematic process changes include the exact medication that requires clarification will be sent via fax, email, and now secured conversation. Secured Conversation can be immediately accessed by the licensed nurse. An additional audit will be completed the following morning for all orders received the previous day by the Admissions Order Entry Department Manager to assure all insulin related orders have been transcribed appropriately and accurately. An alert email will be sent to the facility and regional team for any errors or omissions identified that may require further follow-up. The DON/Unit Managers are completing medication reconciliation audit the following morning Monday through Friday for all new admissions. The weekend supervisor are complete medication reconciliation audit on Saturday and Sunday. The DON/Unit Manager are completing audits via facility reports for changes in condition Monday through Friday and the weekend supervisor on Saturday and Sunday to ensure appropriate follow-up, physician/ nurse practitioner notification, and documentation have occurred. The noncompliance remained at the lower scope and severity			

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	level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy.This citation relates to Complaints IN00420188, IN00420302, and IN00420629. 3.1-37			
F 0688 SS=D 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 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, interview, and record review, the facility failed to provide services to prevent a resident's range of motion from declining and failed to ensure a resident with limited range of motion received appropriate treatment, equipment, and services to prevent further decrease in range of motion for 2 of 3 residents reviewed for range of motion (Resident 34 and 61). Findings include:	F 0688	**1) Resident 34 and 61 were not harmed by the deficient practice. Resident 61 was referred to OT and evaluated. Resident 61's hand was cleaned, nails were cut, and palm protector applied.** **2) All residents have the potential to be affected. Residents that have discharged to the hospital and returned, during the last 14 days, were**	12/05/2023

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	1. The clinical record for Resident 61 was reviewed on 10/27/23 at 2:26 p.m. The Resident's diagnosis included, but were not limited to, chronic respiratory failure and age-related debility. An Occupational Therapy Discharge Summary, dated 7/26/23, indicated that on 7/17/23, Resident 61's bilateral upper body strength was 4-/5 (part movement through full range against gravity and slight to moderate resistance). She was able to grasp and hold items with minimal assistance. She had been discharged from Occupational Therapy due to hospitalization. A Quarterly MDS (Minimum Data Set) Assessment, completed 8/12/23, indicated Resident 61 was cognitively intact, was dependent on staff for ADL (Acts of Daily Living) care and was not receiving restorative range of motion services. On 10/27/23 at 2:22 p.m., Resident 61 was observed laying in her bed with her head turned toward the right watching television. Her arms appeared flaccid. Her right hand was laying on the bed with her fingers curled in toward her palms. Resident 61 indicated that she could not move her hands, arms, or legs by herself, and that staff did not perform range of motion on her hands, arms, or legs and she would like to have range of motion performed. On 10/30/23 at 2:53 p.m., Resident 61 was observed laying in bed on her back. Her right hand had a soft touch call light in it. On 11/2/23 at 10:34 a.m., Resident 61 was observed being provided tracheostomy care by RT (Respiratory Therapist) 31. RT 31 asked Resident 61 to turn her head to the left a little and		**audited to ensure a need for therapy services were not required upon return. Residents receiving restorative services were audited to ensure their programs were being followed and they had the necessary equipment to meet their needs. Care plans were revised as needed accordingly.** **3) Therapy, Nursing staff, and Restorative staff were educated on facility policies "Restorative Program" with an emphasis on ROM. Therapy was educated on the need to screen all residents upon the return from the hospital to identify if their ROM needs have changed and require additional therapy services.** **4) Restorative Manager or Designee will audit and observe 10 residents per week x 1 month, then 5 residents per week x 1 month, then 3 residents per week x 1 month to ensure residents are receiving restorative therapies per orders and have required equipment.** **Therapy Manager or Designee will audit 10 residents per week x 1 month, then 5 residents per week x 1 month, then 3 residents per week x 1**	

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	Resident 61 turned her head slightly toward midline and indicated she could not turn her head any farther. On 11/2/23 at 12:14 p.m., Resident 61 indicated that she had not had occupational therapy since returning from the hospital the last time. She indicated that prior to going to the hospital in July 2023 she had been able to turn her head to both sides. During an interview on 11/2/23 at 2:18 p.m., CNA (Certified Nursing Assistant) 32 indicated that she provided range of motion for Resident 61 when Resident 61 allowed it. Resident 61 often told CNA 32 that it hurt when range of motion was attempted. During an interview on 11/02/23 at 2:20 p.m., LPN (Licensed Practical Nurse) 37 indicated Resident 61 mostly complained of generalized pain and did not have orders for splints of any kind to her hand. On 11/2/23 at 2:25 p.m., the Rehab Director indicated that Resident 61 had not received Occupational Therapy since she returned from the hospital. Resident 61 had received Physical Therapy and a Restorative program had been set up on 9/29/23 for restorative services for her bilateral lower extremities. During an interview on 11/2/23 at 2:29 p.m., the Restorative Manager 2 indicated that she had received the therapy referral for Resident 61 to begin restorative therapy for her bilateral lower extremities on 9/29/23, but it had not been started yet. Restorative Manager 2 had not received any referrals for a range of motion program for Resident 61's upper extremities or neck.		**month to ensure residents that have returned from the hospital have been screened to determine the residents need for therapy services.** **/b>.**	

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	2. The clinical record for Resident 34 was reviewed on 10/30/23 at 9:26 a.m. Resident 34's diagnoses included, but not limited to, hemiplegia (paralysis) affecting the left dominant side, bipolar disorder, anxiety disorder, and contracture of left hand. Resident 34's quarterly MDS (Minimum Data Set) dated 9/18/23 indicated, she was moderately cognitively impaired and required extensive assistance of two persons for bed mobility, transfers, and dressing. A physician's order for Resident 34 dated 9/6/23 indicated, for restorative therapy to provide and don (put on) a left hand/wrist palm protector/ carrot orthotic for up to 6 hours and to monitor skin for irritation or breakdown when donning and doffing(removing) palm protector. A physician's order for Resident 34 dated 7/19/22 indicated, to clean left hand with warm soap and water, pat dry, apply small roll gauze in the palm wrap with roll gauze, and secure with tape as needed for declining to wearing splints. An observation of Resident 34 was made on 10/26/23 at 11:23 a.m. She was lying in bed and her left hand was contracted and wrist/hand at a sharp downward angle. She didn't have anything in her left hand and it appeared her fingernails on that hand were very long. An observation of Resident 34 was made on 10/30/23 at approximately 3:30 p.m. She was lying in her bed and her left hand was contracted and her wrist/hand was a sharp downward angle. She again did not have anything in her hand and her fingernails on her left hand were very long. Restorative therapy was asked to come and see the resident.			

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	An interview with Restorative therapy aide (RA) 1 was conducted on 10/30/23 at 3:37 p.m. RA 1 arrived at Resident 34's room with a palm protector. RA 1 stated, Resident 34 had not had the palm protector since the 18th that month. RA 1 was unable to open Resident 34's left hand without causing Resident 34 to cry out. RA 1 then decided not to further attempt to place the palm protector on instead she grabbed a wash cloth, wet it under the faucet in the bathroom and wedged the damp cloth half way into Resident 34's wet hand. In her attempts to open Resident 34's hand, it was observed that the fingernails on Resident 34's left hand were too long and had the potential to cause a wound on her palm as she had in the past. RA 1 indicated, she was going to get her manager to come down and look at Resident 34's hand. An interview with Restorative Therapy manager (RM) 2 was conducted on 10/30/23 at 4:09 p.m. When asked if the damp wash cloth was the appropriate intervention for Resident 34's left hand, she indicated, "it's a no- no". RM 2 attempted to open Resident 34's hand as well. While she attempted to open the resident's left hand, a strong musty smell engulfed the air. RM 2 agreed the odor was coming from Resident 34's hand. A interview with Resident 34 conducted at the same time RM 2 was attempting to open her hand, indicated, her left hand was last washed two weeks ago. Resident 34's care plan, initiated on 9/6/23, indicated, she was on a restorative program and will be without further decline of range of motion. Interventions included, but not limited to, provide			

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	155272	A. BUILDING 00 B. WING	11/03/2023

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	range of motion restorative program, participate in passive range of motion to left hand/wrist/elbow flexion and extension, and to provide hand hygiene prior to application and upon removal of hand splint (initiated on 7/19/22). A Restorative Program policy was received on 10/31/23 at 12:15 p.m. from DON (Director of Nursing). The policy indicated, "Definitions:..Passive ROM (sic, range of motion): the movement of a joint through the range of motion with no effort from the patient)...The purpose of the policy is to provide direction and guidance to the clinical team to assess and implement a plan of action for resident-specific care to maintain or improve mobility with the maximum practicable independence...Documentation a. Addresses attempt to implement and revise care plan to address changing needs b. Addressing unavoidable decline and/or reduction in ROM and mobility c. Addresses complications including but not limited to: i. Pain ii. Skin integrity iii. Deconditioning of muscle strength/atrophy... v. Contractures..." 3.1-42(a)(2) 3.1-37(a)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-			

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	§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, interview, and record review, the facility failed to follow physician orders for the administration of gastrostomy tube (g-tube) bolus feedings for a random observation during medication administration. (Resident 95) Findings include: The clinical record for Resident 95 was reviewed on 11/2/23 at 10:00 a.m. The diagnoses included, but were not limited to, gastostomy status, congestive heart failure, and acute kidney failure. A current physician order was noted for Kate Farms tube feeding of 375 milliliters (mL) with 140 mL water flush every 4 hours. This order was on the computer screen for Licensed Practical Nurse (LPN) 5 to observe, on the electronic medication administration record (EMAR), prior to administration for Resident 95. A feeding tube care plan, revised 4/3/23, indicated to provide tube feeding per providers' orders.	F 0693	1) Resident 95 was not harmed by the deficient practice. The physician orders for the bolus feed was immediately verified and the nurse was immediately educated to complete the bolus feedings per the physician order. 2) All residents receiving bolus feeds have the potential to be affected. Nurse 5 was educated on following physician orders and “Enteral General Nutrition” with an emphasis on bolus feeds. 3) Nursing staff was educated on facility policy “Enteral General Nutrition” with an emphasis on bolus feeds and the Physician Orders policy with an emphasis on following physician orders.	12/05/2023

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	An observation conducted on 10/30/23 at 12:35 p.m., with Licensed Practical Nurse (LPN) 5 administering a carton of Kate Farms tube feeding that contained 325 milliliters (mL). LPN 5 took the whole carton of Kate Farms and poured such in a styrofoam cup. LPN 5 proceeded to open up another container of Kate Farms tube feeding that contained 325 mL and poured such in a clear cup until the clear cup was 3/4 of the way full. LPN 5 stated she usually administered a full carton and then a half a carton of tube feeding for Resident 95. She approximated the water flushes by utilizing the "5 ounce" clear cup that was filled approximately 3/4 of the way. A policy titled "Enteral General Nutrition (tube feeding) Guidelines", undated, was provided by the Executive Director (ED) on 11/3/23 at 1:45 p.m. The policy indicated the following, "...A physician/provider order is required to include type of feeding and its caloric value, volume, rate, duration, and mechanism of administration i.e., pump or bolus syringe, and water flushes. The licensed competent nurse will provide enteral meals, provide oversight for the pump if used, and connect and/or disconnect G-tube from pump or bolus meals and supplements...." 3.1-44(a)(2)		4) Unit Manager or Designee will audit and observe 10 staff per week x 1 month, then 5 staff per week x 1 month, then 3 staff per week x 1 month to ensure bolus feeds and water flushes are administered per physician orders. **The results of the audit or observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months, then randomly thereafter for further recommendations.**	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with			

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	professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to assure a resident had an inner canula present in her tracheostomy, as ordered by a physician, for 1 of 1 resident reviewed for tracheostomy care (Resident 61). Findings include: The clinical record for Resident 61 was reviewed on 10/27/23 at 2:26 p.m. The Resident's diagnosis included, but were not limited to, tracheostomy and chronic respiratory failure. A physician's order, dated 7/29/23, indicated to replace inner cannula during trach care daily and as needed. A physician's order, dated 7/29/23, indicated to provide trach care every shift and as needed. A care plan, last revised on 7/31/23, indicated Resident 61 was receiving tracheostomy care due to respiratory failure. The goal was for her to be free of signs and symptoms of complications from tracheostomy. The interventions included, but were not limited to, administer treatments per medical provider's order, initiated 5/16/21, and to provide trach care and suctioning per order, initiated 5/16/21. During an interview on 11/2/23 at 10:20 a.m., RT (Respiratory Therapist) 31 indicated he would be providing trach care for Resident 61 and that her inner canula had been previously changed on the night shift.	F 0695	**1) Resident 61 was not harmed by the deficient practice. Resident 61 had an inner cannula placed immediately.** **2) All residents with a tracheostomy have the potential to be affected. An audit of all residents with a tracheostomy requiring an inner cannula have been audited per observation to ensure that the inner cannula is in place. 3) Respiratory therapists and all Licensed Nurses were educated on facility policy "Tracheostomy Care" with an emphasis on ensuring inner cannulas are in place. 4.) Respiratory Manager or Designee will audit and observe 10 residents per week x 1 month, then 5 residents per week x 1 month, then 3 residents per week x 1 month to ensure inner cannulas are in place. The results of the audit or observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months, then randomly thereafter for further recommendations.**	12/05/2023

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	On 11/2/23 at 10:34 a.m., RT 31 was observed providing suctioning and trach care for Resident 61. RT 31 provided suctioning and trach care using aseptic technique. RT 31 did not remove the inner cannula while performing tracheostomy care. When RT was finished providing tracheostomy care, he removed his gloves, did hand hygiene and left the room. RT 31 then returned to Resident 61's room with a package containing an inner cannula. He donned new gloves and using aseptic technique removed Resident 61 from the ventilator and placed the inner cannula into her tracheostomy. During an interview on 11/2/23 at 10:50 a.m., RT 31 indicated he was unsure why there had not been an inner cannula present inside of Resident 61's tracheostomy. The inner cannula was used so that if there was a mucous plug in the tracheostomy, the inner cannula could be quickly changed to eliminate the mucous plug without having to change the entire tracheostomy. An inner cannula should have been present in Resident 61's tracheostomy prior to him placing one. On 11/2/23 at 2:48 p.m., the DON (Director of Nursing) provided the current Tracheostomy Care policy which read "...Definitions... Disposable Inner Cannula: Single use only cannula and should be discarded during inner cannula change out; the inner cannula ...fits inside of the outer cannula with a locking device to hold securely for a 'sleeve-inside-of-a-sleeve' effect....14. For Disposable Inner Cannula...b. Remove present inner cannula following manufacturer guidelines of the tracheostomy; withdraw slowly. c. Dispose of the removed inner cannula. d. Insert and lock the new inner cannula into position..."			

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	3.1-47(a)(4)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to ensure a resident receiving dialysis services had physician orders for dialysis services and monitoring of the site for 1 of 2 residents reviewed for dialysis. (Resident C) Findings include: The clinical record for Resident C was reviewed on 10/26/23 at 2:00 p.m. The diagnoses included but were not limited to: chronic kidney disease and type 2 diabetes mellitus. The Annual Minimum Data Set (MDS) assessment dated 10/11/23 indicated Resident C was cognitively intact. A care plan dated 10/6/23 indicated Resident C received dialysis services in the facility on Mondays, Wednesdays and Fridays. The resident's access site was in her right chest. The resident's physician orders did not include dialysis orders or monitoring the resident's site. An interview was conducted with Resident C on 10/26/23 at 1:59 p.m. She indicated she received dialysis services in the facility on Tuesdays,	F 0698	**1) Resident C was not harmed by the deficient practice. Resident C's orders were reviewed with the NP and new orders obtained to for monitoring of dialysis site.** **2) All residents receiving dialysis have the potential to be affected. An audit of dialysis residents has been conducted to ensure that appropriate physician orders for dialysis site monitoring are in place.** **3) Licensed Nursing Staff was educated on facility policy "Hemodialysis care and monitoring" with an emphasis on appropriate physician orders for dialysis site monitoring. 4) The DON or Designee will audit and observe 10 residents per week x 1 month, then 5 residents per week x 1 month, then 3 residents per week x 1 month to ensure dialysis residents have appropriate physician orders. The results of the audit**	12/05/2023

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	Thursdays and Saturdays. The resident's port was located on her left thigh. The nursing staff do not observe the site or ask her if the site was okay. An interview was conducted with the Director of Nursing on 10/31/23 at 10:47 a.m. She indicated there should be dialysis orders if a resident receives those services. A hemodialysis care and monitoring policy was provided by the Director of Nursing on 10/30/23 at 1:27 p.m. It indicated "...Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial and emotional needs and concerns of the residents. Safety is a primary concern for our residents, staff and visitors. Residents may require hemodialysis in the event of critically low kidney function, usually 12-15% or less, that allows the buildup of lethal toxins in the blood. Hemodialysis may be required due to renal damage attributable to long term uncontrolled diabetes and/or hypertension or for an acute episode due to physical or chemical injury to the kidney. Residents will be individually evaluated by a nephrologist/physician for hemodialysis and will have a vascular access device or VAD placed specific to their needs. It is important the nurse understand the type of venous access device each resident has, what to expect as normal and what to do an in emergency situation even when dialysis is not being performed...III. General Vascular Access Device...b. The nurse will be aware of the specific type of VAD the resident has, for assessment and monitoring purposes. c. Different types of VAD may be have specific assessment parameters. d. Care plans will be updated to reflect individual VAD care and monitoring..." 3.1-37(a)		**or observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months, then randomly thereafter for further recommendations.**	

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F 0726 SS=F Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Based on interview and record review, the facility failed to ensure licensed nurses were able to demonstrate competency in skills and techniques necessary to input physicians orders into the	F 0726	**1) Resident B no longer resides at facility.** **2) All residents have the potential to be affected. All new admissions/readmissions**	12/05/2023

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	electronic medical record, recognize a change in condition, and follow-up with a change in condition. This had the potential to affect all 108 residents that reside in the facility. Findings include: Resident B did not have admission orders entered into the electronic medical record accurately, timely, and that such orders were administered as ordered by the physician for a resident who later experienced a change in condition that was not documented in the medical record. Cross reference F684. During an interview on 10/31/23 at 2:21p.m., LPN 26 indicated she had worked on 10/17/23 from 6:00 p.m. until 10/18/23 at 6:00 a.m. To LPN 26's knowledge, Resident B's admission orders had been taken care of by UM 22. LPN 26 was a fairly new employee to the facility. She had not received report from the previous shift. LPN 26 had not received any requests for clarification of Resident B's admission orders. UM 22 had asked the other nurse working the unit with LPN 26 that assist her with completing Resident B's Nursing Admission Assessment, but the other nurse on duty was unable to assist due to being busy with her patients. UM 22 had phoned her around 12:30 a.m. to make sure the admission assessment had been completed. LPN 26 had not been made aware of any concerns with Resident B's admission orders. During an interview on 10/31/23 at 3:07 p.m., LPN 25 indicated she had worked with QMA 24 on 10/19/23 when Resident B was sent to the hospital. QMA 24 had gotten her to look at Resident B around 1:00 a.m. QMA 24 had told		**for the prior 14 days were audited to ensure orders had been entered correctly.** **Education to all licensed nurses was conducted immediately on the admissions process, transcription of orders, identifying change in condition, and follow-up with change in condition.** **3) Licensed nursing staff have been provided an education fair that includes transcription of orders, identifying change in condition, and follow-up to change in condition. Competencies have been completed and filed in employee files regarding inputting of physician orders, recognizing a change in condition and following up on a change in condition.** **4) SDC or designee will audit new nursing department hires packets to ensure competency and provide education per company policy. This will be an ongoing practice.** **The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months**	

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	LPN 25 that Resident B was vomiting a lot. There was not vomit present when LPN 25 assessed Resident B. Resident B had been restless and was repositioned in bed. LPN 25 had wondered if QMA 24 had mistaken Resident B "spitting up" for vomiting and had looked in the medical record to see if Resident B had any medication for anxiety. LPN 25 had not taken Resident B vital signs or made the physician aware. LPN 25 was not aware that Resident B was a diabetic. LPN 25 indicated that if she had known Resident B was a diabetic, she would have taken her blood sugar. Around 5:00 a.m., a CNA had come up to LPN 25 and told her that Resident B was not responsive. LPN 25 had gone to Resident B's room and started CPR until the ambulance arrived and EMS took over her care. An interview conducted with Registered Nurse (RN) 4, on 11/1/23 at 9:20 a.m., indicated she had worked for the facility since the middle of September of 2023. There was the initial start of employment that was "general orientation" and the following day she was placed on the schedule to receive orientation but "no one wanted to be bothered with me" to help. RN 4 previously worked in home health and didn't have experience working in long-term care, with ventilators, intravenous therapy, or ostomy care. RN 4 commented "I still don't know how to put an order into the computer". A follow-up interview with RN 4, on 11/3/23 at 11:10 a.m., indicated when she was first hired she had one day of "general orientation" but there were no skills checkoffs after that initial day of orientation. The facility assessment was provided by the Executive Director (ED) on 10/26/23 at 3:54 p.m.		**then randomly thereafter for further recommendation.**	

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	The document was dated from 10/1/22 through 9/30/23 and last reviewed on 10/20/23. The document indicated "Nursing facilities will conduct, document, and annually review facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents...Guidelines for Conducting the Assessment...4. The facility assessment should serve as a record for staff and management to understand the reasoning for decisions made regarding staffing and other resources and may include the operating budget necessary to carry out facility functions...Special Treatments...Injections...Total...171...Services and Care We Offer Based on our Residents' Needs...Medications...Awareness of any limitations of administering medications...Administration of medications that residents need...Management of medical conditions...Assessment, early identification of problems/deterioration, management of medical and psychiatric symptoms and conditions such as heart failure, diabetes...Staff training/education and competencies...Our organization develops workforce members, managers, and leaders to achieve high performance by providing ongoing education to continue to grow our workforce to exceed the expectations of our stakeholders...All of our new hires are required to complete a general orientation where they receive training related to our policies and complete competency checks related to their job description...Identification of resident changes in condition, including how to identify medical issues appropriately, how to determine if symptoms represent problems in need of intervention, how to identify when medical interventions are causing rather than helping relieve suffering and improve quality of life...."			

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	An interview conducted with the Director of Nursing, on 11/3/23 at 11:46 a.m., indicated computer training was part of general orientation and followed by shadowing someone on a cart for a day or two. It just depended on the individual and what they need guidance with. The nursing staff that are new hires need more focus on what they need more help with. The facility had hired a new Staff Development Coordinator (SDC) and they are conducting the computer training. The Minimum Data Set (MDS) coordinator was conducting the computer training prior. We were also conducting/offering computer training weekly for everyone if they want such. The facility had provided staff with opportunities in the last 3 months, especially with new staff. With having much newer staff hired in the last couple of months, the opportunity of an SDC opportunity was needed. No skills/competency evaluations were provided during the survey with an exit date of 11/3/23. A policy titled "Staff Education and Competency Testing", undated, was provided by the ED on 11/3/23 at 1:45 p.m. The policy indicated the following, "...Policy...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents...Education needs and competencies are evaluated/measured through clinical observation/skill demonstrations to maintain safe and effective nursing practice skills in care delivery to residents. Competency testing includes knowledge, skills, and ability and may be measured through a variety of methods including but not limited to direct observation, knowledge testing, case studies...d. Specific training and competencies will be completed within the department assigned and retained in the employee			

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	155272	A. BUILDING 00 B. WING	11/03/2023

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	file, either paper or electronic...i. Examples...1. Medication administration safe practices for nurses...."			
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on interview and record review, the facility failed to accurately monitor, document, and track behaviors for 1 of 5 residents reviewed for unnecessary medications, 1 of 4 residents reviewed for dignity, and 1 of 1 resident reviewed for abuse.(Resident 34, Resident F, and Resident 8). Findings include: 1. The clinical record for Resident F was reviewed on 10/31/23 at 10:18 a.m. Resident F's diagnoses included, but not limited to, hemiplegia (paralysis of one side of the body) affecting the right, dominant side, bipolar disorder, major depressive disorder, aphasia (difficulty with speaking), and anxiety disorder. A Psychiatry progress note dated 8/10/23 indicated, Resident F was seen for a follow-up visit for psychiatric medication management. He	F 0740	**1) Resident 34, F, and 8 were not harmed by the deficient practice.** **2) All residents with behavior monitoring have the potential to be affected. An audit was conducted to ensure correct behavior monitoring orders are in place for residents requiring them. An audit was conducted on the last 14 days of behavior monitoring documentation to ensure accurate documentation was in place, any resident found without accurate documentation had the physician and Social Service Director notified so that appropriate follow-up to behaviors was completed.** **3) Licensed nursing staff**	12/05/2023

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	was taking Zoloft (anti-depressant) and melatonin (sleep aide). Resident F "is frequently agitated and cursing at staff. Refuses po[sic, per os, by mouth] meds." Will start Risperadal Consta (an anti-psychotic medication). Resident F's presenting symptoms included, but not limited to, agitation, uncooperative with nursing care, delusions, and verbal aggression. A Psychiatry progress note dated 10/9/23 indicated, Resident F was seen for a follow-up visit for psychiatric medication management. Resident F was still taking Zoloft, melatonin, and Risperdal Consta. He was still refusing medications, had communication difficulties due to his expressive aphasia (a condition where a person may understand speech, but they have difficulty speaking themselves). The note indicated, he was less agitated. Presenting symptoms included, but not limited to, irritability, uncooperative with nursing care, and decline in language ability. The plan included, but not limited to, continuing with Risperadal Consta related to refusal of p.o. meds. Resident F's August 2023 MAR (medication administration record) received on 11/1/23 at 2:24 p.m. from ED (Executive Director) indicated, under behavior monitoring-document number of episodes per shift of target behaviors the codes were as follows: 1 = cursing at staff, 2 = refusal of medication, and 3 = aggressiveness. The dates and codes documented as anything other than "0" or "NA" (meaning not applicable) was: 8/20/23 marked as "x". No behaviors were documented. Resident F's September 2023 MAR received on 11/1/23 at 2:24 p.m. from ED indicated, under behavior monitoring-document number of		**were educated on facility policy "Behavior Management policy" with an emphasis on accurate documentation of resident behaviors in the EMAR/TAR. 4) Social Services or Designee will audit and observe 10 residents per week x 1 month, then 5 residents per week x 1 month, then 3 residents per week x 1 month to ensure behavior monitoring is being documented, monitored, and tracked accurately.** **The results of the audit or observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months, then randomly thereafter for further recommendations.**	

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	episodes per shift of target behaviors the codes were as follows: 1 = cursing at staff, 2 = refusal of medication, and 3 = aggressiveness. For the month the only codes used were "0", "NA" (meaning not applicable) and "x" which indicated no behaviors. Resident F's October 2023 MAR received on 11/1/23 at 2:24 p.m. from ED indicated, under behavior monitoring-document number of episodes per shift of target behaviors the codes were as follows: 1 = cursing at staff, 2 = refusal of medication, and 3 = aggressiveness. The dates and codes documented as anything other than "0", "NA" or "x" which indicated no behaviors were: 10/19/23 - refusal of meds on day shift. Resident F's care plan initiated and revised on 8/11/21 indicated, he uses anti-depressant medication. Interventions included, but no limited to, observe behaviors: record results on behavioral monitoring flow sheet. Another care plan initiated and revised on 8/14/23 indicated, he uses anti-psychotic medication for behavior management/bipolar disorder/agitation/verbal. Interventions included, but no limited to, observe behaviors: record results on behavioral monitoring flow sheet. 2. The clinical record for Resident 34 was reviewed on 10/30/23 at 9:26 a.m. Resident 34's diagnoses included, but not limited to, hemiplegia (paralysis) affecting the left dominant side, bipolar disorder, anxiety disorder, and contracture of left hand. A Psychiatry progress note dated 8/10/23 for Resident 34 indicated, she was seen for chronic psychiatric evaluation and treatment follow-up.			

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	Medications reviewed were Buspar (anti-depressant) Risperadal Contra, Remeron (anti-depressant), Geodon (anti-psychotic), and Zoloft. It indicated, per staff interview, Resident 34 stays in bed and has no behaviors. Presenting symptoms were socially isolating. The plan included, but not limited to, continue medications as ordered, follow-up in 4 weeks, and noted "Pt[patient] at baseline with no complaints of worsened signs/symptoms. A Psychiatry progress note dated 9/11/23 for Resident 34 indicated, she was seen for chronic psychiatric evaluation and treatment follow-up. Upon assessment, resident was in bed, anxious and hallucinating. Per staff report, she stays in bed and has been refusing medication and has had hallucinations. Presenting symptoms included, but not limited to, delusions, hallucinations, and uncooperative with nursing care. The plan included, but not limited to, hold off on medication increase pending labs. A Psychiatry progress note dated 10/4/23 for Resident 34 indicated, she was seen for chronic psychiatric evaluation and treatment follow-up. Upon assessment, resident was in bed, anxious and hallucinating. Per staff report, she stays in bed and has been refusing medication and has had hallucinations. Presenting symptoms included, but not limited to, decline in language ability, delusions, and anxiety. The plan included, but not limited to, "not a candidate for GDR [gradual dose reduction] psych [sic, psychiatric] meds". Resident 34's August 2023 MAR received on 10/31/23 at 12:15 p.m. from DON (Director of Nursing) indicated, under behavioral monitoring for psychotic - document the number of episodes			

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	per shift of target behaviors the codes were as follows: 1 = change in mood, 2 = agitation, and 3 = pain. For the month the only codes used were "0" and "NA" (meaning not applicable) which indicated no behaviors. Under behavior monitoring for suicidal ideations - document number of episodes per shift of target behavior the codes were as follows: 1 = voicing wanting to harm self and 2 = tearful. For the month the only codes used were "0" and "NA" (meaning not applicable) which indicated no behaviors. Resident 34's September 2023 MAR received on 10/31/23 at 12:15 p.m. from DON (Director of Nursing) indicated, under behavioral monitoring for psychotic - document the number of episodes per shift of target behaviors the codes were as follows: 1 = change in mood, 2 = agitation, and 3 = pain. For the month the only codes used were "0" and "NA" (meaning not applicable) which indicated no behaviors except for 9/11/23 were, on day shift, she exhibited agitation. Under behavior monitoring for suicidal ideations - document number of episodes per shift of target behavior the codes were as follows: 1 = voicing wanting to harm self and 2 = tearful. For the month the only codes used were "0" and "NA" (meaning not applicable) which indicated no behaviors except for 9/11/23 were, on day shift, she expressed wanting to harm self. Resident 34's October 2023 MAR received on 10/31/23 at 12:15 p.m. from DON (Director of Nursing) indicated, under behavioral monitoring for psychotic - document the number of episodes per shift of target behaviors the codes were as follows: 1 = change in mood, 2 = agitation, and 3 = pain. For the month the only codes used were "0", "NA" (meaning not applicable) and "x" which			

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	indicated no behaviors except for 10/6/23, on evening shift, she expressed agitation. Under behavior monitoring for suicidal ideations - document number of episodes per shift of target behavior the codes were as follows: 1 = voicing wanting to harm self and 2 = tearful. For the month the only codes used were "0" and "NA" (meaning not applicable) which indicated no behaviors. Under behavior monitoring- psychotic with a start date of 10/27/23, indicated to document number of episodes per shift of target behaviors the codes were: 1 = change in mood, 2 = screaming at staff, and 3 = pain. For the month the only codes used were "0" and "NA" (meaning not applicable). Resident 34's care plan initiated and revised on 2/18/22 indicated, she has suicidal ideations. Interventions included, but not limited to, monitor behavioral episodes and attempt to determine underlying causes. Resident 34 also has a behavior problem and refuses ADL (activities of daily living) care, refusal of medications, and screams/yells at staff. Interventions included, but not limited to, monitor behavioral episodes and attempt to determine underlying causes. Another focus was the use of anti-psychotic medications for behavior management related to her diagnoses of schizophrenia. Interventions included, but not limited to, observe behaviors and record results on behavior monitoring flow sheet. An interview with NP (Nurse Practitioner) 2 conducted on 10/30/23 at 2:25 p.m. indicated, Resident 34 was not stable enough to initiate a GDR of her psychiatric medications. She indicated, she had thought of GDR-ing her medications however, based on staff evaluation, Resident 34 would start having increased behaviors such as refusing medications and			

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	agitation. An interview with Social Services (SS) 26 conducted on 11/1/23 at 3:49 p.m. indicated, Resident 34's behaviors have improved in the last 3 to 4 months. She used to launch her meal trays but, she has since stopped. Resident F's medication have been decreased several months back and his mood seemed to intensify with an increase in yelling at staff. His mood has improved lately. He still gets agitated when not understood related to his expressive aphasia. A Psychotropic medication evaluation for Resident 34 dated 2/17/23 indicated, the last GDR dates for the Remeron, Zoloft, and Buspar were left blank. The Risperadal had a dose change on 2/14/23 and a decrease of Geodon was ordered. The evaluation indicated, "since the last assessment the Resident's Psychiatric Symptoms or Behaviors have: not changed significantly, but resident is stable" A Psychotropic medication evaluation for Resident 34 dated 8/18/23 indicated, the last GDR dates for Remeron, Zoloft, and Buspar were left blank. The Risperadal had a dose change on 8/15/23 and the Geodon had a dose change on 2/17/23 and was to remain unchanged. The evaluation indicated, "since the last assessment the Resident's Psychiatric Symptoms or Behaviors have: not changed significantly, but resident is stable".3. The clinical record for Resident 8 was reviewed on 10/27/23 at 10:30 a.m. Her diagnoses included, but were not limited to, anxiety and depression. The anti-depressant medication, adjustment issues, depression care plan, revised 7/21/23 and the anti-anxiety medication, adjustment issues,			

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	anxiety disorder care plan, revised 7/21/23, both indicated an intervention was to observe behaviors, and record the results on behavioral monitoring flow sheet. An interview was conducted with Resident 8 on 10/27/23 at 10:40 a.m. She indicated, approximately 2 months ago, LPN 36 verbally abused her by saying to her "Haven't you had enough? That's why God has you laying on your back." LPN 36 told her time and time again that nobody at the facility liked her, most recently earlier this week. Resident 8 indicated she was vocal and had cussed out LPN 36 before. Other people were around during both occurrences, but was unsure of whom. LPN 36 was no longer allowed to care for her, but she still provided care to her roommate. Resident 8 spoke to the ED (Executive Director) earlier this week about LPN 36. The ED referenced needing to stay away from each other. An interview was conducted with the DON, in the presence of the ED, on 10/27/23 at 11:35 p.m. The DON indicated she was present during the first interaction between Resident 8 and LPN 36. It was actually LPN 36 who was verbally attacked by Resident 8. Someone from their regional office was also present. LPN 36 was standing at her medication cart as Resident 8 was approaching from the smoking patio. The DON was standing at another medication cart with regional staff. Resident 8 was saying to LPN 36 that she was going to get her fired. Resident 8 "started calling her a bi***, f*** you. I'm gonna have my sister come beat your a**." The DON spoke to Resident 8 at the time. Resident 8 informed her that LPN 36 didn't do anything to her, that she just didn't like her. The DON told Resident 8 that she would move forward with not having LPN 36 provide care to her anymore, if that's what she wanted.			

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	The DON indicated she did not document Resident 8's verbally aggressive behavior that day, but LPN 36 had a note for the occurrence earlier this week. An interview was conducted with the ED, in the presence of the DON, on 10/27/23 at 11:35 a.m. The ED indicated she spoke with Resident 8 in her room recently, because Resident 8 was yelling at LPN 36 again. Resident 8 informed her that she did not like LPN 36, and she wanted her to leave her alone. They agreed the nurse assigned to care for Resident 8 each day would let Resident 8 know was her nurse for the day. An interview was conducted with LPN 36 on 11/2/23 at 2:49 p.m. She indicated there was an incident with Resident 8 at the nurse's desk. Resident 8 came to the desk and asked for medication. LPN 36 went down the hall, got 3 feet away from the nurses station, and Resident 8 started calling her a mother f*****, saying she was gonna whoop her a**, have her sister come whoop her a**. Resident 8 tried apologizing to her today. LPN 36 indicated Resident 8 exuded this sort of behavior 3 out of 5 days a week. One day, LPN 36 was providing medications to her roommate, when Resident 8 told her to get out her room and called her a white bi***. She stated, "Sometimes she's very explosive." LPN 36 would call a manger or social services over to assist. The most recent occurrence was about a week ago. She wrote a progress note about it and informed Resident 8's sister. If Resident 8 couldn't do certain things she wanted, she would sometimes say okay, but other times, she would get really upset. LPN 36 quit providing care to Resident 8 five or six weeks ago weeks ago. If Resident 8 felt like she was being ignored she would get upset. Resident 8 did this to the CNAs (Certified Nursing			

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	Assistants) all day long. "She pretty much has behaviors everyday, yelling out, cussing." The investigative file into Resident 8's 10/27/23 allegation of verbal abuse was provided by the ED on 11/3/23 at 1:30 p.m. The file included a statement from the Regional Director of Clinical Operations, a written statement from CNA 20, a written statement from the DON, and a written statement from LPN 36, all referencing the 9/14/23 occurrence at the nurses desk where Resident 8 was yelling and cursing at LPN 36. The September and October, 2023 progress notes for Resident 8 included a 9/18/23 social services note referencing a verbal altercation with another resident, a 10/19/23 behavior note referencing cursing out a nurse, and a 10/25/23 behavior note referencing cursing at a nurse. There were no other verbally aggressive behaviors referenced in the notes. There was no note referencing the 9/14/23 behavior at the nurse's desk involving LPN 36, nor did the notes include the behaviors 3 out of 5 days a week referenced by LPN 36 during her 11/2/23, 2:49 p.m. interview. The September and October, 2023 MARs/TARs (medication and treatment administration records) did not include behavior monitoring until 10/27/23. A Behavior Management policy received on 10/31/23 at 12:15 from DON (Director of Nursing) indicated, "1. It is the policy of this facility to identify and safely manage residents who are exhibiting behaviors related to psychiatric diagnoses who may present a danger to themselves or others. 2. Residents will be provided with a resident centered behavior management plan to safely manage the resident and others...Procedure...3. Document the			

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	assessment of the behavior in electronic medical records...6. Assess needs and treat appropriately...7. Complete a Care Plan a. Update with changes and/or new behaviors...d. Include resident specific interventions..." 3.1-43(a) 3.1-37(a)			
F 0745 SS=D Bldg. 00	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to ensure the resident was provided clothing for 1 of 4 residents reviewed for Activities of Daily Living. (Resident 225) Findings include: The clinical record for Resident 225 was reviewed on 10/26/23 at 2:30 p.m. The diagnoses included but were not limited to: major depressive disorder, anxiety disorder and blindness. The resident was admitted on 10/11/23. The Annual Minimum Data Set (MDS) assessment dated 10/18/23 indicated Resident 225 was cognitively intact. The resident was needing partial/moderate assistance with bathing and supervision that included verbal cues and touching assistance for personal hygiene and dressing. An ADL care for Resident 225 indicated the resident was needing assistance with ADL's due	F 0745	**1) Resident 225 was not harmed by the deficient practice. Resident 225 was provided clothes from laundry. 2) All residents have the potential to be affected. An audit has been conducted to ensure that all residents have proper clothing available. Any resident identified as not having clothing was provided with appropriate clothing.3) Staff were educated on facility policy "Routine Resident Care" with an emphasis on providing clothes for residents with no clothing. 4) Social Services or Designee will audit new admissions to ensure they have the proper clothing. This will be an ongoing practice. The results of the audit or observations will be reported,**	12/05/2023

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	to blindness. The resident's inventory sheet dated 10/11/23 indicated Resident 225 does not have any clothes. An observation was made of Resident 225 on 10/26/23 at 2:24 p.m. The resident was observed wearing blue jeans and a black sweatshirt. An interview was conducted with Resident 225 on 10/26/23 at 2:25 p.m. He indicated he does not have any clothes to change in to. He has worn the same clothes since admission. The only clothes he has was what he was currently wearing. He would like to have some more clothes, so he could have what he was wearing atleast washed. Observations were made on 10/30/23 at 3:31 p.m. and 10/31/23 at 12:37 p.m., of Resident 225 wearing blue jeans and a black sweat shirt. An observation was made of Resident 225 with CNA 29 on 10/31/23 at 12:44 p.m. The resident was observed wearing blue jeans and a black sweatshirt. Certified Nursing Assistant (CNA) 29 indicated the resident was admitted with no additional clothing. He only has what he was currently wearing. An observation was made of the resident's closet. There was no clothing in the closet. An interview was conducted with CNA 29 on 10/31/23 at 12:47 p.m. She indicated she had not reported the resident had no additional clothing with him on admission. She would go to the laundry room and find him something else for him to wear. A routine resident care policy was provided by the Director of Nursing on 10/31/23 at 3:15 p.m. It		**reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months, then randomly thereafter for further recommendations.**	

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	155272	A. BUILDING 00 B. WING	11/03/2023

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	indicated "...Policy: It is the policy of this facility to promote resident centered care by attending to the total medical, nursing, physical, emotional, mental, social, and spiritual needs and honor resident lifestyle preferences while in the care of the this facility..." 3.1-34(a)(1)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record	F 0761	**1) No residents were harmed by the deficient**	12/05/2023

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	review, the facility failed to ensure medication carts did not contain expired medications along with loose pills located in 2 out of 4 medication carts observed. Findings include: An observation was conducted of Brookshire cart 3 with Licensed Practical Nurse (LPN) 6 on 10/30/23 at 1:50 p.m. There was a vial of Humalog for Resident 43 with a "use by" date of 10/15/23. There was also a vial of Novolog for Resident 70 with a "use by" date of 10/17/23. The second drawer contained 9 loose pills in the center compartment and other loose pills in the right compartment of that same drawer. An observation was conducted of Brookshire cart 1 with Unit Manager 24 on 10/30/23 at 1:55 p.m. There were loose pills scattered in the second and third drawers of the medication cart. There was a packet that contained a 4 milligram tablet of Zofran (anti nausea medication) in the top drawer that didn't have a resident name, instructions, or date. A policy titled "Storage of Medications", revised 8/2020, was provided by the Director of Nursing on 10/30/23 at 4:05 p.m. The policy indicated the following, "...General Guidance...8. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists...9. Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures and humidity...."		**practice. The medications were discarded immediately, per facility policy, and the pills were cleaned out of the medication cart and disposed of, per facility policy.** **2) All residents have the potential to be affected. An audit was conducted on all medication carts to ensure that no expired medications or loose pills were located inside of medication carts. Any medication identified without a label or open date was discarded and reordered. Any loose pills identified were immediately disposed of per facility policy.** **3) Licensed staff were educated on facility policy, "Storage of Medications" with an emphasis on maintaining a clean medication cart, including but not limited to loose pills and expired medications not being present in the medication cart.** **4) Unit Manager or Designee will audit all the med carts on the units 2 x weekly x 1 month and then 1 x weekly x 2 months.The results of the audit or observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months, then randomly thereafter for further**	

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	3.1-25(j)		**recommendations.**	
F 0802 SS=F Bldg. 00	483.60(a)(3)(b) Sufficient Dietary Support Personnel §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). Based on observation, interview, and record review, the facility failed to ensure sufficient staff to carry out timely meal service at the facility for 96 of 108 residents who are served food from the kitchen. Findings include: The ED provided the Meal Service Schedule for the facility on 10/26/23 at 11:00 a.m. It indicated breakfast started at 7:00 a.m. The Cambridge Unit was served at 7:30 a.m. The Main Dining Room was served at 7:45 a.m. The Brookshire Unit was served at 8:15 a.m. It indicated lunch started at 12:00 p.m. The Cambridge Unit was served at 12:30 p.m. The Main Dining room was served at 12:45	F 0802	No resident was harmed by the facility's alleged deficient practice. All residents have the potential to be affected. The facility completed an audit on meal services to ensure all services were timely. A review of the dietary PPD was conducted to ensure the appropriate amount of staffing. A interim dietary manager has been assigned to the building. Education was provided to all dietary staff on the importance of timely meal services. An interim dietary manager as been assigned to the building to assist with	12/05/2023

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	p.m. The Brookshire Unit was served 1:15 p.m. It indicated dinner started 5:00 p.m. The Cambridge Unit was served at 5:30 p.m. The Main Dining Room was served at 5:45 p.m. The Brookshire Unit was served at 6:15 p.m. An interview was conducted with Resident 24, who resided on the Brookshire Unit, on 10/27/23 at 10:10 a.m. She indicated the food just sat on the food cart was never served hot. An interview was conducted with Resident 8, who resided on the Brookshire Unit, on 10/27/23 at 10:56 a.m. She indicated lately, lunch was served late and she was tired of nothing being done about it. An interview was conducted with Resident 8 on 10/30/23 at 3:40 p.m. She indicated she did not get lunch today until 2:30 p.m. and breakfast was served to her at 10:30 a.m. An observation and interview was conducted with Resident 82, from the Brookshire Unit, on 10/30/23 at 3:41 p.m. Her lunch tray was still on her bedside table. She indicated she was served lunch late today. An interview was conducted with Resident 26 on 10/26/23 at 3:09 p.m. He indicated meals were not served in a timely manner. He normally ate in the main dining room. Today breakfast came around 9:30 a.m. and lunch was served at 2:00 p.m. An interview was conducted with Resident 26 on 10/31/23 at 3:22 p.m. He indicated lunch was served late today, at 1:40 p.m. It was cold and he didn't get what was on his meal ticket. Breakfast was served late too, at 10:00 a.m.		management of the dietary department. A review of the dietary PPD was completed and the facility has hired dietary aides to meet the PPD for staffing. The dietary staff has been educated on the process for call-ins to ensure timely delivery of meals. The ED/Designee will meet with the dietary manager weekly to review staffing needs x 1 month, then bi-weekly x 1 month, then 1 time monthly. The ED/Designee will audit timeliness of meals on random shifts and weekends 5 x weekly x 1 month, then 3 x weekly x 1 month, then 1 x weekly for 1 month. /b>	

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	An interview was conducted with Resident 172 on 10/31/23 at 3:23 p.m. He indicated he ate in the main dining room today and was served lunch at 1:40 p.m. Meals were always served late. An interview was conducted with Resident 226 on 10/30/23 at 3:25 p.m. He indicated breakfast was served around 10:00 a.m., and lunch came a little after 2:00 p.m. They were always served late and cold. An interview was conducted with Resident 225 and Resident 86 on 10/30/23 at 3:31 p.m. They both indicated lunch was very cold and arrived at 2:00 p.m. today, and breakfast wasn't served today until 10:00 a.m. Resident 86 indicated she wanted meals served as scheduled. An observation of the kitchen was made with the DDM (Dietary District Manager) on 10/31/23 at 10:00 a.m. The DAM (Dietary Assistant Manager) was observed plating breakfast food for the Brookshire food cart on 10/31/23 at 10:07 a.m. The DAM indicated he was currently plating food for the Brookshire Unit food cart and that they were running behind. Two staff members called off today and he didn't work the previous day. They hadn't had a DM (Dietary Manager) in over a month. The DDM indicated a new DM started yesterday and it had been a month since they had one. The DDM stated, "We've just been struggling with staffing." A test tray of the lunch meal, served to the Cambridge Unit of the facility was served on 10/31/23 at 1:50 p.m. A test tray of the lunch meal, served to the Brookshire Unit of the facility was served on 10/31/23 at 2:29 p.m.			

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	An interview was conducted with the ED (Executive Director) on 10/3123 at 1:10 p.m. She indicated they did not have a policy on dietary staffing. They had enough dietary staff hired, they'd just been late to work or calling in. "It's been a cycle." 3.1-20(h)			
F 0803 SS=D Bldg. 00	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. Based on interview and record review, the facility	F 0803	Resident 225 and 52 were not	12/05/2023

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	failed to ensure a resident was provided milk as preferenced and failed to ensure a resident's preference for an alternative food item, which was on the always available menu, was always available for 2 of 6 residents reviewed for food. (Resident 225 and Resident 52) Findings include: 1. The clinical record for Resident 225 was reviewed on 10/26/23 at 2:30 p.m. The diagnoses included but were not limited to: major depressive disorder, anxiety disorder and blindness. The resident was admitted on 10/11/23. The Annual Minimum Data Set (MDS) assessment dated 10/18/23 indicated Resident 225 was cognitively intact. The resident was needing partial/moderate assistance with bathing and supervision that included verbal cues and touching assistance for personal hygiene and dressing. An ADL care for Resident 225 indicated the resident was needing assistance with ADL's due to blindness. An interview was conducted with Resident 225 on 10/31/23 at 10:00 a.m. He indicated he did not receive his milk as preferenced that morning for breakfast. He was told the kitchen was out of milk. A meal ticket for Resident 225 was provided on 11/1/23 at 3:02 p.m., by a sister facility Executive Director. It indicated the resident was to receive 8 ounces of milk on his tray at breakfast. 2. The clinical record for Resident 52 was reviewed on 10/27/23. Resident 52's diagnoses included, but not limited to, blindness.		harmed by the deficient practice. Resident 225 and 52's food preferences were updated by the dietary manager. All residents have the potential to be affected. Interviewable residents will be interviewed to ensure food preferences are current and updated on residents' meal tickets. Staff were educated on facility policy "Dining and Food Preferences" with an emphasis on ensuring offered always available item are stocked in the dietary department. Resident interviews will be conducted weekly to identify any concerns with food preferences. 5 residents will be interviewed weekly x 4 weeks by dietary manager or designated representative, then 3 residents weekly x 4 weeks, then 5 residents monthly x 1 month. /b>	

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	An interview with Resident 52 was conducted on 10/27/23 at 1:48 p.m. He stated, he had asked for two grilled cheese sandwiches for lunch and was told they don't have grilled cheeses today. An interview with Resident 52 was conducted on 10/31/23 at 3:14 p.m. He stated, he had asked for two grilled cheese sandwiches for lunch with 2 white milks and was told by staff that there weren't any grilled cheese sandwiches today so he then had asked for two peanut butter and jelly sandwiches instead. His lunch had not yet arrived. An interview with CNA (certified nursing assistant) 88 conducted on 10/31/23 at 3:20 p.m. indicated, she had called down to the kitchen for Resident 52's request of two grilled cheese sandwiches and was told they were out of grilled cheeses. An interview with Dietary District Manager conducted on 10/31/23 at 10 a.m. indicated, the always available menu items are a burger, cheeseburger, grilled cheese, peanut butter and jelly sandwich, or cottage cheese. Residents can get any of the always available food items for all 3 meals of the day, even breakfast. 3.1-21(a)(4) 3.1-20(i)(1)			
F 0804 SS=F Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that			

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	conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to provide food that was palatable and served at an appetizing temperature for 96 of 108 residents who eat food from the kitchen. (Residents 8, 24, 225, 226, and 228) Findings include: An interview was conducted with Resident 8 on 10/27/23 at 10:56 a.m. They indicated the "food sucks," and you wouldn't serve it to an animal. The quality was horrible and didn't have the right nutrients. Resident 8 ate a lot of peanut butter and jelly, because the food was so bad. An interview was conducted with Resident 24 on 10/27/23 at 10:10 a.m. She indicated the food was never served hot, sat on the food cart for a long time, and was not quality food. The oatmeal served at breakfast was so sticky, you could wad it up, throw it on the wall, and it would stick. The kitchen served out of date milk and food you wouldn't feed "to a dog." She never got a hot plate. The only thing the kitchen could "trick you with is a boiled egg." Everything they served was low quality and the cheapest you could get. The chicken was processed. It "makes you want to vomit." They cooked a lot of pasta and mixed with burger, Bologna, "anything they can find, a carrot." They put a fake version of macaroni and cheese next to rice and a "nasty burger meat with gravy....They plop everything on your plate that kills you, not builds you up."	F 0804	No resident was harmed by the facility's alleged deficient practice. All residents have the potential to be affected by this alleged deficiency. Education was provided to the interim dietary manager and dietary staff on ensuring food was served that was palatable and served at an appetizing temperature. The Dietary Manager/Designee will conduct random meal trays audits for 5 residents per week x4 weeks, then 3 residents per week x 4 weeks, then 5 resident per month for 1 month to ensure food was served that was palatable and served at an appetizing temperature. /b>	12/05/2023

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	An interview was conducted with Resident 225 on 10/26/23 at 2:27 p.m. They indicated the chicken was always served cold and the food was always "very cold." An interview was conducted with Resident 225 on 10/31/23 at 10:03 a.m. They indicated breakfast this morning was cold, as always. An interview was conducted with Resident 228 on 10/26/23 at 2:07 p.m. She indicated the food was gross and cold. An interview was conducted with Resident 226 on 10/30/23 3:25 p.m. He indicated the food was always cold. An observation of the kitchen was conducted with the DDM (District Dietary Manager) on 10/31/23 at 12:35 p.m. Food temperatures were retrieved from the steam table by the DDM on 10/31/23 at 12:52 p.m. while dietary staff was preparing plates for the Cambridge Unit food cart. The DDM retrieved the following foods at the following temperatures in degrees Fahrenheit: pureed potatoes at 125 degrees, ground pork at 100.7 degrees, pork steaks at 123.9 degrees, mashed potatoes at 124.7 degrees. The DDM removed these foods from the steam table and had them placed back into the oven. A test tray of the lunch meal, served to the Cambridge Unit of the facility was observed on 10/31/23 at 1:50 p.m. It included brussel sprouts, pork steak, and au gratin potatoes. The temperatures were retrieved by the DDM at this time and all of the foods were above 135 degrees Fahrenheit. The au gratin potatoes were hard and didn't taste thoroughly cooked. The pork steak			

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	was dry and chewy. The brussel sprouts were small, mushy, and charred. A test tray of the lunch meal, served to the Brookshire Unit of the facility was observed on 10/31/23 at 2:29 p.m. It included brussel sprouts, pork steak, and au gratin potatoes. The temperatures were retrieved by the DDM at this time and the brussel sprouts were 132 degrees Fahrenheit. The au gratin potatoes were dry and lacked flavor. The pork was dry and chewy. 3.1-21(a)(1) 3.1-21(a)(2)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			

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	Based on observation, interview, and record review, the facility failed to properly store clean dishes, bread in the dry storage area, and refrigerated foods and maintain kitchen equipment in a clean, sanitary condition for 96 of 108 residents in the facility. Findings include: A tour of the kitchen was conducted with the District Dietary Manager (DDM) on 10/26/23 at 11:30 a.m. An interview was conducted with the DDM during this tour. During the initial tour, the preparation refrigerator was observed. There was an opened box of orange juice for the orange juice dispenser with an open bag containing the orange juice contents. the open bag was sticking out of the front of the box. There was orange juice contents on the open bag and box, exposed to air. The DDM indicated the orange juice bag was typically contained within the box. During the initial tour, the stove hood was observed. There was a missing vent cover with exposed pipes. There was a cobweb hanging between 2 front sprinkler pipes directly over the stove. There was a heavy amount of dried splash on the stove and ovens. The DDM indicated there was a leak recently and the vent cover had been missing since at least sometime the previous week. During the initial tour, the dishwasher was observed. There was built up mineral scale splashes dried to the entire front of the machine. There was debris and heavy mineral scale on top of the dishwasher. The DDM indicated the dishwasher, stove, and ovens should be wiped	F 0812	No residents were affected by the alleged deficient practice. Dietary staff properly stored the orange juice dispenser, cleaned between the sprinkler pipes over the stove, cleaned the splash from the stove and ovens, replaced the missing vent cover, cleaned the mineral scales from the dishwasher, cleaned mineral scale from dishware and pitchers, and stored pitchers and bowls properly. All residents have the potential to be affected by deficient practice. The facility completed an audit on the kitchen to ensure all food preparation, service, and dining areas were being maintained in a clean and sanitary condition. Education was provided to all dietary staff employees on the Environment policy with emphasis on ensuring all food preparation/service/dining areas were being maintained in a clean and sanitary condition and that dishware, pot/pans, pitchers and bowls are stored properly. The ED/Designee will conduct a weekly kitchen sanitation audit for 2 months, then monthly x 1 months to ensure all food preparation, service, and dining areas are being maintained in a clean and sanitary condition and that dishware, pot/pans, pitchers and bowls are stored properly.	12/05/2023

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	down monthly. During the initial tour, the clean dish rack was observed. There were 2 clear pitchers and 2 large food containers with significant amount of mineral scale. There were 2 pitchers, cracked at their base on one of the shelves. There was a large metal bowl, not stored inverted, with water sitting in the bottom of the bottom of the bow. There was a pitcher, not stored inverted, with drops of water in it. There were 15 pitchers and 3 storage containers, not stored inverted, on the shelves. The DDM indicated all of the clean dishes should be stored inverted. They descaled dishware monthly and there was definitely lime built up on some of them. During the initial tour, the dry storage area was observed. There was a sugar packet, powder creamer packet, liquid creamer cup, half empty bottle of water, and a noodle on the floor underneath the food racks. There was a significant amount of white sugar stuck to the floor underneath the sugar bags. One of the bread bins contained an opened loaf of bread with bread spilling out of the end of the bag, not contained. The DDM removed the opened loaf of bread and threw it away. The warewashing policy was provided by the ED (Executive Director) on 10/31/23 at 12:07 p.m. It read, "All dishware will be air dried and properly stored." The Equipment policy was provided by the ED on 10/31/23 at 12:07 p.m. It read, All food service equipment will be clean, sanitary, and improper working order. Procedures 1. All equipment will be routinely cleaned and maintained in accordance with manufacturer's direction and		/b>	

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	training materials....3. All food contact equipment will e cleaned and sanitized after every use. 4. All non-food contact equipment will be clean and free of debris." The Food Storage: Dry Goods policy was provided by the ED on 10/31/23 at 12:07 p.m. It read, "All packaged and canned food items will be kept clean, dry, and properly sealed." The Food Storage: Cold Foods policy was provided by the ED on 10/31/23 at 12:07 p.m. It read, All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination." 3.1-21(i)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers,			

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	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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the			

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	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, interview, and record review, the facility failed to ensure hand hygiene was performed prior to staff touching pills with their bare hands and ensure personal protective equipment (PPE) was donned prior and during administration of a aerosol generating procedure (AGP) for 2 of 14 residents observed for medication administration. (Resident 100 and Resident 85) Findings include: 1. An observation was conducted of medication administration with Resident 100 by Licensed Practical Nurse (LPN) 5 on 10/30/23 at 1:00 p.m. LPN 5 proceeded to administer a nebulizer treatment to Resident 100 after she listened to their lung sounds along with obtaining a full set of vital signs. No PPE was donned prior to entering Resident 100's room before or during the administration of such nebulizer treatment. LPN 5 went to the nurses station to take a phone call while the Assistant Director of Nursing (ADON) entered the room to remove the nebulizer treatment mask from Resident 100 and obtained post treatment vital signs without donning PPE prior to entering Resident 100's room.	F 0880	**1) Resident 100 and 85 were not harmed by the deficient practice.** **2) All residents have the potential to be affected. LPN 8 and 5 both received education on the facility's infection control policy with emphasis on hand hygiene and PPE.** **3) Nursing staff was educated on facility policy "Standard Precautions" with an emphasis on proper PPE during administration of nebulizer treatments and proper hand hygiene during administration of oral medications.** **4) Unit Manager or Designee will audit and observe 10 staff per week x 1 month, then 5 staff per week x 1 month, then 3 staff per week x 1 month to ensure proper hand hygiene and proper PPE usage during nebulizer treatments.**	12/05/2023

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	2. An observation was conducted of medication adminstration with Resident 85 by LPN 8 on 11/1/23 at 11:45 a.m. LPN 8 obtained medications for Resident 85 that included Gabapentin 300 milligram capsule, 2 Tylenol 500 milligram tablets, and Flexeril 5 milligram tablet. LPN 8 popped each pill from the medication card into her bare hands and then placed in a medication cup. LPN 8 had donned gloves, disinfected a glucometer, and doffed gloves without performing hand hygiene prior to touching the medication with her bare hands for Resident 85. A policy titled "Standard Precautions", revised 4/1/17, was provided by the Executive Director on 11/2/23 at 12:14 p.m. The policy indicated the following, "...II. When to perform Hand Hygiene...F. For care between residents...G. After glove removal...." Guidance from the Centers for Disease Control and Prevention (CDC), updated 5/8/23, indicated the following, "...Implement Universal Use of Personal Protective Equipment for HCP [Healthcare Personnel]...NIOSH Approved particulate respirators with N95 filters or higher used for...All aerosol-generating procedures...." 3.1-18(b)(2) 3.1-18(l)		/b>	
F 0921 SS=F Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to maintain the floors in a cleanly manner in the kitchen for 96 of 108	F 0921	No residents were harmed by the deficient practice. All residents have the potential to	12/05/2023

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	residents in the facility. Findings include: A tour of the kitchen was conducted with the DDM (District Dietary Manager) on 10/26/23 at 11:30 a.m. During the tour, the stove and oven area was observed. There was a significant amount of dark gunky looking debris and food particles stuck to the floor underneath the stove area. The DDM indicated the floors should be swept and mopped nightly, but it did not look like it was done last night. During the tour, thee walk in refrigerator was observed. There was dark, gunky debris built up around thee baseboards of the floor in the refrigerator. The DDM indicated mopping should be done daily and deep cleaning monthly. During the tour, the dishwasher area was observed. There was a significant amount of gunky debris and mineral scale build up underneath the dishwasher machine. The Environment policy was provided by the ED (Executive Director) on 10/31/23 at 12:07 p.m. It read, "The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation." 3.1-19(f)		be affected. The kitchen floors were swept and mopped with emphasis given to the area underneath the stove area, around the baseboards of the floor in the refrigerator, and underneath the dishwasher machine area. Dietary Manager and staff were educated on safe, functional, sanitary, and comfortable environment for residents with an emphasis on the kitchen floors. ED/Designee will complete observations 5 x a week for 4 weeks, then 3 x a week for 4 weeks, then 1 time a week for 1 month. /b>	
F 0940 SS=F Bldg. 00	483.95 Training Requirements §483.95 Training Requirements A facility must develop, implement, and			

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	maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to- Based on interview and record review, the facility failed to maintain an effective training program for all new and exisiting staff by determining the amount and types of training necessary based on the facility assessment that included, but were not limited to, inputting physician orders, clarifying physician orders, identification of a change in a residents' condition, follow-up with a change in condition, notification of the physician, and documentation in the medical record. The facility failed to ensure newly hired staff received orientation that was based on the training topics that aligned with the facility assessment. This had the potential to affect all 108 residents that reside in the facility. Findings include: Resident B did not have admission orders entered into the electronic medical record accurately, timely, and that such orders were administered as ordered by the physician for a resident who later experienced a change in condition that was not documented in the medical record. Cross reference F684. During an interview on 10/31/23 at 3:07 p.m., LPN 25 indicated she had worked with QMA 24 on 10/19/23 when Resident B was sent to the	F 0940	1 Resident B no longer resides in the facility. 2 All residents that reside in the facility have the potential to be affected by the alleged deficient practice. All licensed nurses have been educated on transcription of physician orders, clarifying physician orders, identification of a change in condition, follow-up with a change in condition, notification of the physician, and documentation in the medical record. All licensed nurses have been provided with a written opportunity to inform the nurse management team of any training, skills or tasks that they still require additional education/training on and education/training has been provided on all request. 3 Licensed nurses have attended an Education Fair and Competency check off that included, but were not limited to, inputting physician orders, clarifying physician orders, identification of a change in a	12/05/2023

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	hospital. QMA 24 had gotten her to look at Resident B around 1:00 a.m. QMA 24 had told LPN 25 that Resident B was vomiting a lot. There was not vomit present when LPN 25 assessed Resident B. Resident B had been restless and was repositioned in bed. LPN 25 had wondered if QMA 24 had mistaken Resident B "spitting up" for vomiting and had looked in the medical record to see if Resident B had any medication for anxiety. LPN 25 had not taken Resident B vital signs or made the physician aware. LPN 25 was not aware that Resident B was a diabetic. LPN 25 indicated that if she had known Resident B was a diabetic, she would have taken her blood sugar. Around 5:00 a.m., a CNA had come up to LPN 25 and told her that Resident B was not responsive. LPN 25 had gone to Resident B's room and started CPR until the ambulance arrived and EMS (Emergency Medical Services) took over her care. An interview conducted with Registered Nurse (RN) 4, on 11/1/23 at 9:20 a.m., indicated she had worked for the facility since the middle of September of 2023. When she started at the facility she "didn't receive much orientation". There was the initial start of employment that was "general orientation" and the following day she was placed on the schedule to receive orientation but "no one wanted to be bothered with me" to help. RN 4 stated she spent half of a 12-hour shift walking around the unit and attempting to shadow what other nurses were doing. RN 4 previously worked in home health and didn't have experience working in long-term care, with ventilators, intravenous therapy, or ostomy care. RN 4 commented "I still don't know how to put an order into the computer". A follow-up interview with RN 4, on 11/3/23 at 11:10 a.m., indicated when she was first hired she		residents' condition, follow-up with a change in condition, notification of the physician, and documentation in the medical record. The facility has changed the licensed nurse orientation process to include a check off of education/training received as it aligns with the facility assessment, written opportunity to identify additional education required, and to provide additional education/training as needed. 4 The SDC will validate through interviews and observation to ensure all newly hired licensed nurses received orientation that was based on the training topics that aligned with the facility assessment. This will be an ongoing practice. 5 The results of the audit or observations will be reported, reviewed and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months, then randomly thereafter for further recommendations.	

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	had one day of "general orientation" but there were no skills checkoffs after that initial day of orientation. The personnel files for LPN 25, Nurse 40, and RN 4 were reviewed on 11/3/23 at 10:59 a.m., and did not consist of any skills checkoffs or further indication of specific orientation provided based on training assessments specific to the facility assessment. These 3 staff members were hired recently and new to the facility. The facility assessment was provided by the Executive Director (ED) on 10/26/23 at 3:54 p.m. The document was dated from 10/1/22 through 9/30/23 and last reviewed on 10/20/23. The document indicated "Nursing facilities will conduct, document, and annually review facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents...Guidelines for Conducting the Assessment...4. The facility assessment should serve as a record for staff and management to understand the reasoning for decisions made regarding staffing and other resources and may include the operating budget necessary to carry out facility functions...Special Treatments...Injections...Total...171...Services and Care We Offer Based on our Residents' Needs...Medications...Awareness of any limitations of administering medications...Administration of medications that residents need...Management of medical conditions...Assessment, early identification of problems/deterioration, management of medical and psychiatric symptoms and conditions such as heart failure, diabetes...Staff training/education and competencies...Our organization develops workforce members, managers, and leaders to			

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	achieve high performance by providing ongoing education to continue to grow our workforce to exceed the expectations of our stakeholders...All of our new hires are required to complete a general orientation where they receive training related to our policies and complete competency checks related to their job description...Identification of resident changes in condition, including how to identify medical issues appropriately, how to determine if symptoms represent problems in need of intervention, how to identify when medical interventions are causing rather than helping relieve suffering and improve quality of life...." An interview conducted with the Director of Nursing, on 11/3/23 at 11:46 a.m., indicated computer training was part of general orientation and followed by shadowing someone on a cart for a day or two. It just depended on the individual and what they need guidance with. The nursing staff that are new hires need more focus on what they need more help. The facility had hired a new Staff Development Coordinator (SDC) and they are conducting the computer training. The Minimum Data Set (MDS) coordinator was conducting the computer training prior. We were also conducting/offering computer training weekly for everyone if they want such. The facility had provided staff with opportunities in the last 3 months, especially with new staff. With having much newer staff hired in the last couple of month the opportunity of an SDC opportunity was needed. No skills/competency evaluations were provided during the survey with an exit date of 11/3/23. 3.1-13(b)(1) 3.1-14(k)(5)			