STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 1, 2, 3, 4, and 5, 2022 Facility number: 000124 Provider number: 155219 AIM number: 100266750 Census Bed Type: SNF/NF:62 Total: 62 Census Payor Type: Medicare:8 Medicaid:54 Total:62 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 8, 2022	F 0000	We do not submit this plan of correction as admittance or denial of the alleged incidents. Please accept the following as a request for a desk review in lieu of of an onsite Post Survey Revisit. All consideration for a desk review would be much appreciated. If there are any additional documents that are needed, please reach out right away.	
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,			

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

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	recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation and interview the facility failed to ensure personal privacy for 2 of 2 residents reviewed. (Resident 112, Resident 110) Findings include: 1. In an observation on 8/1/22 at 9:22 AM, CNA 4 (Certified Nursing Assistant) was observed entering Resident 112's room without knocking or asking for permission to enter. CNA 4 went into Resident 112's room looked at the trash and	F 0550	**F 550** **Resident Rights/ Exercise of Rights** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a. IDT team reviewed and educated all staff on resident rights and Exercise of Rights.	08/26/2022

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	walked out. No verbal interaction was observed. In an observation on 8/1/22 at 10:14AM, the DNS (Director of Nursing Services) was observed walking into Resident 112's room without knocking or asking for entrance. In an observation on 8/2/22 at 9:11AM, QMA 6 (Qualified Medical Assistant) was observed going into Resident 112's room without knocking or asking permission for entrance. Resident 112 and his wife were present in room visiting. In an observation on 8/2/22 at 1:34 PM, the MD (Medical Doctor) entered Resident 112's room without knocking on the door or asking for entrance. The MD did not introduce himself to Resident 112 nor his wife, who was present in the room. In an interview on 8/3/22 at 3:45PM, Resident 112's wife the staff did not knock on the door prior to entering. 2. In an observation on 8/1/22 at 10:39 AM, Resident 110 returned from dialysis. CNA 4 was observed not knocking on his door prior to entering his room. Resident 110 was on the phone at the time of observation. In an observation on 8/3/22 at 10:32AM, Resident 110 return from dialysis. QMA 6 was observed not knocking on Resident 110's door prior to walking in. QMA 6 returned to the room with water for Resident 110, but did not knock or make presence known prior to walking into the room with the door closed. In an interview on 8/2/22 at 9:52AM, the ED (Executive Director) indicated staff should always		b. Education of all staff on resident rights to dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. Full facility audit on resident rights completed. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. Managers Daily rounds which are audited daily accompanied by staff training. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** a. Weekly Qapi for the first 4 weeks, then monthly for 6 months, and quarterly thereafter. **5. Who is the "Team" that will review and audit? Who will oversee that the "Team" is**	

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	ask permission to enter any residents room and treat the room as the residents' home. A policy titled "Quality of Life-Dignity" provided by Regional Nurse Consultant on 8/4/22 at 9:46 AM, stated ....5. Staff are expected to knock and request permission prior to entering residents' rooms. 3.1-3(f)		**conducting the audits and reviews as pledged?** a. All reviews and audits will be completed by the IDT team. The ED/ DNS followed by the MDS, SSD, Therapy Director, and Unit Manager will ensure that all audits and reviews are completed accurately and promptly. **6. By what date the systemic changes for each deficiency will be completed.** a. 8/26/2022	
F 0636 SS=D Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural			

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	problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. Based on observation, interview and record review the facility failed to ensure the accuracy of Minimum Data Set (MDS) assessments in 2 of 16	F 0636	**F 636** **Comprehensive Assessments**	08/26/2022

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	resident assessments reviewed. (Resident 45 and Resident 112.) Findings include: 1. Resident 45 was interviewed on 08/01/22 at 10:05 AM. The resident indicated he was missing teeth. An observation was made of Resident 45 teeth by the DON on 08/04/22 at 11:35 AM. The DON indicated the resident's left back bottom teeth were missing. The quarterly MDS dated 6/25/22 indicated under Section L Oral/Dental Status L0200 Dental was reviewed on 8/4/22 at 10:33 AM. The only responses indicated in L0200 Dental were A. Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose) and F. Mouth or facial pain, discomfort or difficulty with chewing signed by interim MDS coordinator. The MDS Section L Oral/Dental Status L0200 Dental included a line to indicate no natural teeth or tooth fragments (edentulous.) The Regional Nurse Manager was interviewed 8/4/22 at 11:30 AM. He indicated the resident's MDS Section L Oral/Dental Status L0200 Dental charting would be incorrect if the resident had missing teeth. The Director of Nursing Serves (DNS) was interviewed on 8/4/22 at 12:10 PM. She indicated the resident's MDS Section L Oral/Dental Status L0200 Dental was incorrect and should show teeth missing. She indicated the resident did not have partial dentures, and had refused detal services. 2. Resident 112 was observed on 08/02/22		**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a. IDT team reviewed and audited all residents' comprehensive assessments to ensure accurate dental and demographic MDS coding. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. Full facility audit of all residents' comprehensive assessments to ensure accurate dental and demographic coding. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. IDT team will review and audit all residents' MDS coding weekly x4, monthly x6, and quarterly thereafter. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;**	

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	11:48AM. The resident was black/African American. Resident 112 indicated he identified as being African American. The Admission MDS dated August 2, 2022 indicated under Section A1000 Race/Ethnicity the resident was white. The ED (Executive Director) was interviewed on 8/4/22 at 11:12 AM. The ED indicated the resident was African American and the MDS would be corrected. A policy for MDS assessments was requested from the ED on 8/4/22 at 11:50 AM. A policy, entitled "Care Area Assessment" last revised November 2019 by MED-Pass, Inc. was provided by the Regional Nurse Manager on 8/4/22 at 12:13 PM. The policy indicated "Care Area Assessments (CAAs) are used to help analyze data obtained from the MDS ..." No policy was provided by the facility concerning MDS assessment accuracy prior to exit of facility. 3.1-36(c)(5)		a. IDT team will review and audit all residents' MDS coding weekly x4, monthly x6, and quarterly thereafter. **5. Who is the "Team" that will review and audit? Who will oversee that the "Team" is conducting the audits and reviews as pledged?** a. All reviews and audits will be completed by the IDT team. The ED/ DNS followed by the MDS, SSD, Therapy Director, and Unit Manager will ensure that all audits and reviews are completed accurately and promptly. **6. By what date the systemic changes for each deficiency will be completed.** a. 8/26/2022	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review the facility failed to ensure adequate blood	F 0684	**F 684** **Quality of Care**	08/26/2022

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	sugar check practices to ensure accurate readings for 1 of 1 resdient reviewed. (Resident 3, Resident 114) Findings include: 1) During an observation at 7:55AM on 8/2/22, LPN 2 gathered supplies for a blood sugar check. LPN 2 donned gloves, wiped Resident 3's finger with alcohol, stuck the finger with a lancet, the put the glucometer with the test strip inserted onto the resident's finger. LPN 2 did not give the alcohol time to dry. LPN 2 used the first drop of blood from the stick. After the measurement was read LPN 2 wiped the alcohol wipe across Resident 3's finger again. 2) During an observation on 8/2/22 at 8:42AM, LPN 2 gathered supplies for a blood sugar check. Upon entering the room, it was observed Resident 114 had already began eating breakfast. LPN 2 then put on gloves, wiped Resident 114's index finger with alcohol on the pad of the finger, stuck the wiped area of the finger with a lancet, then put the glucometer with a test strip inserted onto the resident's finger. LPN 2 did not give the alcohol time to dry. LPN 2 used the first drop of blood from the stick. After the measurement was read, LPN 2 wiped an alcohol wipe across Resident 114's finger again. During an interview at 9:36AM on 8/2/22, LPN 2 indicated she was not given training by facility regarding checking blood sugars accurately. A policy titled"Obtaining a Fingerstick Glucose Level" was provided by DNS (Director of Nursing Services), on 8/2/22 at 3:27PM, indicated ...The following equipment and supplies will be necessary when performing this procedure. 1.		**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a. Education of all nursing staff on Quality of Care for all residents. b. Full facility audit of all residents on accu-checks completed. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. The nursing management team audited all residents on accu-checks. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. The nursing management team completed skills check offs for all Nurse's and QMA's that perform accu-checks to ensure proper protocol is followed and will perform observations weekly. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	Soap and water 2. Wash cloth and towel. 3. Disinfected blood glucose monitor. 4. 1-2 cotton balls. 5 ....test strip ....Steps to procedure..4. encourage and assist resident, as needed, to increase blood flow to his or her fingers by brisk hand washing with warm water and soap, ...7. Wash the selected fingertip especially the side of the finger, with warm water and soap. (note if alcohol is used to clean the fingertip, allow it to dry completely because the alcohol may alter the reading. Repeated use of alcohol may toughen the skin. 8 ...Discard the first drop of blood if alcohol is used to clean the fingertip 3.1-37		**into place;** a. The nursing management team will perform a routine audit of residents on accu-checks on a weekly (x4), monthly (x6), and quarterly basis. **5. Who is the "Team" that will review and audit? Who will oversee that the "Team" is conducting the audits and reviews as pledged?** a. All reviews and audits will be completed by the IDT team. The ED/ DNS followed by the MDS, SSD, Therapy Director, and Unit Manager will ensure that all audits and reviews are completed accurately and promptly. **6. By what date the systemic changes for each deficiency will be completed.** a. 8/26/2022	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent			

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	with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record review the facility failed to ensure prompt wound assessment and treatment for 1 of 3 residents reviewed. (Resident 112). Findings include: Resident 112's record review began on 8/1/22 at 12:19 PM. There were no wound assessment under miscellaneous or evaluation tabs of the records. Resident 112's diagnoses included non-pressure chronic ulcer to left leg, pseudomonas infection, diabetes, and heart disease. Resident 112 had orders dated 7/27/22 for active protein, pressure reduction devices, and Santyl dressing changes. Resident 112 was admitted on 7/26/22 with no treatments or medication orders until 7/27/22. Resident 112's admission assessment dated 7/27/22 indicated there was a wound to Resident 112's left heel. There was no description or measurements of the wound documented upon admission. Resident 112's progress notes indicated a late entry by the DNS (Director of Nursing Services) entered on 8/2/22 at 11:47 with a service date of 7/27/22 at 11:45AM with a description of the wound. There were no measurements included. A nursing note on 7/27/22 at 16:15 (4:15 PM) documented as late entry indicated the measurements of the wound were 7.4cm x 5.2cm. No depth was indicated. The wound was classified as an unstageable ulcer on the left heel,	F 0686	**F 686** **Treatments/ Services to Prevent / Heal Pressure Ulcers** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a. IDT team reviewed and audited all residents' comprehensive assessments. a. Education of all nursing staff on wound assessments, preventions, and treatments. b. Full facility audit of all residents on wound assessments to ensure accurate and timely documentation. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. Full facility audit of all residents wound assessments and treatments. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**	08/26/2022

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	but there was no other description provided. During an interviewon 08/02/22 at 11:09 AM, the DNS indicated a provider had not seen the wound yet. The DNS indicated wound assessments were done weekly and last week the rounding wound NP (Nurse Practioner) was unable to view the wound due to lack of time on 7/27/22. The DNS indicated the MD was in the facility and would assess the wound. During an observation and interview on 8/2/22 at 1:30 PM, the facility MD (Medical Doctor), indicated he was there for an initial visit for Resident 112. The MD indicated the wound was not on Resident 112's heel but on his left ankle. The MD put the resident's foot down on a towel, and indicated the DNS (Director of Nursing Services) would come in to reapply the dressing. The MD did not measure the wound. A review of Resident 112's MD note dated 8/2/22 at 1:38PM documented the wound on the left lower calf with a 3cm open ulcer. The ulcer had clean margins. A note from the NP (Nurse Practitioner) dated 8/3/22 at 3:32 indicated the wound measurement was 7.11cm length x 4.12cm width x 0.3cm depth. During an interview on 8/4/22 at 3:12 PM, the Regional Nurse Consultant indicated the wound should have been described and measured on admission in the admission paperwork, and Resident 112 should have been seen by the wound NP on 7/27/22. A policy titled "wound care" provided by the Regional Nurse Consultant on 8/4/22 at 3:12 PM, indicated .... Documentation...6. All assessment data (i.e., wound bed color, size, drainage, etc.)		a. IDT team will review and audit wound assessments daily and after admission on the next business day. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** a. IDT team will review and audit wound assessments daily and after admission on the next business day. **5. Who is the "Team" that will review and audit? Who will oversee that the "Team" is conducting the audits and reviews as pledged?** a. All reviews and audits will be completed by the IDT team. The ED/ DNS followed by the MDS, SSD, Therapy Director, and Unit Manager will ensure that all audits and reviews are completed accurately and promptly. **6. By what date the systemic changes for each deficiency will be completed.** a. 8/26/2022	

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	obtained when inspecting the wound... A policy titled "skin management" provided by the Regional Nurse Consultant on 8/4/22 at 3:12 PM, indicated residents will have a skin assessment completed upon admission .... Prevention...3. A head-to-toe assessment will be completed by a licensed nurse upon admission/re-admission and no less weekly... 3.1-40			
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 record review, interview and observation the facility failed to ensure restorative treatment was provided for 1 of 1 resident reviewed with impaired range of motion. (Resident 40.)	F 0688	**F 688** **Increase/ Prevent Decrease in ROM/Mobility** **1. What corrective action(s)**	08/26/2022

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	155219	A. BUILDING 00 B. WING	08/05/2022

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	Findings include: The clinical record of Resident 40 was reviewed on 8/2/22 at 10:42 AM. Resident 40's record indicated diagnoses of hemiplegia and hemiparesis following a nontraumatic subarachnoid hemorrhage affecting her left non-dominant side, contracture of left hand, cognitive communication deficit, altered mental status and need for assistance with personal care. Resident 40's current Care Plan was reviewed on 10/2/22 at 10:53 AM. The Care Plan indicated a restorative nursing focus was initiated 7/1/21 related to the resident's actual contractures/impaired functional range of motion of her left wrist area. Specific interventions of the care plan indicated to apply a splint for up to 2-4 hours to the left wrist twice daily, monitor for and report any pain issues related to the splint application, monitor skin condition under the splint, report any areas of concern and provide hand hygiene prior to application and upon removal of the hand splint. The MDS coordinator was interviewed on 8/2/22 at 11:03 AM. She indicated per the Action of Care Plan the resident was to receive occupational therapy (OT) three (3) times weekly and would wear a splint. She indicated the recommendations were from therapy on 9/21/21 and included a rest hand on splint, a roll style hand splint. The Rehabilitation In-service Training Report dated 9/14/22 was received from the ED on 8/3/22 at 1:00 PM. The in-service training report indicated Resident 40's left hand splint training was provided by Rehabilitation OT on 9/14/21 at 8:45 to Majestic Care South Bend staff.		**will be accomplished for those residents found to have been affected by the deficient practice;** a. IDT team reviewed and audited all residents using splints to ensure accurate care-plans and orders **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. Full facility audit of all residents using splints. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. IDT team will review and audit all residents using splints monthly x6 and quarterly thereafter. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** a. IDT team will review and audit all residents on splints monthly x6, and quarterly thereafter.	

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	The Occupational Therapy Progress Report dated 8/6/21 was received from the Executive Director (ED) on 8/3/22 at 1:00 AM. The report indicated nursing was to take over the entire splint use schedule, skin checks and wash schedule. Education was to be provided to the staff so they could them take over the splint wear schedule. An observation was conducted on 8/1/22 at 3:37 PM of Resident 40. She was lying in bed. Resident 40's left hand was contracted; the resident was not wearing a splint. The Minimum Data Set (MDS) dated 7/24/22 was reviewed on 8/3/22 at 1:00 PM. The MDS indicated the resident had a Basic Interview for Mental Status (BIMS) score of 3 and was not interviewable. The MDS, Section O0500 Special Treatments, Procedures, and Programs indicates the resident did not wear a splint or brace. In an interview on 8/2/22 at 11:13 AM, the Director of Nursing Services indicated Resident 40 did not wear a splint. She further indicated there was no order for the resident to wear a splint. The current medical orders were reviewed on 8/2/22 at 10:59 AM. No current orders were found related to a left hand splint. The current medical orders and discontinued medical orders were requested from the ED on 8/3/22 at 10:18 AM. No current orders or discontinued orders were provided by the facility prior to exit of facility. 3.1-42(a)(2)		**5. Who is the "Team" that will review and audit? Who will oversee that the "Team" is conducting the audits and reviews as pledged?** a. All reviews and audits will be completed by the IDT team. The ED/ DNS followed by the MDS, SSD, Therapy Director, and Unit Manager will ensure that all audits and reviews are completed accurately and promptly. **6. By what date the systemic changes for each deficiency will be completed.** a. 8/26/2022	
F 0698 SS=E	483.25(l) Dialysis			

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Bldg. 00	§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 observation, interview, and record review the facility failed to ensure ongoing communication and assessments for 4 of 4 residents receiving dialysis. (Resident 110, Resident 7, Resident 2, and Resident 6). Findings include: 1) Resident 110's record review began on 8/1/22 at 11:54AM. Diagnoses included heart disease, dependence on renal dialysis, obesity, and end stage renal disease. Resident 110's physician orders for dialysis were to observe the dialysis catheter site for redness, swelling, warmth, drainage, bleeding, and dressing dislodgement every shift. Resident 110 had orders regarding dialysis pick up time, return time, and facility bus to transport. Resident 110 did not have an order for vitals signs prior to or upon return from dialysis. Resident 110's dialysis hand off communication report forms indicated the following: Dated 7/27/22, mental status was documented as A&O (alert and oriented) to person, place and time, vitals signs were recorded, condition of the access site prior to leaving for dialysis was blank. The pre assessment was signed off by QMA 6. The dialysis portion of the form was missing post dialysis weight, food or fluid consumption, and date of signature. The portion to be completed	F 0698	**F 698** **Dialysis** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a. Education of all nursing staff on both pre and post assessments of all dialysis residents b. Full facility audit of all residents on dialysis was completed. c. All assessments are completed using Point-Click-Care (PCC) program. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. IDT team completed an audit of all dialysis residents to ensure that pre and post assessments were completed. **3. What measures will be put**	08/26/2022

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	upon return to the facility was blank with no nurse signature, date, or time. Dated 8/3/22, the form had the resident name in top portion. No other information regarding date, code status, vitals, medication changes, fluid restrictions, condition of access site prior to leaving for dialysis, Covid 19 testing or vaccination status, and nurse signature were blank. The section to be completed by the dialysis unit did not have post dialysis weight, amount of fluid removed, vitals (temperature, pulse, respiration, blood pressure sitting, and blood pressure standing), and amount of food or fluid consumed. There was a signature and date on the form provided by the dialysis unit. The return to facility portion was blank. There was no communication form available for dialysis treatments delivered on 7/29/22 or 8/1/22. The DNS (Director of Nursing Services) provided reports from the dialysis center, faxed to the facility on 8/2/22. The forms received included dialysis documentation dated 7/27/22, 7/29/22, and 8/1/22. On the forms, the only documentation reflected dialysis care. There was no documentation form the facility on the records. During an interview on 8/3/22 at 9:42AM, the DNS indicated the dialysis book was missing and she had requested medical records get the communications from the dialysis provider on 8/2/22. It was late in the evening when the request was submitted and the dialysis provider was closed. The DNS indicated the nurse was responsible for ensuring the section was completed by the dialysis center and reviewing the information upon return.		**into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. IDT team will complete an audit of all dialysis residents routinely. IDT team will use PCC for all dialysis assessments. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** a. Weekly Qapi for the first 4 weeks, then monthly for 6 months, and quarterly thereafter. **5. Who is the "Team" that will review and audit? Who will oversee that the "Team" is conducting the audits and reviews as pledged?** a. All reviews and audits will be completed by the IDT team. The ED/ DNS followed by the MDS, SSD, Therapy Director, and Unit Manager will ensure that all audits and reviews are completed accurately and promptly. **6. By what date the systemic changes for each deficiency will be completed.** a. 8/26/2022	

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	2) Resident 7's record review began on 8/3/22 at 11:49AM. Diagnoses included right, and left leg acquired absence (amputee), kidney failure, and dependence on renal dialysis. Resident 7 was identified by the facility as able to be interviewed on the census sheet provided at survey entrance. Resident 7's physician's orders included to inspect the dialysis site for signs of infection every shift, dialysis pick up time (Monday, Tuesday, Thursday, and Friday), dressing changes to site as needed, and resident dialysis 5 days per week. Resident 7 did not have orders for access site assessment prior to dialysis or upon returning from dialysis. Resident 7 did not have an order for vital signs prior to or upon return from dialysis. The resident's orders for dialysis included a discrepancy regarding what days dialysis was to be performed, one order indicated dialysis was to be completed 5 times a week and one order indicated dialysis was to be completed on Monday, Tuesday, Thursday and Friday. Both orders were active within the system. On 8/3/22 at 12:04PM, LPN 3 indicated she was unable to locate the dialysis communication book, as it was not where it was normally stored. On 8/3/22 at 2:10PM the Unit Manager indicated the dialysis communication books were kept at dialysis until the end of the day, then returned to the unit. Resident 7 was in thier room resting, yet the book was available. On 8/4/22 at 2:40 PM LPN 3 indicated management changed where the dialysis books were kept. Beginning on 8/3/22 they were relocated to the unit managers office. The floor nurse did not have access to the office.			

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	During an interview on 8/4/22 at 3:25 PM, the Unit Manager indicated the dialysis communication books were currently in her office as she checked them daily post dialysis for completeness. The Unit Manager indicated she ensured the dialysis books were back on the floor prior to her leaving each night. She indicated staff knew how to contact her if something was needed from the dialysis books. The Unit Manager indicated she now kept all the books. The dialysis hand off communication report for Resident 7 indicated the following: Dated 7/1/22 The first section was completely blank other than the resident name and date. No code status, covid 19 testing, Covid vaccine status, mental status, allergies, vitals, medication information, no assessment of access site, and no nursing signature. Across the top was written: no report received. The dialysis unit portion haad been completed. The upon return portion had yes or no marked, the additional comments were blank, and the form was signed by the unit manager-dated but with no time indicated. Dated 7/4/22 the pre and post sections are completed. The section to be completed by dialysis had a line through and indicated missed treatment. Additional comments in the post section were blank without an explanation of why thetreatment was missed . Dated 7/5/22 The first section of form was missing covid status, allergies, and was signed by QMA 6. The dialysis unit portion was complete. The upon return was checked marked for yes, no, or non-applicable (n/a). The additional comments section was blank. The form was signed with initials. In the time and date portion a date was			

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	written with no time indicated. Dated 7/6/22 pre dialysis portion missing covid information signed by QMA 6. Section to be completed by dialysis unit has line through and written over was missed treatment. Post dialysis portion additional comments: missed treatment without an explanation signed with initials by Unit Manager. In the time and date designated area there was a date noted and no time indicated. Dated 7/7/22, the pre dialysis portion of the form was missing covid information and allergies. the form was signed by QMA 6. The section to be completed by the dialysis unit had a line through and was written over as a missed treatment. The Post dialysis portion additional comments was blank. The comments did not note missed treatment or an explanation for them. The section was signed with the initials of the Unit Manager. In the time and date designated area there was a date noted but no time was indicated. Dated 7/8/22, the Pretreatment section was missing covid information and allergies. The access site (chest catheter) condition indicated a bruit and thrill were present. This section was signed with initials the DNS was unable to identify. In the section completed by the dialysis unit there was some unusual white patches and lines missing under the nursing signature. The upon return portion indicated a bruit and thrill were n/a and additional comments was blank. The form was signed with the initials of the Unit Manager with a date but no time was indicated. Dated 7/11/22, the Pretreatment section was missing Covid information and allergies. The access site condition indicated a bruit and thrill were present. This section was signed with initials			

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	unable to be identified by the DNS. The section completed by the dialysis unit indicated some medications were given and labs results were given to a facility staff , but the title of the staff was not included. The return portion indicated a bruit and thrill were n/a and additional comments was blank. The form was signed with initials by the Unit Manager with a date but no time was indicated. Dated 7/12/22 the Pretreatment section missing covid information, mental status, allergies, medication information, labs drawn, signs of infection, and location of access site. Access site condition indicated bruit and thrill n/a (not applicable). This section was signed with initials by Unit Manager. In section completed by dialysis unit was completed entirely. The upon return portion again indicated bruit and thrill were n/and additional comments was blank, signed with initials by Unit Manager. In the time and date designated area there was a date noted and no time indicated. Dated 7/13/22 pretreatment filled out without covid information signed by initials unable to be identified by DNS as to name and title. Dialysis unit section had a line through and indicated not scheduled for dialysis today. Upon return portion indicated under additional comments treatment missed. Signed and dated with initials by Unit Manager. In the time and date designated area there was a date noted and no time indicated. The 13th of July was a Wednesday. Resident 7 was not scheduled for dialysis on Wednesdays. Dated 7/14/22, the pretreatment section was missing covid information. The form had bruit and thrill present marked with yes and was signed with initials, but no credentials were indicated. The			

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	initials were unable to be identified by the DNS. The Dialysis unit portion was completed. Upon return, additional comments was blank, bruit and thrill present marked n/a and there was no time indicated on the form. Dated 7/18/22, across the pretreatment portion a line was crossed through and written on top was no report received and it was without a nurse signature. The only information in that section was Resident 7's name and the date. The dialysis unit portion was blank under additional comments. The upon return section identified bruit and thrill present as n/a, signs and symptoms of infection was blank, additional comments blank, and no time indicated. Dated 7/19/22 the pretreatment portion of the form had mental status as A&O x3 (alert and oriented to all spheres), the covid information was blank, the condition of the access site prior to leaving, bruit and thrill was present, signs and symptoms of infection marked no. The form was signed by QMA 6. The dialysis unit portion was complete. The upon return portion had bruit and thrill marked as n/a, additional comments were blank, the form was dated, but there was no time indicated. This portion of the form was signed by the Unit Manager. Dated 7/21/22 the pretreatment portion had mental status as A&O x3, Covid information was blank, the condition of the access site prior to leaving, bruit and thrill present was marked yes, signs and symptoms of infection was marked no, and the form was signed by QMA 6. The dialysis unit portion was complete. The upon return portion had bruit and thrill marked as n/a, additional comments were blank, and no time was indicated. The form was signed by the Unit Manager.			

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	Dated 7/22/22, the pretreatment Covid information was blank, bruit and thrill was marked as n/a, and signed by an unreadable signature. The dialysis unit portion was complete. The upon return portion had bruit and thrill marked as n/a, additional comments were blank, and no time indicated. The form was signed by the Unit Manager. Dated 7/25/22, the pretreatment section had a line through and was written across the top no report received. The dialysis unit portion additional comments were blank, with a line marked through to indicate no report had been received. The upon return portion had bruit and thrill marked as n/a, additional comments were blank, and no time was indicated. The form was signed by the Unit Manager. Dated 7/26/22, the pretreatment portion had mental status as A&O x3, covid information was blank, condition of the access site prior to leaving bruit and thrill present was marked yes, signs and symptoms of infection was marked no. The dialysis unit portion had please see new orders written in additional comments. The upon return portion had bruit and thrill marked as n/a, additional comments were blank without mention of new orders. The upon return section was signed by the Unit Manager. Dated 7/28/22, the pretreatment portion had covid information blank, the condition of the access site prior to leaving bruit and thrill present was marked yes, signs and symptoms of infection was marked no. The dialysis unit portion was complete. The upon return portion was blank with signature, and date, but no time was indicated.			

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	Dated 7/28/22, the pretreatment portion had covid information blank, the condition of the access site prior to leaving bruit and thrill present was marked yes, signs and symptoms of infection was marked no, and signed by an unreadable name. The DNS was unable to identify the person signing the form. The dialysis unit portion was complete. The upon return portion had bruit and thrill marked as n/a, the additional comments were blank, and there was no time indicated. The upon return portion was signed by the Unit Manager. Dated 8/1/22, pretreatment portion had mental status as A&O, covid information was blank, vital signs were blank, the condition of the access site prior to leaving bruit and thrill present was marked yes, signs and symptoms of infection was marked no, and the form was signed by QMA 6. The upon return portion had bruit and thrill marked as n/a, the additional comments were blank, and there was no time indicated. The upon return portion was signed by the Unit Manager. Dated 8/2/22, the pre dialysis poriont was filled out with code status, vitals, resident compliance, condition of access site prior to leaving for dialysis, but no nurse signature. The information had a line crossed through it and a written comment: error no report received. The dialysis unit portion was complete. The upon return portion had bruit and thrill marked as n/a, additional comments were blank, and no time was indicated. The form was signed by the Unit Manager. Dated 8/3/22, the pretreatment portion was filled out without covid information, and signed by an unreadable signature. The Dialysis unit section had a line through it and and comment indicated the residnet was not scheduled for dialysis on			

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	8/3/22. The upon return portion indicated under additional comments the resident doesn't receive treatments on Wednesdays. The form was signed and dated by the Unit Manager. Dated 8/4/22, the pretreatment portion had covid information blank, the condition of the access site prior to leaving bruit and thrill present was marked yes, signs and symptoms of infection was marked no, and the form was signed by a name with no credentials. The DNS was able to identify the person as an LPN. The dialysis unit portion was complete. The upon return portion had bruit and thrill marked as n/a, the additional comments were blank, and there was no time indicated. The upon return portion was signed by the Unit Manager. In an interview on 8/4/22 at 02:40 PM Resident 7, indicated she goes to dialysis 4 days a week, Monday, Tuesday, Thursday, and Friday. Resident 7 indicated she had to stop dialysis early one day due to a blood pressure drop. There was no documentation of the incident in the dialysis communication book. In an interview on 8/5/22 at 8:36 AM, RN 7 (the Dialysis Center Nurse) , indicated the blood pressure incident happened on 7/29/22 after one hour of being on the dialysis machine. She was taken off the machine and monitored closely until her blood pressure returned to normal. RN 7 indicated she personally took Resident 7 back to her room after dialysis and spoke with the staff. 3) During an interview on 8/4/22 at 2:48PM, Resident 2 indicated they were not allowed to have food or drink at dialysis. She indicated she skipped breakfast because dialysis was so early. She indicated she takes her medications prior to going on an empty stomach.			

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	155219	A. BUILDING 00 B. WING	08/05/2022

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	Resident 2's record review began on 8/4/22 at 3PM. Diagnoses included end stage renal disease, dependence on renal dialysis, and cognitive communication deficit. Resident 2's physician's orders regarding dialysis included dialysis fistula check every shift for bruit and thrill, check fistula for pain, change in temp or bleeding, no blood pressures in left arm, dressing changes to site as needed, and resident dialysis 5 days per week. Resident 2 did not have orders for access site assessment prior to dialysis or upon returning from dialysis, vital signs prior to or upon return from dialysis, or a pick up time for dialysis. The dialysis hand off communication report for Resident 2 indicated the following: Dated 7/4/22, the prior to dialysis portion had no covid information, no allergies, and was signed by QMA 6. The dialysis unit portion had a line drawn through and indicated the resident had missed the treatment. The upon return to facility portion indicated no assessment had been performed. A missed treatment was indicated in the additional comments. No information was provided as to whether treatment was refused, if resident was unable to do dialysis, or the reason for a missed session. Dated 7/5/22, the prior to dialysis portion had no covid information, no allergies, and was signed by QMA 6. The dialysis unit portion was complete. The upon return to facility portion additional comments was blank. The section was signed by the Unit Manager. Dated 7/6/22, the prior to dialysis portion had no covid information, no allergies, and was signed by			

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	QMA 6. The dialysis unit portion was complete. The upon return to facility portion additional comments were blank, there was no assessment for bruit, thrill, or signs of an infection. The section was signed by the Unit Manager. Dated 7/7/22, the prior to dialysis portion had no covid information, no allergies, and was signed by QMA 6. The dialysis unit portion had blank additional comments. The upon return to facility portion additional comments were blank. The section was signed by the Unit Manager. Dated 7/8/22, the prior to dialysis portion had no covid information, diet, compliance, medications, or medical problems filled out. The form was signed by 2 initials with no indication of credentials. The dialysis unit portion was complete. The upon return portion had blank additional comments and no time was indicated. The return portion was signed by the Unit Manager. Dated 7/9/22, The prior to dialysis portion had no covid information and was signed by 2 letters (initials) with no credentials. The DNS was unable to identify the signature. Under additional comments, lab results were given to a facility staff with a lab value listed of Hgb 5.9 (low hemoglobin). The upon return to facility portion additional comments were blank. There was no acknowledgement of the lab value. The section was signed by the Unit Manager. Dated 7/10/22 The top section was filled out code status, mental status, fluid restrictions, medication changes, medical problems since last dialysis, labs drawn, access site assessment bruit, thrill, and signs of infection. At the top of the section a line had been drawn through with the comment error			

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	no report received. The dialysis unit portion was completed. The following dialysis portion was signed by the Unit Manager. Dated 7/19/22 The prior to dialysis portion had no covid information, no allergies, and was signed by QMA 6. The dialysis unit portion had a line drawn through and indicated the resident had missed the treatment. The upon return to facility portion indicated there was no assessment with missed treatment in the additional comments. No information was provided as to whether treatment was refused, if resident was unable to do dialysis, or the reason for a missed session. Dated 7/20/22, the prior to dialysis portion had no covid information, no allergies, and was signed by QMA 6. The dialysis unit portion was complete. The upon return to facility portion additional comments were blank. The section was signed by the Unit Manager. Dated 7/21/22, the prior to dialysis portion had no covid information, no allergies, and was signed by QMA 6. The dialysis unit portion had a line drawn through with a comment the residnet had missed the treatment. The upon return to facility portion indicated no assessment with missed treatment in the additional comments. No information was provided as to whether treatment was refused, if resident was unable to do dialysis, or the reason for a missed session. Dated 7/22/22, the prior to dialysis portion had no covid information, no allergies, and was signed by a first name without credentials or a last name. The dialysis unit portion was complete. The upon return to facility portion additional comments were blank. The section was signed by the Unit Manager.			

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	Dated 7/26/22, the prior to dialysis portion had no covid information. The dialysis unit portion was complete. The upon return to facility portion additional comments were blank. The section was signed by the Unit Manager. Dated 7/27/22, the prior portion was filled out with missing covid information and was signed by an LPN. The dialysis unit section was filled out with a line through it a comment indicated the resident had missed the treatment. In the comments section, RN 9 indicated pending lab results were Hgb. The return to facility portion had no assessment of bruit, thrill, or signs of infection indicated. In the additional comments was written missed treatment. This section was signed by the Unit manager. Dated 7/28/22, the form was marked as "Hospital" throughout. Dated 8/1/22 The prior to dialysis portion had no covid information and was signed by QMA 6. The dialysis unit portion was complete. The upon return to facility portion additional comments were blank. The section was signed by the Unit Manager initials but no time was indicated. 4) Resident 6's record review began on 08/04/22 at 3:50 PM. Diagnoses included end stage renal disease, heart disease, and diabetes. Resident 6 had physician's orders directly related to dialysis care including: A review of physician's orders indicated there was an order to monitor AV shunt site on the resident's left upper arm every shift for bruit and thrill, do not take blood pressure in the left arm, no			

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	needle sticks to left arm, hemodialysis three times a week on Monday, Wednesday, and Friday, observe the AV shunt every shift for signs of infection, The dialysis hand off communication report for Resident 6 indicated the following: Dated 7/1/22, The prior to dialysis portion had code status, diet information, condition of access site prior to leaving dialysis filled in, but no signature. Across the section was a line marked through with a comment no report received. The dialysis unit section was complete. The upon return from dialysis additional comments was blank, there was no time, and it was signed by the Unit Manager. Dated 7/4/22, the prior to dialysis portion had no covid information and was signed by QMA 6. The dialysis unit portion was complete. The upon return to facility portion additional comments were blank. The section was signed by the Unit Manager. Dated 7/5/22, the prior to dialysis portion had no covid information and was signed by QMA 6. The dialysis unit portion was complete. The upon return to facility portion additional comments were blank. The section was signed by the Unit Manager. The form was dated for a Tuesday, not one of Resident 6's ordered dialysis days. Dated 7/6/22, the prior to dialysis portion had no covid information and was signed by an RN. The dialysis unit portion was complete. The upon return to facility portion additional comments were blank. The section was signed by the Unit Manager.			

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	Dated 7/7/22, the prior to dialysis portion had no covid information, no allergy information, and was signed illegibly. The DNS was unable to identify the signature. The facility did not have a key or legend to use to identify signatures. The dialysis unit portion was complete. The upon return to facility portion additional comments were blank. The section was signed by the Unit Manager. The form was dated for a Thursday, not one of Resident 6's ordered dialysis days. Dated 7/8/22, the prior to dialysis portion had no covid information, no allergy information, and was signed by QMA 6. The dialysis unit portion was complete. The upon return to facility portion additional comments were blank. The section was signed by the Unit Manager. Dated 7/11/22, the prior to dialysis portion did not have diet, fluid restrictions, new medications, labs, or any signature. The dialysis unit portion had blank additional comments. The upon return portions was blank other than the Unit Manager initials and the date. Dated 7/12/22, the prior to dialysis portion was blank with a line through with the comment no report received written. The dialysis unit portion was complete. The upon return portion additional comments were blank and signed with the Unit Manager initials. The form was dated for a Tuesday, not one of Resident 6's ordered dialysis days. Dated 7/13/22, the prior to dialysis portion had no covid information and was signed illegibly by an unknown person. The DNS was unable to identify the signature. The dialysis unit portion was complete. The upon return to facility portion additional comments were blank. The section was			

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	signed by the Unit Manager. Dated 7/18/22, the prior to dialysis portion had no covid information, no mental status, no allergy information, no location of access site, and was signed with the Unit Manager initials. The upon return from dialysis section additional comments were blank and signed with the Unit Manager initials. Dated 7/19/22, the prior to dialysis portion had no covid information and was signed by QMA 6. The dialysis unit portion was complete. The upon return to facility portion additional comments were blank. The section was signed by the Unit Manager initials. The form was dated for a Tuesday, not one of Resident 6's ordered dialysis days. Dated 7/20/22, the prior to dialysis portion had no covid information and was signed by QMA 6. The dialysis unit portion was complete. The upon return to facility portion additional comments were blank. The section was signed by the Unit Manager. Dated 7/21/22, the prior to dialysis portion had no covid information and was signed by QMA 6. The dialysis unit portion was complete. The upon return to facility portion additional comments were blank. The section was signed by the Unit Manager. The form was dated for a Tuesday, not one of Resident 6's ordered dialysis days. Dated 7/22/22, the prior to dialysis portion had no covid information and was signed by an LPN. The dialysis unit portion had blank additional comments. The upon return to facility portion additional comments were blank. The section was signed by the Unit Manager.			

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	Dated 7/25/22, there was no resident name, date, code status, diet information, compliance, medication, medical problems, labs drawn, bruit present, thrill present, and signs of infection. This portion was not signed. There was a line going through the section with a comment written above the line no report received. The dialysis unit portion was complete. The upon return portion additional comments was blank, there were initials of theUnit Manager. Dated 7/26/22, the prior to dialysis portion had no covid information and was signed by an LPN. The dialysis unit portion had additional comments to see new orders. The upon return to facility portion additional comments were blank. The section was signed by the Unit Manager. The form was dated for a Tuesday, not one of Resident 6's ordered dialysis days. There were 2 forms dated 7/27/22. 1: had the prior to dialysis treatment filled out with an LPN signature. The dialysis portion was empty and the upon return from dialysis was signed with the initials of the Unit Manager with a date but no time. 2: had the prior to treatment section with a line through and the comment written no report received. In that area diet, compliance, medications, labs, access site location, bruit, thrill, and signs of infection were completed. There was no signature. The dialysis unit portion was complete. The return to facility portion had no additional comments, was signed by the Unit Manager. There were 2 forms dated 7/28/22 . 1: had the prior to dialysis treatment filled out with an LPN signature. The dialysis portion was empty and the upon return from dialysis was signed with the			

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	initials of the Unit Manager. 2: had the prior to treatment section with a line through and a comment written no report received. In that area diet, compliance, medications, labs, access site location, bruit, thrill, and signs of infection were completed. There was no signature. The dialysis unit portion was complete. The return to facility portion had no additional comments, was signed by the Unit Manager. The form was dated for a Tuesday, not one of Resident 6's ordered dialysis days. Dated 7/29/22, the prior to dialysis portion was completed and signed by an LPN. The Dialysis unit portion was complete. The upon return portion additional comments were blank. The portion was signed by the Unit Manager. Dated 8/1/22, the prior to dialysis portion had no covid information and was signed by QMA 6. The dialysis unit portion was complete. The upon return to facility portion additional comments were blank. The section was signed by the Unit Manager. Dated 8/2/22, the prior to dialysis portion had a line through it with the comment no report received. It had diet, compliance, medication, medical problems, labs, bruit, and thrill. The portion did not have a signature. The dialysis portion was complete. The section was signed by the Unit Manager. The form was dated for a Tuesday, not one of Resident 6's ordered dialysis days. Dated 8/4/22, the prior to dialysis portion had no covid information and was signed by an LPN. The dialysis unit portion was complete. The upon return to facility portion additional comments were blank. The section was signed by the Unit			

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	Manager. During an interview on 8/5/22 at 8:16AM, PCT 8 (Patient Care Tech) indicated the writing on the forms with the lines through belonged to the dialysis nurse. During an interview on 8/5/22 at 8:36 AM RN 7 indicated she marked no reports received when there the paper was empty or when the book did not accompany the resident to diallysis services. RN 7 was able to show in her computerized charting the sheets scanned in without information on them. RN 7 indicated the DNS had not requested or approached her about education for the nursing home staff. She indicated her company had people available to do the training. A policy provided by DNS on 8/5/22 at 10:44 AM titled, "Qualified Medication Aide (QMA)" was a job description for QMA. It indicated job description did not include doing assessments. A policy provided by DNS on 8/5/22 at 10:44AM titled, "Dialysis Care" last revision date July 2020, indicated .... Continued assessment of the resident's condition and monitoring for complications before and after dialysis treatments .... Assessment of the resident before, during, and after dialysis treatment. Collaboration with the dialysis facility's plan of care ....4. At the time of return paperwork will be reviewed for new orders and/or communication provided by the dialysis center. 3.1-37(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records			

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	§483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			
	Based on observation, interview, and record review the facility failed to ensure adequate labeling and open dates on medications for 2 of 3 carts reviewed. This Affected 11 of 59 residents reviewed. (Resident 47, Resident 4, Resident 49, Resident 48, Resident 7, Resident 45, Resident 44, Resident 40, Resident 50, Resident 114, and	F 0755	**F 755** **Labeling of Drugs and Biologicals** **1. What corrective action(s) will be accomplished for those residents found to have been**	08/26/2022

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	Resident 300) Findings include: 1) In an observation on 8/2/22 at 9:09 AM, LPN 2 indicated the following medications were not labeled properly: Resident 47's Flonase had no open date. A record review indicated the Flonase was ordered on 6/10/22. Resident 4 had 2 opened Flonase nasal inhalers without an open date. Flonase was ordered on 4/25/22. Resident 49 had an opened container of MiraLAX. The container was not labeled with an opened date. The MiraLAX was ordered on 6/23/22. Resident 48 had a bottle of opened MiraLAX without an opened date. The MiraLAX was ordered on 6/16/22. On this cart there was a bottle of opened Tylenol liquid. It did not have an opened date. The pharmacy label was unable to be read with accuracy to identify to whom it belonged. During an interview on 8/2/22 at 9:09 AM, LPN 2 indicated she was aware medications should be labeled with an open date when staff first opened them. 2) In an observation on 8/2/22 at 9:24AM, QMA 3's cart contained the following medications without proper labeling: Resident 7 had an opened bottle of MiraLAX without an opened date. The MiraLAX was		**affected by the deficient practice;** a. Medication/ Insulin found to be out of compliance with labelling/ dating policy were discarded immediately upon finding. b. Education of all nursing staff on drug expiration dating policy and policy placed in the front if each Narcotic book on the medication cart for quick reference. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. The nursing management team audited all medication carts to ensure all opened medications were dated and labeled per policy and any medications to be considered out of compliance were immediately discarded per facility policy. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. The nursing management team will audit medication carts on a weekly basis for 4 weeks, then monthly for 6 months, and	

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	ordered on 3/8/22. Resident 45 had an opened bottle of insulin Lispro, it did not have an opened date. Lispro was ordered on 7/13/22. Resident 44 had an opened bottle of liquid Tylenol without an opened date. Tylenol was ordered on 5/30/22. Resident 40 had 2 medications without opened dates. A bottle of valproic acid (Depakote) ordered on 4/18/22 and a bottle of Silace (docusate sodium) ordered on 5/19/22. Resident 50 had a bottle of liquid docusate sodium; it was opened without an opened date. Docusate sodium was ordered on 3/15/22. Resident 114 had an opened bottle of insulin Lispro without an opened date. Lispro was ordered on 7/21/22. Resident 300 had an opened bottle of MiraLAX in cart without an opened date. The MiraLAX was ordered on 5/17/22 with a discontinued date of 6/17/22. Resident 300 no longer resided in the facility. During an interview on 8/2/22 at 9:24AM, QMA 3 indicated she was trained on ensuring open dates were put on meds when opened and on check for expiration dates. QMA 3 was not able to indicate how long after being opened, medications were allowed to be used. The DNS (Director of Nursing Services) provided a policy and procedure on 8/2/22 at 3:53 PM. The policy labeled; "Administering Medications" indicated ....12. The expiration/beyond use date on		quarterly thereafter. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** a. The nursing management team will utilize the Qapi audit tool medication storage review for weekly, monthly, and quarterly medication carts audits. If 100% compliance is not obtained, an action plan will be developed and reviewed by the monthly Qapi committee. **5. Who is the "Team" that will review and audit? Who will oversee that the "Team" is conducting the audits and reviews as pledged?** a. All reviews and audits will be completed by the IDT team. The ED/ DNS followed by the MDS, SSD, Therapy Director, and Unit Manager will ensure that all audits and reviews are completed accurately and promptly. **6. By what date the systemic changes for each deficiency will be completed.** a. 8/26/2022	

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	155219	A. BUILDING 00 B. WING	08/05/2022

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	the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. The policy labeled; "Storage of Medications" indicated ....4. Drug containers that have missing incomplete, improper, or incorrect labels are returned to pharmacy. 3.1-25(j)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;			

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	§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review the facility failed to ensure side effect monitoring for 1 of 5 residents receiving psychotropic medications. (Resident 59) Findings include: Resident 59's record review began on 08/03/22 at 11:11 AM. Diagnoses included; major depressive disorder, anxiety, and insomnia. Resident 59's current MDS (minimal data set assessment) dated 7/13/22 indicated Resident 59 had minimal cognitive impairment. Resident 59's behaviors were assessed with none occurring per MDS section E. Section N related to medications on the MDS indicated he took antidepressants and antianxiety medications.	F 0758	**F 758** **Free from Unnecessary Psychotropic Meds/PRN Use** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a. Education of all nursing staff on the side effect monitoring of all psychotropic medications and other monitor-required medications. b. Full facility audit of residents on anti-depressants, anti-anxiety, anti-psychotic, anti-coagulant, anti-convulsive, diuretics, opioids, and sedatives completed.	08/26/2022

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	Resident 59 had an order for the following medications: Remeron 15mg for major depressive disorder, Zoloft 100mg for major depressive disorder, Zoloft 50mg for major depressive disorder, and clonazepam 0.5mg for anxiety disorder. Resident 59 did not have an order to monitor for side effects or effectiveness of any of the psychotropic medications ordered. Resident 59"s charting under tasks, indicated no behaviors were being tracked. Resident 59's current care plan dated 4/16/22 had the focus of behaviors for noncompliance, with an intervention to notify the provider for an increase in behaviors. Resident 59's care plan had a focus on antianxiety medications with the goal of being free from adverse reactions of the medication. The interventions for the focus of psychotropic medication included observing for specific adverse reactions and to administer an involuntary movement test every 6 months. In an interview on 08/03/22 at 1:49 PM, the SSD (Social Services Director) indicated Resident 59 had no behaviors and therefore there was no specific monitoring being done. The SSD was unable to indicate why Resident 59 was not monitored daily for side effects. In an interview on 8/4/22 at 11:16AM, the Regional Nurse Consultant indicated Resident 59 should have been monitored for side effects of psychotropic medications. A policy titled "Medication Utilization and Prescribing-Clinical Protocol" provided by Regional Nurse Consultant on 8/4/22 at 9:46AM		**2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. IDT team audited all residents on psychotropic medications and other monitor-required medications to ensure monitoring of all side effects and PRN use. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. IDT team completed an audit of all residents on medications that require monitoring to ensure proper orders are in place for monitoring of all side effects. IDT team will audit residents on psychotropic medications on admission thereafter. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** a. IDT team will audit residents on psychotropic medications and other monitor-required medications	

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	indicated; 1....a. Symptoms shoudl be characterized in sufficient detail (onsetm, duration, frequency, intensity, location, etc....Cause Identification...2. The physcian and staff will evaluate the effectiveness of the medcations in a esidet regimen..Treatment and Management...4. The staff and physcian will identify and address unexpected, unintended, undesirable 3.1-48		on admission and quarterly thereafter. **5. Who is the "Team" that will review and audit? Who will oversee that the "Team" is conducting the audits and reviews as pledged?** a. All reviews and audits will be completed by the IDT team. The ED/ DNS followed by the MDS, SSD, Therapy Director, and Unit Manager will ensure that all audits and reviews are completed accurately and promptly. **6. By what date the systemic changes for each deficiency will be completed.** a. 8/26/2022	
F 0838 SS=E Bldg. 00	483.70(e)(1)-(3) Facility Assessment §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident			

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	population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing			

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	patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. Based on observation, interview, and record review the facility failed to ensure a complete and accurate facility assessment for the time period of 8/2021 through 7/2022. Findings include: During an observation on 08/01/22 at 09:18 AM, the north unit 200 Hall doors were locked with a key pad outside. Staff could be observed on the unit. The unit had 4 doors with resident names. One staff person was assigned to the unit. One resident was in the hospital, one resident was at dialysis and the other 2 residents were in their rooms. CNA 4 (Certified Nurse Aide) was the only staff member observed on the secured unit from 9:18 AM to 10:03 AM. In an interview on 08/01/22 at 10:03 AM, the ED (Executive Director) indicated the agency nurse called in and therefore the DNS (Director of Nursing Services) was to be monitoring the unit. The ED indicated the facility had lower acuity residents residing on the unit. The ED indicated only residents who were one person assist were to reside on the unit. The ED indicated Human Resources was on the unit behind another set of closed doors and could render assistance, but had no clinical knowledge. In an interview on 8/1/22 at 10:14 AM, the DNS indicated the facility opened the unit on Friday 7/29/22. The DNS indicated nursing was to do rounds on the unit every 2 hours. She indicated	F 0838	**F 838** **Facility Assessment** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a. IDT team reviewed and updated the facility assessment to include every room in the facility. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. Full facility audit of all resident rooms to be included in the facility assessment. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. IDT team will review and update facility assessment on a	08/26/2022

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	the facility would try to keep a QMA (Qualified Medication Aide) on the unit. The DNS indicated staff could use the overhead system for an emergency and all staff had her cell phone number. During an observation on 08/02/22 at 10:18 AM, QMA 5 was the only staff on the North Unit. There were 3 residents on the hall. QMA 5, during an interview indicated it had been the Covid unit and now the facility was turning it into a rehab to home type unit. The doors were closed and locked requiring use of a key pad. There were no numbers above the pad to indicate the code. During an observation and interview on 8/3/22 at 11:28AM one door open was open to the North unit. The sign on the door indicated the keep the doors closed at all times. QMA 3 indicated she normally worked evenings and was alone on the unit for long periods of time. QMA 3 indicated during the day it was busier with appointments, management, visitors, and dialysis. A review of the facility assessment dated 8/2021, provided by the ED on 8/1/22 entrance indicated the facility would schedule staffing for only one unit. There was no indication or assessment for 2 units. The facility assessment indicated the facility would have a maximum census of 60. On 8/1/22 the census was reported as 62. On 8/4/22 at 4:48 PM, the ED provided a 14 day account of the daily census on the North Unit. The rooms had the following number of people on the following days: 7/17/22-7/19/22 6 residents 7/20/22-7/26/22 7 residents 7/27/22 9 residents 7/28/22 3 residents		quarterly basis. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** a. IDT team will review and update facility assessment on a quarterly basis. **5. Who is the "Team" that will review and audit? Who will oversee that the "Team" is conducting the audits and reviews as pledged?** a. All reviews and audits will be completed by the IDT team. The ED/ DNS followed by the MDS, SSD, Therapy Director, and Unit Manager will ensure that all audits and reviews are completed accurately and promptly. **6. By what date the systemic changes for each deficiency will be completed.** a. 8/26/2022	

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	7/29/22-7/31/22 4 residents 8/1/22-8/4/22 3 residents A total of 11 residents resided on North unit in the 14 day period. No policy and procedure regarding facility assessment was provided prior to or during exit.			
F 0842 SS=E Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care			

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	operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on observation and record review the facility failed to accurately document assessments	F 0842	**F 842**	08/26/2022

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	in 4 of 5 residente records reviewed. (Resident 112, Resident 2, Resident 6, and Resident 7) Findings include: 1. In nn observation on 8/2/22 at 1:30 PM, the facility MD (Medical Doctor) was observed performing an initial visit for Resident 112. The MD put on gowns and gloves then unwrapped a left heel wound. Once the wound was unwrapped, the MD commented the wound was not on Resident 112's heel but on his ankle. The MD then put the foot back down on a towel. He explained the DNS (Director of Nursing Services) would come in and reapply a dressing. The MD listened to Resident 112's lungs and heart. He indicated the facility would attempt to get IV access but if they were unable, he would order an oral antibiotics. The MD did not bring dressing supplies, scissors, or any measuring device with him to room. On 8/4/22 at 8:10AM, Resident 112's record review indicated the MD had documented the left lower calf had a 3cm open ulcer with clean margins. The note was dated 8/2/22 at 1:38PM. A note from the NP (Nurse Practitioner) on 8/3/22 at 3:32 indicated the wound had been measured and was 7.11cm length x 4.12cm width x 0.3cm depth. A wound assessment dated 7/27/22 at 3:14 PM indicated the wound was unstageable and measured 7.4cm x 5.2cm. 2. Resident 112's admission assessment was dated 7/26/22 at 4:05 AM, by the DNS (Director of Nursing Services). The assessment was signed 7/27/22 at 15:56 by the DNS. Resident 112's admission to the facility was documented as 7/26/22 at 4:12 PM on the hospital discharge paperwork.		**Resident Records** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a. IDT team reviewed and audited all residents wound assessments to ensure accurate documentation. b. IDT completed an audit of all residents' code status. c. Education of all nursing staff on admission wound assessments. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. Full facility audit of all residents wound assessments and code status. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. The IDT team will review and audit wound assessments daily and after admission on the next business day. **4. How the corrective**	

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	3. A review of dialysis paperwork started on 8/4/22 at 4:35PM. The following was noted. a. Resident 2, dated 7/10/22, the top section of the dialysis communication was filled out code status, mental status, fluid restrictions, medication changes, medical problems since last dialysis, labs drawn, access site assessment bruit, thrill, and signs of infection. At the top of the section was a line drawn through with the comment error no report received. The dialysis unit portion was completed. The post dialysis portion was signed with initials by the Unit Manager. No time of return assessment was indicated. b. Resident 6, dated 7/25/22, the predialysis section included resident name, date, code status, diet information, compliance, medication, medical problems, labs drawn, bruit present, thrill present, and signs of infection. This portion was not signed. There was a line going through the section with a comment written above the line. The comment indicated no was report received. The dialysis unit portion was complete. The upon return portion additional comments was blank, there were initials of theUnit Manager, a date but no time. There were two forms dated 7/27/22. 1: had the prior to dialysis treatment filled out with an LPN signature. The dialysis portion was empty and the upon return from dialysis was signed with the initials of the Unit Manager. The form was dated, but had no time. 2: had the prior to treatment section with a line through with the comment no report received. In that area diet, compliance, medications, labs, access site location, bruit, thrill, and signs of infection were completed. There was no signature. The dialysis unit portion was		**action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** a. IDT team will review and audit wound assessments daily and after admission on the next business day. **5. Who is the "Team" that will review and audit? Who will oversee that the "Team" is conducting the audits and reviews as pledged?** a. All reviews and audits will be completed by the IDT team. The ED/ DNS followed by the MDS, SSD, Therapy Director, and Unit Manager will ensure that all audits and reviews are completed accurately and promptly. **6. By what date the systemic changes for each deficiency will be completed.** a. 8/26/2022.	

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	155219	A. BUILDING 00 B. WING	08/05/2022

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	complete. The return to facility portion had no additional comments, and was signed by the Unit Manager. There were two forms dated 7/28/22. 1: had the prior to dialysis treatment filled out with an LPN signature. The dialysis portion was empty and the upon return from dialysis was signed with initials the of the Unit Manager. 2: had the prior to treatment section with a line through and the comment no report received. In that area diet, compliance, medications, labs, access site location, bruit, thrill, and signs of infection were completed. There was no signature. The dialysis unit portion was complete. The return to facility portion had no additional comments, was signed by the Unit Manager. The form was dated for a Tuesday, not one of Resident 6's ordered dialysis days. Dated 8/2/22, the prior to dialysis portion had a line through it with the comment no report received. It had diet, compliance, medication, medical problems, labs, bruit, and thrill. The portion did not have a nurse signature. The dialysis portion was complete. The section was signed by the Unit Manager. The form was dated for a Tuesday, not one of Resident 6's ordered dialysis days. c. Resident 7, 7/10/22 The top section was filled out code status, mental status, fluid restrictions, medication changes, medical problems since last dialysis, labs drawn, access site assessment bruit, thrill, and signs of infection. At the top of the section was a line drawn through with the comment error no report received. The dialysis unit portion was completed. The following dialysis portion was signed with initials by the Unit Manager.			

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	During an interview on 8/5/22 at 8:16AM, PCT 8 (Patient Care Tech for Dialysis provider in house), indicated the comment on the dialysis form "no report received" was written by a dialysis nurse. During an interview on 8/5/22 at 8:36 AM, RN 7 (Registered Nurse for Dialysis provider in house) indicated she marked no reports received when the dialysis report paper was empty or when the communications book did not accompany the resident to services. RN 7 was able to show in her computerized charting the sheets scanned in labeled Resident 2, Resident 6, and Resident 7. The docuaments were without facility pre and post assessment information. An interview on 8/5/22 at 9:16 AM, the DNS indicated the prior to dialysis assessment was to be performed and recorded on the assessment document prior to the resident leaving for dialysis. No policy or procedure was provided regarding accurate documentation prior to exit. 3.1-50(a)(2)			
F 0867 SS=E Bldg. 00	483.75(g)(2)(ii) QAPI/QAA Improvement Activities §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; Based on observation, interview and record review the facility failed to ensure compliance was monitored regarding prior identified concerns.	F 0867	**F 867** **QAPI/QAA Improvement Activities**	08/26/2022

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	This affected 14 residents residing in the facility. The facility also failed to ensure complete records of quality assurance meetings and compliance for 7 of 12 months reviewed (August 2021, September 2021, October 2021, November 2021, December 2021, January 2022, and February 2022. Findings include: The facility annual survey completed on 7/2/2021 identified noncompliance in the areas including dialysis and medication storage. During the annual survey there were findings of noncompliance concerning dialysis, and medication storage. 1) During an observation on 8/2/22 at 9:00AM in a review of 3 medication carts 2 of 3 had medications without opened dates. These medications were prescribed to 11 different residents. One of the residents no longer resided in the facility. See F 755. 2) During an interview on 08/04/22 at 02:40 PM, Resident 7 indicated she had an issue in dialysis with being taken off the machine early due to low blood pressure. Resident 7 did not recall being assessed immediately upon returning to the unit. in an interview on 8/5/22 at 1:52 PM, RN 7 was able to recall the incident and showed their documentation of the incident including making the nursing home staff aware. In an interview on 8/5/22 at 11:21AM, the DNS indicated she was not aware of the incident. A record review of 4 residents receiving dialysis, began on 8/1/22 at 11:51AM. The review indicated incomplete communication from the facility to the		**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a. Education of all nursing staff on both pre and post assessments of all dialysis residents b. Full facility audit of all residents on dialysis were completed and all dialysis assessments are completed using Point-Click-Care (PCC) program. c. Medication found to be out of compliance with labelling/ dating policy were discarded immediately upon finding. d. Education of all nursing staff on drug expiration dating policy and policy placed in the front if each Narcotic book on the medication cart for quick reference **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. IDT team completed an audit of all dialysis residents to ensure that pre and post assessments were completed. The nursing management team audited all medication carts to ensure all opened medications were dated	

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	dialysis centers. The communication books were incomplete and required multiple requests to locate. See F698. 3)During an interview on 8/5/22 at 11:51, the Executive Director (ED) indicated he was unable to provide any QAPI meeting information prior to his becoming the ED. His first QAPI meeting was documented April 2022, covering March 2022. The ED was able to show a spread sheet with identified concerns and when they would be addressed with the QAPI team of managers for all departments. The ED indicated he had read the prior year survey. There was no policy and procedure provided prior to exit regarding quality assurance.		and labeled per policy and any medications to be considered out of compliance were immediately discarded per facility policy. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. IDT team will complete an audit of all dialysis residents routinely. IDT team will use PCC for all dialysis assessments. The nursing management team will audit medication carts on a weekly basis for 4 weeks, then monthly for 6 months, and quarterly thereafter **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** a. Weekly Qapi for the first 4 weeks, then monthly for 6 months, and quarterly thereafter. If 100% compliance is not obtained, an action plan will be developed and reviewed by the monthly Qapi committee. **5. Who is the "Team" that will review and audit? Who will oversee that the "Team" is conducting the audits and reviews as pledged?** a. All reviews and audits will be	

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			completed by the IDT team. The ED/ DNS followed by the MDS, SSD, Therapy Director, and Unit Manager will ensure that all audits and reviews are completed accurately and promptly. **6. By what date the systemic changes for each deficiency will be completed.** a. 8/26/2022	
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the			

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	influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on interview and record review, the facility failed to maintain pneumonia vaccines for 3 of 5 residents reviewed for infection control. (Resident 10, Resident 36 and Resident 47) Findings include: 1. During a record review on August 4, 2022, at 9:46 am, Resident 10's immunization status	F 0883	**F 883** **Influenza and Pneumococcal Immunizations** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	08/26/2022

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	indicated the resident was not current with pneumonia vaccination. A physician's ordered dated March 15, 2022, indicated Resident 10 may have pneumonia vaccine. Resident 10's Minimum Data Set (MDS) assessment dated April 30, 2022, indicated the resident was not current with pneumonia vaccination. The MDS assessment also indicated pneumonia vaccination was not offered. 2. Resident 36's immunization status indicated the resident was not current on pneumonia vaccination. A physician's ordered dated December 27, 2021, indicated Resident 36 may have pneumonia vaccine. Resident 36's Minimum Data Set (MDS) assessment dated June 23, 2022, indicated the resident was not current with pneumonia vaccination. The MDS assessment also indicated the pneumonia vaccination was not offered. 3. Resident 47's immunization status indicated the resident was not current on the pneumonia vaccination. A physician's order dated June 9, 2022, indicated Resident 47 may have the pneumonia vaccine. Resident 47's Minimum Data Set (MDS) assessment dated June 9, 2022, indicated the resident was not current with pneumonia vaccination. The MDS assessment also indicated pneumonia vaccination was not offered.		a. IDT team reviewed and audited all residents to ensure both consent and declination of all vaccines were obtained. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. Full facility audit of all residents on Influenza and Pneumococcal Immunizations completed **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. The IDT team audited and obtained consent and declinations of Influenza and Pneumococcal Immunizations. IDT will obtain consents and declinations of residents on admission thereafter. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** a. IDT will obtain consents and declinations of residents on admission. Audit of all residents quarterly.	

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	During an interview on August 4, 2022, at 11:10 am, the Regional Nurse Consultant indicated he was unable to locate documentation of pneumonia vaccines for Residents 10, 36, and 47. He further indicated the unvaccinated residents were likely to have been admitted prior to current management. During an interview on August 4, 2022, at 12:11 pm, the Director of Nursing indicated she was not previously aware of the residents not being vaccinated for pneumonia. She indicated the Infection Preventionist (IP) had recently left the facility, and she was acting as IP until an IP was hired. An undated, current policy revised in February 2018 indicated residents would be offered a pneumonia vaccine within 30 days of admission. 3.1-18(b)		**5. Who is the "Team" that will review and audit? Who will oversee that the "Team" is conducting the audits and reviews as pledged?** a. All reviews and audits will be completed by the IDT team. The ED/ DNS followed by the MDS, SSD, Therapy Director, and Unit Manager will ensure that all audits and reviews are completed accurately and promptly. **6. By what date the systemic changes for each deficiency will be completed.** a. 8/26/2022	