| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155153 | A. BUILDING 00<br>B. WING | 03/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| HEALTHWIN | 20531 DARDEN RD<br>SOUTH BEND, IN 46637 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: March 11, 12, 13, 14, and 15, 2024<br><br>Facility number: 000073<br>Provider number: 155153<br>AIM number: 100288820<br><br>Census Bed Type:<br>SNF/NF: 111<br>SNF: 10<br>Total: 121<br><br>Census Payor Type:<br>Medicare: 12<br>Medicaid: 71<br>Other: 38<br>Total: 121<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on 3/22/24. | F 0000 | The facility requests that this plan of correction be considered its credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. We respectfully request a desk review for compliance instead of a post visit review on or before April 11, 2024. Healthwin requests consideration for a desk review on all citations. | |
| F 0656<br>SS=D<br>Bldg. 00 | 483.21(b)(1)(3)<br>Develop/Implement Comprehensive Care Plan<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Anne Knouse | Administrator | 04/11/2024 |

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| | comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>Based on observation, interview, and record | F 0656 | **What corrective action(s) will** | 04/11/2024 |

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| | review, the facility failed to develop a person-centered care plan for 1 of 26 residents whose care plans were reviewed. (Resident 45)<br><br>Finding includes:<br><br>During an observation, on 3/12/2024 at 10:17 A.M., a black, scabbed, lesion was noted to the right side of Resident 45's jaw. The resident indicated it kept bleeding and the doctor had not looked at it.<br><br>A record review was conducted on 3/13/2024 at 1:23 P.M. Diagnoses for Resident 45 included, but were not limited to, metabolic encephalopathy, collapsed vertebrae in thoracic region, and pain in thoracic spine.<br><br>An Annual Minimum Data Set (MDS) assessment, dated 1/15/2024, indicated Resident 45's cognition was intact. . She was at risk for pressure ulcers, but none were noted. No other skin problems were noted.<br><br>The record lacked any physician orders or a care plan related to the skin lesion on her jaw.<br><br>During an interview, on 3/14/2024 at 10:31 A.M., LPN 5 indicated the Nurse Practitioner (NP) looked at it last year and thought a referral was made to a dermatologist, but couldn't be sure. Resident 45 kept scratching it open, and she was not sure if it was being monitored. If it was being monitored, it would be documented in the progress notes or assessments.<br><br>During an interview, on 3/14/2024 at 11:45 A.M., the DON indicated Resident 45 was diagnosed in 2022 with actinic keratosis. She did not feel it should be followed by the wound team, but will | | **be accomplished for those residents found to have been affected by the deficient practice:**<br>Resident that was affected had care plan reviewed and updated appropriately.<br><br>**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:**<br>All residents have the potential to be affected. Education provided regarding recuring conditions should remain on care plan.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.**<br>MDS/designee will ensure recurrent issues/conditions regarding resident's remain active in the care plan. DON/designee will conduct random audits of resident care plans weekly x4 then monthly x5.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur:**<br>Audits will be reviewed and discussed in scheduled QAPI meetings. | |

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| | have the resident's physician assess the area again for further guidance. The lesion was not on the care plan.<br><br>A current policy, titled "Healthwin-Comprehensive Care Plan," and revised 1/2023, provided by the DON on 3/14/2024 at 8:30 A.M., included, but was not limited to, "...The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being...."<br><br>3.1-35(a) | | | |
| F 0657 SS=D Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. | | | |

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| | (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br><br>Based on interview and record review, the facility failed to update a fall care plan with new interventions after a fall, for 1 of 3 residents reviewed for falls. (Resident 111)<br><br>Finding includes:<br><br>During an interview, on 3/11/2024 at 2:47 P.M., Resident 111 indicated he had a recent fall, but was unsure when.<br><br>A record review was completed on 3/13/2024 at 1:22 P.M. The resident had intact cognition, with diagnoses including, but not limited to: type two diabetes, concussion without loss of consciousness, history of transient ischemic attack and cerebral infarction.<br><br>An Admission Minimum Data Set (MDS) assessment, dated 2/6/2024, indicated the resident required extensive assistance with the assist of one person for bed mobility, transferring and toileting and supervision with the assist of setup help for eating.<br><br>An Interdisciplinary Team Note, dated 2/20/2024, indicated the resident had slid out of his wheelchair and the intervention included therapy assessment of cushion with anti-slip device placement.<br><br>An Interdisciplinary Team Note, dated 3/6/2024, | F 0657 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>Resident that was affected had care plan reviewed and updated appropriately with selected interventions.<br><br>**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:**<br>All residents have the potential to be affected. Education provided to care plan team regarding care plan revision and timing.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.**<br>Occurrences will be reviewed in the IDT meeting. MDS/designee will update the care plan at that time. Medical records will be notified to update the CNA assignment sheet if applicable. DON/designee will conduct random audits of resident care | 04/11/2024 |

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| | indicated the resident had fallen while being assisted by staff with a new intervention of therapy adding the resident to therapy caseload.<br><br>A Fall Care Plan, dated 2/1/2024, indicated interventions included, but were not limited to: wearing appropriate footwear, hourly safety checks at night and call light within reach.<br><br>During an interview, on 3/14/2024 at 1:22 P.M., the Director of Nursing indicated the care plan should have been updated after his falls, and interventions were selected, but the care plan was not updated.<br><br>On 3/14/2024 at 8:30 A.M., the Director of Nursing provided a policy, titled, "Comprehensive Care Plans", and indicated this was the current policy used by the facility. The policy indicated ..."9. Care plan revisions occur on a routine basis. Examples of adjustments to the care plan include but not limited to order changes, incidents, and behaviors ...."<br><br>3.1-35(c)(1) | | plans that required update due to occurrence weekly x4 then monthly x5.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur:**<br>Audits will be reviewed and discussed in scheduled QAPI meetings. | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>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.<br>Based on observation, record review, and interview, the facility failed to administer a PRN | F 0684 | **What corrective action(s) will be accomplished for those** | 04/11/2024 |

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| | (as needed) diuretic medication per Physician's Orders, for 1 of 5 residents whose medication orders were reviewed. (Resident 174)<br><br>Finding includes:<br><br>During an interview, on 3/11/2024 at 2:37 P.M., Resident 174 was observed to have edema (swelling) to bilateral (both) feet.<br><br>A record review was completed on 3/14/2024 at 10:41 A.M. Resident 174's diagnoses included, but were not limited to chronic congestive heart failure, chronic kidney disease, pacemaker, and a cardiac defibrillator.<br><br>Current Physician Orders included: Daily Weights: See PRN (as needed) medication order for weight gain of 2 lbs. (pounds) or greater in 24 hour in the morning. Lasix (diuretic) 20 mg (milligram) give 1 tablet by mouth every 24 hours as needed for CHF (Congestive Heart Failure) for weight gain of 2 lbs. or greater in 24 hours.<br><br>Resident 174's current weights were as follows:<br>3/7/2024--245 lbs.<br>3/8/2024--245<br>3/10/2024--238<br>3/11/2024---247 (gain of 9 lbs.)<br>3/12/2024--248<br>3/13/2024--250<br>3/14/2024--251<br><br>The March 2024 MAR (Medication Administration Record) indicated Resident 174 did not receive the as needed diuretic medication on 3/11/2024 for the weight gain of 9 lbs.<br><br>During an interview, on 3/15/2024 at 9:35 A.M., the Director of Nursing indicated the resident did | | **residents found to have been affected by the deficient practice:**<br>Facility unable to correct the deficient practice from 3/11/24. PRN medication was administered on 3/12/24.<br><br>**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:**<br>All residents with an order for a PRN diuretic for weight gain have the potential to be affected. Nurses/QMAs will be re-educated on medication administration.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.**<br>DON/designee will conduct random audits of PRN diuretic administration weekly x4 then monthly x5.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur:**<br>Audits will be reviewed and discussed in scheduled QAPI meetings. | |

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| | not receive the medication on 3/11/2024 as ordered.<br><br>On 3/15/2024 at 9:47 A.M., the Director of Nursing provided the policy, titled, " Medication Administration Policy", dated 1/2023, and indicated the policy was the one currently used by the facility. The policy indicated"...Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice...."<br><br>3.1-37 | | | |
| F 0695 SS=D Bldg. 00 | 483.25(i) Respiratory/Tracheostomy Care and Suctioning<br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>Based on observation, record review, and interview, the facility failed to ensure oxygen equipment was stored appropriately and cleaned, for 2 of 3 residents reviewed for oxygen use. (Residents 8 & 83)<br><br>Findings include:<br><br>1. During an observation, on 3/11/2024 at 2:33 P.M., Resident 8's CPAP mask was lying on top of the bedside dresser, not placed in the SloClean | F 0695 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>All residents that were affected were reviewed. Orders were entered for resident 83 to change respiratory supplies weekly and nebulizer was cleaned. Resident 8's mask placed in so clean. | 04/11/2024 |

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| | machine and without a storage bag.<br><br>During an observation, on 3/12/2024 at 8:57 A.M. the resident's CPAP mask was lying on top of the bedside dresser, not placed in the SloClean machine and without a storage bag.<br><br>During an observation, on 3/13/2024 at 9:50 A.M., the resident's CPAP mask was lying on top of bedside dresser, not placed in the SloClean machine and without a storage bag.<br><br>During an observation, on 3/14/2024 at 1:34 P.M., Resident 8's CPAP mask was not bagged and was lying on top of the dresser, not in the SloClean machine and without a storage bag.<br><br>During an interview, on 3/14/2024 at 1:30 P.M., the Director of Nursing indicated CPAP masks should be kept in the SloClean Machine for cleaning purposes while not in use.<br><br>During an interview, on 3/14/2024 1:39 P.M., RN 6 indicated the CPAP mask should be bagged if not in the SloClean machine, and not lying on top of the dresser open to air.<br><br>A record review was completed on 3/15/2024 at 9:53 A.M. Resident 8's diagnoses included, but were not limited to: atrial fibrillation, type two diabetes, obstructive sleep apnea, and asthma.<br><br>Physician Orders, dated 4/2/2023, indicated the CPAP mask was to be placed in the SloClean Machine with tubing intact after removing the mask from the resident in the morning.<br><br>A review of a Care Plan, for altered respiratory status, dated 9/27/2023, indicated interventions included, but were not limited to: CPAP as | | **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:**<br>All residents who require respiratory equipment have the protentional to be affected. All residents utilizing respiratory equipment were reviewed to ensure appropriate supply change orders were present. Nursing staff education on proper storage and changing/cleaning of equipment.<br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.**<br>Order verifying supply change will be audited weekly x4 then monthly x5. CPAP/BiPAP mask visual audits will be conducted to ensure proper storage in SloClean machine weekly x4 then monthly x5. Nebulizer machine visual audits for cleanliness will be conducted weekly x4 then monthly x5.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur:**<br>Audits will be reviewed and discussed in scheduled QAPI meetings. | |

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| | ordered, observe for signs and symptoms of respiratory distress, SloClean as ordered.<br><br>2. An observation of Resident 83 was completed on 3/11/2024 at 10:08 A.M. Resident 83 was wearing her nasal cannula and the oxygen was set to two liters. Resident 83's oxygen tubing and humidification bottle, connected to the oxygen concentrator, was not labeled with a date. Resident 83's oxygen tubing, connected to the nebulizer mask, did not have a date, and the nebulizer mask was sitting in the nebulizer's main body cabinet, unbagged. The nebulizer's main body contained a build-up of dust and loose debris.<br><br>An observation of Resident 83 was completed on 3/12/2024 at 2:29 P.M. Resident 83 was wearing her nasal cannula and the oxygen was set to two liters. Resident 83's oxygen tubing and humidification bottle, connected to the oxygen concentrator, was not labeled with a date. Resident 83's oxygen tubing, connected to the nebulizer mask, did not have a date, and the nebulizer mask was in an undated bag with other respiratory supplies. The nebulizer's main body contained a build-up of dust and loose debris.<br><br>An observation of Resident 83 was completed, on 3/13/2024 at 9:52 A.M. Resident 83 was wearing her nasal cannula and the oxygen was set to two liters. Resident 83's oxygen tubing and humidification bottle, connected to the oxygen concentrator, was not labeled with a date. Resident 83's oxygen tubing, connected to the nebulizer mask, did not have a date, and the nebulizer mask was in an undated bag with other respiratory supplies. The nebulizer's main body contained a build-up of dust and loose debris. | | | |

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| | Resident 83's record review was completed on 3/13/2024 at 10:45 A.M.<br><br>Resident 83's record lacked the documentation to indicate her oxygen tubing, humidification bottle, nebulizer tubing, and oxygen storage bag had been changed.<br><br>A Physician's Order, dated 11/22/2023, indicated two liters of oxygen to keep oxygen saturation level above ninety percent, as needed.<br><br>A Physician's Order, dated 11/30/2023, indicated Ipratropium-Albuterol Inhalation Solution 0.5-2.5 3 milligram/3 milliliter (breathing treatment) for shortness of breath every two hours, or every six hours for wheezing, as needed.<br><br>An interview with LPN 3 was completed on 3/13/2024 at 1:00 P.M. LPN 3 indicated he was the nurse responsible for Resident 83. Resident 83's oxygen tubing and humidification bottle, connected to the oxygen concentrator, was not labeled with a date, but should be dated. Resident 83's oxygen tubing, connected to the nebulizer, was not labeled with a date, but should be dated. The bag Resident 83's nebulizer mask was stored in was not labeled with a date, but should be. Resident 83's nebulizer mask was stored in the same bag as other respiratory supplies, but should be stored separately. Resident 83's nebulizer's main body was dirty, but should be clean. LPN 3 indicated Resident 83 did not have orders to change the oxygen tubing, humidification bottle, and nebulizer tubing, but he followed the facility policy, which was to change oxygen tubing, humidification bottles, and bags storing nebulizers once a week, and document the respiratory supplies were changed in the resident's record. | | | |

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| | An interview with the Director of Nursing (DON) was completed on 3/14/2024 at 9:11 A.M. The DON indicated there was no documentation in Resident 83's record to indicate the resident's oxygen tubing, humidification bottle, or nebulizer storage bag had been changed since receiving the Physician's Order to begin oxygen or nebulizer treatments.<br><br>On 3/14/2024 at 8:30 A.M., an undated policy was received from the Director of Nursing titled, "Oxygen Concentrator Policy", and the Director of Nursing identified the policy as the one currently used by the facility. The policy indicated, "...1. Care of the Resident...j. Cannulas and masks should be changed weekly or as necessary...2. Care of the Concentrator- Document in the resident's clinical record...b. Change tubing weekly. c. Change humidifier bottle weekly. d. Change nebulizer tubing weekly. The main body cabinet should be dusted when needed and can be wiped clean with a damp cloth and mild household cleaner in necessary...."<br><br>On 3/14/2024 at 8:30 A.M., an undated policy was received from the Director of Nursing titled, "Cleaning and Disinfection of C-pap/Bi-pap Equipment", and the Director of Nursing identified the policy as the one currently used by the facility. The policy indicated, "...It is the policy of this facility to follow infection control principles to prevent spread of infection through use of Bi-pap/C-pap equipment...."<br><br>3.1-47(a)(6) | | | |
| F 0744<br>SS=D<br>Bldg. 00 | 483.40(b)(3)<br>Treatment/Service for Dementia<br>§483.40(b)(3) A resident who displays or is | | | |

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| | diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.<br>Based on observation, record review, and interview, the facility failed to ensure a resident received person centered dementia care for 1 of 1 residents reviewed for dementia care. (Resident 6)<br><br>Finding includes:<br><br>A random observation was completed on 3/13/2024 at 9:53 A.M. Resident 6 was in the restroom yelling out she was going to sue the facility because she did not want the help from the two CNAs trying to help her. CNA 8 was heard telling the resident she was going to get the paperwork and a pen so the resident could sue the facility.<br><br>An interview with CNA 8 was completed on 3/13/2024 at 9:55 A.M. CNA 8 indicated there were no excuses for what she said to Resident 6, and she should not have told Resident 6 that she was going to get paperwork and a pen to sue the facility.<br><br>A record review was completed on 3/13/2024 at 2:15 P.M. Resident 6's diagnoses included, but were not limited to: dementia, pseudobulbar affect, traumatic brain injury, anxiety disorder, major depressive disorder, and obsessive-compulsive disorder.<br><br>A Quarterly MDS (Minimum Data Set) assessment, dated 2/7/2024, indicated Resident 6 had severe cognitive impairment, no hallucinations or delusions, and had no behaviors during the assessment period. Resident 6 had the | F 0744 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>Resident was assisted with the completion of toileting needs and then assisted to safe quiet area to allow her space to calm agitation. Dementia Care Plan was immediately added.<br><br>**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:**<br>All residents with dementia have the potential to be affected. Staff will be re-educated on approach to care.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.**<br>DON/Designee will complete random audits on Standard Approach to Care with residents with dementia, such as non-pharmacological interventions, environmental interventions. Audits will be completed weekly x4, monthly x5 months. | 04/11/2024 |

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| | ability to make herself understood and had the ability to understand others.<br><br>There was a Care Plan for anxiety, but Resident 6's record lacked documentation to indicate she had a Care Plan related to dementia care and specific cognitive deficits or needs before 3/13/2024.<br><br>An interview with CNA 1 was completed on 3/14/24 at 10:59 A.M. CNA 1 indicated all CNAs have access to Care Plans, and Care Plans were used to identify a resident's triggers and interventions in order to provide care.<br><br>An interview with the Director of Nursing (DON) was completed on 3/14/24 at 2:48 P.M. The DON indicated facility staff did use the care plan as a way communicate resident needs. In this situation, one person could have just stayed in the bathroom and allowed her a moment to calm down and understand.<br><br>An interview with CNA 9 was completed on 3/14/2024 at 2:51 P.M. CNA 9 indicated she was alone in the restroom with Resident 6 when Resident 6 began yelling and refusing help while on the toilet. CNA 9 indicated she did not call for assistance, but CNA 8 heard the yelling and came into the restroom. CNA 9 did hear CNA 8 tell Resident 6 she was going to get the paperwork and a pen needed to sue the facility, after CNA 8 and CNA 9 could not redirect Resident 6. CNA 9 indicated no paperwork was provided to Resident 6 to sue the facility, and telling Resident 6 the paperwork and pen to sue the facility would be provided should not have been said.<br><br>On 3/15/2023 at 8:39 A.M., the Director of Nursing provided an undated policy titled, Healthwin-Comprehensive Care Plans, and | | **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:**<br>Audits will be reviewed and discussed in scheduled QAPI meetings. | |

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| | indicated it was the policy currently used by the facility. The policy indicated, "...It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident...."<br><br>On 3/15/2023 at 8:39 A.M., the Director of Nursing provided an undated policy titled, "Healthwin Specialized Care Departmental Policy and Procedure", and indicated it was the policy currently used by the facility. The policy indicated, "...Healthwin shall provide a system of dementia care that is person-centered, comprehensive, and interdisciplinary...Activities of Daily Living...Ensure a safe environment for the resident, while promoting autonomy and independence to the extent possible, Keep distractions to a minimum, Remain calm, being aware of the tone of voice used when talking to the resident...."<br><br>3.1-37(a) | | | |
| F 0761<br>SS=D<br>Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have | | | |

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| | access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>Bases on observation, interview, and record review, the facility failed to properly label medications with the patient identification and date the medication was opened, for 3 medications found in 2 of 6 medication carts. (Northwest Cart 1 & East cart 1). The facility also failed to maintain a clean and sanitaty environment for medication storage to preserve medication integrity, for 1 of 6 medication carts observed. (Riverlane Cart)<br><br>Findings include:<br><br>1. During an observation of the Northwest Cart 1 with RN 4, on 3/14/2024 at 9:15 A.M., a bottle of Flonase was found open, but no open date was noted.<br><br>During an interview, on 3/14/2024 at 9:15 A.M., RN 4 indicated the Flonase should have had an open date on the box.<br><br>2. During an observation of the East Cart 1 medication cart with LPN 13, on 3/14/2024 at 2:54 P.M., 2 sealed bottles of nitroglycerin tablets were in the drawer, with no label or patient identifier information.<br><br>During an interview, on 3/14/2024 at 2:54 P.M., | F 0761 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>Medication carts were cleaned. Nitroglycerin bottles we destroyed. Flonase was dated.<br>**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:**<br>All residents have the potential to be affected. Policy updated. Nurses/QMAs educated on Medication care sanitizing policy and Storage of Medications policy.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.**<br>Medication cart audits will be conducted daily x6 months by nurses. Random medication cart observations will be conducted by | 04/11/2024 |

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| | LPN 13 indicated she did not know to whom the nitroglycerin belonged, and they should be labeled.<br><br>A current policy titled, "... Pharmaceuticals 2023 Policies and Procedures," provided on 3/14/2024 at 1:03 P.M. by the DON, indicated, "...When the original seal of a manufacturer's container or vial is initially broken, the container of vial will be dated by nursing on the area supplied by the pharmacy or by applying a "date opened" sticker on the medication and documenting the date opened and the new date of expiration...."<br><br>3. During an observation of the Riverview Lane medication cart with RN 12, on 3/15/2024 at 9:20 A.M., the drawer containing liquid and other pourable medications was found with residue from spilled liquids in the bottom.<br><br>During an interview, on 3/15/2024 at 9:20 A.M., RN 12 indicated she should have cleaned the drawer to store medications in a sanitary manner.<br><br>A current policy titled, "Medication Cart Sanitizing" and revised 11/5/2010, provided by the DON on 3/15/2024 at 10:05 A.M., included, but was not limited to, "...The medication cart shall be disassembled weekly on the night shift. Both interior and exterior surfaces shall be cleaned. Individual cubicles will be removed and each drawer cleaned...."<br><br>3.1-25(j)<br>3.1-25(k)<br>3.1-25(l) | | DON/designee weekly x4 then monthly x5.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur:**<br>Audits will be reviewed and discussed in scheduled QAPI meetings. | |
| F 0812<br>SS=F<br>Bldg. 00 | 483.60(i)(1)(2)<br>Food<br>Procurement,Store/Prepare/Serve-Sanitary | | | |

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| | §483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>Based on observation, interview, and record review, the facility failed to ensure food was handled appropriately, foods were sealed appropriately, and foods were dated when opened. This had the potential to affect the 120 residents who receive meals from the kitchen.<br><br>Findings include:<br><br>1. During a meal observation , on 3/11/2024 at 12:18 P.M., CNA 8 approached a resident and picked up the residents roll with a bare hand and buttered the roll. The CNA then approached another resident, and with bare hands, picked up the resident's roll and buttered it. CNA 8 approached a third resident and asked about needing a roll buttered. The third resident replied yes, and the CNA picked up the roll with a bare | F 0812 | What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br>The dietary and nursing staff members involved immediately were re-educated on the sanitation policy and procedure regarding wearing gloves when touching resident food. The items in the freezer were labeled/dated immediately. Staff members involved were promptly in-serviced on proper sanitary techniques for storing in freezer and cooler.<br>How other residents having the potential to be affected by the same deficient practice will be | 04/11/2024 |

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| | hand and buttered the roll.<br><br>During an interview, on 3/11/2024 at 12:24 P.M., CNA 8 indicated she should not have touched the food with her bare hands.<br><br>2. During a walk-through observation of the main kitchen, on 3/11/2024 at 9:40 A.M., with dietary staff 7, the following was observed in the walk-in freezer: an open, unsealed bag of chicken tenders without a label or date, an open and unsealed bag of fish fillets without a label or date, an open and unsealed bag of beef patties in a box with an open date of 3/9/2024, and an open, unsealed bag of beef franks in a box with an open date of 3/7/2024.<br><br>During an interview, on 3/11/2024 at 9:40 A.M., Dietary Staff 7 indicated the food items should have been sealed back up or placed in a sealed bag with a label and date on them.<br><br>On 3/14/2024 at 8:30 A.M., the Director of Nursing provided a policy titled, "Food Safety Requirements", dated 12/2022, and indicated this was the policy currently used by the facility. The policy indicated " ...1) Food safety practices shall be followed throughout the facility's entire food handling process. This process begins when food is received from the vendor and ends with delivery of the food to the resident. Elements of the process include the following: ...b) Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms ...f) Employee hygienic practices ...iv) Labeling, dating and monitoring refrigerated food, including but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable) discarded ...e) use of gloves when touching and assisting with | | identified and what corrective action(s) will be taken:<br>The facility has determined that all residents who consume food by mouth have the potential to be affected.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**<br>All dietary, nursing, occupational therapy, speech therapy, and life enrichment staff has been in-serviced on the facility's policies and practice guideline for maintaining sanitation guidelines when assisting with meals/snacks. Random audits/observations during meals/snack times will be completed. The freezer and coolers will be audited to make sure all open food items are label/dated. Dietary staff were in-serviced on the importance of food safety with focus on labeling/dating open food items.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur:**<br>The DON/designee and the Dietary Manager/designee will complete random audits of staff performing procedures to ensure staff performance is in accordance with the facility policy. | |

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| | ready-to-eat foods ...b) staff shall not touch food with bare hands, exhibiting appropriate use of gloves, tongs, deli paper and spatulas ...h) Gloves will be worn when directly touching ready-to-eat foods and when serving residents who are on transmission based precautions...."<br><br>3.1-21(i)(3) | | Audits will be daily x 4 weeks, weekly x 2 months and monthly thereafter for 3 months. Audits will be reviewed and discussed in scheduled QAPI meetings. | |