STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155542	A. BUILDING 00 B. WING	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLOVERLEAF OF KNIGHTSVILLE	9325 N CRAWFORD ST KNIGHTSVILLE, IN 47857

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 28, 29, August 1, 2, 3, and 4, 2022. Facility number: 000296 Provider number: 155542 AIM number: 100467820 Census Bed Type: SNF/NF: 84 Total: 84 Census Payor Type: Medicare: 15 Medicaid: 53 Other: 16 Total: 84 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 18, 2022.	F 0000	/p> br> /p>	
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			

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

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	environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to ensure residents' dignity while dining was provided in a timely manner to ensure residents received a palliative and hot meal for 2 residents randomly observed during 1 of 2 dining observations (Residents 28 and 8).	F 0550	It is the practice of this facility to assure the residents are treated with respect and dignity and cared for in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.	09/04/2022

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	Findings include: During a dining observation in the main dining room, on 7/28/22 at 12:37 p.m., Certified Nursing Assistant (CNA) 6 served Resident 28 and Resident 8 their lunches of beef Manhattans (shredded beef, mashed potatoes, and gravy on a slice of bread) and mixed vegetables on one plate, a piece of pie on a smaller plate, and a cup of juice. Resident 28 was observed seated in a high back wheelchair with her eyes closed when the meal was placed on the table in front of her. Resident 8 was observed seated in a wheelchair staring out the dining room window when the meal plates and drink were placed on the table in front of her. On 7/28/22 at 12:58 p.m., Resident 28 was observed seated in a high back wheelchair with her eyes closed and unassisted with the lunch meal plates in front of her while CNA 6 served and assisted another resident with their lunch meal. Resident 8 was observed to pick up her fork and slowly got a bite of pie. On 7/28/22 at 1:03 p.m., CNA 6 was observed seated next to and assisting Resident 28 with bites of her lunch meal. CNA 6 was observed touching her face, adjusting her medical face mask, and brushed her hair back from her face with her bare unwashed hand. Then CNA 6 picked up Resident 28's spoon and gave the resident bites of food without sanitizing her hands. Resident 8, unassisted, was observed holding her fork and slowly got a bite of the pie. On 7/28/22 at 1:15 p.m., CNA 6 went over to Resident 8 and asked if she wanted help. Resident 8 did not reply. CNA 6 walked away and sat down by Resident 28. CNA 6 was observed wiping the back of her neck and forehead and then adjusted		The corrective action taken for those residents found to be affected by the deficient practice include: Residents 28 and 8 are being assisted during meals to ensure a palliative and hot meal in a timely manner. Other residents that have the potential to be affected have been identified by: All residents have the potential to be affected by the alleged deficient practice. All residents have been reviewed to identify those needing assistance with meals. All care plans reviewed and updated. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recure include: The Nursing staff has been in-serviced on Assistance with Meals policy and dining services. The corrective action taken to monitor performance to assure compliance through quality assurance is: A performance improvement Tool has been initiated for random audits for 5 residents who need assistance with meals to make sure they receive assistance and their meal in a timely manner. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will	

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	her face mask with her bare hand, then gave Resident 28 bites of food without sanitizing her hands. On 7/28/22 at 1:48 p.m., Resident 28 had eaten all the vegetables and took a bite of the Manhattan and told CNA 6 the bread was no good. CNA 6 repeated "the bread is no good," as CNA 6 gave Resident 28 another spoonful of mashed potatoes. Resident 8 was observed, unassisted, holding her fork then slowly getting a bite of pie. On 7/28/22 at 1:51 p.m., CNA 6 wiped Resident 28's mouth with a napkin, asked Resident 28 if she was done, removed the clothing protector and pushed Resident 28's wheelchair out of the main dining room. On 7/28/22 at 1:53 p.m., Dietary Aide 5 came into the main dining room and asked Resident 8 if she was finished with her lunch. Resident 8 did not reply. Dietary Aide 5 took Resident 8's lunch plates away, with the beef Manhattan and vegetables untouched and the pie partially eaten. Resident 8 held her cup and took a few sips of the drink, then wiped her mouth with a napkin. Resident 8, seated in the wheelchair was then pushed out of the main dining room back to her room by staff. 1. Resident 28's record was reviewed, on 8/3/22 at 9:47 a.m., a Minimum Data Set (MDS) assessment, dated 6/22/22, indicated Resident 28 had a severe cognitive impairment and required extensive assistance of one staff for eating. 2. Resident 8's record was reviewed, on 8/1/22 at 1:28 p.m., a Minimum Data Set (MDS) assessment, dated 5/10/22, indicated Resident 8 had moderate cognitive impairment and required limited		review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcome of the tools. The date the systemic changes will be completed: Compliance : 9/4/2022	

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	assistance (resident highly involved in activity and staff provided guided maneuvering of limbs or other non-weight-bearing assistance) of one staff physical assistance. On 8/2/22 at 2:14 p.m., the Director of Nursing (DON) indicated the staff should have assisted resident 28 with her meal when the meal plate was brought to the resident in the dining room. DON indicated staff should wash or sanitize their hands before assisting a resident with eating and anytime staff touch their face, hair, or face masks. The Administrator (ADM), on 8/4/22 at 9:42 a.m., provided and identified a document as a current facility policy, titled "Assistance with Meals," dated July 2017, which indicated, "Residents shall receive assistance with meals in a manner that meets the individual needs of each resident...Dining Room Residents: ...1. All residents will be encouraged to eat in the dining room...2. Facility Staff will serve resident trays and will help residents who require assistance with eating...3. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity...." 3.1-3(a)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for			

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	the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to ensure a resident's dialysis (a process of purifying the blood of a person whose kidneys are not working normally) access site was accurate on the care plan for 1 of 1 residents reviewed for dialysis (Resident 74). Findings include: Resident 74's record was reviewed on 8/1/22 at 10:53 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 7/13/22, indicated the resident was cognitively intact and received dialysis (a process of purifying the blood of a person whose kidneys are not working normally). Diagnoses on the resident's profile included, but were not limited to, end stage renal disease (longstanding disease of the kidneys leading to failure).	F 0657	It is the practice of this facility to assure care plans are developed/ revised and that care plans are up to date and reflect current care needs. The corrective action taken for those residents found to be affected by the deficient practice include: Resident 74 care plans have been reviewed and updated accordingly. Other residents that have the potential to be affected have been identified by: All residents have the potential to be affected by the alleged deficient practice. All residents currently receiving Dialysis treatments have been reviewed and the care plans have been updated accordingly	09/04/2022

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	A care plan, revised 7/13/22, indicated the resident had a diagnosis of end stage renal disease and was at risk for complications with dialysis treatment. The dialysis access site was in the chest. The resident preferred hemodialysis. A physician's order, dated 7/14/22, indicated check access site for bruit (a rumbling sound that can be heard) and thrill (a rumbling sensation that can be felt) daily. The order lacked documentation the resident had a dialysis access site to the chest. During an interview, on 8/2/22 at 1:30 p.m., Resident 74 indicated his dialysis access site was a fistula (an access site created for a patient to receive dialysis) to his left forearm. There was no access site in his chest. During an interview, on 8/2/22 at 1:44 p.m., Licensed Practical Nurse (LPN) 16 indicated the resident's dialysis access site was a fistula. There was no port in the resident's chest. During an interview, on 8/2/22 at 1:54 p.m., the Director of Nursing (DON) indicated the resident's dialysis access site was a fistula. During an interview, on 8/3/22 at 9:43 a.m., the DON indicated she reviewed the resident's dialysis care plan and it indicated the resident had a dialysis access site to his chest. This was not accurate, and she updated the care plan to reflect the correct access. On 8/3/22 at 9:43 a.m., the DON provided a document titled, "Care Plans, Comprehensive Person-Centered," and indicated it was the policy currently being used by the facility. The policy		The measures of systemic changes that have been put into place to ensure that the deficient practice does not recur include: The IDT has been in-serviced on the care plan policy to ensure care plan revisions are completed timely and appropriately reflect the current nursing treatments. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated for random audits for residents that currently receive Dialysis treatment to ensure their care plans have been updated accordingly. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcome of tools. The date the systemic changes will be completed: Compliance: 9/4/2022	

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	indicated, "...Policy Interpretation and Implementation: 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person centered care-plan for each resident...8. The comprehensive, person-centered care plan will: ...b. Describe any services that are to be furnished to attain or maintain the resident's highest practicable physical...well-being...13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change...." 3.1-35(b)(1)			
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 interview and record review, the facility	F 0688	It is the practice of this facility to assure a resident who enters the	09/04/2022

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	failed to ensure a restorative program (a person-centered nursing care designed to improve or maintain the functional ability of residents, so they can achieve their highest level of well-being possible) was in place to provide Range of Motion (ROM) to a resident with a contracture for 1 of 1 residents reviewed for limited ROM (Resident 21). Findings include: During the initial pool interview, on 7/28/22 at 11:07 a.m., Resident 21 indicated she had a contracture left hand and wanted her fingers to be exercised. The facility used to provide her these services through the restorative program, but there was no longer a restorative program at the facility. The program had just suddenly stopped a few weeks ago. Resident 21's record was reviewed on 8/2/22 at 2:35 p.m. The profile indicated the resident's diagnoses included, but were not limited to, hemiplegia and hemiparesis following a cerebral infarction (stroke) affecting the left side of the body (paralysis of partial or total body function on one side of the body, whereas hemiparesis is characterized by one-sided weakness, but without complete paralysis) and contracture of left hand (a hand deformity that usually develops over years). An annual minimum data set (MDS) assessment, dated 5/31/22, indicated the resident had no cognitive deficit and had received Occupational Therapy (OT) (a form of therapy for those recuperating from physical or mental illness that encourages rehabilitation through the performance of activities required in daily life) minutes and received restorative program of passive (PROM-the space in which a part of 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. The corrective Action taken for those residents found to be affected by the deficient practice include: Resident 21 is being provided restorative services to ensure there is no decrease in range of motion. Other residents that have the potential to be affected have been identified by: All residents have the potential to be affected. All residents were reviewed to identify those with restorative programs to ensure restorative nursing services are being provided.. Care plans updated accordingly. The measures or systematic changes that have been put into place to ensure that the deficient proactive does not recur include: MDS will in-service all nursing staff on the restorative nursing program. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated for random audits for 5 residents who need restorative services are receiving active range of motion exercises.	

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	resident's body moves when someone or something is creating the movement) and active (AROM-the space in which the resident moves a part of their body by using their own muscles) ROM. A care plan, dated 9/8/20 and revised on 5/31/22, indicated the resident was unable to independently range joints and was at risk for contractures related to cerebral vascular accident (CVA) (stroke) with left sided affected and contracture to left hand. A goal, with a target date of 9/26/22, indicated the resident would tolerate passive range of motion exercises as indicated in individualized restorative nursing program through next review with no complaints of pain or redness/swelling to joints. Interventions included, but were not limited to, nurse to review program routinely addressing progress towards goals, record minutes of task completed in plan of care, and staff to set up and complete PROM to left upper extremity and left lower extremity 10 repetitions times 3 sets at least 6 days weekly. A care plan, dated 8/26/20 and revised on 9/2/20, indicated the resident required assist with activities of daily living (ADL's) (daily self-care activities) due to CVA with left side affected. A goal, with a target date of 9/26/22, indicated the resident would participate in ordered therapy through the next review. Interventions included, but were not limited to, restorative programs as indicated. A restorative nursing program evaluation, dated 5/31/22 at 12:31 p.m., indicated the resident was on an active range of motion program and required a passive range of motion restorative program. The resident required restorative nursing program due to left sided hemiparesis and hemiplegia. The		The MDS, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcome of the tools. The date the systemic changes will be completed: Compliance: 9/4/2022	

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	resident was at risk for decline due to her diagnoses which included, but were not limited to, progression of left sided affected due to CVA. The resident would be encouraged to complete the program at least 6 days weekly. OT program treatment encounter notes, dated 5/25/22 through 6/21/22, indicated the resident had 14 treatment encounters, during the time period. An OT program discharge summary, for services dated 5/25/22 through 6/21/22, recommended the resident receive restorative ROM program services and indicated the resident's prognosis to maintain her current level of functioning was good with consistent staff follow-through. During an interview, on 8/3/22 at 10:40 a.m., Restorative Certified Nursing Assistant (CNA) 11 indicated she used to function as a restorative aide, but there was no longer an active restorative program at the facility. She was unsure why the program had stopped. All of the CNA's had been trained to do ROM and they would try to do as much as they could when time allowed. During an interview, on 8/3/22 at 10:44 a.m., the Therapy Director indicated the resident was in therapy up until a few of weeks ago. Therapy recommended she continue with the restorative program, but the facility no longer had an active restorative program. During an interview, on 8/3/22 at 10:50 a.m., the Director of Nursing (DON) indicated the facility still had a restorative program but due to COVID-19 and staffing shortages, the restorative staff needed to be pulled to the floor as CNAs and, at the current time, the program could not			

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	function as a full-time program. All of the CNAs had been trained to provide ROM to all residents who needed it. During an interview, on 8/3/22 at 11:43 a.m., the resident indicated she had not been getting any ROM from the aides. They work with her up several times a day, when getting her out of bed, cleaning her up, and getting her dressed, and still don't do anything with her ROM. On 8/3/22 at 2:33 p.m., the Administrator provided an undated document, titled, "Restorative Nursing Program," and indicated it was the policy currently being used by the facility. The policy indicated, "... Policy: ...Residents who are referred by...therapy, physician, or nursing, will be evaluated...for a Restorative Nursing Program...Definitions/Staff Roles/General Concepts...The CNA will follow the plan of care...Procedure Evaluation and Documentation...7. The CNA will document minutes of activity assigned...." 3.1-42(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the			

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	resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to ensure a resident did not experience a significant weight loss of more than 5% in 30 days and more than 10% in 180 days and staff did not notify the physician and the resident's responsible party of the significant weight loss for 1 of 1 resident reviewed for nutrition (Resident 8). Finding includes: During a dining observation in the main dining room, on 7/28/22 at 12:37 p.m., Certified Nursing Assistant (CNA) 6 served Resident 8 her lunch of a beef Manhattan (shredded beef, mashed potatoes, and gravy on a slice of bread) and mixed vegetables on one plate, a piece of pie on a smaller plate, and a cup of juice. Resident 8 was seated in a wheelchair and observed staring out the dining room window when the meal plates and drink were placed on the table in front of her. On 7/28/22 at 12:58 p.m., Resident 8 was observed to pick up her fork and slowly ate a bite of pie unassisted by staff. On 7/28/22 at 1:15 p.m., CNA 6 went over to Resident 8 and asked if she wanted help. Resident 8 did not reply. CNA 6 walked away and sat down	F 0692	It is the practice of this facility to ensure that residents do not experience a significant weight loss of more than 5% in 30 days and more than 10% in 180 days. The correction action taken for those residents found to be affected by the deficient practice include: Resident 8 MD and family were notified of resident weight loss. Resident 8 was evaluated by our Dietician and is being tracked by our weekly NAR meetings. Other residents that have the potential to be affected have been identified by: All residents have the potential to be affected by the alleged deficient practice. All resident weights were reviewed to identify any significant weight loss. All residents that are experiencing weight loss have been reviewed with MD and family notification and will be tracked by our weekly NAR meeting. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:	09/04/2022

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	by another resident. Resident 8 picked up her fork and slowly ate a bite of the pie. On 7/28/22 at 1:48 p.m., Resident 8 was observed, unassisted, holding her fork then slowly eating a bite of the pie. The remainder of the lunch meal, the beef Manhattan and mixed vegetables, were untouched by the resident. On 7/28/22 at 1:53 p.m., Dietary Aide 5 came into the main dining room and asked Resident 8 if she was finished with her lunch. Resident 8 did not reply. Dietary Aide 5 took Resident 8's lunch plates away, with the beef Manhattan and vegetables untouched and the pie partially eaten. Resident 8 held her cup and took a few sips of the drink, then wiped her mouth with a napkin. Resident 8, seated in the wheelchair, was then pushed out of the main dining room back to her room by staff. Resident 8's record was reviewed on 8/1/22 at 1:28 p.m. Diagnoses included but were not limited to unspecified dementia with behavioral disturbance (problems with reasoning, planning, judgment, memory, and other thought processes caused by brain damage from impaired blood flow to the brain), heart failure, dysphagia (difficulty swallowing), acquired deformity of neck, and unspecified lack of coordination. A quarterly Minimum Data Set (MDS) assessment, dated 5/10/22, indicated the resident had a moderate cognitive impairment and required limited assistance (resident highly involved in activity with staff provided guided maneuvering of limbs or other non-weight-bearing assistance) of one staff physical assist for eating. An active physician's order, dated 7/18/19,		IDT team In-serviced on Weight Monitoring and Weight Loss policy. Ensuring residents with significant weight loss are added to the weekly NAR (Nutritionally At Risk) meeting with MD and family notification. The corrective action taken to monitor performance to assure compliance through quality assurance is: A performance improvement tool has been initiated for random audit of 5 residents with weight loss to ensure they have proper interventions and are being tracked by NAR. The Director of Nursing or designee will complete this tool weekly x 3, monthly x 3 and then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcome of the tools. The date the systemic changes will be completed: Compliance: 9/4/2022	

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	indicated for the dietitian to evaluate the resident for nutritional intervention, if needed. An active physician's order, dated 8/21/19, indicated to offer the resident a snack cake daily at 10 a.m. and 4 p.m. with the house supplement for decreased consumption. An active physician's order, dated 1/6/21, indicated to offer resident any type of pastry with breakfast daily. A care plan, date initiated 6/15/20 and revised on 9/24/21, indicated the resident had dysphagia related to dementia and was at risk for aspiration (choking). Interventions included, but were not limited to alternate liquids and solid bites, encourage resident to eat slowly and take small bites and small single sips, observe for signs and symptoms of aspiration (SOB [shortness of breath], coughing, choking, elevated temperature, lung sounds) and report if noted, provide appropriate diet consistency as order by MD (physician), sit upright as close as possible to 90 degrees as possible, and therapy to evaluate and treat as indicated. An active physician's order, dated 1/3/22, indicated the resident was to have a regular/general diet, mechanical soft ground meat texture with thin consistency. A Registered Dietician (RD) note, dated 2/15/22, indicated the resident weighed 135.5 pounds (lbs.) on 2/1/22 and had triggered for significant weight change in February of 6.4% weight loss in 30 days and 5.8% loss over 180 days. RD recommended to continue regular/general diet, mechanical soft ground meat texture thin consistency with house supplements between meals twice a day and ice			

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	cream or Magic Cups with lunch and dinner trays. RD will continue to monitor the resident's intake and weight trends and will provide additional recommendations as needed. An Interdisciplinary weight team (IDT) note, dated 2/22/22, indicated Resident 8's current weight was 135.5 lbs., with average consumption of 26% to 50% of a regular mechanical soft diet with thin liquids, multivitamin supplement intervention (MVI) with minerals, house supplement twice a day with 100% consumed, offered snack cake twice a day with 62% consumed, and magic cup added twice a day for weight loss. Resident 8 was added to Nutritional at Risk (NAR) and weekly weights. An active physician's order, dated 2/28/22, indicated to add Resident 8 to NAR and obtain weights weekly due to weight loss. An IDT note, dated 3/12/22, indicated Resident 8's current weight was 132.4 lbs., with average consumption of 0-25% of a regular mechanical soft diet, thin liquids, MVI with minerals, house supplement twice a day with 80% consumed, offer snack cake twice a day with 52% consumed, magic cup added twice a day with 71% consumed. Resident 8 to continue on NAR and weekly weights. An RD note, dated 3/21/22, indicated the resident weighed 131.5 lbs. and had triggered for significant weight change in March of 8.4% weight loss in 90 days and 2.3% loss over 30 days with the resident's decrease in intake possibly related to decline in cognition. RD recommended resident to continue current interventions. No new nutritional interventions.			

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	An IDT note, dated 4/13/22, indicated Resident 8's current weight was 129.8 lbs., with average consumption of 51% to 75% of a regular mechanical soft diet, thin liquids, MVI with minerals, house supplement twice a day with 91% consumed, offer snack cake twice a day with 52% consumed, magic cup added twice a day with 87% consumed. Recommended increased house shake to three times a day. Resident 8 to continue NAR and weekly weights. Physician and the resident's responsible party notified of weight loss. An active physician's order, dated 4/13/22, indicated a house supplement (a supplemental drink) 120 milliliters (ml) three times a day. An RD note, dated 4/27/22, indicated Resident 8 weighed 129.8 lbs. and had triggered for significant weight change in April of 10.4% loss in 90 days and 9.4% loss in 180 days. RD recommended to continue regular/general diet, mechanical soft ground meat texture thin consistency with house supplements three times a day and magic cup twice a day, will continue to monitor and provide additional recommendations as needed. No new nutritional interventions. An IDT note, dated 5/3/22, indicated Resident 8's current weight was 130 lbs. with average consumption of regular mechanical soft diet with thin liquids of 0% to 25% consumed, magic cup twice a day with 100% consumed, and house supplement three times a day with 96% consumed. The resident ate meals in the dining room with set up assistance only. Continue with current plan of care. A care plan, date initiated 6/11/20 and revised on 5/26/22, indicated the resident was at risk for potential alteration in nutrition or weight status.			

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	Interventions included, but were not limited to, observe and report to physician signs or symptoms of significant weight loss, which was 3 pounds in a week, over 5% in one month, and over 10% in 3 months or 6 months, and Registered Dietician (RD) to evaluate and make diet change recommendations PRN (as needed). An active physician's order, dated 6/7/22, indicated Magic Cup (ice cream supplement) two times a day for weight loss. An IDT note, dated 6/8/22, indicated Resident 8's current weight was 127.7 lbs. with average consumption of regular mechanical soft diet with thin liquids of 26% to 50% consumed, magic cup twice a day with 66% consumed, and house supplement three times a day with 80% consumed, and received snacks twice a day with 75% consumed. The resident ate meals in the dining room with set up assistance only. Continue with current plan of care. An RD note, dated 6/13/22, indicated Resident 8 weighed 131.1 lbs. and had triggered for significant weight change in June of 11.4% loss in 180 days, which was up from the last review. RD recommended to continue regular/general diet, mechanical soft ground meat texture thin consistency with house supplements three times a day and magic cup twice a day. A progress care plan note, dated 7/5/22 at 12:32 p.m., indicated a care plan meeting was held on that day with Resident 8 and the resident's responsible party invited but declined to attend the meeting. Resident 8's current weight was 127.8 lbs. with diet of regular/mechanical soft ground meat for meals and magic cup/house supplement drink for supplements. No nursing/care concerns			

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at that time.

An RD note, dated 7/6/22, indicated the resident had triggered for significant weight change in July of 12.1% loss in 180 days and 5% loss in 30 days. RD recommended to continue regular/general diet, mechanical soft ground meat texture thin consistency with house supplements three times a day and magic cup twice a day, with nursing to encourage good intake of food and supplements. RD will continue to monitor and provide additional recommendations as needed.

An IDT note, dated 7/7/22, indicated Resident 8's current weight was 127.8 lbs., with average consumption of regular mechanical soft diet with thin liquids of 51% to 75% consumed, magic cup twice a day with 35% consumed, and house supplement three times a day with 81.6% consumed, and received snacks twice a day with 40% consumed. The resident ate meals in the dining room with set up assistance only. Continue with current plan of care.

A Nutritional Risk Assessment, dated 8/1/22, indicated Resident 8 had significant weight change over 30, 90, 180 days and weighed 118.4 lbs. The resident was on a regular mechanical soft diet with ground meat, fed self with staff supervision of 25% intake of most meals and 0% intake of bedtime snacks. BMI (body mass index) of 19.1 normal weight, however, cause for malnutrition given the resident's low food intake. Resident to continue physician's orders for magic cup twice a day and house supplements three times a day. RD recommended Resident 8 be evaluated if additional nursing help was needed at mealtime.

The medical record lacked documentation the

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	physician and the resident's responsible party had been notified of the resident's significant weight loss. During an interview, on 8/4/22 at 11:23 a.m., the RD indicated she had completed Resident 8's annual nutritional risk assessment and the resident had significant weight loss for 30 days and 180 days. The RD indicated she was going to start a new intervention of possible staff assistance with meals for the resident. All of the RD's notes and documentation went into the facility's electronic computer system for the Administrator (ADM), Director of Nursing (DON), and Assistant Director of Nursing (ADON) to review and it was their responsibility to notify the resident's physician and the resident's responsible party of the significant weight loss. On 8/4/22 at 9:24 a.m., the ADM provided and identified a document as a current facility policy titled, "Weight Monitoring and Weight Loss Intervention," dated 9/13/14. The policy indicated, "...Policy: All residents will be weighed on admission, readmission and at least monthly. More frequent weights may be obtained as per facility policy...Weight loss intervention will be implemented for those residents experiencing significant unplanned weight loss...Guidelines: Weight loss intervention is implemented to prevent further weight loss and to maintain/improve the resident's nutritional status...Steps: ...1. 5% weight loss in 30 days...Notify physician and responsible party...3. 10% weight loss in 180 days...Continue Step 1...Referral to physician/specialist as recommended...4. Additional steps...Review with Interdisciplinary weight team until weight has stabilized. Keep records of interventions implemented and the progress made...."			

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	3.1-46(a)(1)			
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; §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			

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	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 record review and interview, the facility failed to ensure physician documentation of rationale for declination of gradual dose reductions (GDRs) for 3 of 5 residents reviewed for unnecessary medications (Residents 40, 56, and 52). Findings include: 1. Resident 40's record was reviewed on 7/29/22 at 2:06 p.m. The profile indicated the resident's diagnoses included, but were not limited to, major depressive disorder with recurrent, severe psychotic symptoms (a distinct type of depressive illness in which mood disturbance is accompanied by either delusions, hallucinations, or both). An annual Minimum Data Set (MDS) assessment, dated 4/19/22, indicated the resident had no cognitive deficit, had a mood severity score of 6 (scores of 5-9 are classified as mild depression), and received medications which included, but were not limited to antidepressants. A quarterly MDS assessment, dated 6/25/22,	F 0758	It is the practice of this facility to assure that a licensed physician provides documentation of rationale for declination of a gradual dose reduction. The corrective Action taken for those residents found to be affected by the deficient practice include: Residents 40, 56, and 52 were reviewed by the pharmacist and MD to assure that a proper rationale is provided for all gradual dose reductions. Other residents that have the potential to be affected have been identified by: All residents have the potential to be affected by the alleged deficient practice. All residents receiving Psychotropic medications were reviewed to ensure documentation of GDR's are in place. The measures of systematic changes that have been put into place to ensure that the deficient practice does not recure include:	09/04/2022

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	indicated the resident had no cognitive deficit, had a mood severity score of 6 and received medications which included, but were not limited to antidepressants. A care plan, dated 3/29/20 and revised on 5/6 22, indicated the resident was on an antidepressant medication related to diagnosis of depression. A goal with a target date of 9/24/22, indicated the resident would be free from discomfort or adverse reactions related to antidepressant therapy through the review date. Interventions included but were not limited to gradual dose reduction (GDR) as per facility policy educate the resident and significant other on the reduction. A document titled, "Note to Attending Physician/Prescriber," dated 2/28/22, indicated to review Abilify (aripiprazole-antidepressant medication to treat depression) 2 milligrams (mg) at bedtime, Lexapro (escitalopram oxalate-antidepressant) 5 mg daily, and Trazodone (antidepressant and sedative-to promote calm or induce sleep) 50 mg at bedtime for major depression for continued use. The physician had checked to continue the therapy as ordered. The document lacked documentation of a physician rationale. The physician had signed and dated the document on 3/12/22. A current physician's order, dated 6/5/20, indicated give one 2 mg tablet of aripiprazole at bedtime related to major depressive disorder, recurrent, severe with psychotic symptoms. A current physician's order, dated 6/6/20, indicated give one 50 mg tablet of Trazodone hydrochloride (HCl) by mouth one time a day related to major depressive disorder, recurrent, severe with psychotic symptoms.		The MD and IDT team have been In-serviced on GDR's and the proper documentation required for a declination of a gradual dose reduction. The corrective Action taken to monitor performance to assure compliance through quality assurance is: A performance improvement Tool has been initiated for random audits for 5 residents who receive Psychotropic Meds to assure they have proper documentation of a GDR. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcome of the tools. The date the systemic changes will be completed: Compliance: 9/4/2022	

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A current physician's order, dated 6/25/22, indicated give one 20 mg tablet of escitalopram oxalate by mouth one time a day for mood.

2. Resident 56's record was reviewed on 7/29/22 at 2:24 p.m. Diagnoses included but were not limited to anxiety (intense, excessive, and persistent worry and fear about everyday situations) and psychotic disorder (mental disorder characterized by a disconnection from reality).

A quarterly Minimum Data Set (MDS) assessment, dated 7/4/22, indicated the resident was cognitively intact, received medications which included, but were not limited to, antianxiety (medication to treat anxiety) and antipsychotic (medication to treat psychotic disorder) medications on a routine basis.

A care plan, date initiated 11/28/18 and revised on 3/4/19, indicated the resident received an antianxiety medication and was at risk for drug related side effects. Interventions included, but were not limited to give antianxiety medications ordered by physician, observe for side effects and effectiveness, pharmacy to review resident's medications routinely with recommendations as indicated, quarterly and prn (as needed) GDR (gradual dose reduction) as per facility policy.

A document, titled "Note to Attending Physician/Prescriber," dated 2/28/22, indicated the resident received Buspirone (antianxiety medication) 10 milligrams (mg) TID (three times a day) for psychosis and anxiety. Current Federal Regulations require that all psychopharmacological medications be reviewed periodically. It is time to evaluate this therapy. The physician had checked to continue the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	therapy as ordered. The document lacked documented physician rationale. The physician had signed and dated the document on 3/5/22. A current physician's order, dated 2/22/19, indicated Buspirone tablet 10 mg. Give one tablet orally three times a day for anxiety. 3. Resident 52's record was reviewed on 8/2/22 at 9:21 a.m. Diagnoses included but were not limited to depression (mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily life), anxiety (intense, excessive, and persistent worry and fear about everyday situations) and delusions (type of mental health condition in which a person cannot tell what is real from what is imagined). A quarterly Minimum Data Set (MDS) assessment, dated 7/7/22, indicated the resident had a moderate cognitive impairment, received medications which included, but were not limited to, antianxiety (medication to treat anxiety), antipsychotic (medication to treat delusional disorder), antidepressant medication (medication used to treat depression/anxiety disorder) on a routine basis. A care plan, date initiated 10/10/20 and revised on 3/29/22, indicated the resident received an antianxiety medication and was at risk for drug related side effects. Interventions included but were not limited to give antianxiety medications ordered by physician, observe for side effects and effectiveness, pharmacy to review resident's medications routinely with recommendations as indicated, quarterly and prn (as needed) GDR (gradual dose reduction) as per facility policy. A document titled, "Note to Attending			

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	155542	A. BUILDING 00 B. WING	08/04/2022

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	Physician/Prescriber," dated 2/28/22, indicated the resident received Lorazepam (antianxiety medication) 1 milligram (mg) three times a day (TID), Zyprexa (medication used to treat certain mental disorder) 5 mg two times a day (BID), and Prozac (antianxiety medication) 40 mg daily for anxiety and delusions. Current Federal Regulations require that all psychopharmacological medications be reviewed periodically. It is time to evaluate this therapy. The physician had checked to continue the therapy as ordered. The document lacked documented physician rationale. The physician had signed and dated the document on 3/2/22. A current physician's order, dated 5/11/22, indicated give one tablet of Lorazepam 0.5 mg by mouth three times a day for anxiety. A current physician's order, dated 7/22/21, indicated give one tablet of Zyprexa tablet 5 mg by mouth two times a day related to delusional disorders. A current physician's order, dated 12/14/20, indicated give one capsule of Prozac 40 mg by mouth one time a day for depression. On 8/1/22 at 12:01 p.m., the Administrator provided and identified a document as a current facility policy titled, "Documentation/Communication of Consultant Pharmacist Recommendations," dated 5/21/18. The policy indicated, "...Policy: The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist observations and recommendations regarding residents' medication therapy are communicated to those with authority and/or responsibility to implement the recommendations and responded to			

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	in an appropriate and timely fashion...Procedure: ...3. Recommendations are acted upon and documented by the facility staff and/or the prescriber. If the prescriber does not respond to recommendation directed to him/her within a reasonable timeframe, the Director of Nursing and/or the consultant pharmacist may contact the Medical Director ...." 3.1-48(b)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			

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	Based on observation, interview, and record review, the facility failed to ensure an opened multi-dose vial of tuberculin (TB) protein derivative solution (a sterile solution containing the growth products of or specific substances extracted from the tubercle bacillus and used in the diagnosis of tuberculosis) had documentation of the date the vial was opened for use for 1 of 2 medication storage rooms reviewed. Findings include: During an observation tour of the B-wing medication storage room, on 8/4/22 at 9:24 a.m., no open date was observed on an opened multi-dose vial of TB protein derivative solution. During an interview, on 8/4/22 at 9:53 a.m., the Director of Nursing (DON) indicated the TB vial would have been used for both residents and staff. The nurse who had opened the vial must have just forgotten to put the date opened on the vial. All of the nurses should know that any multi-dose vial of medication should have a open date documented on the vial. On 8/4/22 at 10:17 a.m., the DON provided a document, dated 5/21/18, and revised on 5/20/20, titled, "Specific Procedures for All Medications," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: ...5...When opening a multi-dose container, place the date on the container...." 3.1-25(j) 3.1-25(k)(6)	F 0761	It is the practice of this facility to assure medication storage is in accordance with State and Federal laws, all drugs, and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The corrective action taken for those residents found to be affected by the deficient practice include: No specific residents were identified. No residents had any negative effects form the alleged deficient practice. Other residents that have the potential to be affected have been identified by: All residents have the potential to be affected. Medication rooms and carts audited and all medications not labeled with an opened date were removed. The measures of systematic changes that have been put into place to ensure that the deficient practice does not recur include: All licensed staff will be in-serviced on facility policy and procedures and expectations regarding storage of all drugs, and biologicals. The corrective action taken to monitor performance to assure compliance through quality assurance is: A performance Improvement Tool has been initiated that checks to	09/04/2022

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			ensure medication storage is properly stored per policy. The Director of Nursing, or designee, will complete this weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcome of tools. The date the systemic changes will be completed: Compliance: 9/4/2022	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional			

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	standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure staff wore a beard or hair restraints when in the kitchen for 2 of 2 days of observations in the kitchen, failed to ensure hand hygiene was completed prior to assisting a resident with their lunch meal for 1 of 1 resident observed for dining (Resident 28), and failed to ensure hand hygiene was completed prior to pureeing residents' food for 1 of 1 observation of pureed food. Findings include: 1. During an observation in the facility kitchen, on 7/28/22 at 10:07 a.m., Dietary Aide 5 was observed to wear a hairnet and a medical face mask. The medical face mask failed to fully cover dietary aide 5's beard, leaving the sides and bottom of his beard exposed, while he washed dishes at the dishwasher and put away clean dishes in the kitchen. Dietary Aide 5 indicated he had forgotten to shave that morning before coming to work. On 7/28/22 at 1:41 p.m., Dietary Aide 5 was observed in the facility kitchen washing dishes at the dishwasher wearing a hairnet and medical face mask. The medical face mask failed to fully cover Dietary Aide 5's beard. On 7/28/22 at 1:46 p.m., Dietary Manager (DM) indicated Dietary Aide 5 was wearing a hairnet and surgical mask but was not wearing a beard cover. All staff should wear hairnets and beard covers when in the kitchen. On 7/29/22 at 9:33 a.m., Dietary Aide 5 was observed in the facility kitchen washing dishes at	F 0812	It is the practice of this facility to assure that sanitary practices are in place related to having a clean environment, proper storage of items, beard nets, and proper handwashing technique. The corrective Action taken for those residents found to be affected by the deficient practice include: Immediate education provided with staff on wearing hair restraints and beard nets, proper hand hygiene and Pureed food policy. Other residents that have the potential to be affected have been identified by: All residents have the potential to be affected. Please see systematic changes below to prevent reoccurrence. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: All Dietary staff in-serviced on hand hygiene/Dining Service, hair restraints, beard net use and Pureed Food Policy. The corrective action taken to monitor performance to assure compliance through quality assurance is: A performance improvement tool has been initiated for random audit of the kitchen environment, pureeing food, hand hygiene, beard and hair net use. The Administrator, or designee will	09/04/2022

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	the dishwasher wearing a hairnet and medical face mask. The medical face mask failed to fully cover Dietary Aide 5's beard. On 7/29/22 at 11:55 a.m., the Director of Nursing (DON) indicated staff were going today to purchase beard restraints. All staff should wear hairnets and beard restraints when in the kitchen. 2. During a continuous dining observation in the main dining room, on 7/28/22 at 12:37 p.m. to 1:53 p.m., Certified Nursing Assistant (CNA) 6 served Resident 28 lunch of a beef Manhattan (shredded beef, mashed potatoes, and gravy on a slice of bread) and mixed vegetables on one plate, a piece of pie on a smaller plate, and a cup of juice. Resident 28, seated in a high back wheelchair, was observed with her eyes closed when the meal was placed on the table in front of her. On 7/28/22 at 12:58 p.m., Resident 28, seated in a high back wheelchair was observed with her eyes closed and unassisted with the lunch meal plates in front of her, while CNA 6 served and assisted another resident with their lunch meal. On 7/28/22 at 1:03 p.m., CNA 6 was observed seated next to and assisting Resident 28 with bites of her lunch meal. CNA 6 was observed touching her face, adjusting her medical face mask, and brushed her hair back from her face with her bare unwashed hand, then CNA 6 picked up Resident 28's spoon and gave the resident bites of food without sanitizing her hands. On 7/28/22 at 1:15 p.m., CNA 6 was observed wiping the back of her neck and forehead and adjusted her face mask with her bare hand, then gave Resident 28 bites of food with a spoon without sanitizing her hands.		complete this tool weekly x3, monthly x3, and then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcomes of tools. The date the systemic changes will be completed: Compliance: 9/4/2022	

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	On 7/28/22 at 1:48 p.m., Resident 28 had eaten all the vegetables and took a bite of the Manhattan and told CNA 6 the bread was no good. CNA 6 repeated "the bread is no good," as Resident 28 took another spoonful of mashed potatoes from CNA 6. On 7/28/22 at 1:51 p.m., CNA 6 wiped Resident 28's mouth with a napkin, asked Resident 28 if she was done, removed the resident's clothing protector, and pushed Resident 28's wheelchair out of the main dining room. CNA 6 was not observed to sanitize her hands. On 8/2/22 at 2:14 p.m., the Director of Nursing (DON) indicated staff should have assisted Resident 28 with her meal when the meal plate was brought to the resident in the dining room and staff should wash or sanitize their hands before assisting a resident with eating and anytime staff touched their face, hair, or face masks. 3. During an observation in the facility kitchen of pureed food preparation, on 8/3/22 at 11:00 a.m., Cook 18 was observed to puree meat and sauce in the food processor without sanitizing her hands. Cook 18 took the used processor pan to the dishwasher, sprayed the soiled pan with water, then placed the processor pan into the dishwasher, wiped her wet hands with a paper towel, took a cleaned cookie sheet to the clean dishes area and stacked it on the other clean cookie sheets, picked up a piece of trash off of the floor and placed the trash into a lidded trash bin touching the trash can lid to open the trash bin with her bare hand, grabbed the wet processor pan from the dishwasher rack and put the wet food processor pan back onto the processor machine, without washing or sanitizing her hands.			

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	Next, Cook 18 retrieved a container of potato salad from the refrigerator and placed several scoops of the potato salad into the wet food processor container and pureed the potato salad. Cook 18 placed the pureed potato salad into a pan, then took the soiled processor pan to the dishwasher, sprayed the soiled pan with water, then placed the processor pan into the dishwasher and wiped her wet hands with a paper towel, ran the dishwasher to clean the processor pan, shook off the excess water from the pan then placed the wet processor pan back onto the processor machine. Cook 18 retrieved a container of coleslaw and placed several scoops of the coleslaw into the wet food processor pan and pureed the slaw. Cook 18 placed the pureed slaw into a pan, then took the soiled processor pan to the dishwasher, sprayed the soiled pan with water, then placed the processor pan into the dishwasher, wiped wet hands with a paper towel, grabbed an ice scoop and placed ice into a large bowl, then placed the coleslaw bowl onto the ice in the bowl. Next, Cook 18 put on oven mitts and removed a pan from the oven, removed the oven mitts and removed the foil covering the meat in the pan with her bare hand, opened the trash container lid, placed the foil into the trash bin, washed her hands, then placed the used paper towel into the lidded trash bin, touching the lid as she threw away the paper towel. On 8/3/22 at 11:31 a.m., Dietary Manager (DM) indicated the cook should have washed her hands prior to pureeing the foods in the processor and after spraying the dirty processor pan. Cook 18 should have allowed the food processor pan time to dry before using it again. 4. On 8/3/22 at 12:30 p.m., during a second dining observation, the Human Resources Director was			

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	observed walking into the kitchen without a hair restraint to speak with kitchen staff . The Human Resources Director, on 8/3/22 at 12:32 p.m., indicated she had forgotten to place a hair restraint on when she went into the kitchen. The Director of Nursing (DON), on 7/29/22 at 11:55 a.m., provided and identified a document as a current facility policy, titled "Dress Code and personal Hygiene," dated 2009, which indicated, "...The organization has strict requirements regarding hair: ...Employees will wear hairnet that completely covers the hair while in the kitchen or serving food ...There are no authorized substitutes for the required hair covering...Beard and mustache must be covered with effective hair restraint...." The Administrator (ADM), on 8/4/22 at 9:42 a.m., provided and identified a document as a current facility policy, titled "Assistance with Meals," dated July 2017, which indicated, "Residents shall receive assistance with meals in a manner that meets the individual needs of each resident...Dining Room Residents: ...1. All residents will be encouraged to eat in the dining room...2. Facility Staff will serve resident trays and will help residents who require assistance with eating...3. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity...." The Administrator (ADM), on 8/4/22 at 9:45 a.m., provided and identified a document as a current facility policy, titled "Personnel Standards," dated 5/23/19, which indicated, "...Policy: Dining Services personnel shall follow sanitary standards...c. Hands must be washed after each trip to the restroom, after leaving storage rooms,			

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	dumpster areas, washrooms, etc., after touching hair, mouth, or nose, and at any other time necessary...." 3.1-21(i)(1) 3.1-21(i)(3)			
F 0912 SS=D Bldg. 00	483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq Ft/Resident §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; Based on record review, observation, and interview, the facility failed to provide at least 80 square feet per resident in multiple occupancy resident rooms for 2 of 50 resident rooms observed (Rooms 14 and 15). Findings include: On 8/1/22 at 11:10 a.m., the Administrator provided a copy of a waiver request letter, dated 9/22/21. The letter indicated a waiver had been requested for rooms 14 and 15 of the facility. During a maintenance tour with the Maintenance Director, on 8/4/22 at 9:58 a.m., rooms 14 and 15 were measured. The current measurements of the rooms, were as follows: a. Room 14, licensed for 3 beds, measured 226.2 total square feet. Square footage per resident equaled 75.4 square feet. At the same time, 2 beds were observed in the room. b. Room 15, licensed for 3 beds, measured 226.2	F 0912	What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice. Rooms 14 and 15 identified on the 2567 are single occupant rooms. Facility records indicate the existence of room waiver variance from ISDH. Rooms with less than required 80 sq ft per resident are not used as a semiprivate but single occupancy. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. No other residents are affected by this waiver practice. No other residents' safety is affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Residents in waiver rooms will occupy a single occupant with no	09/04/2022

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	total square feet. Square footage per resident equaled 75.4 square feet. At the same time, 2 beds were observed in the room. During an interview, on 8/4/22 at 10:11 a.m., the Administrator indicated each of the rooms were licensed for 3 beds. Currently, each room had 2 beds in each room. The facility was requesting a waiver for the rooms. 3.1-19(l)(2)		double occupants thereby ensuring their environmental safety. How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place. The waiver rooms are single occupant rooms with no double occupant	
F 9999 Bldg. 00	3.1-14 PERSONNEL (s) Professional staff must be licensed, certified, or registered in accordance with applicable state laws or rules. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure staff members did not work with expired certifications for 1 of 10 employees randomly selected for review. Findings include: On 8/4/22 at 1:00 p.m., Qualified Medication Aide (QMA) 17's employee file was reviewed. The employee's QMA/Certified Nursing Assistant (CNA) certification expired on 7/12/22. The file lacked documentation QMA 17 renewed her certification. During an interview, on 8/4/22 at 1:45 p.m., the Human Resources (HR) Coordinator indicated QMA 17's certification expired on 7/12/22. She	F 9999	It is the practice of this facility to assure that Professional staff must be licensed, certified, or registered in accordance with applicable state laws or rules. The corrective Action taken for those residents found to be affected by the deficient practice include: QMA 17 immediately renewed her certification (8/4/22). Other residents that have the potential to be affected have been identified by: All professional staff records were reviewed to ensure all had current certifications or licensure. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: Human Resource was educated on Professional licensure/certifications to ensure all professional staff have a current	09/04/2022

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CLOVERLEAF OF KNIGHTSVILLE	9325 N CRAWFORD ST KNIGHTSVILLE, IN 47857

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	was working on getting it renewed. QMA 17 had worked since the certification expired. During an interview, on 8/4/22 at 2:27 p.m.., the HR Coordinator indicated QMA 17 was the facility's scheduler, so her normal duties were not direct care related. There was one day since the expiration of her certification, QMA 17 passed medications. During an interview, on 8/4/22 at 3:09 p.m., the Director of Nursing (DON) indicated QMA 17 was the facility's scheduler but had passed medications on 7/26/22 when her certification was expired. On 8/4/22 at 3:11 p.m., the Administrator provided a document titled, "Nurse Aide Qualifications and Training Requirements," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy Interpretation and Implementation: ...3. In keeping with the Omnibus Budget Reconciliation Act of 1987 (OBRA), our facility will only employ those nurse aides who meet the requirements set forth in the federal and state statutes concerning the staffing of long-term care facilities...."		certification or licensure. The corrective action taken to monitor performance to assure compliance through quality assurance is: A performance improvement tool has been initiated for random audit of the professional staff certification/licensure. The Administrator, or designee will complete this tool weekly x3, monthly x3, and then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcomes of tools. The date the systemic changes will be completed: Compliance: 9/4/2022	