STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E064	A. BUILDING 00 B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE CARE STRATEGIES	505 N GAVIN ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00442950. Complaint IN00442950- Federal/State deficiencies related to the allegations are cited at F609 and F610. Survey dates: September 22, 23, 24, 25, and 26, 2024 Facility number: 000311 Provider number: 15E064 AIM number: 100285520 Census Bed Type: NF: 34 Total: 34 Census Payor Type: Medicaid: 31 Other: 3 Total: 34 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 7, 2024.	F 0000	By submitting the following material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 10/27/2024 to the state findings of the recent health survey. We are requesting paper compliance.	
F 0577 SS=E Bldg. 00	483.10(g)(10)(11) Right to Survey Results/Advocate Agency Info Based on record review and interview, the facility failed to ensure the most recent survey results were readily accessible to residents and resident representatives.	F 0577	It is the practice of this facility to ensure the most recent survey results are readily accessible to residents and resident representatives.	09/27/2024

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

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	Findings include: A review of the facility survey binder on 9/22/24 at 10:04 a.m., located behind the nurse's station, indicated the most recent survey included in the survey binder was dated 11/27/23. The additional surveys included in the survey binder were all dated prior to 11/27/23. Signage at the nurse's station indicated to ask for the survey binder. During an interview, on 9/23/24 at 10:11 a.m., the Administrator indicated the survey dated 11/27/23 was the previous annual survey and the survey binder only needed to include annual surveys. He was not aware complaint surveys were required to be included in the survey binder. Review of survey activities conducted by the Indiana Department of Health indicated complaint surveys were conducted on the following dates: 12/21/23, 2/23/24, 3/15/24, 6/20/24, 7/24/24, and 8/20/24. A current facility policy, revised 4/07, titled, "Survey Results, Examination of", provided by the Administrator, on 9/23/24 at 2:20 p.m., indicated the following: " ...2. A copy of the most recent standard survey, including any subsequent extended surveys, follow-up revisits reports, etc. along with state approved plans of correction of noted deficiencies, is maintained in a 3-ring binder located in an area frequented by most residents, such as the main lobby or resident activity center ...." 3.1-3(b)(1)		1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice. a. No residents were affected by the alleged deficient practice. b. Survey binder was updated to include missing survey results. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. No residents were affected by the alleged deficient practice. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. Survey binder was updated to include missing survey results on 09/23/2024. b. Administrator has been educated on 09/27/2024 regarding regulation for all surveys for the last 3 years be maintained accessible to residents and resident representatives. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: a. Administrator and/or Designee will complete an audit tool to be completed once a week for the next three months. Any identified issues will be immediately	

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			addressed. The outcomes will be reviewed through the facility quality assurance program. Monitoring will continue as planned or will be increased by the quality assurance committee, if needed, to obtain 100% compliance. Additional action will be taken by the quality assurance committee if warranted, based on the outcomes of tools.	
F 0585 SS=E Bldg. 00	483.10(j)(1)-(4) Grievances Based on record review and interview, the facility failed to implement a grievance process according to facility policy for resident and resident representative concerns. Findings include: During record review on 9/24/24 at 10:30 a.m., the facility grievance binder, provided by the Administrator, indicated the following: The most recent grievance was filed on 1/23/24. During an interview, on 9/24/24 at 10:45 a.m., the Administrator indicated the Social Services Director (SSD) was the grievance official for the facility. During an interview, on 9/24/24 at 10:49 a.m., the SSD indicated she was the facility grievance official. Her grievance process was when a resident made a complaint or expressed a concern, it was investigated and resolved immediately. Since issues were resolved immediately there was no need to write the information on a grievance	F 0585	It is the practice of this facility to ensure a grievance process accordingly to facility policy. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice. a. No residents were identified during the survey. b. Education was provided 10/09/2024 to facility grievance official and all staff on completing grievance forms per facility policy 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. All residents have the potential to be affected by the alleged deficiency.	10/27/2024

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	form. She indicated in the last 9 months, there had not been any concerns or complaints that had not been resolved immediately. A current facility policy, revised 4/17, titled, "Grievances/Complaints, Filing", provided by the Administrator, on 9/24/24 at 11:19 a.m., indicated the following: " ...3. All grievance, complaints, or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response ....8. Upon receipt of a grievance and/or complaint, the Grievance Officer will review and investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and/or complaint ....11. The Administrator will review the findings of the Grievance Officer to determine what corrective action, if any, need to be taken ...." 3.1-7(b)		3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. a. Education was provided 10/09/2024 to facility grievance official and all staff on completing grievance forms per facility policy. b. Administrator and/or Designee will review grievance form during daily manager meeting and assigned to appropriate manager for follow up and completion. The completed grievance form will be kept in binder. 4. How the corrective actions will be monitored to ensure the deficient practices will no occur. a. Administrator and/or Designee will complete an audit tool to ensure compliance of completion of grievance forms per facility policy. This audit will be completed once a week for the next three months. Any identified issues will be immediately addressed, and education provide provided as needed. The outcomes will be reviewed through the facility quality assurance program. Monitoring will continue as planned or will be increased by the quality assurance committee, if needed, to obtain 100% compliance. Additional action will be taken by the quality assurance committee if warranted, based on the outcomes of tools.	

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F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations Based on interview and record review, the facility failed to report an allegation of abuse to the Indiana Department of Health for 1 of 4 residents reviewed for abuse (Resident C) Finding includes: During an interview on 9/24/24 at 10:02 a.m., the Administrator indicated, on 8/11/24, Resident C reported an allegation of Resident D touching her breast that day in the common area. The Administrator had a file of the facility's investigation. Video surveillance had been reviewed for the specified time frame and the allegation was unsubstantiated by the facility. The facility had not reported the alleged abuse to the Indiana Department of Health. During an interview on 9/25/24 at 4:52 p.m., the Administrator indicated he felt Resident C's abuse allegation was not required to be reported the State of Indiana due to the resident's history of false allegations and the investigation results. The facility followed Indiana Department of Health guidelines for reporting of alleged abuse. A current facility policy, dated 2/1/23 and titled "ABUSE PREVENTION AND PROHIBITION POLICY," provided by the Administrator on 9/22/24 at 4:30 p.m., indicated the following: "...PURPOSE...To ensure the resident's right to remain free from verbal, sexual, physical, and mental abuse, mistreatment, neglect, corporal punishment, involuntary seclusion, and exploitation...PROCEDURES...RESIDENT TO RESIDENT... 3. The Administrator and/or DON, SSD, shall be notified of the incident	F 0609	It is the practice of this facility to ensure an allegation of abuse is reported to Indiana State Department of Health. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice. a. Resident C has had a psych/social follow up completed and no further concerns noted from the voiced allegation. Resident C & D have not had any further incidents. b. Administrator was educated on 10/09/2024 regarding the long-term abuse and incident reporting policy and procedures with the Indiana State Department of Health. c. All staff were in-serviced on 10/09/2024 regarding the long-term care abuse and incident reporting policy and procedures with the Indiana State Department of Health. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. All residents have the potential to be affected by the alleged deficient practice.	10/27/2024

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	immediately...6. The incident shall be reported to the state/certification agency, the ombudsman, and Adult protective Services as applicable per guidelines supplied by the department of health...." Review of the Indiana Department of Health policy titled "Long Term Care Abuse and Incident Reporting Policy," effective date 12/8/24 through 12/8/24 and retrieved from https://www.in.gov/health/ltc/files/LTC-Abuse-Reporting.pdf indicated the following: "...B. Types of Incidents Reportable Under Federal and State Rules...ii. Sexual contact 1. Required to report: Touching a resident's sexual organs and the resident being touched indicates the touching is unwanted through verbal or non-verbal cues...." Cross reference F610. This Federal tag relates to complaint IN00442950. 3.1-28(c)		3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. Administrator was educated on 10/09/2024 regarding the long-term abuse and incident reporting policy and procedures with the Indiana State Department of Health. b. All staff were in-service on 10/09/2024 regarding the long-term care abuse and incident reporting procedures with the Indiana State Department of Health. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur. a. Administrator and/or Designee will complete an audit tool to ensure compliance for reporting allegations of abuse. This will be an ongoing audit. Any identified issues will be immediately addressed, and education provided as needed. The outcomes will be reviewed through the facility quality assurance program. Monitoring will continue as planned or will be increased by the quality assurance committee, if needed, to obtain 100% compliance. Additional action will be taken by the quality assurance committee if warranted, based on the outcome of the tools.	

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F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation Based on interview and record review, the facility failed to conduct a complete and thorough investigation of alleged sexual abuse for 1 of 4 residents reviewed for abuse. (Resident C) Findings include: Confidential interviews were conducted during the course of the survey and indicated the following: Approximately three weeks ago, it was reported to the Social Services Director (SSD) and the Administrator that a male resident,without consent, touched Resident C's breast while seated in a high-backed reclining mobility chair near the entrance of the facility. The location was close to the surveillance camera and the alleged perpetrator was still a resident in the facility. It was reported to the SSD and the Administrator on the date it occurred. During an interview on 9/23/24 at 4:45 p.m., the Administrator indicated the facility had not received any allegations of resident to resident inappropriate touching from 8/3/24 to 9/22/24. The facility's investigations provided from 8/3/24 to 9/22/24 lacked alleged abuse investigations for Resident C or Resident D. During an interview on 9/24/24 at 10:02 a.m., the Administrator indicated, on 8/11/24, Resident C had reported to him an allegation of Resident D touching her breast that day in the common area. The Administrator had a file of the facility's investigation. Video surveillance had been reviewed for the specified time frame and the	F 0610	It is the practice of this facility to complete a thorough investigation of allegations of abuse. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice. a. Resident C has had a psych/social follow up completed and no further concerns noted from the voiced allegation. Resident C & D have not had any further incidents. b. The management team along with any staff member that assist with the investigation process has been education 10/09/2024 on the Abuse Prevention and Prohibition Policy which includes procedures for investigation. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. All residents have the potential to be affected by the alleged deficient practice. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. The management team along with any staff member that assists	10/27/2024

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	allegation was unsubstantiated by the facility. The alleging resident also had a known history of false allegations. Review of the facility's investigation indicated it included a statement of alleged abuse by Resident C reported to the Administrator, an interview with Resident D by the SSD (who denied touching Resident C), a summary of the follow-up with Resident C, and two photo snips from the video surveillance. It was unable to be determined who was in the photos due to the size (both approximately the size of a postage stamp). The facility's investigation did not include the following: the time the information was reported to the Administrator, the time the alleged event occurred, and the time the follow-up was completed. The investigation lacked a skin assessment of Resident C and additional interviews held with staff or other residents regarding abuse or incidence of inappropriate touching. 1. Resident C's clinical record was reviewed on 9/24/24 at 2:03 p.m. Diagnoses included, general anxiety, moderate major depressive disorder, and post-traumatic stress disorder. The clinical record lacked documentation of allegations of sexual abuse during the period from 8/1/24 to 9/24/24. A quarterly Minimum Data Set (MDS) assessment, dated 8/26/24, indicated the resident was cognitively intact. She had a functional limitation in range of motion for her upper and lower extremities on both sides. A wheelchair was used for mobility. The resident was dependent on staff for dressing, toileting, mobility and personal hygiene.		with the investigation process has been educated 10/09/2024 on the Abuse Prevention and Prohibition Policy which includes procedures for investigation. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur. a. Administrator and/or Designee will complete an audit checklist tool to ensure that the investigation has been completed. This will be an ongoing audit. Any identified issues will be immediately addressed, and education provided as needed. The outcomes will be reviewed through the facility quality assurance program. Monitoring will continue as planned or will be increased by the quality assurance committee, if needed, to obtain 100% compliance. Additional action will be taken by the quality assurance committee if warranted, basesd on the outcome of the tools.	

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	The resident had a current care plan, last revised on 9/24/24, regarding false accusations that peers had touched her inappropriately. Interventions included investigate accusations as needed (1/17/23). 2. Resident D's clinical record was reviewed on 9/24/24 at 2:19 p.m. Current diagnoses include, major depressive disorder, generalized anxiety disorder, and bipolar disorder. The resident had a current care plan, last revised 12/8/23, regarding hypersexuality related to kissing peers in the cheek and allegations of inappropriate touching. Interventions included investigate all allegations (5/7/22). A quarterly MDS assessment, dated 8/27/24, indicated the resident was moderately cognitively impaired and displayed no maladaptive behaviors during the assessment period. During an interview on 9/25/24 at 3:40 p.m., the SSD indicated Resident C came to the SSD office after her smoke time on 8/11/24 (she could not remember if it was the 11:00 a.m. smoke break or the 1:30 p.m. smoke break) and reported to her that Resident D touched her on the side of her breast while they were sitting in the common area just before the smoke break. The resident suggested they review the surveillance cameras. The SSD reported the above information immediately to the Administrator and they began the investigation. She interviewed Resident D, who denied touching Resident C. The SSD had not interviewed other residents to ensure they had not been affected. She had not interviewed staff regarding the allegation because she thought the Administrator interviewed the staff members. When she			

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	assisted with investigations regarding abuse allegations, she just interviewed who the Administrator told her to interview. The Administrator determined who needed interviewed based on the individual investigations. The facility would not know if other residents were affected if there were no additional interviews. During an interview on 9/25/24 at 1:09 p.m., CNA 19 indicated she had worked on 8/11/24. She was not asked any questions by Administration nor included in an investigation of an abuse allegation between Resident C and Resident D regarding inappropriate touching. During an interview on 9/25/24 at 1:17 p.m., QMA 5 indicated she was familiar with all of the residents in the building. She was not asked any questions by Administration nor included in an investigation of an abuse allegation between Resident C and Resident D regarding inappropriate touching. During an interview on 9/25/24 at 1:25 p.m., CNA 20 indicated she was not asked any questions by Administration nor included in an investigation of an abuse allegation between Resident C and Resident D regarding inappropriate touching. During an interview, while the clips of the video surveillance were reviewed on 9/25/24 at 4:52 p.m., the Administrator indicated he requested the video surveillance from the corporate office for 8/11/24 from 1:00 p.m. to 1:30 p.m. The facility did not have access to the video surveillance from 1:00 p.m. to 1:30 p.m. The corporate staff sent him five photos from the surveillance footage during the requested time frame for review, rather than the entire video for the requested timeframe. The			

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	time snips were at 1:01 p.m., 1:06 p.m., 1:16 p.m., 1:26 p.m., and 1:31 p.m. The time snips provided by corporate did not show Resident D touching Resident C's breast in the five photos. The Administrator had been made aware of Resident C's previous false allegations of sexual abuse when he started at the facility in February. Since that time, he was not aware of any further reports of sexual abuse from Resident C until the allegation on 8/11/24. Other resident and staff interviews were not included in the investigation because he stopped the investigation due to a lack of evidence found in the five photos provided from corporate. He believed the facility followed Indiana State guidelines for thorough investigations of alleged abuse. A current facility policy, dated 2/1/23, titled "ABUSE PREVENTION AND PROHIBITION POLICY," provided by the Administrator on 9/22/24 at 4:30 p.m., indicated the following: "PURPOSE...To ensure the resident's right to remain free from verbal, sexual, physical, and mental abuse, mistreatment, neglect, corporal punishment, involuntary seclusion, and exploitation...SEXUAL ABUSE: Inappropriate touching of any resident... PROCEDURES... Upon receipt of an allegation of abuse, the Executive Director shall immediately investigate and document all his/her relevant findings and outcome... Facility investigation of suspected abuse will include: 1. Time, Date, Place, and Individuals present. 2. Description of the event as reported. 3. Response of staff at the time of the event: 4. Follow-up action; and 5. Administrator's review... PROCEDURE: The investigation is the process to try to determine what happened...a. Investigation of abuse: When an incident or suspected incident of abuse is reported, the Administrator or designee will			

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	investigate the incident with the assistance of appropriate personnel. The investigation will include: i. Who was involved ii. Resident's statements... iv. Involved staff and witness statements of events. v. A description of the resident's behavior and environment at the time of the incident vi. Injuries present including a resident assessment. vii. Observation of resident and staff behaviors during the investigation...." This Federal tag relates to complaint IN00442950. 3.1-28(d)			
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan Based on interview and record review, the facility failed to develop and implement a baseline care plan for 1 of 1 resident reviewed for pressure ulcers. (Resident 31) Finding includes: Resident 31's clinical record was reviewed on 9/24/24 at 2:42 p.m. She admitted to the facility on 6/19/24. Diagnoses included pain in the right lower leg, alcohol abuse in remission, and stage 3 chronic kidney disease. The clinical record lacked a baseline care plan. During an interview on 9/26/24 at 2:51 p.m., RN 10 indicated a Braden Scale risk assessment should have been completed on admission to the facility. The risk for pressure ulcers was a guide to determine what pressure ulcer prevention interventions were implemented. During an interview on 9/26/24 at 4:27 p.m., the	F 0655	It is the practice of this facility to develop and implement baseline care plans. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice. a. Resident #31 care plan has been reviewed and updated. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. All residents have the potential to be affected by the alleged deficiency. b. An audit of all resident care plans has been completed for baseline care plans and no other deficiencies noted.	10/27/2024

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	DON indicated she was unable to provide a copy of the resident's baseline care plan because it was not developed on admission. A current facility policy, dated 1/2023, titled "Pressure Ulcer/Wound Care," provided by the Infection Preventionist on 9/26/24 at 10:25 a.m., indicated the following: "Policy: ... It is the Policy... that each resident who enters the facility without pressure ulcers, does not develop pressure ulcers unless the individual's clinical condition demonstrates that they are unavoidable... Procedure: ... 19. Care plan is updated to reflect assessment and planned interventions." Cross Reference F686. 3.1-30(a)		3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. The interdisciplinary team has been educated 10/17/2024 on the baseline care plan and timeliness for this plan. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur. a. The MDS Coordinator and/or Designee will complete an audit tool to ensure compliance of the baseline care plan. This audit will be completed upon a new admission, then weekly x4 weeks, then monthly x3 months. Any identified issues will be immediately addressed, and education provided as needed. The outcomes will be reviewed through the facility quality assurance program. Monitoring will continue as planned or will be increased by the quality assurance committee, if needed, to obtain 100% compliance. Additional action will be taken by the quality assurance committee if warranted, based on the outcome of the tools.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on observation, interview, and record review, the facility failed to assess a resident upon	F 0686	It is the practice of this facility to assess a resident upon admission	10/27/2024

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	admission for risk of pressure ulcers and failed to develop and and implement interventions to prevent the development of pressure ulcers when risk was identified. (Resident 31) Finding includes: During an observation on 9/23/24 at 10:12 a.m., Resident 31 was in bed in her room. During an observation on 9/23/24 at 12:54 p.m., the resident was in her bed on her back. She was covered from toes to chin. During an observation on 9/24/24 at 1:44 p.m., the resident was asleep in her bed on her back. Her legs were bent at the knees with her heels directly against the mattress. During an observation on 9/24/24 at 2:24 p.m., the resident was in bed in her room and resting while covered with a blanket. Resident 31's clinical record was reviewed on 9/24/24 at 2:42 p.m. She admitted to the facility on 6/19/24. Diagnoses included, pain in the right lower leg, alcohol abuse in remission, and stage 3 chronic kidney disease. An Admission Skin Observation Tool, dated 6/19/24, indicated the resident's had no skin issues. An admission Minimum Data Set assessment, dated 6/27/24, indicated the resident was cognitively intact. She lacked any rejection of care behaviors. The resident was dependent on staff assistance for bathing, lower body dressing, transfers, and putting on and taking off footwear. She required substantial assistance for toileting		for risk of pressure ulcers and to develop and implement interventions to prevent the development of pressure ulcers when risk is identified. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice. a. Resident #31 record has been reviewed. The plan of care was reviewed and updated as needed including interventions. The weekly skin assessments are complete with measurements. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. All residents have the potential to be affected by the alleged deficiency. b. An audit of residents who are at risk for development of pressure ulcers has been completed. The weekly skin assessments are completed. The braden skin assessments are completed per policy. No further issues identified. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. The License nurses have been educated on 10/17/2024 regarding	

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	and rolling left and right. The resident was at risk for pressure ulcers and did not have any pressure ulcers or other skin concerns. Skin treatments included a pressure reducing device for the bed. A current physician's order, dated 6/25/24, included to complete skin assessments on days shift every Tuesday. The clinical record lacked an admission Braden Scale For Predicting Pressure Sore Risk. The first Braden Scale For Predicting Pressure Sore Risk was dated 8/7/24, seven weeks after admission, and indicated the resident was at risk for developing pressure injuries. A Nurse Practitioner's wound evaluation, dated 7/2/24 at 7:09 a.m., indicated the resident's left and right heel deep tissues injuries were first visualized on this date. The left heel was with deep purple discoloration that measured 1.0 centimeter (cm) length (L) by 1.0 cm width (W), circular shape, and skin intact. The right heel was with deep purple discoloration that measured 1.0 cm L x 2.5 cm W, more linear in shape and skin intact. A current physician's order, dated 7/2/24, included apply skin preparation wipes to bilateral heels topically three times a day for deep tissue injuries, float heels while in bed, turn frequently, and a low air loss bed was recommended. A care plan, initiated on 7/3/24, indicated the resident had an activity of daily living self-care performance deficit including eating, bed mobility, transfers, and toileting. Interventions included, assist as indicated with bed mobility (7/3/24) and extensive assistance of one staff was indicated for eating (7/3/24).		Pressure Ulcer/Wound Care which includes weekly skin assessments with measurements, and interventions. b. RD to review the identified residents with identified skin concerns to identify supplement intervention. c. Director of Nursing and/or Designee will complete a chart review after admission to ensure any identified skin issues. Any new identified areas will be addressed per the policy. Physician will be notified for new orders. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur. a. The Director of Nursing and/or Designee will complete an audit tool to ensure compliance of the wound care program. This audit will be completed upon a new admission, then weekly x4 weeks, then monthly x3 months. Any identified issues will be immediately addressed, and education provided as needed. The outcomes will be reviewed through the facility quality assurance program. Monitoring will continue as planned or will be increased by the quality assurance committee, if needed, to obtain 100% compliance. Additional action will be taken by the quality assurance committee if warrantedd, based on the outcome	

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	A current care plan, initiated on 7/15/24, indicated the resident had episodes of refusing boots to her feet and removed the boots after they were placed on the resident's feet. Interventions included, attempt to place the boots on each time care is provided (7/19/24) and explain the importance of care (7/15/24). A care plan, initiated on 8/7/24, indicated the resident was at risk for pressure ulcers related to required assistance with bed mobility and incontinence. Interventions included, administer treatments as ordered and monitor for effectiveness (8/7/24) and monitor nutritional status (8/7/24). A current physician's order, dated 8/30/24, included place the pressure relief boots on the resident's feet at all times, except when bathing. The clinical record lacked weekly skin assessments of the bilateral heel wounds to include a description and measurements of each wound on 9/5/24 and 9/19/24. A Nurse Practitioner's wound evaluation, dated 9/24/24 at 12:19 p.m., indicated the resident's left heel wound was with purple localized discoloration and measured 2 cm L x 2 cm W, with intact skin. The left heel wound etiology was deep tissue. The right heel wound was with purple localized discoloration and measured 5 cm L by 7 cm W, with intact skin. A current physician's order, dated 9/25/24, included administer a protein supplement mixed with applesauce/juice/water every day in the morning for wounds.		of the tools.	

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	Review of the Resident Matrix, provided by the Administrator on 9/22/24 at 3:20 p.m., indicated the resident had an unstageable pressure ulcer (a full-thickness skin and tissue loss where the stage of the injury is uncertain because the base of the wound is covered by dead tissue). During an observation on 9/26/24 at 8:38 a.m., the resident was in bed asleep on her back. Her legs were bent at the knee and feet were covered with a sheet. During an interview on 9/26/24 at 9:41 a.m., the DON indicated Resident 31 did not have any skin impairment on admission. Some of the weekly skin assessments lacked measurements and descriptions. She was unable to locate additional weekly wound assessments in the clinical record. During an observation on 9/26/24 at 11:38 a.m., Resident 31 was in the dining room, seated in a wheelchair at the table. She wore non-skid socks. Pressure relief boots were not in place. During an observation on 9/26/24 at 2:30 p.m., Resident 31 was in bed on her back with her knees bent and her eyes open. Her feet were covered with a blanket. During an interview on 9/26/24 at 2:51 p.m., RN 10 indicated a Braden Scale risk assessment should have been completed on admission to the facility. The resident's risk for pressure ulcers was a guide to determine what pressure ulcer prevention interventions were implemented. During an interview on 9/26/24 at 3:47 p.m., Resident 31 indicated she did not have any wounds when she admitted to the facility. She was unable to turn herself in bed and required			

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	assistance from staff for repositioning. She did not have pressure relief boots on her feet. During the interview, CNA 22 entered the residents room and brought a pair of pressure relief boots. The CNA indicated the DON had requested she bring them to the resident. During a wound observation on 9/26/24 from 3:49 p.m. to 3:57 p.m., accompanied by the DON, Resident 31 was on her back in bed with one pillow under her calves, and her knees bent. Due to her legs being bent at the knee, the resident's heels were resting slightly against the bed. She did not have pressure relief boots in place. The DON demonstrated the right heel wound measured 5 cm L by 2.5 cm W, approximately the size of a quarter, and contained a dark maroon scab that covered the base of the wound. The edges were beginning to detach and wound depth was unable to be determined. The left heel wound measured 1.0 cm L by 1.0 cm W, approximately the size of a pencil-top eraser, and contained a dark maroon scab that covered the base of the wound. The depth was unable to be determined. During the observation, the DON indicated she believed the right heel was an unstageable pressure ulcer and the left heel was scabbed. After the skin protectant was applied to both heels, the area was allowed to dry, pressure relief boots were applied, and a pillow was placed back under the resident's calves. The resident did not resist the pressure relief boots during the observation. The resident was not offered to reposition in bed prior to staff leaving the resident's room. During an interview on 9/26/24 at 3:58 p.m., CNA 22 indicated Resident 31 required total assistance for med mobility and up to two-person assistance. The resident was cooperative with care. The CNA was unaware of any specific turn and reposition			

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	schedule for the resident. Resident 31 did not have pressure relief boots when she admitted and she was unaware of any pressure ulcer prevention interventions in place to prevent pressure ulcers. The pressure relief boots were added after she developed the pressure ulcers and the resident was non-compliant with the pressure relief boots. A current facility policy, dated 1/2023, titled "Pressure Ulcer/Wound Care," provided by the Infection Preventionist on 9/26/24 at 10:25 a.m., indicated the following: "Policy: ... It is the Policy... that each resident who enters the facility without pressure ulcers, does not develop pressure ulcers unless the individual's clinical condition demonstrates that they are unavoidable... Procedure: ... 12. Document resident's skin condition. If Pressure Ulcer is present, nurse will measure LxWxD [length by width by depth] and record stage, measurement, color, drainage, and odor on weekly basis or with any significant change... 14. Document preventative measures and equipment used... 15. Braden Scale skin assessment is completed upon: a. Admission, then weekly times 3...." 3.1-40(a)(1) 3.1-40(a)(2)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information Based on observation and interview, the facility failed to make nurse staffing information readily available in a readable format to residents and visitors daily for 3 of 3 days reviewed. Findings include: During an observation, on 9/22/24 at 10:14 a.m., no	F 0732	It is the practice of this facility to make nurse staffing information readily available in a readable format to residents and visitors daily. 1. What corrective actions will be accomplished for those residents	09/27/2024

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	direct care staffing numbers were posted. During an observation, on 9/23/24 at 10:52 a.m., no direct care staffing numbers were posted. During an observation, on 9/24/24 at 11:08 a.m., no direct care staffing numbers were posted. During an interview, on 9/24/24 at 12:34 p.m., the DON indicated the schedule book was kept at the nurse station, and this was used for staff posting. The schedule book contained the handwritten schedules for staff. During an interview, on 9/24/24 at 1:44 p.m., the Administrator indicated he was not sure what staff posting was missing. He referred to the schedule book as it listed the daily staff schedule, and the shift assigned. A current facility policy, revised 7/16, titled, "Posting Direct Care Daily Staffing Numbers", provided by the DON, on 9/24/24 at 2:39 p.m., indicated the following: " ...1. Within two (2) hours of the beginning of each shift, the number of Licensed Nurse's (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format ..."		found to be affected by the deficient practice. a. No residents were affected by the alleged deficient practice. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. No residents were affected by the alleged deficient practice. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. A new updated form was completed and placed in accessible area to residents and visitors on 09/23/2024. b. All staff that complete the "Daily Nurse Staffing Information" forms have been provided a revised form and provided education on the completion and accessibility to residents and visitors. c. Each morning, upon arrival to the facility, the Administrator and/or Designee will ensure that the current day's Nurse Staffing Information is completed. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur. a. Administrator and/or Designee will complete an audit tool to ensure compliance of posting. This audit tool will be completed	

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			once a week for the next three months. Any identified issues will be immediately addressed, and education provided as needed. The outcomes will be reviewed through the facility quality assurance program. Monitoring will continue as planned or will be increased by the quality assurance committee, if needed, to obtain 100% compliance. Additional action will be taken by the quality assurance committee if warranted, based on the outcomes of tools. All of these forms will be maintained in a binder after removal from the display case.	
F 0742 SS=D Bldg. 00	483.40(b)(1) Treatment/Srvcs Mental/Psychoscial Concerns Based on observation, interview, and record review, the facility failed to implement care plan interventions to de-escalate a resident experiencing a behavioral difficulty in a common area with peers for 1 of 4 residents reviewed for behavior management. (Resident 13) Findings include: Confidential interviews were conducted throughout the survey. During a 9/24/24 confidential interview, a resident indicated that Resident 13 was out of control the previous night. Resident 13 beat on walls, punched holes, and threw furniture. He threw furniture that almost hit people. The interviewed resident indicated they were scared.	F 0742	It is the practice of this facility to implement care plan interventions to de-escalate a resident experiencing a behavioral difficulty. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice. a. Resident #13 was transferred to Neuro Psych Hospital on 09/24/2024 for further treatment. b. The resident plan of care was reviewed and updated to reflect interventions as needed. c. Staff were educated on 10/09/2024 regarding the location of interventions for the resident along with documenting the	10/09/2024

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	Resident 13's record was reviewed on 9/24/24 at 2:20 p.m. Current diagnoses included schizophrenia, profound intellectual disability, generalized anxiety disorder, and borderline personality disorder. An 8/15/24, quarterly, Minimum Data Set (MDS) assessment indicated Resident 13 was severely cognitively impaired and had displayed both physical behavioral symptoms directed towards others and not directed towards others, four to six days of the assessment period. The resident had the following care plan problems/needs: I have behaviors not directed towards others as evidenced by placing self on floor, crawling on floor, pulling on hand railing making it become loose, threatening to throw self on the floor, exposing self, threatening to urinate on wall/floor, spitting, banging on walls, med carts, etc., initiated on 9/22/21 and revised on 9/24/24. Approaches to this problem included the following: Ensure that peers and others are giving him 'space' when he is placing his self on the floor to ensure safety of others until resident is able to be calmed or taken to a quite area, initiated on 3/27/24. Give resident space, initiated on 4/5/24. Offer to take resident to a quite area, initiated on 3/25/24. Resident 13 has behaviors of yelling out in common area, yelling that he was given the wrong medication, yelling for a doctor, for us to call Dr. [name], etc, initiated: 5/28/22 and revised on: 9/23/24. Approaches to this problem included: If in a common area/high activity area, please take me to my room to assist me. Staff will ensure that		interventions attempted. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. All residents have the potential to be affected by the alleged deficiency. b. An audit of residents that exhibit difficult behaviors in a common area has been completed and the plan of care updated with interventions. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. An in-service was completed on 10/09/2024 for all staff on challenging behaviors and location of interventions of residents on behavioral management programming. b. Behaviors will be reviewed during clinical meeting to ensure appropriate behavioral plan in place along with interventions. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur. a. The Interdisciplinary Team will review 5 residents' behavior care plans weekly for the next four weeks. Then reviews will be completed for 5 residents 1 time every 4 weeks for the next	

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	resident is given space when yelling out, initiated: 3/27/24. Resident 13 has self-injurious behaviors of placing/throwing self on floor, crawling on floor, laying in middle of halls, banging on walls, hitting at the floor and slapping his stomach, banging on hand rails, hitting elbow on wall, banging head on the floor, swinging bedside table in circles, tipping over tables and chairs, etc., initiated on 6/15/22 and revised on 9/24/24. Approaches to this problem included the following: Assist with removing peers from area, initiated on 9/24/24. Ensure that resident is given space when having behaviors, attempt to keep others away from resident until he can be taken to a quite area, or calmed down to ensure safety of others, initiated on 3/27/24. Try to assist resident to safe area, initiated on 6/11/23 and revised on 8/13/23. I have potential to be physically aggressive to others related to poor impulse, grab at others, or/and attempt to/or hit/bite at others, try to choke staff/place arm around staffs' necks, spit at staff, attempt to hit staff, poke his fingers in staff faces, bite others, tip over/toss chairs/tables, etc, incident with peer 3/23/24, initiated on 2/6/21 and revised on: 9/24/24. Approaches to this problem included when resident is agitated, attempt to assist resident to area away from peers, etc. A 9/22/24 at 2:39 p.m., Behavior Note indicated Resident 13 was upset after having a soda, he wanted staff to get him another soda, but he was a quarter short and staff was trying to find a quarter for him. He laid down on the floor, was slapping his stomach, hitting his head on the ground, yelling out,and slapping the floor. Staff found a quarter for him, and got him a soda, however the resident still kept putting himself on the ground		quarter. If compliance is maintained for the next 6 months, then reviews will be completed during admission, quarterly, significant change, or as needed. If discrepancies are noted, then immediate action will be taken to correct. Findings from review and any corrective actions will be discussed during quality assurance meetings and the current plan revised as warranted.	

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	15E064	A. BUILDING 00 B. WING	09/26/2024

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	and yelling. During an observation on 9/23/24 at 10:06 a.m., Resident 13 was seated at the table in the dining/activity area. He was interacting with his peers. A 9/23/24 at 2:47 p.m., Social Service Note indicated Resident 13 placed his self on the floor and was slapping his stomach and the floor, yelling out and hitting is head on the ground. The resident was upset when staff were looking for a quarter due to needing a quarter to get a pop out of the machine. After a quarter was found resident continued to yell out for several more minutes, then stopped. A 9/23/24 at 5:08 p.m. Behavior Note indicated, Resident 13 came out of his room and placed himself on the floor very slowly and began yelling for a doctor, staff unable to redirect resident. The resident made his way to the nursing carts, and began banging and hitting the med carts and yelling. No behavioral interventions attempted were indicated in the clinical record. A 9/23/24 at 10:00 p.m., Behavior Note indicated Resident 13 was pounding on the walls and the doors. The resident threw a table at another resident and then punched a hole in the wall. An injection of diphenhydramine was effective and the resident was calm so far the rest of the evening. A 9/24/24 at 6:49 a.m., Behavior Note indicated the resident began to bang on dining room table this morning before breakfast calling for a doctor, staff was unable to redirect resident for several			

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	minutes. resident eventually got up from the table and began walking the hallway. Will continue to monitor. A 9/24/24 at 7:53 a.m., Social Service Note indicated the previous evening, Resident 13 came out of his room, placed his self on the floor, started yelling out for an unknown doctor, screaming that he was given the wrong medication, etc. Staff asked resident if he would like something to eat and he stated that he wanted a peanut butter and mayonnaise sandwich. Staff got the resident the requested sandwich from the kitchen and resident allowed for staff to assist him with getting up and in the wheelchair while he ate. As soon as he finished the sandwich, the resident threw himself on the floor again and started to yell out. Staff was able to redirect resident and resident calmed down. After writer left, resident started having behaviors again of yelling out, banging and hitting the medication carts, lasting several minutes. The resident calmed down for a few minutes and then he started to pound on the walls, throwing a table and punched a hole in the wall. No peers were around resident at the time of behavior. Staff notified the psychiatric nurse practitioner and a new order was given for diphenhydramine 25 mg [an antihistamine which is also used for sleep] via intramuscular injection to be administered. PRN [as needed] administered and effective with no further behaviors. A new order was received to send the resident out for evaluation at psychiatric unit. A message was left for the resident's representative. No behavioral interventions attempted were indicated in the clinical record. A 9/24/24 at 10:34 a.m. Social Service Note indicated the resident had been accepted at a			

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	Neuro-Psych hospital where they would receive and evaluation and treatment. The resident was scheduled for transport at 8:45 p.m. A 9/24/24 at 10:36 a.m. Nurse's Note indicated the resident's behavior increased during the day of 9/23/24 and the Nurse Practitioner gave orders for the resident to be admitted to a psychiatric facility for evaluations and treatment. During an observation on 9/24/23 at 2:38 p.m., Resident 13 was walking in the hallway. During an interview on 9/24/24 at 3:53 p.m., RN 17 indicated she had obtained the order for diphenhydramine for Resident 13 the evening on 9/23/24. She was told the resident punched walls and doors. He put a hole in the wall. RN 17 witnessed him hit doors and walls. There were a lot of residents in the area. She herself did not attempt to remove the resident or his peers from the area. During an interview on 9/24/24 at 4:31 p.m., CNA 18 indicated she witnessed Resident 13 after he began his behavioral event on 9/23/24. As she entered the area, a resident stated he threw a table and almost hit them. An over bed table was on its side on the floor. Resident 13 was hitting walls. He hit the wall under the bay window and put a hole in it. There were four or more residents in the area. Some residents just sat and watched. One resident tried to get too close and was told to stay back. Resident 13 hit the walls, windows, and the door a number of times. CNA 18 did not attempt to remove Resident 13 or his peers from the area. During an observation an interview on 9/24/24 at 4:47 p.m., the Administrator indicated the security cameras, which were mounted on the walls to			

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	cover the dining area and lounge, were controlled by the corporate office. The corporate office had informed him the cameras were not working properly during the resident's behavioral episode. He was able to provide a single photo of the area, which was not completely visible due to a "stink bug" being on the lens. During an observation on 9/24/24 at 4:55 p.m., the Administrator moved medication and treatment carts from in front of the bay window in the lounge and displayed a patched area where the resident had put a hole the previous evening. During an interview on 9/25/24 at 4:02 p.m., the Social Services Director indicated the resident's care plan indicated staff should try to remove the resident or his peers when Resident 13 was having an explosive behavioral episode. A current, undated, facility policy, titled, "Care Strategies Behavior Management Program", which was provided by the DON on 9/26/24 at 1:59 p.m., indicated the following: "...The facility will treat, or make referrals to provide appropriate intervention in establishing a plan to treat for those residents identified as needing 'Behavioral Management'...." 3.1-43(a)(1)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility failed to ensure shift to shift narcotic count and reconciliation was completed for 2 of 2 carts reviewed for medication reconciliation. (West cart and East cart) Findings include:	F 0755	It is the practice of this facility to ensure shift to shift narcotic count and reconciliation is completed. 1. What corrective actions will be accomplished for those residents found to be affected by the	10/27/2024

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	1. During a medication storage observation of the West medication cart, on 9/22/24 at 11:21 a.m., accompanied by QMA 6, the "Narcotic Count Sheet" was reviewed and the following dates lacked shift to shift count and reconciliation signatures of controlled medications: a. August 2024- lacked a narcotic card count: 19th, 20th, 21st, 22nd, 23rd, 24th, 25th, 26th, 27th, 28th, 29th, 30th, and 31st. September 2024- lacked a narcotic card count: 1st, 2nd, 3rd, 6th, 8th, 9th, 10th, 14th, 15th, and 16th. b. August 2024- lacked shift-to-shift narcotic reconciliation signatures: 8/16: 10:00 p.m. - 6:00 a.m., 8/17: 10:00 p.m. - 2:00 a.m., 8/21: 6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 9:00 p.m., 8/25: 6:00 p.m. - 10:00 p.m. and 10:00 p.m. - 6:00 a.m., 8/27: 6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 10:00 p.m., 8/29: 6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 6:00 p.m., 8/31: 6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 6:00 p.m., September 2024- lacked shift-to- shift narcotic reconciliation signatures: 9/1: 6:00 a.m. - 2:00 p.m., 2:00 p.m. - 6:00 p.m., and 10:00 p.m. - 12:00 a.m., 9/5: 10:00 p.m. - 6:00 a.m., 9/11: 10:00 p.m. - 6:00 a.m., 9/14: 2:00 p.m. - 6:00 p.m. During an interview, at the time of the		deficient practice. a. There were no residents identified during the survey. b. Facility wide audit was conducted to determine narcotic count had been counted and coincided with narcotic count sheet. There are no discrepancies noted. c. The License Nurses and Q.M.A.'s were educated 09/27/2024 on the Controlled Substance policy which included shift to shift count. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. All residents have the potential to be affected by the alleged deficiency. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. The License Nurses and Q.M.A.'s was educated 09/27/2024 on the controlled substance policy which included shift to shift count. b. Director of Nursing and/or Designee will audit Narcotic count sheets three times weekly to determine the physical inventory sheet was completed by oncoming and off going staff. Identified issues will be	

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	observation, QMA 6 indicated the narcotic count was completed when the medication cart was transferred from one employee to the next. 2. During a medication storage observation of the East medication cart, on 9/22/24 at 11:38 a.m., accompanied by QMA 5, the " Narcotic Count Sheet" was reviewed and the following dates lacked shift to shift count and reconciliation signatures of controlled medications: a. August 2024- lacked a narcotic card count: 25th, 27th, 29th, 31st. September 2024- lacked a narcotic card count: 1st, 4th, 5th, 6th, 7th, 8th, 12th, 13th, 14th b. August 2024- lacked shift-to-shift narcotic reconciliation signatures: 8/13: 10:00 p.m. - 6:00 a.m., 8/15: 6:00 a.m. - 2:00 p.m. and 10:00 p.m. - 6:00 a.m., 8/23: 10:00 p.m. - 6:00 a.m., 8/25: 6:00 a.m. - 2:00 p.m. and 10:00 p.m. - 6:00 a.m. September 2024- lacked shift-to-shift narcotic reconciliation signatures: 9/1: 6:00 a.m. - 2:00 p.m., 9/3: 10:00 p.m. - 6:00 a.m., 9/8: 6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 6:00 p.m., 9/9: 6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 6:00 p.m., 9/11: 6:00 p.m. - 10:00 p.m. and 10:00 p.m. - 6:00 a.m., 9/12: 8:00 p.m. - 10:00 p.m., 9/14: 6:00 p.m. - 10:00 p.m. and 10:00 p.m. - 6:00 a.m., 9/15: 6:00 p.m. - 10:00 p.m. and 10:00 p.m. - 6:00		immediately addressed with re-education and or disciplinary action. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur. a. Director of Nursing and/or Designee will audit Narcotic count sheets three times weekly to determine the physical inventory sheet was completed by oncoming and of going staff. This audit tool will be completed 3 times a week for the next 4 weeks, then 2 times a week for the next 4 weeks, then 1 time a week for the next 4 weeks. Identified issues will be immediately addressed with re-education and or disciplinary action. The outcomes will be reviewed through the facility quality assurance program. Monitoring will continue as planned or will be increased by the quality assurance committee, if needed, to obtain 100% compliance. Additional action will be taken by the quality assurance committee if warranted, based on the outcomes of tool.	

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	a.m. During an interview, at the time of the observation, QMA 5 indicated the narcotic count sheet was completed by the oncoming nurse and the off going nurse at shift change. During an interview, on 9/22/24 at 1:58 p.m., the Director of Nursing (DON) indicated the expectation for staff was to complete the narcotic count sheet in full at the start and end of each shift. An undated, current facility policy, titled, "Controlled Substances", provided by the DON on 9/23/24 at 11:21 a.m., indicated the following: " ... At each shift change, a physical inventory of controlled medications, as defined by state regulation, is conducted by two licensed clinicians and is documented on an audit record ..." 3.1- 25(b)(3)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to appropriately date stored medications, discard expired insulin vials, and label medications with resident information in 2 of 2 medication carts observed for medication storage. (West cart and East cart) Findings include: 1. During a medication storage observation of the West medication cart, on 9/22/24 at 11:21 a.m., accompanied by QMA 6, the following was observed:	F 0761	It is the practice of this facility to appropriately date stored medications, discard expired insulin vials and label medications with resident information. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice. a. There were no residents identified during the survey. b. All medication carts have been	10/27/2024

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	a. One Levemir (insulin) vial with approximately 25 units remaining, with an open date of 8/12/24. b. Sixty-six (66) single packets of 4% lidocaine (topical anesthetic) patches without resident identifiers or manufacturer container information. During an interview, at the time of the observation, QMA 6 indicated she was not insulin certified and did not know how long insulin was good for. During an interview, at the time of the observation, the Director of Nursing (DON) indicated opened insulin was good for 30 days. 2. During a medication storage observation of the East medication cart, on 9/22/24 at 11:38 a.m., accompanied by QMA 5, the following was observed: One Humalog (insulin) Kwikpen with approximately 50 units remaining, lacked an open date. During an interview, at the time of the observation, QMA 5 indicated opened insulin was good for 28 days and should be dated when opened. During an interview, on 9/23/24 at 8:30 a.m., LPN 7 indicated the lidocaine patches in the bottom of the West medication cart were ordered from a medications supply company instead of from the pharmacy for each individual resident. LPN 7 indicated only two residents utilized the patches. During an interview, on 9/23/24 at 10:28 a.m., the DON indicated the lidocaine patches on the		inspected and insulin without a date has been processed through medication destruction policy. c. The medication without labels has been processed through the medication destruction policy. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. All residents have the potential to be affected by the alleged deficiency. b. An audit of the medication carts has been completed and no further issues identified. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. License Nurses and Q.M.A.'s has been educated 10/17/2024 regarding the insulin administration policy and the storage of medication policy. b. All new License Nurse and Q.M.A.'s will be educated during orientation. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur. a. Director of Nursing and/or Designee will audit the medication carts and mediation storage at random times. These audit findings will be documented. The	

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	bottom of the West medication cart were stock medications and are kept as a commonly used item in the facility. She indicated stock medications do not require resident identifiers. A current facility policy, revised 1/23, titled, "Insulin Administration-Use of Kwik Pen", provided by the DON, on 9/23/24 at 10:59 a.m., indicated the following: " ...Do not use the pen past the expiration date or more than 28 days after first opening ..." A current facility policy, revised 11/20, titled, "Storage of Medications", provided by the DON, on 9/23/24 at 10:59 a.m., indicated the following: " ... Drugs and biological's are stored in the packaging, containers, or other dispensing systems in which they are received ..." A current facility policy, revised 7/12, titled, "Medication Policies", provided by the DON, on 9/23/24 at 11:21 a.m., indicated the following: " ...Floor stock medications are kept in the original manufacture's containers with expiration date and lot number clearly visible." A current facility policy, revised 7/12, titled, "Provider Pharmacy Requirements", provided by the DON, on 9/23/24 at 1:22 p.m., indicated the following: " ...4. The provider pharmacy agrees to perform the following pharmaceutical services, including but not limited to: ...e. Labeling all medications in accordance with all state and federal regulations ....ii. All prescription medications have labels that show: 1. The generic and/or brand name of the product. 2. The strength and dosage form of the medication, including strength per ml of liquid medications, when appropriate. 3. The medication's expiration date. 4. The resident's name. 5. Specific directions for use.		audits will be completed weekly x2 weeks, bi-weekly x2 weeks, then monthly x1 month. If discrepancies are noted, then immediate action will be taken to correct. Findings from review and any corrective actions will be discussed during quality assurance meetings and the current plan revised as warranted.	

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	6. Prescriber's name. 7. Dispensing date. 8. Name, address, and telephone number of the dispensing pharmacy. 9. Identification of dispensing pharmacy. 10. Prescription number. 11. Quantity dispensed. 12. Precautionary labels indicating special storage requirements or procedures." 3.1-25(j) 3.1-25(k)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure refrigerators functioned at a level to maintain safe food temperatures. This deficient practice had the potential to impact 34 of 34 residents who resided in the facility. Findings include: During the initial kitchen tour on 9/22/24 at 9:50 a.m., the following concerns regarding food refrigeration were noted: The standard white, two-section, (freezer on top) refrigerator registered a temperature of 48 degrees Fahrenheit (F). Inside the refrigerator were multiple trays of pre-poured drinks (milk and juices) and blocks of sliced cheeses. During an interview at this time, Cook 13 indicated the refrigerator should register between 36 to 38 degrees F. He believed the door may have been left open too long during breakfast meal service. He would let the Dietary Manager know and keep and eye on the temperatures. Review of the "Refrigerator Temperature Logs"	F 0812	It is the practice of this facility to ensure refrigerators functioned at a level to maintain safe food temperatures. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice. a. There were no residents identified during the survey. b. The items in the refrigerator were disposed. c. The facility purchased a new refrigerator and new temp log put into place. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. All residents who receive meals in the facility have the potential to be affected. b. The dietary staff have been educated 09/27/2024 on the Food	10/27/2024

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	for September 2024 indicated the logs for the three refrigerator and/or freezer units in the facility kitchen had not been completed in multiple days. The white refrigerator and freezer had not had temperatures recorded since 9/18/24, resulting in four days with no documented temperatures. The silver freezer and silver refrigerator had not had any temperature recorded since 9/19/24 resulting in three days with no recorded temperatures. During an interview at this time, Cook 13 indicated the temperatures should be recorded daily. During an interview on 9/22/24 at 10:40 a.m., the Dietary Manager indicated she had been informed of the concerns with the white registered. She had turned up the thermostat. She believed the refrigerator had been open too long during the breakfast meal. The "Refrigerator Temperature Logs" for September 2024, provided by the Dietary Manager on 9/22/24 at 1:40 p.m., contained the following information: The white refrigerator log had 19 entries, all of which were recorded as 38 degrees F. There was no recorded variance in temperature at any time. The silver refrigerator log had 17 entries, all of which were recorded as 38 degrees F. There was no recorded variance in temperature at any time. The log did not contain guidance of acceptable temperature ranges. During an observation of lunch meal preparation on 9/25/24 at 11:20 a.m., the standard white, two-section (freezer on top) refrigerator registered a temperature of 50 degrees F. At this time, Cook		Receiving and Storage policy. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. The dietary staff have been educated 09/27/2024 on the Food Receiving and Storage policy. b. Dietary Manager and/or Designee will review temperature logs daily to ensure that the temperatures have been recorded and appropriate temperatures are maintained. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur. a. Dietary Manager and/or Designee will complete an audit tool to monitor the completion of the refrigerator temperature logs. This tool will be completed weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility quality assurance program. Monitoring will continue as planned or will be increased by the quality assurance committee if needed to obtain 100% compliance. Additional action will be taken by the quality assurance committee if warranted based on the outcome of tools.	

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	15E064	A. BUILDING 00 B. WING	09/26/2024

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	14 tested a small glass of orange juice that had been maintained in the white refrigerator. The orange juice registered at 57.6 degrees F. Inside the white refrigerator was two packages of deli ham, three blocks of sliced cheese, three trays of poured milk (approximately 60 glasses), one tray of orange juice glasses, and one tray of grape juice glasses. During an interview on 9/25/24 at 11:56 a.m., the Dietary Manager indicated she had not checked the refrigerator temperature of the white refrigerated since the identified concern on 9/22/24. She had relied on her dietary staff to accurately monitor and record the temperatures. They had indicated all the temperatures had been 40 degrees F or less. During a 9/26/24, 11:33 a.m., interview, Cook 13 indicated every facility resident ate meals prepared in the facility kitchen. A current, 2001, facility policy titled, "Food Receiving and Storage", which was received by the dietary manager on 9/25/24 at 3:09 p.m., indicated the following: "...Refrigerated foods must be stored below 41 [degree sign] F...." 3.1-21(i)(1)			
F 0865 SS=F Bldg. 00	483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(QAPI Prgm/Plan, Disclosure/Good Faith Attmpt Based on record review and interview, the facility failed to develop and implement approaches to maintain a Quality Assurance and Performance Improvement (QAPI) program to prevent repeat deficiencies. The deficient practice the the potential to impact 34 of 34 residents.	F 0865	It is the practice of this facility to develop and implement approaches to maintain a Quality Assurance and Performance Improvement (QAPI) program. 1. What corrective actions will be	10/22/2024

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	Findings include: Review of the Summary Statement of Deficiencies, for the facility's last annual recertification and licensure survey completed on 11/17/23, indicated the facility had deficiencies related to a lack of properly labeled medications and completed shift-to-shift narcotic reconciliation sheets. The plan of correction indicated, "Ongoing corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program to ensure ongoing compliance." During an interview on 9/26/24 at 4:53 p.m., the Administrator indicated he was unable to provide the facility's most recent QAPI plan because they did not have one. The facility needed a more formal process for QAPI, where minutes were part of the meetings. He did not have any record keeping of the minutes for the meetings that were held. He had reviewed the deficiencies from the last annual survey and was familiar with them. His major focus was on the environmental issues such as cleaning, remodeling, and pest control to ensure the resident's rooms were great for them. He had one audit tool to provide. Continued deficiencies in previous areas of concern indicated the QAPI Plan was ineffective. Review of an Assessment Audit Tool for "Pharmacy Services/Procedures/Pharmacist/Records" contained the following dates 7/31, 8/7, 8/14, 8/22, and 9/4. The year was excluded. The audit tool was signed by the Administrator dated 9/4/24. It lacked information regarding which medication or treatment cart was audited on the specific dates. Further information was not provided prior to facility exit on 9/26/24.		accomplished for those residents found to be affected by the deficient practice. a. Concerns identified through survey, audits, and observations will be presented to the next monthly QAPI Meeting for review. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. All residents have the potential to be affected. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. Interdisciplinary QAPI members will be in-serviced 10/22/2024 on facility QAPI procedure, reporting of concerns and trends identified through observations and audits, and action plans to be developed as indicated based on these findings. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur. a. Facility Administrator will review all QAPI reports monthly with the Interdisciplinary QAPI members to ensure all identified areas of concern trends noted through observation and audits are monitored and action plans implemented as identified.	

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	Review of a facility document, dated 2/22/22, titled "BROOKSIDE CARE STRATEGIES 2022 QAPI PLAN," provided by the Administrator on 9/22/24 at 4:30 p.m., indicated the following: "... RESPONSIBILITY AND ACCOUNTABILITY... The administrator has responsibility and is accountable to the facility and our corporation for ensuring that QAPI is implemented throughout our organization... HOW OUR FACILITY WILL CONDUCT PERFORMANCE IMPROVEMENT PROJECTS [PIPS]... Our facility will conduct Performance Improvement Projects that are designed to take a systemic approach to revise and improve care or services in areas that we identify as needing attention. We will conduct PIPS that will lead to changes and guide corrective actions in our systems... An important aspect of our PIPS is a plan to determine the effectiveness of our performance improvement activities and whether the improvement is sustained...." Cross reference F755 Cross reference F761 3.1-52(b)(2)		b. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The Quality Assurance Committee will identify any trends or patterns and make recommendations to revised the plan of correction as indicated.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on interview and record review, the facility failed to develop and implement an infection control program which enabled the facility to analyze patterns of known infectious symptoms, prevent the spread of infection, and/or develop programs to prevent recurrence. Findings include:	F 0880	It is the practice of this facility to develop and implement an infection control program which enables the facility analyze patterns of known infectious symptoms, prevent the spread of infection, and/or develop programs to prevent recurrence.	10/27/2024

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	A record review, on 9/24/24 at 10:20 a.m., of the Infection Control Binder, indicated the "Infection Log" and color coded mapping was completed utilizing the antibiotic "Order Listing Report". This report was not printed until 9/23/24 (after the start of the survey), at which point it was printed for the following months: March 2024, April 2024, May 2024, June 2024, July 2024, August 2024, and September 2024. The tracking log lacked indication of tracking and trending of resident infections prior to 9/23/24. During an interview, on 9/24/24 at 10:35 a.m., the Infection Preventionist (IP) indicated she had only been in this position since 9/11/24 and split her time between two different locations. She had printed out the antibiotic orders for the previous months on 9/23/24 and filled out the "Infection Log" pages and mapping based on these orders. She was not aware of whom was the IP before her. A current, undated, facility policy, titled, "Infection Prevention and Control Program Standards", provided by the Administrator, on 9/22/24 at 4:15 p.m., indicated the following: "... establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of disease and infection...The facility will investigate, control, and prevent infections by documenting and analyzing the occurrence of nosocomial infections, recommend corrective action, and review findings..." 3.1-18(a)		1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice. a. No residents were identified during the survey. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. All residents have the potential to be affected. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. The facility has new IP nurse started 09/11/2024. b. The new IP nurse has began the infection control log and color-coded mapping which will include trending. c. The infection control log will be reviewed weekly during clinical meetings. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur. a. Director of Nursing and/or Designee will complete an audit tool to monitor the completion of the log including trends. This tool will be completed weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be	

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			immediately addressed. The outcomes will be reviewed through the facility quality assurance program. Monitoring will continue as planned or will be increased by the quality assurance committee if needed to obtain 100% compliance. Additional action will be taken by the quality assurance committee if warranted based on the outcomes of tools.	
F 0917 SS=E Bldg. 00	483.10(i)(4), 483.90(e)(2)(3) Resident Room Bed/Furniture/Closet Based on observation and interview, the facility failed to ensure residents had safe, comfortable chairs in their rooms for resident use. This deficient practice had the potential to impact 34 of 34 of the facilities residents. Findings include: Confidential interviews were completed throughout the survey. 1. During a confidential interview, a resident indicated they would like a chair in their room. They sat on their bed or table. During an observation at that time, the resident sat on their bedside table. 2. During a confidential interview, a resident indicated would like a chair for guests. Visitors usually sit side by side with the resident on the bed. 3. During a confidential interview, a resident indicated it was hard to bring a chair from the dining room if you wanted to sit in a chair.	F 0917	It is the practice of this facility to ensure residents have safe, comfortable chairs in their rooms for resident use. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice. a. No residents were identified during the survey as stated were confidential interviews. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. All residents have the potential to be affected. b. Social Service completed interviews with residents and care planned along with documentation of the residents that have requested no chair.	10/27/2024

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	4. During a confidential interview, a resident indicated they would like a chair in their room. During random observation, the following resident rooms were observed to contain no chair: Resident room 1 on 9/22/24 at 9:56 a.m. Resident room 5 on 9/22/24 at 10:59 a.m. Resident room 7 on 9/22/24 at 11:46 a.m. Resident room 17 on 9/23/24 at 10:00 a.m. Resident room 21 on 9/23/24 at 10:18 a.m. Resident room 9 on 9/23/24 at 2:54 p.m. Resident room 11 on 9/23/24 at 2:55 p.m. Resident room 21 on 9/23/24 at 2:57 p.m. During an interview on 9/26/24 at 11:04 a.m., the Administrator indicated there was not enough room in resident rooms for a chair. He was not aware residents needed to be provided chairs in their rooms. The residents had not asked for a chair. During an interview on 9/26/24 at 3:19 p.m., the DON indicated the facility did not have a policy about furniture in resident rooms. 3.1-19(m)(4)		c. All other residents identified will have a sitting chair placed in the room. 3. What measures will be put in place and what systemic changes will be make to ensure that deficient practice does not recur. a. Upon a new admission, a chair will be placed in the room. b. During facility rounds, the management staff will ensure resident rooms have chairs in place. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur. a. Administrator and/or Designee will complete an audit to ensure chairs are in the resident rooms. This will be an ongoing audit. Any identified issues will be immediately addressed, and education provided as needed. The outcomes will be reviewed through the facility quality assurance program. Monitoring will continue as planned or will be increased by the quality assurance committee, if needed, to obtain 100% compliance. Additional action will be taken by the quality assurance committee if warranted, based on the outcome of the tools.	
F 0919 SS=F Bldg. 00	483.90(g)(1)(2) Resident Call System			

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	Based on observation, interview and record review, the facility failed to provide a fully functional call light system for all resident rooms and resident bathrooms. This deficient practice impacted 34 of 34 residents who resided in the facility. Findings Include: During random observations of the facility the following resident rooms were noted to have a hand bell or table top bells placed on tables, chest of drawers, and/or refrigerator tops: a. Resident room 1 on 9/22/24 at 9:56 a.m. b. Resident room 5 on 9/22/24 at 10:59 a.m. c. Resident room 7 on 9/22/24 at 11:46 a.m. d. Resident room 17 on 9/23/24 at 10:00 a.m. e. Resident room 21 on 9/23/24 at 10:18 a.m. f. Resident room 9 on 9/23/24 at 2:54 p.m. g. Resident room 11 on 9/23/24 at 2:55 p.m. h. Resident room 21 on 9/23/24 at 2:57 p.m. Confidential interviews were conducted during the course of the survey. During a confidential interview, a resident indicated the call lights have never worked since they moved in. They had never lived in a nursing home without call lights. The facility just give them a bell, which had been months ago. During a confidential interview, a resident indicated when they were in the restroom and needed help, they had to yell and hope their roommate or neighbor would get them help. During a confidential interview, a resident indicated the call lights didn't work. Residents were given a bell. The call lights hadn't worked in	F 0919	It is the practice of this facility to provide a fully functional call light system for all resident rooms and bathrooms. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice. a. All resident rooms and bathrooms have hand bells or a tabletop bell. b. Staff have been educated in the use of the hand bells or tabletop bells for the resident rooms and bathrooms. They will complete every 2-hour check and anticipate resident needs on any resident that is unable to utilize the call bell. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. All residents have the potential to be affected. b. Staff have been educated in the use of hand bells or tabletop bells for the resident rooms and bathrooms. They will complete every 2-hour check and anticipate resident needs on any resident that is unable to utilize the call bell. 3. What measures will be put in place and what systemic changes will be made to ensure that	10/27/2024

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	a long time- maybe four to six months. During a confidential interview, a resident indicated the call light system had been inoperable since they came to the facility. The residents had been provided manual bells. It was difficult to determine which room it came from when a manual bell rang. Resident C was physically unable to ring the manual bell that was provided. The resident summoned assistance by yelling out and was known to use a personal telephone to call the facility at times when assistance was needed. During a confidential interview, an employee indicated the call light system had not been working for at least four to five months. Management was aware and had issued manual bells. It was very difficult to distinguish who needed assistance where when a bell rang without a light indicator. Resident C was not physically able to use a manual hand bell that was provided due to impaired mobility of the upper extremities. During a confidential interview, an employee indicated the whole call light system had been down at least a couple of months. Resident C had successfully used the call light system to summon assistance before it quit working. The resident had not been able to utilize the provided manual bell since the call light system broke. When the resident attempted to use the manual bell, the bell was just knocked over due to limited mobility. The resident yelled out, and at times, called the facility with a personal telephone when staff assistance was needed. During a confidential employee interview at the time of observation, a call light cord outlet in a resident's room, lacked a call light cord. A manual		deficient practice does not recur. a. The call light system was placed out of service by contracted vendor 09/05/2024 at which time the resident were given hand bells or tabletop bells. b. The facility has contacted vendor (Circuit Masters) and they have diagnosis a blown transformer. The vendor has ordered the part and once received will install. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur. a. Maintenance Director and/or Designee will complete preventative maintenance log once the system repaired for monthly inspection of the call light system. This will be an ongoing audit. Any identified issues will be immediately addressed, and education provided as needed. The outcomes will be reviewed through the facility quality assurance program. Monitoring will continue as planned or will be increased by the quality assurance committee, if needed, to obtain 100% compliance. Additional action will be taken by the quality assurance committee if warranted, based on the outcome of the tools.	

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	bell was on top of the dresser and out of reach. The call lights had not been working for approximately two months. Management was aware and had provided manual bells to the residents. Due to physical limitations, one resident was unable to ring a manual bell. As a result, the resident yelled out until assistance came or used a personal telephone to call the facility. The resident had previously been able to summon assistance by use of the call light system before it quit working. It took longer for staff to respond to the residents' needs since the call light system quit working. During an interview on 9/24/24 at 4:50 p.m., the Administrator indicated the call light system had been down for a short while. All residents had manual bells. The facility was taking bids and had not yet signed a contract for the systems replacement or repair. During an interview on 9/25/24 at 10:13 a.m., the Maintenance Director indicated the facility was informed the system was total down and needed replaced on September 5, 2024. A current facility policy, revised on 1/2023, titled "Policy and Procedure: Call Light," provided by the DON on 9/26/24 at 3:19 p.m., indicated the following: "Policy: To see that residents are provided access to a call light... Purpose: To set guidelines to ensure that staff respond promptly to resident's call for assistance and ensure that the call system is in proper working order... Procedure: 1. All facility personnel must be aware if [sic] call lights at all times...." 3.1-19(u)(1) 3.1-19(u)(2)			