STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00349986, IN00350707, IN00351155, IN00351305, IN00351611, IN00351853 and IN00351920. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00349986 - Substantiated. Federal/State deficiencies related to the allegations are cited at F550, F687, F690, F692 and F842. Complaint IN00350707 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00351155 - Substantiated. Federal/State deficiencies related to the allegations are cited at F554, F725 and F732. Complaint IN00351305 - Substantiated. Federal/State deficiencies related to the allegations are cited at F554, F687, F725, F732 and F842. Complaint IN00351611 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00351853 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00351920 - Substantiated. Federal/State deficiences related to the allegations were cited at F725, F732 and F842. Survey dates: April 26, 27, 28, 29, 30 and May 3, 2021. Facility number: 012548	F 0000	The Plan of Correction is the center's credible allegation of compliance. Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. The facility respectfully requests a desk review for this plan of correction.	

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

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	Provider number: 155790 AIM number: 201023760 Census Bed Type: SNF/NF: 85 Total: 85 Census Payor Type: Medicare: 14 Medicaid: 50 Other: 21 Total: 85 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on May 7, 2021.			
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and			

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	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 treat 1 of 2 residents reviewed with impaired hearing and 1 randomly observed resident with a urinary catheter with respect and dignity. (Resident L and Q) Findings include: 1. During an observation, on 4/28/21 from 10:00 a.m. to 10:40 a.m., Registered Nurse (RN) 1 asked Resident L if he had pain. He indicated he did. RN 1 told him she already gave him a pain pill and she would be performing wound care. She did not ask permission. The RN asked the resident to roll over to his right side, facing away from her and to hold onto the grab bar. The resident had difficulty hearing the RN, the RN did not attempt to make eye contact or speak louder and then rolled him to his side. She removed his bed linens and opened	F 0550	1. Resident L and Q were not harmed. Resident L refused audiology services. Resident Q was provided a privacy bag for the catheter bag. 2. An audit was completed to validate all residents with an indwelling catheter have a privacy/dignity bag for the catheter drainage bag. All residents with a hearing impairment have been offered audiology services. 3. All staff have been educated on respect and dignity when communicating with residents that have a hearing impairment and privacy/dignity bags for catheter drainage bags. 4. The DNS/designee will	06/02/2021

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	his brief. The resident was incontinent of bowel. The RN asked if he was finished, but he did not verbalize understanding or reply. With the resident's back turned to her, the RN told the resident she was going to get help and it was going to be a little while. The resident looked straight ahead and did not acknowledge understanding. At 10:15 a.m., the RN left the room with the resident exposed from the waist down, both front and back, still holding onto the grab bar. After the RN left the room, the resident indicated he did not understand what she said and asked why she was gone for so long. The resident was still exposed and holding onto the grab bar when she returned five minutes later. He indicated his arm was sore. When the RN told the resident she was removing his dressing to his coccyx, his face was away from her and she did not confirm he understood. The RN did not attempt to engage the resident in conversation during the 40 minutes of care. Resident L's medical record was reviewed on 4/30/21 at 4:18 p.m. Diagnoses included, but were not limited to, encephalopathy (brain disease), type 2 diabetes mellitus and major depressive disorder. Resident L's quarterly Minimum Data Set (MDS) assessment, dated 1/26/21, reflected he had no cognitive impairment, no hallucinations or delusions and no behavior symptoms. It indicated his hearing was adequate and he did not have hearing aid(s). Resident L's care plan, initiated on 4/28/21, reflected he was at risk for impaired communication related to "HOH" (heard of hearing). Interventions included allowing adequate time for the resident's response and		audit all residents with an indwelling catheter three times a week for 8 weeks to validate each resident has a privacy/dignity bag covering the catheter drainage bag and the catheter bag is positioned off the floor. SS/designee will interview residents with a hearing impairment once weekly for 8 weeks to validate communication is delivered effectively and with dignity and respect. All findings will be reported to the QAPI committee monthly and the QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	incorporating visual prompting, cues or gestures. During an interview, on 4/28/21 at 1:00 p.m., Resident L indicated he had difficulty hearing the staff. They did not try to make sure he understood them. It was frustrating and made him feel like "a second-rate citizen." During an interview, on 4/30/21 at 10:09 a.m., Social Worker (SW) 2 indicated Resident L refused audiology services. They discussed hearing aids with him and he was not interested in them. 2. During an observation, on 4/28/21 at 9:50 a.m., Resident Q was in a wheelchair being escorted into his room from the common area by an unidentified staff member. His urinary catheter drainage bag was touching the floor under his wheelchair and was not in a privacy bag. Dark yellow urine was visible inside the bag. There were six residents in the common area, and Resident Q's roommate was lying in bed, within eye site of the drainage bag. Qualified Medication Aide (QMA) 3 entered the room and indicated the bag should be off the floor and "he needs a bag." Resident Q's medical record was reviewed on 05/03/21 at 12:30 p.m. Diagnoses included, but were not limited to, Parkinson's disease, acute kidney failure, hydronephrosis (excess fluid in a kidney due to a backup of urine), neuromuscular dysfunction of the bladder and acute pyelonephritis (inflammation of the kidney due to a urinary tract infection). Resident Q's quarterly MDS assessment, dated 4/08/21, indicated he had moderately impaired cognitive status, required extensive assistance by one to two people for activities of daily living and			

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	had an indwelling urinary catheter. During an interview, on 04/28/21 at 9:50 a.m., Resident Q indicated he did not know what a privacy bag was. He just had whatever the doctor gave him. A current facility policy, titled "Catheter Drainage Bag and Tube Maintenance," dated 4/20/17 and provided by the Executive Director on 4/29/21, reflected "...Definitions...Privacy bag/covered bag: an outer covering made from cloth or disposable materials that provides for dignity for the resident and prevents the spreading of infection ..."Procedure...g. Drainage bags will be covered when the resident is out of the room for dignity and infection prevention purposes...." The Federal Tag relates to Complaint IN00349986. 3.1-3(t)			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview and record review, the facility failed to determine it was safe for 1 randomly observed resident to self-administer medications. (Resident O) Finding includes: During an observation with the Regional Nurse Director (RND), on 4/26/21 at 9:15 p.m., Resident O was lying in bed with the bedside table in front of her. No staff members were in the room with the resident. Ten pills were sitting on top of the	F 0554	1. Resident O was not harmed. Resident O took her medications at 10:00PM. 2. All residents requesting to self-administer medications have been assessed and an order obtained from the physician to self-administer medications. 3. All Nursing staff have been educated on the self –administration of medication policy and procedure.	06/02/2021

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	bedside table in a pill dispenser cup. The resident indicated the nurse left them for her to take because she did not take her pills until 10:00 p.m. The RND encouraged her to take them in front of her, but the resident refused to take them until 10:00 p.m. During an interview, on 04/26/21 at 9:15 p.m., the RND indicated there were ten pills in the dispenser cup. Pills should not be left at the bedside for the resident to self-administer. During an observation and interview, on 04/26/21 at 9:15 p.m., Qualified Medication Aide (QMA) 4 was standing next to her medication cart in the common area. The QMA indicated she left the pills at Resident O's bedside. She did not think the resident had orders to self-administer medications. Resident O's medical record was reviewed on 4/27/21 at 12:00 p.m. Diagnoses included, but were not limited to, depressive episodes, anxiety disorder, gastroesophageal reflux disease (GERD), hypertension, hyperlipidemia (high cholesterol) and constipation. Resident O's quarterly minimum data set (MDS) assessment, dated 3/17/21, reflected she had moderately impaired cognitive status. She required setup by one staff member for eating. Review of Resident O's orders, on 4/27/21, reflected no orders to self-administer medications. Resident O's Medication Administration Record, dated May 2021, reflected the following medications were scheduled for bedtime (8:00 p.m.). 1, 40 milligrams (mg) tablet of atorvastatin calcium		4. The DON/Designee will monitor residents 3 times a week for 8 weeks to validate medications are administered as ordered. All findings will be reported to the QAPI committee monthly and the QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	to treat high cholesterol; 1, 25 mg tablet of metroprolol succinate extended release to treat hypertension; 1, 75 mg tablet of clopidogrel (Plavix), blood thinner for a history of cerebral vascular accident (stroke); 2, 8.6 mg tablets of Senna-Tabs for constipation; 1, 40 mg tablet of pantoprazole delayed release, proton pump inhibitor to treat GERD; 1, 100 mg tablet of Colace stool softener for constipation; and 1, 300 mg tablet of absenting to treat nerve pain. Resident O's care plan, revised on 10/06/20, indicated she had impaired visual function and wore glasses as tolerated, refused care at times and had paranoid delusions. It did not reflect she could self-administer medications. During an interview, on 5/3/21 at 4:00 p.m., the RND indicated before a resident could self-administer medications the resident had to be assessed and the physician had to write an order. Resident O was not previously evaluated for whether it was safe for her to self-administer her medications and did not have a physician's order to do so. They spoke to her physician on 4/27/21 after the medications were found at her bedside on 4/26/21. Her physician did not think it was appropriate for her. A current facility policy, titled "Resident Self-Administration of Medications," dated 8/01/16 and provided by the Regional Nurse Director on 5/03/21 at 3:00 p.m., reflected "...Procedure: 1. a. Resident may not self-administer medication until the assessment is completed by the IDT [interdisciplinary team] and determined to be safe to do so ...c. Physician/Provider order is required for residents			

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	to self-administer medication...3. IDT team will assess for safety of self-administering of medication including the following: a. cognitive functioning; physical ability (open packages, obtain cup and water etc.); c. emotional ability...." A current facility policy, titled "Medication Administration," dated 4/20/17 and provided by the Executive Director on 4/29/21 at 9:00 a.m., reflected "...b. Resident Safety...vi. Do not leave medication at bedside...." This Federal Tag relates to Complaint IN00351305 and IN00351155. 3.1-11(a)			
F 0687 SS=E Bldg. 00	483.25(b)(2)(i)(ii) Foot Care §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. Based on observation, interview and record review, the facility failed to provide proper nail care to the feet for 5 of 5 residents whose toenails were observed (Residents L, M, N, O and R). Findings include: During an interview, on 4/30/21 at 10:09 a.m., the	F 0687	1. Residents L, M, N, O and R received foot care and were not harmed. 2. An audit was completed of all residents to determine who needed foot care and foot care was provided and/or the resident was placed on the list for a	06/02/2021

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	Regional Nurse Director (RND) indicated residents were offered ancillary services at admission, including the services of a podiatrist. If they declined to be treated by the podiatrist, Certified Nurse Aides (CNA) were responsible for toenail care after first consulting the nurse. The nurse decided whether a CNA could perform nail care based on the resident's health status, such as circulation, diabetes or the condition of the nails. The CNAs were expected to perform nail care during showers. The CNAs did not chart whether they performed nail care, only they completed the shower. There was no tool to communicate to the CNAs how much assistance a resident required for toenail care; CNAs were expected to communicate with the nurse. 1. During an observation, on 4/26/21 at 8:34 p.m., Resident L was lying in bed. There were areas with dry, thick leathery tissue (necrosis) on the top of his right foot and the fourth toe on his right foot. There was also a necrotic area on the first and second toe of his left foot and a bandage on his left heel. His toenails were long and jagged. Resident L's medical record was reviewed on 4/30/21 at 4:18 p.m. Diagnoses included, but were not limited to, encephalopathy (brain disease), type 2 diabetes mellitus and heart disease. Resident L's quarterly Minimum Data Set (MDS) assessment, dated 1/26/21, reflected he had no cognitive impairment. He required extensive assistance by one person for personal hygiene and total dependence by one person for bathing. Resident L's care plan, revised on 01/06/21, reflected he had activities of daily living (ADL) self-care performance deficit related to coronary artery disease, hypertension, diabetes,		podiatrist evaluation. 3. All nursing staff and social services have been educated on foot care. 4. The DNS/Designee will audit new admissions and 5 residents weekly for 8 weeks to validate foot care is provided and any resident requiring podiatry services is scheduled to be evaluated by the podiatrist. All findings will be reported to the QAPI committee monthly and the QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	hypothyroidism, depression and respiratory failure with shortness of breath while lying flat. It did not address personal hygiene, bathing or nail care. During an interview, on 4/30/21 at 10:09 am., the RND indicated Resident L had bad circulation as evidenced by multiple wounds on his feet, so the nurse made the decision the CNAs could not trim his toenails. During an interview, on 4/30/21 at 10:009 a.m., Social Worker (SW) 2 indicated Resident L did not consent to be treated by the podiatrist. Because of his circulation issues, the facility did not trim his toenails unless long nails created a walking or balance issue. He consented to see the podiatrist on 4/27/21 and was seen on 4/28/21. Resident L's "Vendor Consultation Consent (Ancillary Services or Insurance Plan Enrollment Consent), dated 4/27/21, indicated he consented for the facility contracted ancillary services, including podiatry. Resident L's Visit Note, dated 4/28/21, indicated a Doctor of Podiatry Medicine (DPM) examined the resident on 4/28/21. The resident complained of painful nails to both feet. His nails were thick, friable, dystrophic (calcified), discolored and tender to touch. The DPM trimmed and ground the toenails to decrease thickness and alleviate pain. 2. During an observation and interview, on 4/26/21 at 8:57 p.m., Resident M was lying in bed. He indicated he had a blister on his left foot and "they're taking care of it." His toenails were long, thick and sharp. He indicated he was supposed to see a podiatrist, but it had been a while.			

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	Resident M's medical record was reviewed on 4/29/21 at 3:38 p.m. Diagnoses included, but were not limited to, paraplegia and osteomyelitis (inflammation of the bone caused by infection). Resident M's quarterly MDS assessment, dated 4/23/21, indicated he had no cognitive impairment. He required extensive assistance by two people for personal hygiene and total dependence on two people for bathing. Resident M's care plan, revised on 3/01/21, reflected he had an ADL self-care performance deficit related to paraplegia. He required staff participation with bathing and preferred bed baths during the day three times a week. The care plan did not address nail care. During an interview, on 4/30/21 at 10:09 a.m., the RND indicated Resident M had circulatory issues as evidenced by healing wounds, and he was not medically stable, so his nail care had to be performed by a podiatrist. During an interview, on 4/30/21 at 10:09 a.m., SW 2 indicated Resident M was on the schedule to see the podiatrist on 2/21/01 but was unable to due to COVID-19 precautions. The podiatrist only came every 62 days, so the last time he was treated by the podiatrist was 10/29/20. He was treated by the podiatrist on 4/28/21. Resident M's Visit Note, dated 10/29/20, indicated the resident complained of painful nails on both feet. His nails were thick, friable, dystrophic, discovered and tender to slight touch. The resident had "extremely dry and flaky skin." The DPM applied lotion to his toes and feet, clipped and ground his toenails to alleviate pain, and			

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	established the next visit in 62 days. Resident M's Visit Note, dated 2/25/21, indicated the DPM was unable to attempt services because the resident was in a yellow (quarantined) zone. The next established visit was in 62 days. Resident M's Visit Note, dated 4/28/21, reflected a DPM examined the resident on 4/28/21. "Nails are noted to be thick, friable, dystrophic [calcified], discolored...The DPM trimmed and ground the nails "to decrease thickness and alleviate pain," and "educated patient on the need for routine foot care to avoid complications associated with feet." 3. During an observation and interview, on 04/26/21 at 9:05 p.m., Resident N was lying in bed. Her toenails were long and sharp and had scants amount of chipped red nail polish. Resident N indicated her toenails were a mess and she was embarrassed by them, "I need them cut." The skin on her feet was dry and flaky. Resident N's medical record was reviewed on 4/30/21 at 4:00 p.m. Diagnoses included, but were not limited to, morbid obesity, arthritis and major depressive disorder. Her diagnoses did not include diabetes. Resident N's quarterly MDS assessment, dated 2/14/21, reflected she had no cognitive impairment. She required extensive assistance by two people for personal hygiene and total dependence by two people for bathing. Resident N's care plan, revised on 10/06/20, reflected she had an ADL self-care deficit related to weakness, limited range of motion, obesity and recent hospitalization. She required staff participation for personal hygiene and bathing.			

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	She preferred bed baths three times a week. The care plan did not address nail care. Resident N's Vendor Consultation Consent, dated 1/10/20, indicated she refused consent for the facility contracted ancillary services provider consultation(s), including podiatry. Resident N's "General Healthcare Services Consent," dated 4/28/21, indicated she requested podiatry services on 4/28/21. During an interview, on 4/30/21 at 10:09 a.m., SW 2 indicated Resident N declined to sign consent for podiatrist services on 1/10/20. She signed the consent on 4/28/21 and was seen by podiatry 4/28/21. The activities department did her nails at times if she was not on isolation precautions related to COVID. During an interview, on 04/30/21 at 12:13 p.m., Resident N indicated she had been a resident at the facility for one and a half years and no one had trimmed her toenails. She asked multiple times to be put on the list for podiatry. They said she could sign a form, but they never gave it to her. She was so embarrassed of her feet she would tuck them under her sheets. "I was so ashamed." She tried to do it herself, but because of her weight and a hernia, she could not bend down to her feet. Podiatry came and trimmed her toes on 4/28/21, and a friend painted them for her. The podiatrist told her, she was now on the list and she would be on the list for future visits. Resident N's Visit form, dated 4/28/21, indicated a DPM examined the resident on 4/28/21. The resident complained of painful toenails on both feet. "She was so happy to have us and said it has been forever since having her nails trimmed." Her			

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	nails were noted to be thick, friable, dystrophic, discolored and tender to touch. The nails were trimmed and ground to decrease thickness and alleviate pain. 4. During an observation, on 04/26/21 at 9:10 p.m., Resident O was lying in bed. Her toenails were long and sharp. Resident O's medical record was reviewed on 4/27/21 at 12:00 p.m. Diagnoses included, but were not limited to, transfer myelitis (inflammation of both sides of one section of the spinal cord), muscle weakness and neuralgia (nerve pain). Her diagnosis did not include diabetes. Resident O's quarterly minimum data set (MDS) assessment, dated 3/17/21, reflected she had moderately impaired cognitive status. She required extensive assistance by one person for personal hygiene and total dependence for one person for bathing. Resident O's care plan, revised on 10/06/20, reflected she had an ADL self-care performance deficit related to activity intolerance. She required staff participation with bathing and preferred a shower in the evening three times weekly. She also required staff participation with personal hygiene and oral care. The care plan did not address nail care. During an interview, on 4/30/21 at 10:09 a.m., SW 2 indicated Resident O was seen by the podiatrist on 4/28/21. Prior to 4/28/21, she was most recently treated by the podiatrist on 2/25/21. Resident O's Visit Notes, dated 4/28/21, 2/25/21 and 10/29/20, indicated the DPM examined and treated the resident on those dates. The resident			

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	complained of painful nails to both feet. Her 1st and 5th nails were thick, friable, dystrophic, discolored, and tender to touch. "Nails were noted to be long and dystrophic 2, 3, 4 right and 2, 3, 4 left." The skin on both feet were dry and scaly. The DPM applied lotion to her toes and feet and ground and trimmed the nails to decrease thickness and alleviate pain. 5. During an observation and interview, 4/29/21 at 9:05 a.m., Resident R had long, yellow and sharp toenails. He indicated someone trimmed his toenails for him, but "it's been a while." Resident R's medical record was reviewed on 5/3/21 at 2:00 p.m. Diagnoses included, but were not limited to, cerebral infarction (stroke), hemiplegia and hemiparesis (paralysis). His diagnoses did not include diabetes. Resident R's quarterly MDS assessment, dated 1/01/21, reflected he had no cognitive impairment. He required extensive assistance by one person for personal hygiene and total dependence by one person for bathing. He had impaired range of motion on both upper and lower extremities. Resident R's care plan, revised on 10/07/20, reflected he had an ADL self-care performance deficit related to left hemiplegia, impaired balance and limited mobility related to a cerebral vascular accident. He required staff participation with bathing. The care plan did not address personal hygiene or nail care. Resident R's "Vendor Consultation Consent (Ancillary Services or Insurance Plan Enrollment Consent), dated 5/29/20, indicated he refused consent for the facility contracted ancillary services provider consultation and "will instead			

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	make my family and facility care providers aware of my ancillary service provider(s) of choice." During an interview, on 4/30/21 at 10:009 a.m., SW 2 indicated Resident R declined to sign consent for podiatry services on 5/29/20. He was hemiplegic and had stroke, so he had some vascular issues that would put him at risk. CNAs were expected to ask his nurses and him if they could trim his toenails. During an interview, on 4/29/21 at 1:18 p.m., an anonymous CNA indicated there were not enough CNAs on the units. When asked what she was not able to do because she did not have time, she stated, "we don't do nail care." During an interview, on 4/30/21 at 2:00 p.m., a second anonymous CNA indicated she could only trim residents' nails on her slow days. There was no record, e.g., assignment sheet, of which residents' toenails she could trim and no place to document nail care was performed. A current facility policy, titled "Nail and Hair Hygiene Services," dated 4/14/17 and provided by the RND on 4/29/21 at 10:00 a.m., reflected "Policy...The facility will provide routine care for the resident for hygienic purposes and for the psychosocial well-being of the resident...Routine care also includes nail hygiene services including routine trimming, cleaning and filing. Routine nail hygiene may be performed in conjunction with bathing or performed separately. Care for ingrown or damaged nails will be provided on an individual care need basis. These services are provided by the facility as part of regular grooming care. Procedure: 1. Routine Nail Hygiene. a. Residents will have routine nail hygiene and hair hygiene as part of the bath or shower. i. Nails should be			

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	trimmed immediately after bathing or alternatively, soaking nails in warm soapy water prior to trimming or filing to reduce tearing and provide ease of trimming or filing...f. Ingrown nails including toe nails and finger nails will be reported to the nurse. i. The nurse will inspect the nails and obtain a podiatrist consult if indicated. ii. Resident with a diagnosis of diabetes will have podiatrist referral for trimming of nails, ingrown nails, calluses, or corns." This Federal Tag relates to Complaint IN00349986 and IN00351305. 3.1-47(a)(7)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that			

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	catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview and record review, the facility failed to ensure 1 of 3 residents reviewed with an urinary catheter received appropriate treatment and services to prevent urinary tract infections (Resident Q). Finding includes: During an observation, on 4/28/21 at 9:50 a.m., Resident Q was in a wheelchair being escorted into his room from the common area by an unidentified staff member. His urinary catheter drainage bag was touching the floor under his wheelchair and was not in a privacy bag. Dark yellow urine was visible inside the bag. Qualified Medication Aide (QMA) 3 entered the room and indicated the collection bag should be off the floor and "he needs a bag." Resident Q's medical record was reviewed on 05/03/21 at 12:30 p.m. Diagnoses included, but were not limited to, Parkinson's disease, acute kidney failure, hydronephrosis (excess fluid in a kidney due to a backup of urine), neuromuscular dysfunction of the bladder and acute pyelonephritis (inflammation of the kidney due to a urinary tract infection).	F 0690	1. Resident Q was not harmed and does not have a UTI. 2. All residents with an indwelling catheter have been assessed for a UTI. Any findings will be communicated to the physician for treatment. An audit was conducted of all residents with an indwelling catheter to validate the bag and tubing were positioned off the floor. 3. All nursing staff have been educated on Catheter Drainage Bag and Tube Maintenance. 4. The DNS/designee will complete an audit 3 times a week for 8 weeks validating residents with an indwelling catheter have the bag and tubing positioned correctly. Any finding s will be corrected immediately and education with staff member rendered. All findings will be reported to the QAPI committee monthly and the QAPI committee will determine when 100% compliance is achieved or if	06/02/2021

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	Resident Q's quarterly minimum data set (MDS) assessment, dated 4/08/21, indicated he had a moderately impaired cognitive status, required extensive assistance by one to two people for activities of daily living and had an indwelling urinary catheter. Resident Q's primary health physician progress note, dated 4/20/21, indicated the physician spoke with the resident's spouse regarding concerns "including the possibility of another UTI [urinary tract infection]." The resident's Nurse Practitioner progress note, dated 4/14/21, noted he was on an antibiotic for a UTI. Resident Q's care plan, revised on 4/13/21, reflected he had urinary incontinence and a UTI. It was not updated to reflect he had an indwelling urinary catheter. During an interview, on 4/29/21 at 4:00 p.m., the Regional Nurse Director indicated urinary catheter collection bags should remain off the floor. If the catheter collection bag was not designed to prevent visualization of its contents, the bag should be covered for privacy. A current facility policy, titled "Catheter Drainage Bag and Tube Maintenance," dated 4/20/17 and provided by the Executive Director on 4/29/21, reflected "...Definitions...Privacy bag/covered bag: an outer covering made from cloth or disposable materials that provides for dignity for the resident and prevents the spreading of infection...Procedure... g. Drainage bags will be covered when the resident is out of the room for dignity and infection prevention purposes... i. Drainage bags will not be placed on the floor...."		ongoing monitoring is required.	

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	The Federal Tag relates to Complaint IN00349986. 3.1-41(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 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 2 of 3 residents reviewed who received hydration by gastrostomy tubes (feeding tubes) were offered sufficient fluid intake to maintain proper hydration and health. (Residents G and P) Findings include: 1. During an observation, on 4/27/21 at 12:04 p.m., Licensed Practical Nurse (LPN) 6 put 30 milliliters (mls) of water in a disposable cup and 200 mls in a	F 0692	1. Resident G and P were not harmed. Physician and family members were updated. 2. All nurses have completed a skills competency on Enteral Feeding Tube/G-tube Flushing to include required documentation. 3. All nurses will be educated on Enteral Feeding Tube/G-tube Flushing and complete the skills competency to include documentation requirements.	06/02/2021

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	second disposable cup. The LPN then crushed 3 pills: two, 325 milligram (mg) tablets of acetaminophen and one, 4 mg tablet of ondansetron (used to treat nausea and vomiting). She added a small amount of water from the cup containing 30 ml of water to a pill dispenser cup containing the crushed pills. LPN 6 then administered 10 mls of water into Resident G's feeding tube. Next, she administered the three crushed pills mixed with water and flushed the feeding tube with another 10 mls of water. The LPN then administered 10 ml of liquid guaifenesin (used to treat mucus) and administered the remaining amount of water from the 30-ml cup (less than 10 ml). Next, LPN 6 administered Resident G's nutrition, 8 ounces of TwoCal, and then flushed 200 mls of water into the resident's feeding tube. Resident G's physician orders, reviewed on 4/30/21, included the following: "four times a day for enteral feed - Tube feeding is TwoCal @ 237 mls via bolus: flush feeding tube with 120 mls of water before and after tube feeding administration. Every shift for enteral feed - Flush feeding tube with 60 mls of water before and after medication administration and 10 mls between each individual medication." During an interview, on 4/27/21 at 2:40 p.m., LPN 6 indicated she flushed 10 ml's of water before and after Resident's G's pills and after administering his liquid guaifenesin. She administered 200 mls of water after his bolus feeding of TwoCal, for a total of 230 ml's of water. She should have administered 60 mls of water before and after his medications and 120 mls of water before and after his bolus feeding for a total of 300 mls of water.		4. The DNS/Designee will observe 3 nurses a week for 8 weeks administering enteral tube feeding, medications, and flushes. Any concerns will be addressed immediately and education rendered. All findings will be reported to the QAPI committee monthly and the QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	Resident G's medical record was reviewed on 04/30/21 at 8:59 a.m. Diagnoses included, but were not limited to, epilepsy, dysphagia (difficulty swallowing), weakness and pervasive developmental disorder. Resident G's quarterly minimum data set (MDS), dated 3/09/21, indicated he had severely impaired cognitive skills and required total dependence of one to two staff for activities of daily living, such as bed mobility, transfers, dressing and eating. He had an unplanned weight loss of more than five percent, received 51% or more of his nutrition by feeding tube and his average fluid intake per day by feeding tube was 501 ml per day or more. During an interview, on 4/30/21 at 9:35 a.m., the Dietician indicated Resident G's water requirements were 1,365 to 1,596 mls per day. When writing his orders for free-water flushes, she factored in the flushes with feedings and medications. She estimated he should be getting 500 mls of water with his medications and another 800 mls of water flushes with his bolus feedings. His bolus feeding of TwoCal would provide another 664 mls of water in a 24-hour period. Resident G's MAR, for April 2021, reflected an order to document the resident's total intake of water every shift. The following 22 entries were blank: the day shifts, on 4/10/21, 4/12/21, 4/17/21, 4/18/21, and 4/23/21. the evening shifts, on 4/5/21, 4/27/21, 4/15/21, 4/17/21, 4/18/21, 4/19/21, 4/22/21, 4/23/21; 4/26/21, 4/27/21, 4/29/21 and 4/17/21. the night shifts, on 4/12/21, 4/14/21, 4/18/21, 4/19/21, and 4/26/21.			

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	For the remaining dates, nurses charted the following total quantities of water in a 24-hour period (across three shifts): 590 mls on 4/28/21; 600 mls on 4/05/21, 4/08/21, 4/11/21, 4/13/21, 4/21/21 and 4/24/21; 640 mls on 4/20/21 and 4/25/21; 680 mls on 4/09/21; and 720 mls on 4/01/21, 4/2/21, 4/3/21, 4/18/21. Resident G's Medication Administration Record (MAR), for April 2021, reflected 24 entries were blank for the order: flush feeding tube with "120 mls of water before and after tube feeding administration," scheduled for 5:00 a.m., 11:00 a.m., 5:00 p.m., and 11:00 p.m. - 5:00 p.m. on 4/05/21; 5:00 p.m. in 4/07/21; 5:00 a.m. on 4/13/21; 11:00 p.m. on 4/14/12; 5:00 a.m. and 5:00 p.m. on 4/15/21; 5:00 a.m., 11:00 a.m. and 5:00 p.m. on 4/17/21; 5:00 p.m. and 11:00 p.m. on 4/18/21; 5:00 a.m., 5:00 p.m. and 11:00 p.m. on 4/19/21; 5:00 a.m. on 4/20/21; 5:00 p.m. on 4/22/21; 11:00 a.m. and 5:00 p.m. on 4/23/21; 5:00 p.m. and 11:00 p.m. on 4/26/21; 5:00 a.m. and 5:00 p.m. on 4/27/21; 5:00 p.m. on 4/29/21; and 5:00 p.m. on 4/30/21. Resident G's MAR, for April 2021, reflected 22 entries were blank for the order: "four times a day for enteral feed ...TwoCal give 237 via PEG-tube [feeding tube]" scheduled for 5:00 a.m., 11:00 a.m., 5:00 p.m., and 11:00 p.m. -			

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	5:00 p.m. on 4/05/21; 5:00 p.m. in 4/07/21; 5:00 a.m. on 4/13/21; 11:00 p.m. on 4/14/12; 5:00 a.m. and 5:00 p.m. on 4/15/21; 5:00 a.m., 11:00 a.m. and 5:00 p.m. on 4/17/21; 5:00 p.m. and 11:00 p.m. on 4/18/21; 5:00 a.m. and 5:00 p.m. on 4/19/21; 5:00 a.m. on 4/20/21; 5:00 p.m. on 4/22/21; 11:00 a.m. and 5:00 p.m. on 4/23/21; 5:00 p.m. and 11:00 p.m. on 4/26/21; 5:00 a.m. and 5:00 p.m. on 4/27/21; and 5:00 p.m. on 4/29/21. Resident G's MAR, for April 2021, reflected 21 entries were blank for the order "flush feeding tube with 60 mls of water before and after medication administration and 10 mls between each individual medication:" the day shifts, on 4/10/21, 4/17/21, 4/18/21 and 4/23/21; the evening shifts, on 4/05/21, 4/07/21, 4/15/21, 4/17/21, 4/18/21, 4/19/21, 422/21, 4/23/21, 4/26/21, 4/27/21 4/29/21, and 4/30/21; and the night shifts, on 4/12/21, 4/14/21, 4/18/21, 4/19/21, and 4/18/21. Resident G's Nutritional Assessment, dated 3/9/21, indicated his total fluid estimated needs were 1,300 to 1,596 mls of water. He was projected to receive 664 ml of water from his formula, and 800 ml of water from flushes for a total of 1,464 mls of water in a 24-hour period plus an undocumented amount of projected water from flushes with his medications. Resident G's care plan, revised on 10/06/21, reflected he had a potential for fluid deficit related			

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	to tube feeding. Interventions included to obtain lab tests per physician orders and provide initial/brief nutrition education for the family/significant others about the importance of consuming adequate fluids. 2. During an observation, on 04/28/21 at 12:00 p.m. to 12:45 p.m., Registered Nurse (RN) 7 administered Resident P's tube feeding as follows. She flushed 30 mls of water into his feeding tube, 12 ounces of Jevity 1.5 nutrition (1 and ½ 8-ounce containers) and 75 mls of water. Resident P's medical record was reviewed on 4/29/21 at 10:30 a.m. Diagnoses included, but were not limited to, congenital trachea-esophageal fistula (abnormal connection of places between the esophagus, the tube which leads from the throat to the stomach, and the trachea, the tube which leads from the throat to the windpipe and lungs), dysphagia (difficulty swallowing) and presence of gastrostomy (feeding tube). Resident P's physician's orders included the following. Give 350 ml of Jevity 1.5 Cal/Fiber liquid (nutritional supplement) via feeding tube four times a day with 75 ml of water pre and post-feeding via feeding tube, ordered on 4/26/21. Document total intake of formula and water every shift, ordered on 4/27/21. Resident P's Nutritional Assessment, dated 4/27/21, indicated he should receive 1,350 mls of water from flushes, 1,064 ml of water from his formula and a 100 mls from flushes with medications for a total projected water intake from formula(s) and flushes of 2,514 mls. Resident P's MAR, for April 2021, indicated nurses charted the following total quantities of			

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	water in a 24-hour period (across three shifts): 240 mls on 4/27/27 and 265 on 4/28/21. There were 3 blank areas for the order to administer 8 ounces of Jevity 1.5 Cal/Fiber Liquid five times a day for 5:00 a.m. on 4/24/21, 4:00 p.m. on 4/25/21 and 4:00 p.m. on 4/26/21. During an interview, on 4/30/21 at 3:30 p.m., the Dietician indicated Resident P needed 2,021 to 2,040 ml of water a day. During an interview, on 04/29/21 at 4:30 p.m., the Regional Nurse Director (RND) indicated she was unable to find explanations for the missed documentation on 4/25/21 and 4/26/21. The nurses' documentation of his fluid intake could not be correct; the nurses must not understand how to document his intake. A current facility policy, titled "Enteral Feeding Tube/G-tube Flushing," dated 4/05/19 and provided by the RND on 4/31/21 at 2:40 p.m., indicated "...Instill the amount of flush ordered using the ordered solution...a. documentation to include but not limited to: i. the flush for liquid totals...." This Federal Tag relates to complaint IN00349986. 3.1-44(a)(2)			
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each			

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	resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observations, interviews and record reviews, the facility failed to provide sufficient numbers of nurses and nurse aides to provide care to 3 of 5 residents reviewed who required assistance with activities of daily living (Residents N, R and M) and one randomly observed resident who received intravenous medications (Resident P). Findings include: During an interview, on 4/30/21 at 10:09 am., the Regional Nurse Director (RND) indicated Certified Nurse Aides (CNAs) were responsible for providing toenail care to residents who did not have diabetes or refused podiatry services after consulting with the nurse about the residents' health status, such as circulation, diabetes or the condition of the nails. The CNAs were expected to	F 0725	1. Residents N, R, M, and P were not harmed. 2. All residents have the potential to be affected. The facility has implemented a recruiting initiative for licensed nurses, QMAs, and C.N.A.s. The facility is employing agency staff to maintain appropriate staffing numbers. 3. All licensed nurses and QMAs will be in-serviced on medication administration and Foot Care. All staff will be in-serviced on answering call lights 4. The staffing schedule will be reviewed daily with the Administrator, DON, Human Resources manager, and staffing	06/02/2021

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	perform nail care during showers. 1. During an observation and interview, on 04/26/21 at 9:05 p.m., Resident N was lying in bed. Her toenails were long and sharp and had scants amount of chipped red nail polish. Resident N indicated her toenails were a mess and she was embarrassed by them, "I need them cut." The skin on her feet were dry and flaky. During an interview, on 04/30/21 at 12:13 p.m., Resident N indicated she had been a resident at the facility for one and a half years and no one had trimmed her toenails. She was so embarrassed of her feet she would tuck them under her sheets. "I was so ashamed." She tried to do it herself, but because of her weight and a hernia, she could not bend down to her feet. Resident N's medical record was reviewed on 4/30/21 at 4:00 p.m. Diagnoses included, but were not limited to, morbid obesity, arthritis and major depressive disorder. The diagnoses did not include diabetes. Resident N's quarterly minimum data set (MDS) assessment, dated 2/14/21, reflected she had no cognitive impairment. She required extensive assistance by two people for personal hygiene and total dependence by two people for bathing. Resident N's care plan, revised on 10/06/20, reflected she had an activities of daily living (ADL) self-care deficit related to weakness, limited range of motion, obesity and recent hospitalization. She required staff participation for personal hygiene and bathing and preferred bed baths three times a week. The care plan did not address nail care.		coordinator to validate appropriate staffing numbers and identify the distribution of staff based on resident needs. The DON/Designee will report all findings to the monthly QAPI committee. The QAPI committee will determine when compliance is achieved or if further monitoring is required.	

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	2. During an observation and interview, on 4/29/21 at 9:05 a.m., Resident R had long, yellow and sharp toenails. He indicated someone trimmed his toenails for him, but "it's been a while." Resident R's medical record was reviewed on 5/3/21 at 2:00 p.m. Diagnoses included, but were not limited to, cerebral infarction (stroke), hemiplegia and hemiparesis (paralysis). His diagnoses did not include diabetes. Resident R's quarterly MDS, dated 1/01/21, reflected he had no cognitive impairment. He required extensive assistance by one person for personal hygiene and total dependence by one person for bathing. He had impaired range of motion on both upper and lower extremities. Resident R's care plan, revised on 10/07/20, reflected he had an ADL self-care performance deficit related to left hemiplegia, impaired balance and limited mobility related to a cerebral vascular accident. He required staff participation with bathing. The care plan did not address personal hygiene or nail care. During an interview, on 4/30/21 at 10:009 a.m., Social Worker (SW) 2 indicated Resident R declined to sign consent for podiatry services on 5/29/20. The CNAs were expected to ask his nurses and him if they could trim his toenails. 3. During an observation, on 4/28/21 at 9:25 a.m., CNA 8 was entering Resident M's room to provide incontinent care. She requested help from CNA 9. CNA 9 obtained linens from the clean linen room and returned to the resident's room. CNA 8 indicated she needed help because the resident sometimes had spasms during care. CNA 10 came up to CNA 9 and angrily indicated they needed			

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	her on another unit. CNA 9 angrily left the unit. CNA 8 asked Qualified Medication Aide (QMA) 3 to help provide care to Resident M, but the QMA was in the middle of administering medications. CNA 8 closed the door and provided incontinent care without assistance. Resident M's medical record was reviewed on 4/29/21 at 3:38 p.m. Diagnoses included, but were not limited to, paraplegia, osteomyelitis (inflammation of the bone caused by infection), unstageable pressure ulcer to his sacral region and urine retention. He had a suprapubic urinary catheter (a tube inserted into the bladder through a cut in the stomach to drain urine). Resident M's quarterly MDS assessment, dated 4/23/21, indicated he had no cognitive impairment. He required extensive assistance by two people for bed mobility and personal hygiene. Resident M's care plan, revised on 3/01/21, reflected he had ADL self-care performance deficit related to paraplegia. He required two staff for assistance with bed mobility. During an interview, on 4/29/21 at 12:55 p.m., Resident M indicated on Saturday (4/24/21), the nurse could not flush his urinary catheter tube. He had an appointment with a urologist to address the issue. The doctor told him, if the urine could not go through the catheter tubing, it would go through the path of least resistance, the penis. Last night, he was wet and asked the CNA to clean him up. The CNA told him he was not wet and refused to change him. He asked again, and the CNA refused. By morning, he was soaked with urine. During an interview, on 4/29/21 at 1:18 p.m., an			

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	anonymous CNA indicated there were not enough CNAs on the units. When asked what she was not able to do because she did not have time, she stated, "we don't do nail care." Other staff, like the nurses, did not help the CNAs. Residents were not cleaned up properly, for example, she found food under a resident's arm pits. Every morning, when she came to work, Resident M "is reeking of urine and feces," because he was not cleaned from the previous shift. The CNA sometimes had no help to provide care to residents who required two peoples to assist with activities of daily living. During an interview, on 4/30/21 at 2:00 p.m., a second anonymous CNA indicated she could only trim residents' nails on her slow days. There was no record, e.g., assignment sheet, of which residents' toenails she could trim and no place to document nail care was performed. 4. During an interview, on 4/27/21 at 10:30 a.m., Resident P complained no one came last night and turned off his intravenous (IV) pump, "it beeped all night." He used his call light, and someone came and said they'd tell a nurse. Two hours later, he pushed his call light and the same thing happened. They said they would call a nurse, but the nurse did not come. He just took out the tubing from his arm and turned off the pump himself. He had been at the facility for five days and felt like he was being treated like a machine, not a human. During an observation, on 4/27/21 at 10:30 a.m., Resident P had an IV pump next to his bed with two empty bags of IV fluid. Resident P's medical record was reviewed on 4/29/21 at 10:30 a.m. Diagnoses included, but were			

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	not limited to, congenital trachea-esophageal fistula (abnormal connection of places between the esophagus, the tube which leads from the throat to the stomach, and the trachea, the tube which leads from the throat to the windpipe and lungs), dysphagia (difficulty swallowing), muscle weakness, anxiety disorder and depressive episodes. Resident P's medication administration record (MAR), for April 2021, reflected ertapenem (antibiotic) was scheduled to be administered in the evening by IV at 8:00 p.m. During an interview, on 05/03/21 at 4:00 p.m., the Nursing Staff Scheduler (NSS) indicated she scheduled staff to the building (census) with a goal of 3.5 staff per patient day (PPD). For a census of 83 residents, she multiplied 83 by x 3.5 PPD, which was 290.5 hours, Staff worked 8 hours shifts and 290.5 divided by 8 hours meant they needed 36.31 nursing staff. The NSS indicated her calculations to accomplish the goal of 3.5 PPD was 1.95 CNAs multiplied by the census and divided by 8 hours; added to 0.1 QMAs multiplied by the census and divided by 8 hours; added to .87 Licensed Practical Nurses (LPNs) multiplied by the census and divided by 8 hours; added to .58 Registered Nurses (RNs) multiplied by the census and divided by 8 hours. For a census of 83 residents, she needed 20 CNAs, 1 QMA, 9 LPNs and 6 RNs. The NSS indicated two unit managers and the medical records nurse were included in the number of staff providing direct resident care to achieve the 3.5 PPD. The calculations did not change during the			

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	weekend. There was no calculation to determine how to split the staff among the shifts, the NSS just knew night shifts required less staff. The NSS utilized as needed [PRN] staff, agency staff and staff from sister facilities. The facility's staff posting, dated 4/26/21, the night Resident P complained of his IV beeping, reflected the census was 86. There was a 24-hour total of 36 staff: 17 CNAs, no QMAs, 11 LPNs and 1 RN. There was no RNs and 3 LPNs on the night shift. The facility's goal of 3.5 PPD would require 37.6 staff. The facility's staff posting, dated 4/27/21, reflected the census was 85. There was a 24-hour total of 32 staff: 19 CNAs, no QMAs, 9 LPNs and 4 RNs. The facility's goal of 3.5 PPD would require 37.1 nursing staff. The facility's staff posting, dated 4/28/21, reflected the census was 85. There was a 24-hour total of 29 staff: 17 CNAs, no QMAs, 8 LPNs and 4 RNs. The facility's goal of 3.5 PPD would require 37.1 nursing staff. The facility's staff posting, dated 4/29/21, reflected the census was 84. There was a 24-hour total of 30 staff: 18 CNAs, no QMAs, 9 LPNs and 3 RNs. The facility's goal of 3.5 PPD would require 36.75 staff. During an interview, on 4/29/21 at 12:00 p.m., the Executive Director indicated the staff posting form did not reflect the number of hours each staff member worked. One could calculate the total number of hours because the RNs and LPNs worked 8 hours a day and CNAs worked 7.5 hours a day.			

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	A current facility policy, titled "Staffing in a Crisis Situation," dated 3/25/20 and provided by the Executive Director on 4/27/212 at 12:30 p.m., reflected "...Staffing the facility in the event of an emergency, where staff are unable to work due to weather conditions and/or an outbreak of infection: 1. During an emergency type situation, the management team will monitor staffing availability on a daily basis to assure adequate numbers of staff members are present to assist with patient care...." This Federal Tag relates to Complaints IN00351155, IN00351305 and IN00351920. 3.1-17(a)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of			

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	each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on record review and interview, the facility failed to post the total number and actual hours worked of licensed and unlicensed nursing staff directly responsible for resident care per shift daily. Finding includes: During an observation, on 4/27/21 at 10:00 a.m., of the staff numbers posted on the hallway at the main entrance of the facility reflected the census was 85 residents. There were no Registered Nurses (RNs), 5 Licensed Practical Nurses (LPNs), no Qualified Medication Aides (QMAs) and 8 Certified Nurse Aides (CNAs) on the day shift. 2 RNs, 3 LPNs and 7 CNAs on the evening shift. 2 RNs, 1 LPN and 4 CNAs on the night shift. The form did not provide the total number and actual hours worked by nursing staff. During an observation, on 4/28/21 at 10:00 a.m., the census posted in the hallway was 85. The posting reflected there were 2 RNs, 3 LPNs and 8	F 0732	1. No residents were harmed. 2. All residents have the potential to be affected. The total number and actual hours worked by the nursing staff have been added to the Nursing Hours form used to Post nursing hours daily. 3. The Scheduler has been educated on the revised form and posting the total actual hours worked daily 4. The ED/ designee will verify the Nursing Hours are posted daily for accuracy. The QAPI committee will review systematic changes, effectiveness and continued compliance at least one time monthly and ongoing monitoring will be determined as deemed appropriate by the committee. The ED will report to the QAPI committee all findings and the QAPI committee will	06/02/2021

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	CNAs on the day shift. 1 RN, 3 LPNs and 4 CNAs on the evening shift, and 1 RN, 2 LPNs and 3 CNAs on the night shift. The form did not provide the total number and actual hours worked by nursing staff. On 4/29/21 at 11:35 a.m., the Nursing Staff Schedule (NSS) provided the staff numbers posted daily from 03/01/21 to 04/29/21. The form was not completed (was blank) on the following 5 days: 03/26/21, 04/06/21, 04/17/21, 4/22/21 and 4/23/21. The remaining forms did not include the total number and actual hours worked by the nursing staff. During an interview, on 4/29/21 at 11:37 a.m., the NSS indicated she was responsible for completing the posting of staff numbers. The posting only provided the number of staff per shift per day, not the number of hours each staff person worked. Determining the total number and actual hours worked by each nursing staff member would be a Human Resources question. During an interview, on 4/29/21 at 12:00 p.m., the Executive Director indicated the form was given to them to use by their corporate team. It did not include the total number and actual hours worked, but one could do a calculation. RNs and LPNs worked 8 hours a day; CNAs work 7.5 hours a day. The Executive Director did not know how visitors to the facility would be aware of the number of hours in a nursing staff member's shift. The facility did not have a policy or procedure for the staff posting. This Federal Tag relates to Complaints IN00351155, IN00351305 and IN00351920. 3.1-17(b)(1)		determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	155790	A. BUILDING 00 B. WING	05/03/2021

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	3.1-17(b)(3)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes,			

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	organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on interview and record review, the facility failed to maintain medical records which were complete and accurate when 3 of 3 residents reviewed who received nutrition by feeding tube were missing accurate documentation for the administration of their nutrition and water intake. (Residents G, P and B).	F 0842	1. Resident G, B, and P were not harmed. 2. All residents receiving enteral tube feedings and flushes have the potential to be affected. An audit was completed to validate all residents with an enteral feeding and flushes have	06/02/2021

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	Findings include: 1. Resident G's medical record was reviewed on 04/30/21 at 8:59 a.m. Diagnoses included, but were not limited to epilepsy, dysphagia (difficulty swallowing), weakness and pervasive developmental disorder. Resident G's Medication Administration Record (MAR), for April 2021, reflected an order to document the resident's total intake of water every shift. The following 22 entries were blank: the day shifts, on 4/10/21, 4/12/21, 4/17/21, 4/18/21, and 4/23/21; the evening shifts, on 4/5/21, 4/27/21, 4/15/21, 4/17/21, 4/18/21, 4/19/21, 4/22/21, 4/23/21; 4/26/21, 4/27/21, 4/29/21 and 4/17/21; and the night shifts, on 4/12/21, 4/14/21, 4/18/21, 4/19/21, and 4/26/21. Resident G's MAR, for April 2021, reflected 24 entries were blank for the order: flush feeding tube with "120 mls of water before and after tube feeding administration," scheduled for 5:00 a.m., 11:00 a.m., 5:00 p.m., and 11:00 p.m. - 5:00 p.m. on 4/05/21; 5:00 p.m. in 4/07/21; 5:00 a.m. on 4/13/21; 11:00 p.m. on 4/14/12; 5:00 a.m. and 5:00 p.m. on 4/15/21; 5:00 a.m., 11:00 a.m. and 5:00 p.m. on 4/17/21; 5:00 p.m. and 11:00 p.m. on 4/18/21; 5:00 a.m., 5:00 p.m. and 11:00 p.m. on 4/19/21; 5:00 a.m. on 4/20/21; 5:00 p.m. on 4/22/21; 11:00 a.m. and 5:00 p.m. on 4/23/21; 5:00 p.m. and 11:00 p.m. on 4/26/21; 5:00 a.m. and 5:00 p.m. on 4/27/21;		an order for recording the amount of feeding and flush administered. 3. All nurses have completed a skills competency on Enteral Feeding Tube/G-tube Flushing to include required documentation. 4. The DNS/Designee will audit all residents' medication administration record three times a week to validate for administration and documentation of enteral tube feeding, medications, and flushes for 8 weeks. Any concerns will be addressed immediately and education rendered. All findings will be reported to the QAPI committee monthly and the QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	5:00 p.m. on 4/29/21; and 5:00 p.m. on 4/30/21. Resident G's MAR, for April 2021, reflected 22 entries were blank for the order: "four times a day for enteral feed ...TwoCal give 237 via PEG-tube [feeding tube]" scheduled for 5:00 a.m., 11:00 a.m., 5:00 p.m., and 11:00 p.m. - 5:00 p.m. on 4/05/21; 5:00 p.m. in 4/07/21; 5:00 a.m. on 4/13/21; 11:00 p.m. on 4/14/12; 5:00 a.m. and 5:00 p.m. on 4/15/21; 5:00 a.m., 11:00 a.m. and 5:00 p.m. on 4/17/21; 5:00 p.m. and 11:00 p.m. on 4/18/21; 5:00 a.m. and 5:00 p.m. on 4/19/21; 5:00 a.m. on 4/20/21; 5:00 p.m. on 4/22/21; 11:00 a.m. and 5:00 p.m. on 4/23/21; 5:00 p.m. and 11:00 p.m. on 4/26/21; 5:00 a.m. and 5:00 p.m. on 4/27/21; and 5:00 p.m. on 4/29/21. Resident G's MAR, for April 2021, reflected 21 entries were blank for the order "flush feeding tube with 60 mls of water before and after medication administration and 10 mls between each individual medication:" the day shifts, on 4/10/21, 4/17/21, 4/18/21, and 4/23/21; the evening shifts, on 4/05/21, 4/07/21, 4/15/21, 4/17/21, 4/18/21, 4/19/21, 422/21, 4/23/21, 4/26/21, 4/27/21 4/29/21, and 4/30/21; and the night shifts, on 4/12/21, 4/14/21, 4/18/21, 4/19/21, and 4/18/21. The resident's printed MAR included the following chart codes available for nurses to use			

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	when a treatment or medication was not administered: 2 = drug refused, 3 = absent from home, 5 = held/see nurses notes, 6 = hospitalized, 8 = nauseated/vomiting, 9 = other/see nurses notes. 2. Resident P's medical record was reviewed on 4/29/21 at 10:30 a.m. Diagnoses included, but were not limited to, congenital trachea-esophageal fistula (abnormal connection of places between the esophagus, the tube which leads from the throat to the stomach, and the trachea, the tube which leads from the throat to the windpipe and lungs), dysphagia (difficulty swallowing) and presence of gastrostomy (feeding tube). Resident P's physician's orders included the following. Give 350 ml of Jevity 1.5 Cal/Fiber liquid (nutritional supplement) via feeding tube four times a day with 75 ml of water pre and post feeding via feeding tube, ordered on 4/26/21. Document total intake of formula and water every shift, ordered on 4/27/21. Resident P's MAR, for April 2021, indicated nurses charted the following total quantities of water in a 24-hour period (across three shifts): 240 mls on 4/27/27 and 265 on 4/28/21. There were 3 blank areas for the order to administer 8 ounces of Jevity 1.5 Cal/Fiber Liquid five times a day for 5:00 a.m. on 4/24/21, 4:00 p.m. on 4/25/21 and 4:00 p.m. on 4/26/21. During an interview, on 04/29/21 at 4:30 p.m., the Regional Nurse Director (RND) indicated she was unable to find explanations of missed documentation on 4/25/21 and 4/26/21. The nurses' documentation of his fluid intake could not be correct; the nurses must not understand how to document his intake.			

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	3. Resident B's medical record was reviewed on 4/30/21. Diagnoses included, but were not limited to cerebral palsy, dysphagia following a cerebrovascular accident (stroke) and presence of a gastrostomy. Resident B's MAR, for February 2021, reflected 3 entries were blank for the order to document the total intake of formula and water every shift: the day shift on 2/19/21, the evening shift on 2/20/21 and the night shift on 2/12/21. Resident B's MAR, for February 2021, reflected no documentation on 02/08/21 at 4:00 p.m. for the order: "two times a day for supplement, mix Juven [nutritional supplement] in 360 mls of water." A current facility policy, titled "Enteral Feeding Tube/G-tube Flushing," dated 4/05/19 and provided by the RND on 4/31/21 at 2:40 p.m., indicated "...documentation to include but not limited to: i. the flush for liquid totals...." The facility was requested to provide their policy for documenting medication and treatment administration. In response, the Executive Director provided a current facility policy, titled "Medication Administration," dated 4/20/17, on 4/29/21, which included only the following related to documentation "...document reason for PRNs [as needed medications/treatments] given...." The RND provided a current facility policy, titled "Missed Medication Incident," dated 05/18/18, on 05/03/21 at 1:30 p.m. It did not include a procedure for documentation in the resident's record for a missed medication or medication error. During an interview, on 4/29/21, the RND			

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	indicated there should be no blanks in the residents' MARs. This Federal Tag relates to complaint IN00349986, IN00351920 and IN00351305. 3.1-50(a)(1) 3.1-50(a)(2)			