DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155188	A. BUILDING 00 B. WING	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENFIELD HEALTHCARE CENTER	200 GREEN MEADOWS DR GREENFIELD, IN 46140

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: September 6, 7, 8, 11, 12, & 13, 2023 Facility number: 000099 Provider number: 155188 AIM number: 100291140 Census Bed Type: SNF/NF: 115 Total: 115 Census Payor Type: Medicare: 1 Medicaid: 103 Other: 11 Total: 115 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 15, 2023	F 0000	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Andrew Clark	Executive Director	09/29/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	(C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on observation, interview and record review the facility failed to have a care plan meeting and failed to develop a care plan to self administer medications for 2 of 6 residents reviewed for care planning (Resident 10 and Resident 64). Findings include: 1.) During an interview with Resident 10 on 9/06/23 at 1:39 p.m., indicated the facility had never had a care plan meeting to talk about her goals, needs and desires. The resident indicated she had the desire to discharge to an assisted living and other goals she needed the facility to assist her with that she would have talked to the facility about during a care plan meeting. During an interview with Social Services (S.S.) on 9/11/23 at 10:35 a.m., indicated the Social Service Director (S.S.D.) was responsible to ensure care	F 0657	**F657** **Care Plan Timing and Revision** Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1 Residents 10 and 64 were not harmed by the alleged deficient practice. Resident 10 has had a care conference completed.	09/29/2023

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	plan meeting were completed. Care plan meetings were suppose to be completed every 3 months or with a change in condition. S.S. was unsure why one has not been completed for Resident 10. Review of the record of Resident 10 on 9/13/23 at 12:08 p.m., indicated the resident's diagnoses included, but were not limited to, psychosis, Alzheimer's disease, vascular dementia, bipolar disorder, chronic pulmonary disease, hypertension, major depressive disorder, arteriosclerotic heart disease, polyarthritis and chronic migraine. The Quarterly Minimum Data Set (MDS) assessment for Resident 10, dated 9/7/23, indicated the resident was cognitively intact for daily decision making. The resident was consistent and reasonable. 2. The clinical record for Resident 64 was reviewed on 9/13/2023 at 10:55 a.m. The medical diagnosis included chronic obstructive pulmonary disease. An Annual Minimum Data Set Assessment, dated for 6/29/2023, indicated that Resident 64 was cognitively intact. An interview and observation with Resident 64 on 9/7/2023 at 11:36 a.m. indicated that he had his nasal spray on the bedside table and that he would self-administer the medication. A physician order, dated for 12/10/2020, indicated Resident 64 could keep his nasal spray at beside. A self-administration assessment, dated for 3/20/2023, indicated Resident 64 was safe to self-administer his nasal spray. A care plan for self-administration of medications		Resident 64 has had a self-administration assessment completed. The care plan for each resident has been updated accordingly. 2 All residents have the potential to be affected by the alleged deficient practice. An audit of all residents has been completed to determine the date of the last care conference schedule. Any resident that has been found to not have had a care conference in the last 90 days has had a care conference completed. An audit of all residents with a physician order to self-administer medications have been audited to ensure a care plan is in place to self- administer medications. 3 DON/Designee has educated the Social Service department, the MDS department and the care plan team on the Plan of Care Overview Policy with an emphasis on scheduling a care conference quarterly, with any change in condition and as requested by the resident and/or resident representative; as well as incorporating resident preferences and goals in the plan of care. 4 DON/Designee will audit 10 residents weekly x 12 weeks to verify care plan scheduled within 90 days of the last care plan meeting. DON/Designee with	

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	was added to Resident 64's chart on 9/12/2023. An interview with the Director of Nursing on 9/13/2023 at 2:35 p.m. indicated there was no previous care plan for self-administration of Resident 64's nasal spray. A policy entitled, "Resident Self-Administration of Medication", was provided by the Director of Nursing on 9/13/2023 at 11:05 a.m. The policy indicated the care plan will be documented to contain the storage of the medication, responsible party for storage of the medication, documenting the administration of the drugs, and location of where the drugs will be administered. A policy entitled, "Plan of Care Overview", was provided by the Director of Nursing on 9/13/2023 at 11:10 a.m. The policy indicated, " ...The purpose of the policy is to provide guidance to the facility to support the inclusions of the resident or resident representative in all aspects of person-centered care planning and that this planning includes the provision of services to enable the resident to live with dignity and supports the resident's goals, choices, and preferences including, but not limited to, goals related to their daily routine and goals to potentially return to a community setting ...Residents/representatives will be informed of their PoC [plan of correction] in the most understandable manner possible ...offered opportunities to voice their view ...Gestures and actions will be recognized as methods to voice opinions ...will have the right to participate in development and implementation of his/her own PoC including but not limited to ...right to participate in goal establishment and outcomes ..." 3.1-35(a) 3.1-35(d)(1)		review 5 residents with a self-administration of medication order weekly x 12 weeks to verify that a care plan is in place. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during the QAPI Meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance Date of completion: 9/29/23	

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F 0679 SS=E Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.			
	Based on observation, interview and record review the facility failed to provide an ongoing activity program on the memory care unit for 7 of 9 resident's reviewed for activities (Resident 5, Resident 26, Resident 32, Resident 37, Resident 55, Resident 71 and Resident 77). Findings include: During an observation on 9/6/23 at 1:55 p.m., 6 residents were sitting in the common area, there were no activities occurring on the memory care unit. The TV was on with the volume turned down. Residents were observed talking to themselves. During an observation on 9/6/23 at 2:06 p.m., there were no activities occurring on the memory care unit. Resident 71 was wandering the memory care unit hallway and Resident 26 was wandering into the nursing station. There were no staff present. During an observation on 9/7/23 at 10:52 a.m., there were 6 residents sitting in the common area, there were no activities occurring on the memory care unit.	F 0679	**F679** Activities Meet Interest/Needs Each Resident Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1 Residents 5, 26, 32, 37, 55, 71, 77 were not harmed by the alleged deficient practice. Activities immediately initiated appropriate activities on each memory care unit. 2 All residents on memory	09/29/2023

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	During an observation on 9/7/23 at 1:47 p.m., there were no activities occurring on the memory care unit. Resident 55 and Resident 71 was wandering the memory care unit. During an observation on 9/8/23 at 10:54 a.m., there were 6 residents sitting in the common area, there were no activities occurring on the memory care unit. During an observation on 9/8/23 at 2:04 p.m., there were no activities occurring on the memory care unit. Resident 26 was wandering up and down the hallway and into other resident rooms. During an observation on 9/11/23 at 10:29 a.m., 6 residents were sitting in the common area, there were no activities occurring on the memory care unit. During an observation on 9/11/23 at 2:37 p.m., 7 residents were sitting in the common area, there were no activities occurring on the memory care unit. During an observation on 9/12/23 at 11:11 a.m., 6 residents were sitting in the common area, there were no activities occurring on the memory care unit. Resident 26 was wandering the memory care unit and in and out of other resident rooms. During an interview with CNA 1 on 9/12/23 at 11:13 a.m., indicated the memory care unit was her normal work area. CNA 1 indicated there were not enough activities on the memory care unit. The CNA's try to do things with the residents, but the memory care unit needed an assigned activity person. CNA 1 indicated the activity department did not take the memory care unit residents		care unit have the potential to be affected by same alleged deficient practice. Activities/Designee initiated appropriate daily activities for the memory care unit with a calendar schedule of future activities. 3 DON/Designee has educated the activities department on the Activities Program policy with an emphasis on activities which are designed to meet the needs and interest of each resident. 4 Activities Director/Designee will observe activities conducted on memory care unit 4 x wk x 12 wks. Activities Director/Designee will report on audits monthly to interdisciplinary team for 3 months during QAPI meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance. Date of completion: 9/29/23	

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outside.

1.) During an observation on 09/07/23 at 10:53 a.m., Resident 5 was sitting by herself at the dining room table, the resident was anxious, crying and screaming there were no activities occurring on the memory care unit.

During an observation on 09/07/23 at 12:38 p.m., Resident 5 was laying in bed screaming. There were no activities occurring.

During an observation on 9/11/23 10:25 at a.m., Resident 5 was sitting in her geriatric chair talking to herself. There were no activities occurring.

Review of the record of Resident 5 on 9/13/23 at 1:50 p.m., indicated the resident's diagnoses included, but were not limited to, schizophrenia, dementia, Parkinson disease, depressive disorder, intellectual disabilities, anxiety and osteoarthritis.

The Annual MDS assessment for Resident 5, dated 3/1/23, indicated the resident was severely impaired for daily decision making.

The activity assessment for Resident 5, dated 11/15/23, indicated the resident likes looking at magazines, colors, watches sports on TV, music, cooking/baking, sitting outdoors, family events

2.) Review of the record of Resident 26 on 9/13/23 at 1:31 p.m., indicated the resident's diagnoses included, but were not limited to, cerebral infarction, vascular dementia, hypertension and major depressive disorder.

The Annual MDS assessment for Resident 26, dated 6/21/23, indicated the resident was severely impaired for daily decision making. It was very

important for the resident to listen to music, be around animals, do her favorite activity and go outside. It was somewhat important for the resident to have books, newspapers, magazines, do things in groups of people and attend religious services.

3.) During an observation on 9/06/23 at 2:02 p.m., Resident 32 was sitting in the common area. There were no activities occurring on the memory care unit.

During an observation on 9/07/23 at 11:03 a.m., Resident 32 was sitting in the common area with 6 other residents. there were no activities occurring on the memory care unit.

Review of the record of Resident 32 on 9/12/23 at 11:40 a.m., indicated the resident's diagnoses included, but were not limited to, dementia with behavioral disturbance, paranoid personality disorder, psychotic disorder with delusions, major depression, cognitive communication deficit.

The quarterly activity assessment for Resident 32, dated 1/7/23, indicated the resident preference was dogs, in the past the resident use to play bingo, read and exercised by walking, baked and cooked with family, keep up with the news, shopping/trips, parties and social events. The resident currently would sometimes do crafts, likes watching TV/ listening to music and spending time outdoors.

The Significant Change Minimum Data Set (MDS) assessment for Resident 32, dated 8/15/23, indicated the resident was severely cognitively impaired for daily decision making. It was very important to listen to music, be around music, do her favorite activity, go outside to get fresh air

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and participate in religious services. It was somewhat important to have books, newspaper, magazines, do things in groups of people and keep up with the news.

4.) During an observation on 9/08/23 at 11:00 a.m., Resident 37 was sitting in the common area with 5 other residents. There were no activities occurring on the memory care unit.

During an observation on 9/08/23 at 1:26 p.m., Resident 37 was laying in bed awake, there no activities occurring, no radio or no TV was on.

During an observation on 9/11/23 at 10:31 a.m., Resident 37 was sitting in the common area with 5 other residents, the resident was hitting self in the face. There were no activities occurring on the memory care unit.

Review of the record of Resident 37 on 9/13/23 at 12:45 p.m., indicated the resident's diagnoses included, but were not limited to, cerebrovascular disease, diabetes, anxiety, major depressive disorder and history of falling.

The Significant Change MDS assessment for Resident 37, dated 6/5/23, indicated the resident was severely cognitively impaired for daily decision making. It was very important for the resident to have books, newspapers, magazine, music to listen to, be around animals, keep up with the news, do things in groups of people, do her favorite activity and go outside.

5.) During an observation on 9/8/23 at 1:29 p.m., Resident 55 was sitting in the common area holding a baby doll. There were no activities occurring on the memory care unit.

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	Review of the record of Resident 55 on 9/12/23 at 12:35 p.m.., indicated the resident's diagnoses included, but were not limited to, vascular dementia with behavioral disturbance, psychotic disorder, diabetes, chronic kidney disease, hypertension, anxiety, chronic obstructive pulmonary disease and major depressive disorder. The Annual MDS assessment for Resident 55, dated 1/23/23, indicated the resident was severely cognitively impaired for daily decision making. It was very important to listen to music, be around pets, do things in groups and attend her favorite activity. It was somewhat important to participate in religious 6.) Review of the record of Resident 71 on 12:29 p.m., indicated the resident's diagnoses included, but were not limited to, psychosis, dementia, schizophrenia, chronic obstructive pulmonary disease, depressive disorder, hypertension, anxiety, insomnia and vitamin D deficiency. The Significant Change MDS assessment for Resident 71, dated 3/29/23, indicated the resident was severely impaired for daily decision making. The plan of care for Resident 71, dated 4/14/21, indicated the resident was dependent on staff for activities, cognitive stimulation, social interaction related to cognitive deficits. The interventions included, all staff to converse with resident while providing care, invite the resident to activities, assist and escort activity functions and thank the resident for coming. The activity assessment for Resident 71, dated 9/24/22, indicated the resident liked dogs, cards, bingo, games, reading, exercise of walking, hunting/fishing, TV/music, shopping, going			

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outside, gardening and social events.

7.) During an observation on 9/07/23 at 12:16 p.m., Resident 77 was laying in bed awake. there no activities occurring, no radio or no TV was on.

During an interview with Resident 77's family member on 9/08/23 at 11:05 a.m., indicated when they visited Resident 77 they never seen any activities occurring on the memory care unit.

Review of the record of Resident 77 on 9/13/23 at 1:20 p.m., indicated the resident's diagnoses included, but were not limited to, dementia, osteoporosis, depressive disorder, anxiety disorder, cognitive communication deficit and chronic kidney disease.

The Annual MDS assessment for Resident 77, dated 2/7/23, indicated the resident was severely cognitively impaired for daily decision making. It was very important for the resident to have books, newspapers, magazines, listen to music, do things in groups of people, do her favorite activities and participate in religious activities. It was somewhat important for her to be around animals, keep up with the news and go outside and get fresh air.

During an interview with the Activity Director on 9/13/23 at 11:40 a.m., indicated the memory care unit did not have assigned activity staff, the one that was assigned on the memory care unit was no longer employed at the facility. The Activity Director indicated she attempted to spend one hour in the morning on the memory care unit and one hour in the evening. The memory care unit did not have an activity calendar at this time, when there was a activity aide assigned on the memory care unit, they have their own activity calendar.

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	The activity program policy provided by the Director Of Nursing (DON) on 9/13/23 at 11:10 a.m., indicated the facility would provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. The activity program was designed to encourage restoration to self care and maintenance of normal activity that is geared to the individual resident's needs, scheduled daily, consist small and large groups which were designed to meet the resident needs and interest of each resident. The activity program would include, but were not limited to, social activity, outdoor activities, activities away from the facility, religious programs, creative activities, intellectual and education activities, exercise and individualized activities. 3.1-33(a) 3.1-33(b)(1) 3.1-33(b)(2) 3.1-33(b)(3) 3.1-33(b)(4) 3.1-33(b)(5) 3.1-33(b)(6) 3.1-33(b)(7) 3.1-33(b)(8)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			

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	Based on observation, interview, and record review, the facility failed to ensure smoking materials were kept in a secure location, per facility policy, for 1 of 3 residents reviewed for smoking. (Resident 86) Findings include: 1. An observation and interview was conducted of Resident 86 on 9/7/23 at 3:36 p.m. There was a green lighter located on his bedside table. Resident 86 indicated he holds his own cigarettes and lighter. No facility staff told him he needed to turn his cigarettes and lighter into the facility. The clinical record for Resident 86 was reviewed on 9/11/23 at 2:58 p.m. The diagnoses included, but were not limited to, alcohol use with alcohol-induced persisting dementia, mood disorder, major depressive disorder, opioid abuse, in remission, and post-traumatic stress disorder. An admission minimum data set (MDS) assessment, dated 8/21/23, indicated Resident 86 was cognitively intact. A smoking assessment, dated 8/14/23, indicated Resident 86 utilized cigarettes, had a diagnosis of dementia, and did not have any adaptive equipment marked. The question to indicate if Resident 86 was independent with smoking was left blank. A smoking care plan, dated 8/15/23, indicated Resident 86 smoked cigarettes. The interventions listed to complete a smoking evaluation, encourage resident to express feelings regarding addiction, and obtain and monitor lab and/or diagnostic studies, as ordered.	F 0689	**F689** Free of Accident Hazards/Supervision/Devices Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1 Resident 86 was not harmed by the alleged deficient practice. DON/Designee conducted updated smoking assessment and determined resident to be independent smoker. Individualized care plan reviewed and updated. The smoking materials were immediately removed from the resident room/person and stored in a secure location. 2 All residents that utilize smoking materials have the potential to be affected by same alleged deficient practice. DON/Designee conducted 100% audit on all smokers in the facility to ensure there were no smoking materials in the resident room or in the possession of the resident.	09/29/2023

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	155188	A. BUILDING 00 B. WING	09/13/2023

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	The smoking policy provided by the Director Of Nursing on 9/13/23 at 10:30 a.m., indicated the facility staff would secure smoking materials in a locked area when not in use by the resident for supervised smokers. 3.1-45(a)(1)		All residents that utilize smoking materials have been educated on the smoking policy and have signed an updated Smoking Policy Acknowledgement form. 3 DON/Designee has educated all staff on the Smoking Policy with an emphasis on the resident is to return all smoking material to a staff member upon completion of smoking activity. 4 DON/Designee will audit 10 residents that utilize smoking materials 5 x wk x 4 wks, then 3 x wk x 4 wks, then weekly X 4wks to ensure that all smoking materials are being maintained by staff and that there are no smoking materials in the resident room or on the resident person. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during QAPI meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance. Date of Completion: 9/29/23	
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.			

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	§483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.			
	Based on interview and record review, the facility failed to follow-up with pharmacy	F 0756	**F756** Drug Regimen Review, Report Irregular, Act on	09/29/2023

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	recommendations and give a rationale for declining a gradual dose reduction (GDR) for 2 of 5 residents reviewed for unnecessary medications. (Resident 13 and Resident 57) Findings include: 1. The clinical record for Resident 13 was reviewed on 9/11/23 at 3:03 p.m. The diagnoses included, but was not limited to, multiple sclerosis, hemiplegia, and benign prostatic hyperplasia. A pharmacy recommendation, dated 3/10/23, indicated the following, "...This resident is currently receiving OXYBUTYNIN ER [extended release] 24 hour medication 5 mg [milligrams] one tablet twice daily...24 hour dose medications should be given once daily...Recommendation...Please review and consider changing to OXYBUTYNIN ER 10 MG ONCE DAILY". The physician response indicated no changes and Urology to follow. Another pharmacy recommendation, dated 5/29/23, indicated the following, "...This resident is currently receiving OXYBUTYNIN ER [extended release] 24 hour medication 5 mg [milligrams] one tablet twice daily...24 hour dose medications should be given once daily...Recommendation...Please review and consider changing to OXYBUTYNIN ER 10 MG ONCE DAILY". The physician response indicated no changes and Urology to follow. There was no documentation that the Urologist was contacted for the recommendations on 3/10/23 and 5/29/23. A visit summary, dated 3/21/23, indicated Resident 13 was seen for a kidney stone by a		Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1 Resident 13 and 57 were not harmed by the alleged deficient practice. Urology was immediately contacted for resident 13 and a follow up appointment has been scheduled. DON obtained order for clarification of medication for resident 57 and all new orders have been implemented accordingly. 2 All residents with a pharmacy recommendation have potential to be affected by same alleged deficient practice. DON/Designee conducted 100% audit on current pharmacy recommendations to ensure all follow up completed and rationales present. 3 RDCO has educated the DON regarding the Medication Regimen Review policy with an emphasis on “if the primary physician or non-physician	

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	Urologist. The medication list had oxybutynin chloride listed for 5 milligrams twice daily for bladder spasm. There was no indication the medication was extended release. 2. Resident 57's record was reviewed, on 9/11/23, at 10:23 a.m. The record indicated Resident 57 had diagnoses that included, but were not limited to, type 1 diabetes mellitus and inflammation of the esophagus. Current physician's orders included, but were not limited to: Omeprazole oral capsule, delayed release, 20 milligrams (mg) by mouth every morning and at bedtime for digestive health. A pharmacy recommendation, dated 5/29/23, indicated "This resident is receiving a proton pump inhibitor (PPI), Omeprazole 20 mg BID (twice a day). Recommendations: Please consider changing to Omeprazole 20 mg once daily. Rationale for Recommendation: Dosing more frequent than once daily significantly increases the risk for adverse effects and medication cost. The risk of fracture was increased in patients who receive high-dose, defined as multiple daily doses. Due to the increased risk of Clostridium difficile infection, the manufacturer recommends use of the lowest dose for the shortest duration appropriate to the indication." The physician/prescriber's response was "No change" with no rationale for the response to decline the recommendation. During an interview, on 9/12/23 at 1:04 p.m., the Director of Nurses indicated the rationale for 5/29/23 was because he had grade D erosive esophagitis. She indicated she had spoken to the Nurse Practitioner, but the rational isn't documented anywhere.		practitioner fails to address the irregularity in a timely manner the director of nursing will escalate the concern to the medical director”. 4 DON/Designee will audit all pharmacy recommendations for follow up completion and rationales present 1 x month x 3 months. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during QAPI meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance. Date of completion: 9/29/23	

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	A policy titled "Medication Regimen Review", revised 2/28/23, was provided by the Executive Director on 9/12/23 at 4:40 p.m. The policy indicated the following, "...Policy...The pharmacist will report any irregularities to the attending physician, the facility's medical director and director of nursing, and these reports must be acted upon in a timely manner that meets the needs of the residents...4. Attending Physician or Non-Physician Practitioner (if state law allows) Responsibilities...b. If there is to be no change in the medication, the attending physician or non-physician practitioner if state law allows must document his/her rationale in the resident's medical record...d. If the attending physician fails or non-physician practitioner if state law allows to address the irregularity in a timely manner the director of nursing will escalate the concern to the medial [sic] director...." 3.1-25(i)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.			

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	(iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure that food was dated, out of date food was removed, and a storage scoop was not stored inside of a container with food. This had the affect 112 of 115 residents who resided in the facility. Findings include: A dietary observation, dated 9/6/2023 at 10:48 a.m., indicated in the dry food storage there was a large storage container with no date on the container, a container of cane sugar dated 1/5/2021, white rice in a container dated for 4/3/2021, flour in a container without a date, a box with an open plastic bag contained tea leaves without a date on it, and a portioning scoop was found inside of the brown sugar. Two additional scoops were hanging on the side of the rack with one labeled as "flour" with a brown granulated substance about an inch deep at the bottom of the hanging container. Numerous boxes were found in the middle of the floor of dry goods. An interview with Dietary Aide 2 on 9/6/2023 at 10:48 a.m. indicated that the dietary staff had not had time to stock the boxes of goods that were delivered on 9/5/2023. She further indicated that she did not believe the dates on the containers of rice and cane sugar were correct, because they would clean the containers when getting new products in but verified no other date was on any	F 0812	**F812** **Food Procurement, Store/Prepare/Serve-Sanitary** Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1 No resident was harmed by the alleged deficient practice. All food that was not dated was immediately disposed of per company policy. All out dated food was immediately disposed of per company policy. Scoop was removed from brown sugar and brown sugar was disposed of and scoop was cleaned and sanitized per company policy. 2 All residents with an oral diet have the potential to be affected by the alleged deficient practice. An audit of the kitchen has been	09/29/2023

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	of the containers. She indicated she did not know the last time the scoops were cleaned or a rotation of cleaning for them. The dietary staff should be labeling all food items when they are opened. An observation of the large refrigeration unit on 9/6/2023 at 10:58 a.m., indicated three pitchers of lemonade with no date, a large container of iced tea with no date, a serving tray of cabbage with a date of 9/2/2023, a large serving tray of cooked macaroni and beef in a sauce with no date, a tray of Italian sausage with a date of 8/30/2023, and turkey with a date of 8/30/2023. An interview with Dietary Aide 2 on 9/6/2023 at 10:58 a.m. indicated that cabbage, macaroni noodles with beef in sauce, Italian sausage, and turkey had a used by date on them and should have all been pulled and disposed of prior to this observation. She indicated they usually do this every day, but they did not have time to do that this morning. She further indicated that all prepared drinks, iced tea and lemonade, should be labeled and dated when it is prepared. An observation of the front refrigeration unit on 9/6/2023 at 11:01 a.m., indicated seven bottles of sour cream with the use by date of 8/31/2023 and potato salad with no date. Dietary Aide 2 removed these items. An interview with the Director of Nursing on 9/13/2023 at 3:04 p.m., indicated that 112 of 115 residents received food from the kitchen. A policy entitled, "Storage of Resident Food", was provided by the Executive Director on 9/12/2023 at 4:40 p.m. The policy indicated, " ...Foods will be stored in a closed container with sealable lids ...Staff will date the container when		completed to ensure that all food is appropriately dated, no outdated food present and there are no scoops present in any multi-use containers. 3 ED/Designee has provided education to all kitchen staff employees regarding the Sanitation and Food Storage policy with an emphasis on maintaining dates on all food items and maintaining a clean, sanitary environment in the kitchen. 4 Dietary Manager/Designee will complete an audit to validate that all food items are dated, there are no outdated food items present and that there no scoops stored in multi-use containers 5 x wk x 4 wks, then 3 x wk x 4 wks, then weekly x4wks. Dietary Manager/Designee will report on audits monthly to the interdisciplinary team for 3 months during QAPI meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance. Date of Completion: 9/29/23	

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	good or beverages are brought into the facility ...The dietary staff will monitor refrigeration storage areas for resident's food monitoring for outdated, unsafe, or otherwise food unfit for consumption ..." 3.1-21(i)(3)			
F 0925 SS=D Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, interview, and record review, the facility failed to ensure an effective pest control program related to mitigation efforts to minimize the potential for ants for 1 of 2 residents reviewed for environment. (Resident 30) Findings include: An observation conducted of Resident 30's room, on 9/6/23 at 3:10 p.m., noted open containers of food with food spillage located on the floor underneath her bedside table. An observation conducted of Resident 30, on 9/7/23 at 10:56 a.m., noted her bending over in attempt to make contact with the floor with her hands. Resident 30 indicated she was trying to "kill the ants". There were approximately 8-10 ants crawling on the floor by Resident 30's feet and the lower part of her bedside table. There were open containers of food and drinks with spillage located on the floor. An observation conducted of Resident 30, on 9/8/23 at 9:40 a.m., noted a couple of ants on the floor and on the legs of her bedside table. There	F 0925	**F925** Maintains Effective Pest Control Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1 Resident 30 was not harmed by the alleged deficient practice. Pest Control was immediately contacted and the resident room was treated according to facility policy. 2 All residents have the potential to be affected by same alleged deficient practice. All	09/29/2023

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	were open containers of food and drinks. Resident 30 indicated she woke up one morning with a container of applesauce left open overnight. There were ants crawling in the applesauce and they also lined her cup. She took a drink of the beverage before she noticed the ants were lining her cup. She wasn't sure if she "drank any or not". The clinical record for Resident 30 was reviewed on 9/12/23 at 2:55 p.m. A quarterly minimum data set (MDS) assessment, dated 8/30/23, indicated Resident 30 was cognitively intact. An interview conducted with the Maintenance Director (MD), on 9/12/23 at 10:15 a.m., indicated he bought a bug killer from the store to use on site if needed. He contact the pest control company and they are going to treat Resident 30's room for ants. Resident 30's room hasn't been treated prior for ants. With ants it was due to leaving food out somewhere. The ants are back today in Resident 30's room, and he was going to spray her room today. The MD stated, "we need to do a better job cleaning the room after meals". An interview conducted with the Executive Director (ED), on 9/12/23 at 12:10 p.m., indicated the pest control company was coming to spray Resident 30's room on 9/12/23. A policy titled "Pest Control", dated 9/15/21, was provided by the ED on 9/12/23 at 4:40 p.m. The policy indicated the following, "...B. If a problem should develop, the Environmental Services Director will contact [name of pest control company] for an additional visit...1. A problem list is hung at the nurse's station for [name of pest control company] personnel to review before starting so special attention can be given to this area...."		resident rooms have been audited to ensure no pests were present and any concerns were immediately addressed per facility policy. 3 ED/Designee will education the maintenance director and maintenance staff regarding the pest control policy. 4 Maintenance Director/Designee will audit, through direct observation, for the presence of any ants, 10 rooms weekly x 8 wks, then 5 rooms weekly x 4 weeks. The maintenance director will audit completion of monthly exterminator visits, per facility policy, 1 x monthly x 3 months. Maintenance Director/Designee will report on audits monthly to the interdisciplinary team for 3 months during QAPI meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance. Date of completion: 9/29/23	

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	3.1-19(f)(4)			