STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. BUILDING 00 B. WING	10/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEST BEND NURSING AND REHABILITATION	4600 W WASHINGTON AVE SOUTH BEND, IN 46619

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 17, 18, 19, 20, 21, 24 and 25, 2022 Facility number: 000246 Provider number: 155355 AIM number: 100275420 Census Bed Type: SNF/NF: 55 Total: 55 Census Payor Type: Medicare: 1 Medicaid: 40 Other: 14 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 11/7/22.	F 0000	**Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement**	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Emily Bailey	Executive Director	11/23/2022

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	environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, record review and interviews, the facility failed to ensure 1 resident in a sample of 24 received feeding assistance and/or supervision to maintain their dignity during meals. (Resident 38) Findings include: During an observation of the noon meal service,	F 0550	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** · Resident 38 was reviewed by RD and found to have no concerns with intake or weight loss. Care Plan updated to show preference	11/15/2022

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	conducted on 10/21/2022 at 12:10 P.M. a nursing staff member delivered a meal tray to Resident 38, who was seated in the dining room at a table in the corner. The tray cover was removed but the food was not set up for the resident and his silverware remained wrapped in his napkin. The staff member exited the dining room to continue passing meal trays to resident rooms. Resident 38 was observed to start feeding himself pureed food with his fingers. There were no staff members in the dining room to assist and/or cue the resident to utilize silverware. The resident was noted to drip food onto the front of his shirt and chin. At 12:16 P.M., the Administrator was noted to sit down beside Resident 38 and fed him the rest of his lunch. The resident was not noted to resist the assistance. During an observation of the noon meal, conducted on 10/24/2022 at 12:32 P.M., Resident 38 was observed seated in his wheelchair in his room. A bath towel had been wrapped around his chest area and his food tray was noted to be on his overbed table in front of him. There were no staff noted in his room and the resident was observed to dip his fingers into a white pureed food item and then lick his fingers. At 12:36 P.M., Resident 38 appeared to have fallen asleep and was noted drooling saliva and the white food item out of his mouth. At 12:44 P.M., CNA 46 walked by Resident 38's room and noticed he was sleeping. She entered his room, woke him up, asked if he needed help and then left the resident's room. The resident was then observed to once again, dip his fingers into his pureed food. At 12:51 P.M., Employee 25 was noted to be seated beside Resident 38 in his room. The staff member was holding a spoon of pureed food in her right hand but was noted to be looking at her phone, which she held in her left hand. Although		in trying to feed himself with his fingers. OT to evaluate for adaptive equipment and Speech to evaluate for diet consistency. Staff were educated on feeding assistance and queuing. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** · All residents requiring feeding assistance could be affected by this deficient practice. DNS or Designee will ensure that all residents who require assistance or queuing are provided with the appropriate assistance. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** · Director of Nursing Services (DNS) or Designee will in-service nursing staff on assisting those who require feeding assistance. Not placing their tray in front of them until someone is able to assist them. DNS/Designee will round during each meal to ensure residents are receiving the appropriate assistance per care plan. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	Employee 25 was holding a spoon of food, Resident 38 was continuing to dip his fingers into his pureed dessert. CNA 16, who was feeding Resident 38's roommate, indicated Resident 38 did not always like to be fed, liked to try to feed himself but really needed help to eat. She indicated when she was assisting Resident 38 to eat, she often used plastic spoons and filled them for the resident and then he was able to take the spoonful of food and feed himself. Resident 38 was asked if he like the pureed vegetable that Employee 25 had placed on the spoon and he shook his head "No.' When Employee 25 asked if he wanted the pureed peaches, Resident 38 shook his head "yes" and accepted a spoonful of the food. Resident 38 was admitted to the facility on 10/02/2012 with diagnoses including, but not limited to: hemiplegia and hemiparesis following cerebral vascular accident of the dominant right side, chronic obstructive pulmonary disease, aphasia, diabetes mellitus, dementia with behavioral disturbance, anemia, hyperlipdemia, muscle weakness, dysphagia, contracture right wrist/hand, cognitive communication deficit, contracture right elbow and right ankle, chronic bronchitis, lack of coordination, gastritis and personal history of nicotine dependency. Review of the most recent Quarterly MDS Assessment, completed on 9/12/2022 indicated the resident required extensive staff assistance of two staff for bed mobility and transfer needs. In addition, the resident required extensive staff assistance of one staff for wheelchair locomotion, dressing, toileting and personal hygiene needs. The resident required limited staff assistance for eating needs.		**recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** · Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the Meal Observation QAPI Audit tool weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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	The current diet order for Resident 38 was for a pureed diet with nectar thick liquids. The resident was to receive his food in bowls for easier self feeding. The current care plan for Resident 38's eating needs included a care plan which addressed the resident's risk for aspiration related to dysphagia. In addition, there was a plan which indicated the resident preferred teat his meals with his hands and declined staff assistance. The plan included interventions to continue to offer and encourage resident to utilize silverware for all meals and/or provide food able to be held in his hands if able, Finally there was a plan to address the resident's need for assistance with Activities of daily living, including eating. The plan had an intervention to provide assistance with eating as needed. During an interview with the Unit Manager/Infection Preventionist, conducted on 10/25/2022 at 11:15 A.M. she indicated staff should "absolutely not" be using their cell phones while feeding residents. During an interview with the Registered Dietician, conducted on 10/25/2022 at 11:39 A.M. she indicated Resident 38 did like to eat with his fingers, did require some assistance and was to receive a pureed diet. Review of the facility policy and procedure, titled, "Meal Service and Distribution" provided by the Administrator on 10/24/2022 at 3:50 P.M. included the following procedures: "...1. Residents will be assisted in the dining room as needed. Positioning and assistance at mealtime must be appropriate for residents' needs...3. Residents' meals are distributed promptly with supervision provided as needed...7. Staff will be available in			

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	the dining rooms during meal service to assist residents with eating and to handle any emergency that might arise...." 3.1-3(a)			
F 0565 SS=D Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to			

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	participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. Based on observation, interview, and record review, the facility failed to ensure a Resident Council concern was addressed and acted on promptly regarding hot foods that were served cold or for cold foods that were served warm, for 4 of 4 Resident Council Meeting minutes reviewed. Findings include: Resident Council Meeting Minutes were received from the Activities Director on 10/19/22 at 11:15 A.M., and reviewed at that time. Resident Council Meeting Minutes dated 6/23/22 at 1:50 P.M., regarding Nutrition Services, indicated residents a concern with meals being served cold and had to ask to have their meals warmed in the microwave. There was no follow-up to the concern in the meeting follow-up notes, and the food temperature concern was not addressed. Nutrition Services did not address the concern. Resident Council Meeting Minutes dated 7/27/22 at 2:30 P.M., regarding Nutrition Services, indicated the temperature of the food was not appropriate. The minutes did not clarify the in what way the food temperatures were not appropriate. The follow-up note dated 7/27/22, indicated, "Residents aware Floor staff can warm up in microwave to their liking." Nutrition Services did not address the concern. Resident Council Meeting Minutes dated 9/14/22	F 0565	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** · Resident council will meet once monthly in private space and invite any IDT per residents preferences. Follow up for concerns will be conducted and acted upon timely. Alert and oriented residents were interviewed to ensure their preferences and needs for meals were being met. Follow up stated concerns with meals/food temps. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** · All residents have the potential to be affected by this practice. Staff educated by the Culinary/CEC/Designee on meals, food temps, or per resident preference of serving. All managers were educated by the ED on following up with resident council recommendations and addressing any concerns timely.	11/15/2022

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	at 1:40 P.M., regarding Nutrition Services, indicated the temperature of the food was not appropriate. The food was cold. The follow-up dated 9/14/22 indicated, "IP [Infection Preventionist], to inservice Floor staff on warming res [resident] trays when needed..." Nutrition Services did not address the concern. On 10/19/22 at 1:15 P.M., during a Resident Council meeting observation, the Resident Council President indicated sometimes the meals trays were served at inappropriate temperatures. Residents in attendance indicated the hot food is not served hot and the cold food is not served cold, and that Nutrition Services had not ever addressed the concern. There were no follow-up notes provided regarding the 10/19/22 Resident Council meeting. On 10/19/22 at 2:00 P.M., an interview with the Activities Director indicated she did not know that Dietary Services where supposed to address the concern of foods being served at inappropriate and apprizing temperatures. On 10/20/22 at 12:52 P.M., The policy titled, Resident Council, dated 1/11 and most recently revised on 2/20, was provided by the Administrator who indicated it was the currant policy. The policy indicated, ..."The council will be used to communicate concerns, give suggestions for future programming and events, and otherwise participate in and guide facility life...Concerns or suggestions from the meeting will be addressed by the appropriate department...The facility responses to concerns/suggestions will be reviewed by the Resident Council President and the resident council on their next meeting..."		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** · Meal Rounds for all meals will be conducted daily Monday through Friday. Weekend managers will observe one meal on weekend duty. The CM/Designee will review all resident council concerns and report to the resident council president with follow up. All follow up will be reviewed by the ED/SED to ensure timeliness and completion. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** · Culinary QAPI conducted weekly x 4 weeks, monthly x 6 months and then quarterly thereafter. If threshold of 90% is not achieved, an action plan will be developed to ensure compliance. Findings will be submitted to the CQI committee for review and follow up. A resident council audit tool will be conducted monthly x 6 months then quarterly thereafter. If the threshold of 90% is not achieved,	

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	3.1-3(g)(l)		an action plan will be developed to ensure compliance. Findings will be submitted to the CQI committee for review and follow up.	
F 0636 SS=D Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning.			

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	(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months.			
	Based on observation, record review and interviews, the facility failed to complete a thorough bladder incontinence assessment for 1 of 1 residents reviewed for incontinence. (Resident 16) Finding includes: During the initial tour of the facility, conducted on 10/17/2022 between 10:00 A.M. - 11:40 A.M., Resident 16 was not observed in his room or on the unit. During an interview with the Director of	F 0636	**What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · A complete and thorough bladder incontinence assessment was completed for Resident 16. **How other residents having the potential to be affected by the same deficient practice will be**	11/15/2022

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	Marketing and Admission, conducted on 10/17/2022 at 11:40 A.M., he indicated Resident 16 was at dialysis. During an interview with alert and oriented, Resident 16, conducted on 10/21/2022 at 2:30 P.M., he indicated he could use the bedside commode when it was placed for him by himself but needed physical assistance to use the toilet in the bathroom. Resident 16 was admitted with diagnoses, including but not limited to: End stage renal disease with dependency on renal dialysis, acquired absence of the left leg below the knee, peripheral vascular disease, hypertension, phantom limb syndrome with pain, , hyperlipidemia, , partial traumatic amputation of finger, osteomyelitis, acquired absence of right leg below knee, clostidium difficile (history of), open wound right lower leg, mild cognitive impairment, dysphagia, anemia, muscle weakness and fatigue. The most recent annual Minimum Data Set (MDS) assessment, completed on 8/8/2022 indicated Resident 16 was occasionally incontinent of his bladder and required supervision for toilet use. The current care plan for Resident 16 regarding toileting needs indicated the resident required assistance for toileting care plan for toileting needs. The care plan indicated the resident was to be offered assistance to toilet upon rising, before/after meals, prior to bed and as needed throughout the night. Review of the IDT Bladder Continence Review, dated 8/10/2022 indicated one form with two questions answered. The first question was: "Is the resident mentally and physically aware of the		**identified and what corrective action(s) will be taken:** · All residents have the potential to be impacted by this deficient practice. A facility audit will be completed by DNS/designee for all residents. All residents identified in this audit will be reviewed and ensure appropriate toileting program is in place per policy. All care plans will be updated based off the bladder incontinence assessments. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The DNS/designee will in-service MDS Coordinator on complete and thorough bladder incontinence assessment. Residents requiring a toileting program will be monitored/reviewed weekly by the DNS/designee to ensure appropriate toileting programs. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance	

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	need to void and able to use a toilet, commode, urinal or bedpan " and "Yes" was marked. The second question was: "Resident is able to resist or inhibit the sensation of urgency, postpone or delay voiding and urinate according to a timetable rather than to the urge to void? " and "No" was marked. The form then listed types of toileting programs to select for the resident, however, "N/A" was marked. During an interview with CNA 22, conducted on 10/25/2022 at 2:11 P.M., she indicated Resident 16 toileted himself. During an interview with the MDS coordinator, conducted on 10/25/2022 at 2:15 P.M. she indicated Resident 16's bladder incontinence assessment did not consider any 3 day individual voiding pattern. She indicated she had not yet implemented tracking forms for bladder and bowel incontinence to assist with completing a thorough bladder incontinence assessment. Review of the facility policy and procedure, titled "Bowel and Bladder Program" provided by the Administrator on 10/24/2022 at 3:50 P.M., included the following: "Each resident will be assessed at admission regarding continence status and whenever there is a change in urinary tract function. The following areas will be considered during the assessment process: prior history of bladder/bowel function, Medications that may effect continence, patterns of fluid intake, Use of urinary tract stimulants, functional and cognitive abilities, Type and frequency of physical assistance needed, Pertinent diagnoses that could effect function, Potential complications related to incontinence, Test or studies (post-void residuals, urine cultures) and Environmental factors restriction access to the toilet. A new 3-day		Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Bladder Program” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up	

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	155355	A. BUILDING 00 B. WING	10/25/2022

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	Voiding/Elimination Pattern will only be completed if there is a change in level of continence including when a catheter is removed....After completion of the 3-Day voiding/elimination pattern, the MDS Coordinator or designee will complete the IDT Bladder Continence review and determine if the resident is a candidate for one of the following: Prompted voiding, Scheduled voiding, Formal bladder re-training program or check and change...." 3.1-33(a)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, record review and interviews, the facility failed to ensure documentation was accurate regarding the wearing of a contracture prevention device for 1 of 3 residents reviewed for limited range of motion and positioning needs. (Resident 44) Finding includes: During the initial observation of the facility, conducted on 10/17/2022 between 10:00 A.M. - 11:40 A.M., Resident 44 was observed seated in a reclining geri chair in her room. Her right harm was noted to be contracted into a tight fist and there was no contracture prevention device noted. The morning care for Resident 44 was observed per staff request on 10/18/2022 at 10:05 A.M. The resident was not offered any positioning device for her contracture. CNAs 18 and 19 were queried as to any splint device and they indicated they did not think the resident utilized any device.	F 0641	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Resident # 44 was reviewed by therapy and due to her refusal to use contracture prevention device, it was discontinued. This resident experienced no negative outcome related to this finding. **How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken:** · All residents have the potential to be affected by this finding. A facility audit was completed by Director of therapy (DOT)/Designee and	11/15/2022

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	They attempted to prop her right arm up with a pillow but the resident refused the pillow. Resident 44 was observed on 10/18/22 at 11:49 AM , seated in her geri chair in her room. Her right hand was completely fisted and there was no contracture prevention device on her right hand or arm. Resident 44 was observed on 10/21/22 at 12:13 P.M ., seated in her reclining geri chair in her room with her lunch tray in front of her. There was no splint device noted to her right contracted hand. Resident 44 was observed, on 10/24/22 at 12:03 P.M., seated in her reclining chair in he room watching television. Her right contracted hand did not have any splint device or contracture prevention device in place. Resident 44 was admitted to the facility with diagnosis, including but not limited to: hemiplegia and hemiparesis following Cerebral vascular accident affecting right side, chronic bronchitis, anemia, hypertension, aphasia, diabetes, hyperlipidemia, morbid obesity, calculus of the kidney, Crohn's disease, depressive episodes, adjustment disorder with mixed anxiety and depressed mood, pseudobulbar affect, anxiety disorder, history of sepsis, contracture of right lowe rleg and left knee, dysphagia, contract right knee, contracture right hand and muscle weakness. The most recent Minimum Data Set assessment, completed on 9/10/2022 for an annual assessment indicated the resident had limited range of motion affected one side for her upper extremities. The current health care plans for Resident 44		DNS/Designee for all residents that wear contracture prevention devices or splints to check for accuracy of assessment and charting on 11/15 and to ensure placement of splint per plan of care. There were no identified concerns related to the audit. **Measures put in place to ensure the deficient practice does not recur:** · DOT/Designee and DNS/Designee will Inservice all nursing staff on accuracy of assessments for contracture prevention devices and splints. · DNS/Designee will round each day to ensure residents with a care plan for splints/contracture reducing device have the contracture prevention device in place **How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality insurance program will be put in place:** DNS/Designee and DOT/Designee will audit three residents x4 weeks, Monthly x 6 months and quarterly thereafter to access for accuracy of assessments related to contracture prevention devices or splints. If a threshold of 100% is not met, an action plan will be implemented. Findings will be reviewed in monthly QAPI committee.	

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	included the following plan: "...Resident to have cone splint to right hand to reduce the risk of further contracture and increase ROM. Splint to be donned by OT for starting wear schedule of 2 hours until patient tolerates increased hours. The plan had interventions for the resident to wear the splint from 7:00 A.M. - 11:00 A.M. daily...." The resident also had a care plan indicating she refused care, including the use of the hand splint. During an interview with CNA 16, conducted on 10/18/2022 at 11:30 A.M., she indicated Resident 44 would refused to have anyone touch her right contracted hand and would not allow staff to apply the hand splint. During an interview with CNA 20, conducted on 10/25/22 at 2:19 P.M., she indicated Resident 44 absolutely refused to have "the splint" placed in her hand. Review of Treatment Administration Record for Resident 44, provided by the Medical Records Nurse on 10/25/2022 at 2:33 P.M. indicated the resident was to have a rolled dry sheet placed in her right hand. The resident was documented as having worn the sheet in place in the mornings on 10/17/2022 and 10/19/2022 - 10/24/2022. The resident was only documented to have refused the contracture prevention device on 10/18/2022 and 10/25/2022. During an interview with LPN 9, on 10/25/2022 at 2:33 P.M. she indicated the nurses should be documenting refused if the resident had refused the device and not documented the device as being applied. The policy and procedure regarding completing treatments was requested on 10/25/2022 at 3:40 P.M. During an interview with the Director of			

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	Nursing Services on 10/25/2022 at 3:50 P.M. she indicated the facility did not really have a policy specific to treatments, except for dressing changes.			
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. (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 interview and record review the facility failed to provide a quarterly care conference for 1 out of 2 reviewed for care planning. (Resident 2)	F 0657	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	11/15/2022

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	Finding includes: A clinical record review was completed on 10/20/2022 at 2:32 P.M., for Resident 2, diagnosis include but not limited to: hypertensive heart and chronic kidney disease with heart failure, type 2 diabetes mellitus with diabetic neuropathy, dementia with behavioral disturbance, and cerebral infarction without residual deficits. During an interview on 10/17/2022 at 10:41 A.M., Resident 2 indicated that she has not had a care plan conference meeting. She was admitted on 5/6/2022 and had her first care conference on 5/13/2022 with her Real Service guardian. During an interview on 10/20/2022 at 3:16 P.M., the Memory Care Support Specialist indicated that she should have had her next care conference on 8/17/2022 and schedules all Real Services conferences on the same day which was 8/9/2022, she was missed. On 10/25/2022 at 9:34 A.M., the Administrator provided a policy titled , "IDT Comprehensive Care Plan Policy", revised on 10/2019, and indicated the policy was the one currently used by the facility. The policy indicated "...Resident, resident's representative or others as designated by resident will be invited to care plan review...." 3.1-35(2)(B)		**practice:** · Residents and representatives have the right to information regarding their care and goals while in the facility. Residents and representatives will be invited to join in a care conference per assessment, changes, and requests. This meeting will include needed members of IDT and documented under care plan summary observations. Identified per survey, 1 of 2 residents reviewed, did not document care conference held on 08/25/2022. IDT note put in since we have confirmation from guardian services that we did hold conference for resident 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken:** · All residents have the potential to be affected by this practice. ED will educate MCSS/SSD on importance of attending scheduled care conferences and inputting care plan summary observations. **Measures put in place to ensure the deficient practice does not recur:** · SSD/MCSS will complete audit of all residents to determine who may need an updated invitation and care conference	

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			scheduled per assessment, changes, or requests. If a resident is missing these items, invitation will be completed, with copies of invite placed in binder and documentation when meeting is conducted. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality insurance program will be put in place:** · Care Conferences QAPI conducted weekly x 4 weeks, monthly x 6 months and then quarterly thereafter. If threshold of 90% is not achieved, an action plan will be developed to ensure compliance. Findings will be submitted to the CQI committee for review and follow up.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review and interview, the facility failed to ensure edema was assessed and interventions implemented for 1 of 1 residents reviewed for edema. (Resident 44) In addition, the facility failed to ensure	F 0684	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	11/15/2022

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	communication and coordination for Hospice services was completed for 1 of 1 residents reviewed for Hospice service. (Resident 20) Findings include: 1. During the initial observation of the facility, conducted on 10/17/2022 between 9:30 A.M. - 9:50 A.M., Resident 44 was observed seated in a geri chair. Her feet were bare and the tops of both feet and the left lower leg and ankle were noted to be edematous Resident 44 was admitted to the facility on 2/16/2017 with diagnosis, including but not limited to: hemiplegia and hemiparesis following cerebral vascular accident affecting right side, chronic bronchitis, anemia, hypertension, aphasia, Type 2 diabetes, hyperlipidemia, morbid obesity, calculus of the kidney, Crohn's disease, depressive episodes, adjustment disorder with mixed anxiety and depressed mood, pseudobulbar affect, anxiety disorder, history of sepsis, contracture of right lowe rleg and left knee, dysphagia, contract right knee, contracture right hand, muscle weakness. The medication regimen for Resident 44 did not include any specific medications to address excess fluid and/or edema. The most recent assessment for skin, completed on 10/19/2022 indicated the resident did not have any edema and/or tenting to skin. The assessment indicated lotion was to be applied to feet. The previous assessment for skin, completed on 10/12/2022 also indicated the resident did not have any edema or tenting of the skin. The medication regimen for Resident 44 did not		· Resident 44 was evaluated by NP. NP noted that resident's legs are at baseline and believed to be adipose deposits and not edema. NP to continue to monitor. · Resident 20 hospice records received and filed in facility. Communication Binders reinitiated in facility. No missed orders found. Resident showed no adverse effects from the concern. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** · All residents have the potential to be affected by the alleged deficient practice. DNS/Designee will conduct an audit to assess for new or worsening edema. No concerns noted from audit. · All residents on hospice were reviewed by DNS/Designeeto ensure hospice documentation was present · Hospice Communication Binder reinitiated for all residents on hospice. No concerns with change in procedures. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** · DNS or Designee will in-service all nursing staff	

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	include any specific medications to address excess fluid and/or edema. LPN 9 was requested to observed and assess Resident 44 for edema on 10/25/2022 at 12:00 P.M. LPN 9 indicated, during an interview that Resident 44 had some visible edema especially around her ankles with more edema noted on the left ankle area. She touched the resident's feet and ankles and indicated the edema was non pitting. A progress note, dated 10/25/2022 at 12:04 P.M., composed by LPN 9 indicated the following: "Resident assessed for edema in right and left feet, and ankles. None pitting edema noted. Resident states it hurts when pressing on her feet. Resident is already on routine pain meds, received her Norco approximately around 10 am. NP (nurse practioner) notified to assess when she arrives to facility." A policy regarding assessing for edema was requested on 10/25/2022 at 12:15 P.M. and was not received. 2. On 10/21/22 at 11:42 A.M. Resident 20's clinical records were reviewed. Resident 20's Face Sheet indicated the resident was originally admitted to the facility on 1/6/2011. The most recent Minimum Data Set (MDS) was a Quarterly Assessment dated 8/16/22 and indicated Resident 20 was most recently admitted to the facility on 5/31/2021 with diagnoses that included, but were not limited to: Parkinson's disease, stroke, schizophrenia, and dementia. The resident had a Brief Interview for Mental Status of 11, indicating moderate cognitive impairment, and was under hospice care.		regarding the timely assessment of new or worsening edema. · Hospice Communication Binder reinitiated for all residents on hospice. · DNS/Designee will review Hospice Communication binder daily to ensure documentation from hospice is available. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** · Ongoing compliance with this corrective action will be monitored through the facility QAPI tool. The DNS/designee will be responsible for completing the QAPI Audit tool “residents change in condition” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up Ongoing compliance with this corrective action will be monitored through the facility Hospice QAPI tool. The DNS/designee will be responsible for completing the QAPI Audit tool weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2	

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	Resident 20's Physician Orders indicated the resident began hospice care 2/2020, and revised orders for hospice care on 5/2/2022. Review of the resident's signed hospice agreement dated 2/19/20, indicated hospice services began 2/2020, Resident 20's Care Plans included, "...Resident requires hospice..." dated 02/20/2020. The Care Plan indicated the resident required, "Hospice Aide visits: 2 times per Week...Hospice Licensed Nurse Visits: 2 times per week..." Review of the resident's Hospice Plan of Care updates, from the hospice service, indicated the most recent hospice update in the resident's medical record was on 8/2/2021. On 10/21/22 at 1:49 P.M., an interview with the Infection Preventionist-Registered Nurse (I.P.RN), indicated she was the Unit Manager for the 2nd floor. The I.P.RN indicated the facility and the hospice service no longer utilized a communication book to document updates concerning the resident. The I.P. RN indicated the hospice facility was supposed to send progress notes to the facility's medical records where they would be uploaded to the resident's medical records, and that the facility had not seen an update from hospice since 2021. On 10/21/22 at 2:18 P.M., an interview with the Director of Nursing indicated the hospice facility was supposed to have faxed over Resident 20's assessment, but the file was too large to send electronically. The Director of Nursing indicated the hospice facility was to train the staff at the facility on how to access the hospice electronic		quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up	

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	records, but has not done so to this date. On 10/21/22 at 2:21, the Director of Nursing provided the current policy titled, Hospice Policy, dated 1/16 and most recently updated on 8/19. The policy indicated, "It is the policy of this facility that when a resident elects the hospice benefit that the contracted hospice company and facility will coordinated to establish both a person centered plan of care reflecting the physical, spiritually, mental and psychosocial needs of the resident as well as a pattern of communication between the hospice company, healthcare professional, facility staff and resident/representative..." 3.1-37(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review, the facility failed to ensure that oxygen tubing and storage bags were dated, tubing placed in a storage bag when not in use, room identifier on the door, and an incomplete oxygen order without a flow rate and parameters. And not administering oxygen when a resident oxygen saturation drops in the 80's, with the lack of documentation and physician notification of a	F 0695	**What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Resident 49 had oxygen administered per physician order. Humidification and tubing were changed and dated and were	11/15/2022

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	change in condition, for 1 of 2 residents reviewed for respiratory. (Resident 49) Finding includes: A clinical record review was completed on 10/19/2022 at 12:35 P.M., for resident 49, diagnoses included but not limited to: vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, acute respiratory failure with hypoxia, shortness of breath, anxiety disorder, and hypertensive heart disease with heart failure. During an observation on 10/17/2022 at 10:00 A.M., the concentrator was turned on with tubing laying across the middle of her bed undated and a bag hanging unlabeled on the machine and no signage was on the door indicating oxygen is in use. During an interview on 10/17/2022 at 2:12 P.M., Resident 49 indicated she wears the oxygen when she is in her room and does not when she leaves the room, she gets short of breath. During an observation on 10/18/2022 at 8:37 A.M., no oxygen signage was on the door, oxygen tubing was undated an hanging over the concentrator and not stored in a labeled storage bag. During an observation on 10/20/2022 at 8:00 A.M., no oxygen signage was on the door, oxygen tubing was undated and hanging over the concentrator and not stored in a labeled storage bag. A Physician Order, dated 9/15/2022, indicated Oxygen at lpm per nasal cannula as needed; PRN		properly stored **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents have the potential to be impacted by this deficient practice. A facility audit will be completed by DNS/designee for all residents that require oxygen. All residents identified in this audit will be reviewed and ensure administration of oxygen per physician order and tubing/humidification has been changed, properly stored and dated. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The DNS/designee will in-service nurses on oxygen administration. Any resident requiring oxygen will be reviewed daily by the DNS/designee to ensure administration of oxygen per physician order and tubing/humidification has been changed, is properly stored and dated appropriately. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	1, PRN 2, PRN 3. A Physician Order, dated 9/15/2022, indicated oxygen sats every shift. On 9/21/2022 at 4:58 P.M., under the vital sign tab signs oxygen saturation indicated she was 83%. The Treatment Administration Record (TAR) indicated on 9/21/2022, 2 P.M. - 10 P.M., an oxygen saturation of 83 %. The TAR dated 9/21/2022, for PRN (as needed) oxygen lpm per nasal cannula was not signed indicating oxygen was administered that shift. During an interview, on 10/20/2022 at 1:25 P.M., the Director of Nursing indicated there should be a magnet on the door if she has a concentrator in the room, tubing and bag dated and stored in bag when not in use, and the order was incomplete there should be a flow rate and parameters for oxygen saturation. If a resident oxygen saturation decreases to the 80's there would be documentation in progress notes, SBAR (Situation, Background, Assessment and Recommendation report) done, a note in vital signs, TAR (Treatment record) signed that oxygen was initiated and physician notified of change in condition. She could not find any documentation or notification to physician and indicated there should have been. On 10/20/2022 at 1:56 P.M., the Director of Nursing provided a policy titled, "Oxygen Therapy and Devices", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Oxygen Safety 1) No smoking signs need to be affixed to the FRONT and BACK of doors (OSHA regulations). Oxygen		**recur, i.e., what quality assurance program will be put into place:** · Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “oxygen therapy” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up	

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	Devices 1) Nasal cannula e. change out weekly and PRN f. Place in a labeled bag when not in use...." On 10/20/2022 at 1:56 P.M., the Director of Nursing provided a policy titled, "MatrixCare Physician Orders Policy", revised 8/2019, and indicated the policy was the one currently used by the facility. The policy indicated "...a. Nurse managers and/or designated nurses will review the physician order report (re-caps) for accuracy, order omissions, and obtain any necessary order clarifications...." On 10/20/2022 at 1:56 P.M., the Director of Nursing provided a policy titled, " Resident Change of Condition Policy," revised 11/2018, and indicated the policy was the one currently used by the facility. The policy indicated "...It is the policy of this facility that all changes in resident conditions will be communicated to the physician and family responsible party, and that appropriate, timely, and effective intervention takes place. a. All symptoms and unusual signs will be documented in the medical record and communicated to the attending physician promptly...." 3.1-47(a)(6)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the			

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	general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, record review and interview, the facility failed to ensure their system to account for and monitor controlled drugs was implemented appropriately for 1 of 2 medication carts reviewed. (Resident 15) Finding includes: During an observation of the narcotic drawer from the secured dementia unit, conducted on 10/25/2022 at 10:05 A.M., there was an unopened bottle of Morphine Sulfate for Resident 15. Review of the medication narcotic count	F 0755	**What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · A facility wide audit completed of controlled substances including storage, labeling, and documentation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	11/15/2022

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	reconciliation forms for the secured dementia unit medication cart indicated there was no form in the book, counted per shift change by incoming and outgoing nursing staff. A handwritten, undated white piece of copy paper was located beside the narcotic medication drawer's locked box. The form had Resident 15's name and the name of the medication and prescribed PRN (as needed) dose written on the form but was otherwise blank. RN 14 indicated Resident 15 was a Hospice patient and perhaps that was why she did not have a narcotic reconciliation form in the book for the nursing staff to count each shift. He indicated he did not know why there was a paper beside the drawer with the resident's name and medication handwritten on the form. He indicated there should have been a form located in the narcotic "book" and the medication amount should have been acknowledged at the beginning and/or end of each shift. Review of the policy and procedure titled, "Storage and Expiration of Medications, Bilogicals, Syringes and Needles," provided by the Administrator on 10/25/2022 at 3:44 P.M. included the following: "...12. Controlled Substances Storage: ...12.2 After receiving controlled substances and adding to inventory, Facility should ensure that Schedule II - V controlled substances are immediately placed into a secured storage area...." There was no specific instructions in the policy and procedure provided to describe the "inventory" form and use. 3.1-25(n) 3.1-25(e)(3)		**action(s) will be taken:** · All residents have the potential to be impacted by this deficient practice. A facility audit will be completed by DNS/designee for all residents. All residents identified in this audit will be reviewed and facility will ensure proper storage, labeling and documentation per policy. All discrepancies will be resolved per policy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The DNS/designee will in-service all licensed nurses and QMA's per policy. All controlled substances will be reviewed weekly by the DNS/Designee to ensure appropriate storage, labeling, and documentation. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool	

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			"Medication Storage Review" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on interview and record review the facility failed to ensure an abnormal involuntary movement scale (AIMS) was completed timely for a new admission on a psychotropic medication for 1 of 5 residents reviewed for unnecessary	F 0757	**What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	11/15/2022

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	medication. (Resident 37) Finding includes: A clinical record review was conducted on 10/19/2022 at 2:29 P.M., for Resident 37, diagnoses included but not limited to: Parkinson's disease, dysphasia following cerebral infarction, dementia with behavioral disturbance, cerebral infarction, and gastro-esophageal reflux disease without esophagitis. The record indicated the resident was admitted on 6/24/2022. A Physician Order, dated 6/24/2022, indicated quetiapine tablet (antipycotic); 25 mg; amt: 25 mg; gastric tube at bedtime. An AIMS was completed on 7/18/2022. During an interview on 10/24/2022 at 8:39 A.M., Director of Nursing indicated an AIMS was not done and should have been done within 72 hours. On 10/24/2022 at 3:30 P.M., the Director of Nursing provided a policy titled, "Psychotropic Management", revised 10/22, and indicated the policy was the one currently used by the facility. The policy indicated "... 8. Potential adverse side effects to psychotropic medications will be observed each shift by a licensed nurse. An AIMS assessment will be completed for residents who are taking antipsychotic medications as a tool to monitor for adverse side effects. The assessment should be completed within 72 hours of a new order to initiate an antipsychotic, within 72 hours of an increase in antipsychotic medication and then every six months while taking antipsychotic medication...." 3.1-48(a)(3)		· Resident 37 had current medication regimen reviewed by attending physician. No new orders or adjustments suggested. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents have the potential to be impacted by this deficient practice. An audit was completed to identify anyone on an Antipsychotic to make sure any changes are followed with an AIMS or that an AIMS was completed within 6 months. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · ED/designee will in-service SSD/MCSS regarding AIMS due with any increase in an antipsychotic or within 6 months of last assessment. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and	

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			Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “unnecessary medications” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which			

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	the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review and interview, the facility failed to ensure medications were labeled, dated when opened and/or disposed of when expired on 1 of 3 medication carts. This deficient practice potentially affected 3 residents. (Residents 12, 15 and 48) Finding includes: During an observation of the medication cart on the secured, dementia unit, conducted on 10/25/2022 at 10:05 A.M., with RN 14, the following was noted: There was a small, partially full vial of injectable Haldoperilol (antipsychotic) without any label or date opened on it. During an interview with RN 14 he indicated he did not know who the vial was for but it had probably been utilized for someone who was having behaviors and used only once. RN 14 did not know why it was still in the medication cart drawer. There were two, opened bottled of Lataprost eye drops labeled for Resident 12. The first bottle had no date to indicate when it had been opened and the second bottle had an opened date of 5/28/2022 on it. RN 14 was unsure how long eye drops remained good after they had been opened. There was an Albuterol Sulfate inhaler that had been opened for Resident 15 but there was no date to indicate when it had been opened. There was a Basaglar insulin pen for Resident 48 with an open date of 9/22/2022. During an interview with RN 14, during the medication cart	F 0761	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · It is the practice of this facility to label drugs and biologicals used in the facility in accordance with currently accepted professional principles. All incorrectly labeled, dated, expired medications were disposed of in accordance with the pharmacy policies. All medications stored appropriately in accordance with the pharmacy policies. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents have the potential to be affected by this finding. A facility audit will be completed by DNS/designee for all medication storage areas to ensure all medications are stored, labeled, and dated correctly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The DNS/designee in-serviced nurses on Medication	11/15/2022

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	observation, he indicated insulin could be used for 28 days after it had been opened. The pen would have expired on 10/20/2022, five days prior. Review of the current facility pharmacy policy titled, "Storage and expiration of Medications, Biological's, Syringes and Needles" provided by the Administrator on 10/25/2022 at 11:50 A.M. included the following: "...5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened.." Review of the current facility pharmacy policy, titled "Medication Storage Guidance," provided by the Administrator on 10/25/2022 at 3:44 P.M. indicated the following: "...Xalatan Opthalmic Solution (Latanoprost) ...date when opened and discard after 6 weeks...Basaglar pen...room temperature...opened 28 days...." 3.1-25(k)(1)(2)(3)(4)(5)(6)(7) 3.1-25(o)		Storage. DNS/designee will conduct daily rounds to ensure medications are stored and labeled correctly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Medication Storage” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;			

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	§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure meals were consistently served at appetizing and safe temperatures for 53 of 55 residents who participated in meal service at the facility, particularly when the facility was aware of food temperature concerns through documented Resident Council Meeting Minutes. Findings include: Resident Council Meeting Minutes were received from the Activities Director on 10/19/22 at 11:15 A.M., the following concerns were noted: Resident Council Meeting Minutes dated 6/23/22 at 1:50 P.M., regarding Nutrition Services, indicated residents a concern with meals being served cold and had to ask to have their meals warmed in the microwave. There was no follow-up to the concern in the meeting follow-up notes, and the food temperature concern was not addressed. Nutrition Services did not address the concern. Resident Council Meeting Minutes dated 7/27/22 at 2:30 P.M., regarding Nutrition Services, indicated the temperature of the food was not appropriate. The minutes did not clarify the in what way the food temperatures were not appropriate. The follow-up note dated 7/27/22, indicated, "Residents aware Floor staff can warm up in microwave to their liking." Nutrition Services did not address the concern. Resident Council Meeting Minutes dated 9/14/22 at 1:40 P.M., regarding Nutrition Services, indicated the temperature of the food was not	F 0804	**What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · It is the practice of this facility to ensure food is prepared and served in compliance with currently accepted professional standards in relation to temperatures. Facility acquired warming plates to keep room trays temperatures at compliance level. Culinary staff will temp foods before and during meal service to ensure food is served at the proper temperature. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents have the potential to be affected by this finding. A meal service audit was conducted by RD/designee for meal tray temperatures and any findings will be immediately corrected. Meal service will be monitored to ensure proper meal service temperature. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	11/15/2022

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	appropriate. The food was cold. The follow-up dated 9/14/22 indicated, "IP [Infection Preventionist], to inservice Floor staff on warming res [resident] trays when needed..." Nutrition Services did not address the concern. On 10/19/22 at 1:15 P.M., during a Resident Council meeting observation, the Resident Council President indicated sometimes the meals trays were served at inappropriate temperatures. Residents in attendance indicated the hot food is not served hot and the cold food is not served cold, and that Nutrition Services had not ever addressed the concern. There were no follow-up notes provided regarding the 10/19/22 Resident Council meeting. On 10/24/22 at 12:32 P.M., during a meal service tray distribution observation, temperature of mechanical meat was served at 119 degrees Fahrenheit (F), green beans were served at 110 degrees, and mashed potatoes were served at 125 degrees. On 10/19/22 at 2:00 P.M., an interview with the Activities Director indicated she did not know that Dietary Services where supposed to address the concern of foods being served at inappropriate and appetizing temperatures. On 10/24/22 at 12:34 P.M., an interview with the Dietary Manager indicated meats should be served at 145 degrees or greater, green beans and mashed potatoes should be served at 135 degrees or greater. 1.3-21(a)(2)		**practice does not recur:** · The CDM/designee in-serviced culinary staff on appropriate meal service temperatures. CDM/designee will conduct daily am check list to ensure food quality and appropriate temperatures. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool "Food Quality" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up	
F 0805 SS=E	483.60(d)(3) Food in Form to Meet Individual Needs			

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	155355	A. BUILDING 00 B. WING	10/25/2022

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Bldg. 00	§483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. Based on observation, interview and record review, the facility failed to ensure the recipe was followed for puree diet for 4 of 4 residents who receive a puree diet. Finding includes: During an observation, on 10/24/2022 at 10:45 A.M., the Culinary Manager made 5 portions of country fried steak placing the meat in the food processor, ground the meat then added 1 and 3/4 cup of hot water and no food thickener. She then scraped it indicated it was thick enough and placed in pan, covered and place in steamer. During an interview, on 10/24/2022 at 10:55 A.M., the Culinary Manager indicated she did not follow the recipe she did not add the thickener cause she did not think it needed it and she added the wrong amount of water. On 10/24/2022 at 3:30 P.M., the Administrator provided a recipe titled, "Pureed Country Fried Steak recipe and indicated it was the one used by the facility dated 9/21/2022. The recipe indicated, " for 5 serving 5 fritters, 3/4 cup 3 tablespoon of hot water, 1 tablespoon 3/4/ teaspoon of food thickener. WASH HANDS 1. Place prepared Country Fried steak in food processor. 2. Add water or broth and process until smooth in texture. 3. Add thickener and process briefly until mixed. Scrape down sides with spatula and reprocess. 4. Pour into steam table pan coated with cooking spray. 5. Cover tightly and heat in conventional	F 0805	**What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · It is the practice of this facility to ensure food is prepared and served in compliance with currently accepted professional standards by following recipes as written. RD and ED provided immediate education to CDM regarding food consistencies. No concerns noted for any of the residents who were served “pureed country fried steak” **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents have the potential to be affected by this finding who have altered diets. A meal service audit was conducted by RD/designee for preparations and consistencies with no concerns noted. Meal service will be monitored to ensure proper food preparation per recipe. **What measures will be put into place or what systemic**	11/15/2022

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	oven at 350? F. until temperature reaches 165? F, HELD FOR A MINIMUM OF 15 SECONDS...." On 10/24/2022 at 3:42 P.M., the Administrator indicated that they did not have a policy on puree diets. 1.3-21(a)(3)		**changes will be made to ensure that the deficient practice does not recur:** · The CDM/designee in-serviced culinary staff on food handling, food storage and kitchen/pantry sanitation. CDM/designee will conduct daily am check list to ensure proper food handling, food storage and kitchen/sanitation. CDM/Designee will review pureed recipe with cook to ensure recipe is followed for each meal. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool "Food Prep" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up	
F 0812 SS=E	483.60(i)(1)(2) Food			

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Bldg. 00	Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure food was stored and prepared in a sanitary manner for 1 of 1 kitchens. In addition, the facility failed to ensure food was stored in a sanitary manner in 1 of 2 nutrition pantries. This deficient practice potentially affected 53 of 55 residents who consumed food. Findings include: 1. During observation on 10/24/2022 at 9:40 A.M., food crumbs were noted on the counter the dishes are drying after being washed. The Culinary Manager lifted up the silverware rack and visible crumbs of food noted. Also noted dirt and debris	F 0812	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · It is the practice of this facility to ensure food is prepared and stored in compliance with currently accepted professional standards. All refrigerators and small appliances will be cleaned and sanitized. All incorrectly labeled, dated, or expired foods were disposed of. Food service rendered per Infection control standards. New Dishwasher	11/15/2022

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	on the floor behind the counter and on the bottom shelf of the drying counter. During an interview on 10/24/2022 at 9:41 A.M., the Culinary Manager indicated there were food crumbs under the clean dishes and should have been cleaned before running the dishwasher. The dishwasher backs up with water and crumbs when you run the machine and it runs down under the clean dishes. She indicated behind the counter on the floor there is visible dirt and the bottom shelf holding the drying dishes is dirty and they should be cleaned. 2. During an observation, on 10/24/2022 at 9:58 A.M., the wash machine was running dishes and the digital reading of the temperature during the wash cycle was at 148 degrees. The Culinary Manager put the machine on pause and the temperature rose to 155 then when she started the machine it went back down to 148. During an interview, on 10/24/2022 at 10:06 A.M., the Culinary Manager indicated the machine is not working correctly the temperature should be between 155-160 degrees during the wash cycle and it was below 150 degrees. 3. During an observation on 10/24/2022 at 3:04 P.M., of the second floor nourishment refrigerator located in the dining room with the Culinary Manager, their was a container of resident food dated 10/17/2022 containing a pork chop with a foul odor, a package of cheese that was not wrapped and dried out with a date of 10/15/2022, and a styrofoam cup with broccoli salad undated. During an interview on 10/24/2022 at 3:06 P.M., the Culinary Manager indicated the food should have been labeled with an expiration date, the		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents have the potential to be affected by this finding. A kitchen and Pantry audit will be completed by RD/designee for kitchen sanitation and any findings will be immediately corrected. Meal service will be monitored to ensure proper food handling. · The dish machine was replaced to ensure it reached the appropriate temperatures. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The CDM/designee in-serviced culinary staff on food handling, food storage and kitchen/pantry sanitation. CDM/designee will conduct daily am check list to ensure proper food handling, food storage and kitchen/sanitation. · RD/Designee will monitor the dish machine to ensure it is meeting the manufacturer's instructions. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	pork should have been disposed of, cheese should have been wrapped, and the broccoli labeled. On 10/24/2022 at 10:27 A.M., the Administrator provided a policy titled, "Cleaning Dishes and Dish Machine", dated 10/17, and indicated the policy was the one currently used by the facility. The policy indicated "... 1. Check thee machine for cleanliness and clean it after each meal or more often as needed. Fill tanks with clean water. Clear detergent trays and spray nozzles of food and foreign objects. Use an acid cleaner on the machine once a week or as needed to remove mineral deposits caused by hard water. Note: Check the dish machine gauges throughout the cycle to assure proper temperatures. Hot Water Machine Type: Single tank, Type of Temperature: dual temperatures , Wash Temperature of Machine: 160 degrees F, Sanitation Temperatures of the Machine: 180 degrees F...." On 10/24/2022 at 10:40 A.M., the Administrator indicated that their machine is a single tank/dual temperature machine. On 10/26/2022 at 12:00 P.M., the Culinary Manager provided a policy titled," Cleaning and Sanitizing", revised 10/17, and indicated the policy was the one currently used by the facility. The policy indicated "... !. Work areas and floors will be kept clean and orderly. Each person will be responsible for cleaning what he or she uses...." On 10/24/2022 at 3:12 P.M., the Culinary Manager provided a policy titled,"Food Brought in by Family and Visitors", and indicated the policy was the one currently used by the facility. The policy indicated "...4) If food must be stored, it will be labeled with the resident's name, the date the item		**recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Food Safety & Sanitation” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up	

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	was brought in, and the date it should be consumed or discarded. These items may be stored in facility pantries, refrigerators or freezers, or resident's personal refrigerators, if applicable. Staff will monitor for food in need of disposal...." 3.1-21			